EXPLORATION OF FACTORS INFLUENCING THE USE OF REPRODUCTIVE HEALTH CARE SERVICES IN CHILD MARRIAGE IN SELECTED VILLAGE DEVELOPMENT COMMITTEES (VDCs) OF DANG DISTRICT, NEPAL

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ABSTRACT

Child marriage is associated with adverse reproductive health outcome for adolescent and young women. Despite national and international initiatives to end child marriage in Nepal, the practice is still alarmingly high to deteriorate the health conditions of women in present situation and future. Very limited studies have been done regarding the health care seeking practices among the child brides in Nepal. With persistence efforts to end child marriage, it is essential to support health of already married adolescent and young women. This qualitative study explores the facilitators and barriers of reproductive health care utilization among child brides in rural villages of Dang district, Nepal. It has specifically focused on the perspectives and experiences of women married as a child and the key informants in the community. The study included thirteen in-depth interviews and four focus group discussions with 17 – 20 years of women and married before the age of 18 years and ten in-depth interviews with key informants from the community. The result is mainly divided into four main groups. They are: perception of health, illness and symptoms of childbirth, experiences in using health care services, determinants of health care accessibility and utilization, and key informant’s suggestions for improving status of early-married women. The facilitators were perceived awareness of own health, motivation after using health care facilities; encouragement provided by the health care personnel and enforced communication about the use health care services among the women in the community. Moreover, the barriers were shyness and embarrassment, transportation and distance of health care facilities, qualities of services, verbal abuse of health care provider and household work overload. Also, recommendations provided by the key informants were the provision of separate health care providers to deal with early-married women, proper training of health care providers, supervision and monitoring of the services and involving male members of the community in awareness campaigns. This study may provide valuable information for further planning and development of the strategies to address the health issues of early-married women and adolescent girls. Additionally, insight into how young married women consider healthcare will helps to understand and design future plans and programs to improve the health status of women married as a child in Nepal.

Key words: Child marriage, Reproductive Health, Utilization, Health care services
<table>
<thead>
<tr>
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<th>Description</th>
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<tr>
<td>PHCC</td>
<td>Primary Health Care Centre</td>
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<td>DOHS</td>
<td>Department of Health Services</td>
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<td>VDC</td>
<td>Village Development Committees</td>
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<td>SHP</td>
<td>Sub Health Post</td>
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<td>FCHV</td>
<td>Female Community Health Volunteer</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>UNICEF</td>
<td>United Nations Children Emergency Fund</td>
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<td>IDI</td>
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DEFINITION OF TERMS

Adolescent: “Adolescence, or the second decade of life, is a period in which an individual undergoes major physical and psychological changes. Alongside this, there are enormous changes in social interactions and relationships. It is a phase in an individual’s life rather than a fixed time period; a phase in which an individual is no longer a child but is not yet an adult.” - (WHO, 1993)

Health system: “A health system is the sum total of all the organizations, institutions and resources whose primary purpose is to improve health.”-WHO

Health services: “Health services are visible functions of any health system including all services related with the diagnosis and treatment of disease, or the promotion, maintenance and restoration of health. Service provision is the inputs such as money; staff, equipment and drugs are combined to allow the delivery of health interventions.”- (WHO)

Reproductive health: International Conference on Population and Development defined “Reproductive health implies as people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.”- (UN, 1994)

Adolescent pregnancy: It is defined as pregnancy in girls aged 10–19 years (Ganchimeg et al., 2014)
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1. INTRODUCTION

Marriage is both social and ritual inevitable norm in Nepal. It is almost a universal phenomenon for both men and women. This practice is carried out comparatively in an earlier age for girls compared to boys. So the age of a girl is vastly linked with the timing of marriage. The practice embedded deep into the society, marriage has involved large numbers of children, especially girls under the age of 18 years, in Nepal depriving them of education, health care services, and human rights.

Sustainable Development Goals proposed target 5.3 “eliminate all harmful practices, such as child, early and forced marriage and female genital mutilations,” under Goal 5 “Achieve gender equality and empower all women and girls.” This has been emphasized to empower women and achieve gender equality (UN, 2015). The global approach and initiative to eliminate child marriage have focused to decrease the vulnerability and empower girls and women.

Nepal is among the top twenty countries in the world with highest rates of child marriage (UNFPA, 2012b). In Nepal, 52 % of 20-49 years of women are married as a child with about 17 % married before the age of 15 years (UNICEF, 2014). According to Nepal Demographic Health Survey, 41 % of women 20-24 years old married by the age 18 years in Nepal (NDHS, 2012; UNFPA, 2012b). Although the prevalence of child marriage persists in the entire country, two regions Mid-western region (53 %) and Far-western region (48%) have the highest prevalence in 2011 (UNFPA, 2012b).

Child marriage exposes adolescent girls into multiple health problems. Child marriage negatively influences the education, health status of the mother and their offspring. They are likely to suffer from depression, cervical cancer, malaria, obstetric fistulas and maternal mortality (Nour, 2009). The girls are left without the support from the society, with limited chances of employment and decision-making power regarding the choice of partner and age at marriage. During the adolescent period, the girls are not matured physically, mentally, and socially for married life (Maharjan, Karki, Shakya, & Aryal, 2012) and this is followed by lack of support from society required for healthy and safe development until maturity (UNFPA, 2015). Their engagement in sexual activity in childhood makes them vulnerable to sexually transmitted infections such as HIV (Nour,
2009), and expose them for early and multiple pregnancies ending up with many children while still young (Godha, Hotchkiss, & Gage, 2013; UNFPA, 2012b; UNICEF, 2014). Child marriage is associated with the termination of pregnancy, unwanted pregnancy, lack of use of family planning devices before first pregnancy and less use of the maternal health care services (Godha et al., 2013; A. Raj, Saggurti, Balaiah, & Silverman, 2009). This study seeks to improve the knowledge of the health care seeking practices among the child brides in Nepal and to explore the facilitators and barriers of reproductive health care utilization among young mothers in rural villages of Dang, Nepal.
1.1 Structure of Thesis

The thesis comprises of six chapters:
Chapter one consists of introduction and literature review consistent with the objectives of the research. The literature review includes the description of the overview of child marriage, consequences of child marriage (adolescent pregnancy, violence and health, the health of newborn child), strategies to improve the health of early-married women, current status of knowledge and gaps and goals and objectives of the study.

Chapter two includes the description of research setting that is Nepal and the health care system of Nepal. Analytical framework (Health Belief Model) is included in this chapter that has been used study project.

Chapter three consists of detail description of research design and methodology. This chapter further contains a description of selected of the research site, participants, and data collection methods. Data analysis, reflexivity, and discussion on methodology are also mentioned. The ethical consideration and dissemination of the final study are included in this chapter.

In chapter four, the findings of the study divided into themes and subthemes are presented.

Chapter five presents a discussion of the findings and their implications.

Chapter six includes conclusions and recommendations.
1.2 Literature Review: What is Child Marriage or Early Marriage?

According to UNICEF, child marriage is defined as “formal marriage or informal union before the age 18” (UNICEF, 2016a) and early-marriage is defined as “formal marriage or customary and statutory unions recognized as marriage before the age of 18” (UNICEF, 2005). It is a violation of human rights (Greene, 2014). It hinders the growth of an individual, regarding right to health, right to education, right to choose a partner (Loaiza Sr & Wong, 2012).

According to United Nations Article 16 “marriage shall be entered into only with free and full consent of the intending spouses” (UN, 1948). However, marriage shall occur among the adolescent group with the agreement between parents. Child marriage is referred to “early” or “forced “ marriage because children are not able to freely decide on the timing of their marriage or give consent (UNFPA, 2012b). The terms “child marriage” and “early marriage” has been used interchangeably throughout the study.

1.3 Overview of Child Marriage

Globally, 700 million women are married before the age of 18 years with wide the presence of it in South-Asia (46%) and Sub-Saharan Africa (37%) (UNFPA, 2012b; UNICEF, 2014). According to World Health Organization (WHO), more than 30% of girls in low and middle-income countries marry before 18 years of old; around 14% before the age of 15 years (WHO, 2014).

The variation in the prevalence of child marriage is found across countries where this practice is carried out. It ranges from 2 % in Algeria to 75 % in Niger. The prevalence of child marriage persists high in developing nations and comparatively remained uniform from 2000 to 2010 in rural and urban areas 50 % and 23 % respectively (UNFPA, 2012b). The prevalence is common among girls residing in rural areas, in a poor household and illiterate groups (UNFPA, 2012b). Some countries including Nepal has made significant progress in preventing marriage among girls under the age of 18 years. However, incidence remains high in South Asia, Sub-Saharan Africa, Latin America and the Caribbean that draws the attention of stakeholders and researchers to mitigate the associated problems (UNFPA, 2012b; UNICEF, 2014).

South Asia alone has almost 50 % of child brides (Anita Raj, McDougal, & Rusch, 2012; UNFPA, 2012b) with 24.4 million of women ages between 20 to 24 years have
been married before the age of 18 years in 2010. Furthermore, it has been estimated that 130 million more girls will be married by 2030 (UNFPA, 2012b). In South Asia, the percentage of child marriage is highest (66%) in Bangladesh. Regarding the prevalence of child marriage, a huge difference among women in poor context (72%) compared to rich (18%) is found in South Asia. It has the lowest contraceptive prevalence rate which accounts for only 15% (UNFPA, 2012b).

Nepal has highest rates of child marriage in the world with 37 % of girls married before the age of 18 years and 10 % married before the age of 10 years (UNICEF, 2016c). Young people, community leaders, and government officers report that there has been a change in the situation regarding child marriage in Nepal and that there are greater awareness and fewer child marriages (Maharjan et al., 2012; Verma, Sinha, & Khanna, 2013). There was a substantial decline in child marriage from 2001 to 2006 in Nepal. The Nepal demographic health survey (2001) found that 40 % of women aged 15-19 were married, whereas this was reduced to 32.2% in 2006 (Maharjan et al., 2012). From 2006 to 2011, the age at marriage is increasing among both men and women. In 2011, 28.8% women were married between 15 – 19 years compared to 6.9% men.

1.4 Causes of Child Marriage

Child marriage in Nepal is socially valued customary practice passed from generation to generation. The religion has played a vital role for its high value in the society. The central part of a marriage ceremony is “Kanyadan” which means “the gift of a virgin.” This considered as a medium to earn a credit of piety for parents (Maharjan et al., 2012). Dowry system, the practice of giving gifts to the groom and his family by the bride’s family, is another cause of child-marriage in Nepal, specifically in Terai Region of the country. The higher the educational level of a girl; the higher is the chance for a girl getting married to a well-educated boy. This means that the boy’s family can demand more money and gifts from the bride’s family as dowry. This compels the girl’s family to marry their daughter child to avoid heavy expenses in the marriage (Maharjan et al., 2012). The recent trend of self-initiated marriage (Maharjan et al., 2012) might have decreased the value of this negotiation in dowry.
Poverty is another factor for persistence of child marriage in Nepal. Families with limited resources cannot afford education for girls. Instead, they prefer them to get married early to reduce the financial burden on the family (Maharjan et al., 2012).

In Nepal, marriage is bounded by social values and norms and marriage is considered as necessary and inevitable. It is the responsibility of the parents to protect the chastity of daughters unless they get married. Parents choose to marry their daughter from the fear of sexual violence and girl's decision of starting sexual activity before marriage. Therefore, parents do not consider delaying marriage as beneficial (Verma et al., 2013).

Nepalese parents have a great influence in the marriage of young people (Choe, Thapa, & Mishra, 2005). The national survey conducted by PLAN, Save the Children and World Vision found that the parents decided upon the marriages of their children in 63% of the cases for women (age 20-24 at the time of survey). The authors concluded that there has been a ‘paradigm shift’ in decision making from parents to children, from arranged to love marriages (Maharjan et al., 2012). Eloping away for “Love marriage” which is self-initiated marriage at an early age is found among adolescence age group even if their parents are against and aware of child marriage (Maharjan et al., 2012). Parents and key informants blame mass media and mobile phones for the trend of love marriage (Maharjan et al., 2012; Verma et al., 2013). The average age at first love marriage is found to be 16 years for both boys and girls (MOHP, 2012).

During the time of humanitarian crisis, child marriage scales up as families marry their daughters to decrease the financial burden and protect them from sexual violence (GirlsNotBrides, 2016). Likewise, Nepal had suffered from many such crises. The recent one was being hit by devastating natural disaster earthquake of 7.8 magnitudes in April 2015 with several intense aftershocks, which ruined the normal life patterns of the people. With several immediate relief responses, the protection of vulnerable women and children was one of the focal issues. The leading problem of poverty and vulnerability in the time of such disasters in society, which is previously vulnerable, tends to go up. As a consequence, adolescent girls end up marrying for protection, for instance, from sexual violence or the parents cannot afford to keep the girls home. Although they have not planned for marriage before, for such an emergency disaster, the incidence is likely to soar up due to this reason (Emma, 2015; Tong, 2015).
1.5 Child Marriage and Pregnancy

Child marriage and adolescent pregnancy are hindering the progress of maternal and child health status. Globally, the second cause of death for the adolescent is complications during pregnancy and childbirth. World Health Organization (WHO) estimated about 16 million girls between ages 15 to 19 years and about 1 million girls less than 15 years deliver every year, most of them occur in low and middle-income countries (WHO, 2014). Pregnancy is particularly risky before age 16 years old (Nove, Matthews, Neal, & Camacho, 2014). Meanwhile, 90 % of the adolescent pregnancy between 15 – 19 years occurs remaining inside marriage (UNFPA, 2015). Girls who entered in child marriage are particularly subjected to early pregnancy while still in the developmental stage of adolescents, which raises the risk for their health (UNFPA, 2014). Approximately, 70,000 maternal deaths in 2013 were associated with adolescent pregnancies. Adolescence pregnancy is a leading cause of maternal and child mortality and put up the ill-health and poverty cycle (WHO, 2014).

Many studies have explored the relationship between the child marriage and adverse health outcomes, which includes unintended pregnancy, pregnancy-related complications (Ganchimeg et al., 2013; Ganchimeg et al., 2014), fetal mortality and physical and sexual violence (K. G. Santhya, 2011). A study demonstrates that married women under the age of 16 years had higher unintended pregnancy (46 %) compared to women married after 16 years (36 %) and it is a major contributing factor for high maternal and infant mortality (Adhikari, Soonthorndhada, & Prasartkul, 2009). Child marriage is associated with adverse outcome of the reproductive health such as stillbirth, miscarriage and pregnancy termination (Kamal & Hassan, 2013; Patra, 2016). A multi-country study presented adolescent mothers are at increased risk of complication compared to mothers at 20 – 24 years of age and possesses higher risks of eclampsia, puerperal endometritis, systemic infections (Ganchimeg et al., 2014). In the combined results of a study in 144 countries for maternal death, the maternal mortality in the adolescent mother was seen slightly higher compared to mothers between age 20- 24 years, while in the individual countries no specific link with the age and maternal mortality was identified. The same study has drawn the inference that the result is not an
indication to move the focus away from prevention of adolescent pregnancy (Nove et al., 2014).
Inadequate knowledge about contraception, lack of information and less access to the health care services according to their need increases the risk of unwanted pregnancies (Figo Committee For The Ethical Aspects Of Human & Women's, 2015). Also, countries with highest adolescent maternal deaths tend to have highest maternal deaths overall. However, Nepal is one of the countries in the study with highest adolescent maternal mortality but not among the highest overall maternal mortality ratio (Nove et al., 2014). This might indicate the country’s necessity to focus towards adolescent mothers.
A study in Nepal among adolescent pregnant women and primigravida women between 20 to 29 years indicated that the adolescent women are more likely to have unplanned pregnancies. Also, they have inadequate psychological and social support from family members (A. K. Sharma, Verma, Khatri, & Kannan, 2002). Also, they also receive less medical care during pregnancy (UNICEF, 2014) while they require more contacts and support from the health care services. Nepal is among the countries where the institutional delivery for the women married before the age of 15 years is more than twice as low as compared to women married as a adult (UNICEF, 2014). In contrast to this, a study in two Asian and two African countries revealed that Nepalese women with age $\leq 19$ years at first marriage had more access to skilled prenatal services in comparison to women of age $\geq 20$ years (Namasivayam, Osuorah, Syed, & Antai, 2012). Furthermore, a study in Nepal regarding health seeking behavior of women with uterine prolapse showed that 47 % of these women had experienced adolescent pregnancy (Shrestha et al., 2014). Young married female are likely to suffer from the physical problem as lower abdominal pain, and foul-smelling vaginal discharge in additions to maternal morbidity and mortality (Maharjan et al., 2012). Women in Dang district are likely to have more than one abortion, those who were married until they reach the age of 20 years. The culture of early marriage in Dang risks the health of both mother and child as by the age of 20 years they already have three or four births (K.C., 2016). It is necessary to address the health situation of these girls to prevent further adverse consequences either by delaying pregnancy until the age of 20 years or adequate access
to quality health care services for whom first pregnancy is inevitable (Patra, 2016; A. Raj et al., 2009). However, in Nepalese society, it is always expected for the married women to be pregnant, as soon as possible, within one to two years of marriage. Thus, early-married women are likely to give birth early; as a consequence, they have reproductive health problems even in the later stage of life.

1.6 Child Marriage and Violence
Violence in child marriage is evidenced by studies. In Pakistan, about one-third of women aged 15–24 years reported the experience of controlling behaviors and spousal violence by their husbands. Child marriage was highly linked with controlling behaviors, form of spousal violence (physical or emotional) including severe physical violence compared to adult married women (M. Nasrullah, Zakar, & Zakar, 2014). Fear and exacerbation of the violence inhibit them from seeking the help leading to excessive tolerance and suicide as a choice. A small percentage (20–22%) of younger women (aged 15–24 years) had sought help in Bangladesh, India, and Nepal. The limitation of health seeking behavior in South Asia for this practice is due to the acceptance of violence inside marriage and insensitive approach of health care providers. In Nepal, despite the existence of a law against the violence and services availability for the victims, there are many issues about implementation (Jejeebhoy, Santhya, & Acharya, 2014). This might lead to the problems of serious health threats. Effective interventions are mandatory to stop this violence and raising awareness about seeking health care services whenever necessary. They also experience community stigmatization; violence and less social support, which prevent to take the initiatives.

1.7 Health Condition of a Child Born From Child Brides
The age of mother at first birth is conversely related not only to the health of mother but also to the health outcome of newborn and children. The younger the age of mother, the poorer is the health outcome of the child. Particularly, the health problems associated with it are stunting, anemia, underweight, diarrhea, infant mortality, and wasting. Teenage mothers have the children with worst health status and outcome (Finlay, Ozaltin, & Canning, 2011).

A study conducted in Sarlahi district (rural area) of Nepal, found that there is adverse
outcome in the health of infants. The study reported low birth weight (LBW) (51%), preterm birth (24%), and small for gestational age (73.5%) among the infants of mothers’ aged 12 - 15 years than women ages 20 -24 years (V. Sharma et al., 2008). Also, during early motherhood, adolescent mothers were less likely to seek immunization for their infants compared to adult mothers (K. Santhya, 2011). Meanwhile, newborns delivered from adolescent mothers face a substantially higher risk of death than those born from women aged 20 to 24.

Furthermore, a study among nulliparous adolescent mother, in low and middle-income countries including Nepal, showed the prevalence of low birth weight and preterm birth among 16- 19 years of adolescent mothers (Ganchimeg et al., 2013). Similar results including severe neonatal conditions were reported in a study conducted by World health organization (Ganchimeg et al., 2014).

1.8 Strategies to Improve Health of Women in Child Marriage
Globally initiatives from many organizations, researchers and donors have been taken to end child marriage or delaying the marriage over the past five to ten years (Greene, 2014) with the intention of protecting the young people from social, physical, and psychological negative impacts in their life. Ending child marriage and its related harmful practices are internationally recognized to achieve gender equality and empower all women and girls as mentioned in post-2015, the 2030 Agenda Sustainable Development Goals (SDG) (UN, 2015). The elimination of child marriage is likely to improve the overall status of women including the reproductive health. Several international organization as Universal declaration of human rights, Convention on the Elimination of Discrimination Against Women (CEDAW), have considered marriage or child marriage without the consent of both spouses is a violation of human rights (Ellen Travers & Moudouthe, 2015).

For tackling the child marriage and early child bearing, policies have been undertaken internationally (WHO, 2014) and by the individual countries at governmental level for instance in India (Winter & Nambiath, 2016) and Nepal (Ellen Travers & Moudouthe, 2015).
1.8.1 Status of Child Marriage in Nepal: Legislation and Policies

In Nepal, the country code has limited the age of marriage as 20 years for both men and women without parental consent and at age 18 years with the parental consent since 2010. The law states imprisonment for up to 3 years and fine up to Nepalese Rupees 10,000 for child marriage (ICRW, 2013; Maharjan et al., 2012). However, the awareness level is low and the practice of child marriage is deep rooted in the society and it is hardly considered as illegitimate and punishable (Girlsnotbrides, 2015). Although there exists positive legislation against child marriage, high numbers of girls continue to marry before the age of 18 years (ICRW, 2014). The causes described are frailty of the existing laws, inadequate punitive and fines for this practice (de Alwis, 2008). The government of Nepal developed strategies to empower girl child and held their position high to achieve gender equality. It is further committed to Girl Summit to endeavor to end child marriage by 2030 (UNICEF, 2016b). As a part of national strategy, theory of change to end child marriage was incorporated which included strategies as empowering girls, providing quality education to girls, involving men and boys, families and communities, strengthening implementation laws and policies (Girlsnotbrides, 2015).

1.8.2 Adolescent’s Friendly Services

Adolescent’s need of access to the health care services are crucial because they are vulnerable to human right abuses specially related to sexuality, marriage and giving birth. This is because they are not getting information related to reproductive health and care which impedes the approaches to services to protect their health (UNFPA, 2014). The avoidance of accessible health care services in adolescents is due to behaviors of the health care providers such as scolding, asking the difficult questions and offensive procedures being carried out (L. Atuyambe et al., 2008). Adolescent friendly interventions to empower them with knowledge about pregnancy, delivery and early childhood needs to be introduced and implemented was indicated in a study in developing context in Uganda (L. Atuyambe et al., 2008).

In Nepal, Adolescent Sexual and Reproductive health (ASRH) was piloted in 26 public health care facilities in 2009. Later, in 2011 the National ASRH program was designed, which was implemented in more than 1000 health facilities in 59 districts until July 2014 in support of various stakeholders. The target was to extend ASRH services in 1000
health facilities by 2015 and it was extended in 2011 in Dang (MOHP, 2013/2014). The priority issues addressed are early marriage, early pregnancy, low use contraceptives, poor health and hygiene (menstrual hygiene), adolescent’s nutrition, Gender Based Violence (GBV), substance abuse (Alcohol/smoking/drugs) and STI, HIV and AIDS (DOHP, 2012/2013).

### 1.9 Current Status of Knowledge and Knowledge Gaps

Women in child marriage are more in need of frequent health services due to numerous factors such as age, physical and mental immaturity and more likely to have complications if they are pregnant. Their lack of experiences, psychological and emotional immaturity leads to poor health outcomes among adolescent mothers (LeGrand & Mbacke, 1993). Many studies highlighted the health seeking practices of early-married women for themselves and for their children as comparatively poor (K.C., 2016; Maharjan et al., 2012; Heidi W Reynolds, Emelita L Wong, & Heidi Tucker, 2006). Maternal health care usage among the adolescent-married women is less in rural areas compared to urban parts (Shahabuddin, Delvaux, Abouchadi, Sarker, & De Brouwere, 2015). The factors that demotivated the use of health care among these women are lower level of education, poor economic status (Choe et al., 2005; Verma et al., 2013), lack of power for decision-making (UNFPA, 2015) and sociocultural factors (UNFPA, 2014).

A multi-country study among 15 countries regarding the maternal and child healthcare services showed that, in five countries, the women at 18 years or less were less likely to use health care than the older women. Due to variation in the services use, based on age, in Asia, it was suggested country specific study and research is needed to identify the differences in use of services according to the mother’s age (Heidi W Reynolds et al., 2006).

There is a variation in decision-making and utilization of health care services among Nepalese women. A study with 315 participants (105 teenagers) in Nepal reflected women herself, their husband and mother-in-law perceived husband as the most influential person for decision of health care services use (antenatal and delivery care) especially for teenagers and young adults (Upadhyay, Liabsuetrakul, Shrestha, & Pradhan, 2014). In addition, young people are more reluctant to use health services even
though they know about and have access to sexual health care services (Regmi, van Teijlingen, Simkhada, & Acharya, 2010). In the context of child brides who are supposed to go to their husband’s home, having little or no decision-making role, are less likely to use health services. This might be a reason that women have to wait for decision before approaching the health services. A study from Pakistan shows that sociocultural factor plays the main role as an obstacle in the use of maternal health services among the child brides. Eventually, ongoing support is needed to support those individuals (M. Nasrullah, Zakar, & Kramer, 2013).

The antenatal examination is a key criterion for mother of any age to ensure the wellbeing of both mother and baby. The antenatal examination with four visits is recommended standard criteria by World Health Organization (WHO), which is also incorporated as a standard number of visits by Nepal. However, women’s use of health care for antenatal check-up varies with various backgrounds of women. Being married at young age is one of them. In Nepal, married girls at age 15-17 years had lower number of antenatal visits than expected compared to adult married women (MOHP, 2012). A study in Nepal indicated only 50 % of women had 4 or more antenatal visits and 85% had at least one visit. The study indicates older age, higher parity, high level of education and economic status as the factors influencing four or more visits and reception of quality care (Joshi, Torvaldsen, Hodgson, & Hayen, 2014).

Likewise, search for skilled health care provider during delivery situation explicitly influences the health outcome of a mother. A review of literature study on health seeking behavior among married adolescent women on maternal health services in Bangladesh revealed that women with poor education are less likely to seek skilled maternal health services compared with high educational status. The usage of maternal health care services among rural married adolescent is poorer than in urban areas. The women with rich status, previous experience in childbirth and higher women’s autonomy uses the maternal health care services more frequently (Shahabuddin et al., 2015).

From the perspectives of both users and health care providers utilization of the Skilled Birth Attendant (SBA) services in rural Nepal is poor and contributing factors are lack of knowledge of the value of SBA, distance of health facilities, unavailability of
transport services and poor availability of SBAs. Additionally, tradition of isolating women during and after childbirth, cultural practices and beliefs and low prioritization of birth care are also affecting the utilization of the services (Onta et al., 2014). Both assistance in delivery by skilled birth attendants in last birth and institutional delivery was lower among the married women at 15 – 17 years of age (Godha et al., 2013).

To prevent adolescent pregnancy in child marriage where the couples do not abstain from sex, consistent use of appropriate contraceptive methods is recommended (UNFPA, 2015). However, the overall use of the contraceptives is unsatisfactory in South Asia and Sub-Saharan Africa. The use contraceptive among married or in union girls between 15 to 19 years is only 22 % compared to 61 % women aged between 15 to 49 years. The use of contraception is low in regions where incidence of child marriage is high (UNFPA, 2012b). The present situation (2011) in Nepal shows about 14 % of currently married women of age 15 – 19 years use any modern method of contraception for family planning and use of current modern contraceptive method has not increased in last 5 years (NDHS, 2012). This indicated the unsatisfactory use of contraceptives among adolescent group. Married-adolescents are less likely to use the modern contraception methods as only 1 in 5 of them use it and its utilization is even poorer among women who had no sons, living in rural area, or married as minors (A. Raj et al., 2009). Women married under the age of 18 years were less likely to use contraception and this trend continued into their young adulthood. The study also highlights delaying marriage of girl increases the use of contraception among young wives in Nepal (A. Raj, Vilms, McDougal, & Silverman, 2013).
1.10 Rationale of the Study

The current study explores the health care seeking behavior of early-married women and their perception towards health and illness in rural areas of Dang district, Nepal. It also aims to understand the behavior of early-married women towards healthcare seeking practices from the perspectives of health care providers along with their suggestions and feedbacks to improve the current status of health seeking pattern.

Despite considerable progress being achieved in child marriage reductions throughout the world including Nepal, it has not been eradicated yet, and it is still common especially in the low and middle-income countries (UNFPA, 2012b). With the high prevalence of child marriage in the world and Nepal, the need of married-adolescent girls for adequate health care services is widely recognized. Moreover, maternal morbidity and mortality risk in adolescent age are higher compared to women in 20 to 24 years, with a more worst scenario in developing nations than developed nations (Nove et al., 2014). Two studies reported maternal mortality ratio of 28% (Blanc, Winfrey, & Ross, 2013) and 17 % (Nove et al., 2014) higher in 15-19 years adolescent in comparison to 20-24 years women.

Along with the implementation of strategies and efforts to end child marriage globally, it is necessary as demonstrated above to support the adolescent married women (A. Raj, 2010) and there exists research gap in this area (Svanemyr, Chandra-Mouli, Raj, Travers, & Sundaram, 2015). Similarly, Nepal is not an exception and only a few studies have addressed the health-seeking behavior of these women. Identifying perceptions of early-married women toward use of health care services with qualitative exploration aid in developing strategies to support them in area of health related issues. A study has indicated that early-married women often miss access to information and health care services due to social isolation and lack of power in the decision-making process (Lynn Atuyambe, Mirembe, Johansson, Kirumira, & Faxelid, 2005; Shahabuddin et al., 2015).

Also, a multi-country study in South-Asia has indicated that despite the persistence of reproductive health problems only a little information is available on it. This has halted the progress of adolescent health programs. Together with this, inconsistencies with the use of the maternal health care services was presented in the study indicating further research to address this issue along with the use of modern contraceptive methods.
(Godha et al., 2013). In Asia, study and research are needed to identify the differences in use of services according to mother’s age (H. W. Reynolds, E. L. Wong, & H. Tucker, 2006). This indicates maternal age is one of the factors that influences use of health care services. Moreover, a study in Bangladesh has pointed that maternal health programs should target rural and uneducated married adolescent women and it is necessary to investigate through the qualitative approach to widening the understanding of maternal health seeking behavior of both married and unmarried adolescent women (Shahabuddin et al., 2015). In support with this study, the adolescent mother’s health care seeking practices is poor for them and to their children has been demonstrated in a developing country Uganda. They also experience community stigmatization, violence, and less social support. Adolescent friendly interventions to empower them with knowledge about pregnancy, delivery, and early childhood needs to be introduced and implemented (L. Atuyambe et al., 2008). A recent study in India among the adolescent women found that delivery complications were likely to occur among adolescent mother compare to women of 20-24 years. With this finding, postponing first pregnancy until the ages of 20 years would be beneficial for both mother and babies (Patra, 2016). Family Planning and maternal health care services are anticipated to have a crucial role for the improvement of reproductive health. Therefore, reproductive health of married-adolescent girls need to be addressed to improve overall reproductive health issue and it is important to better understand adolescent mothers’ needs. Nepal also being a developing country with similar context of child marriage, these results supports the need of exploration in related the field.

In Nepal need of adolescent health has been recognized and adolescent health care services are expanding with components child marriage and adolescent pregnancy. Nevertheless, health needs of early-married women are to be considered separately where they are considered as adult after being married when they are still adolescent (UNICEF, 2005). As the prevalence of early-marriage in Terai region of Nepal is high, this study might contribute in uplifting the health status of young women who are already married. In some countries becoming pregnant outside of marriage is common while in Nepal it is acceptable only within the boundary of marriage (UNFPA, UNICEF, CREHPA, & FHD/MoHP, 2015). In Nepal, child marriage is a norm, culturally
influenced and pregnancy is expected within one to two years of marriage. It is therefore necessary to address issues of child marriage to prevent this potential maternal and child health complications related to early pregnancy. In the mid and far-western regions of Nepal, the utilization of skilled birth attendants (SBA) services is 28.7% and 30.7%, respectively, which is lower than use in the Eastern, Central, and Western regions (Division/MoHP, 2011). This shows understanding from the perspectives of both service users and service providers regarding barriers to accessibility and use of health care services is important (Onta et al., 2014). Early-married girls are even more vulnerable and their need of the health care services should be taken more seriously. Furthermore, approaching and managing adverse health consequences from violence in early marriage are crucial.

It is, therefore, necessary to identify what has been already done successfully and what further interventions are needed with the exploration of facilitators and barriers for the use of health care services among this group of the population. Particularly, policies targeted towards married- adolescent girls is obligatory for their safety and protection as young women require more access to equal opportunities, services, social support education, employment and empowering life skills (Rowbottom, 2007). Identifying long-term interventions will be essential in escalating the adolescents’ use of reproductive health care services.
1.11 Goal and Objectives

Goal

- To explore the influencing (facilitators and barriers) factors for the use of the health care services among early-married women in rural Nepal.

Specific objectives

More specifically the objectives of this research project is to:

- Identify and explore the perceived barriers and facilitators in accessing health care services.
- Explore how they consider their need for health services.
- Explore the experiences from accessing and using health services.
- Identify changes in health care services that can improve access and use of contraception, skilled antenatal care, childbirth care and postnatal care among the child brides.
- Identify effective interventions to reduce barriers and improve access of skilled care for early-married girls during antenatal, childbirth and postnatal periods.
2 BACKGROUND INFORMATION OF NEPAL

Nepal is a developing country in South Asia, lies between two countries India and China. Geographically the country is divided into three regions: Himalayan region in the north, mid hill region and Terai region in the south. According to 2011 census, the population of Nepal is 26,494,504 (CBS, 2014a).

The commonly spoken language is Nepali; however, the diversity of language prevails throughout the country with 92 languages spoken as mother tongue reported in census 2011 (NDHS, 2012). The population largely varies on the basis of caste and ethnic background. The major ethnic/caste groups in Nepal are Chhetri, Brahmins, Magar, Tharu, Tamang, and Newar with diversity of 103 ethnic/caste groups. Dalits are extremely poor population accounting for 13 % of the population.

The number of adolescent population in Nepal is about 6 million which comprises of 24 % of the total population (UN, 2012). The median age at first marriage for women age group 25-49 is 17.5 years. The overall male and female (age 15 to 19 years) literacy rate is 87.0% and 66.7 % respectively. The literacy rate for female 15-19 years is comparatively higher compared to older women which is around 86 % (NDHS, 2012). The higher level of education is linked with greater knowledge about health care use for themselves and for their children (NDHS, 2012).

According to Nepal living Standard survey, one-fourth of the population of Nepal live below poverty line (CBS, 2011). Agriculture is the major occupation with 76 % of households involved in agricultural activities. Remittances is another major sources of income in Nepal, with about 56 % of households (CBS, 2011).
Only 17 percent of the population resides in the urban area of the country (NDHS, 2012). The wealth quintiles by residence shows 62 % are living in urban area from richest quintile while 14 % in rural area. On the basis of development region, only 10 % of households fall under richest quintile in mid-western region, while 41.5 % are in lowest wealth quintile (NDHS, 2012). Nearly 27 % of population aged 15-19 years is economically active which had decreased from 2001 (approximately 49%). This decline is due to attainment of higher education level and international migration. The greater portion of women labor is found in agricultural activity (CBS, 2014c). Childbearing begins early in Nepal, with almost one quarter (23 %) of women giving birth by age of 18 and nearly half (48 %) by age 20. About 17 % of adolescent women at 15-19 years of age are already mothers or pregnant with their first child. Teenage pregnancy is higher in rural areas, women with no education and middle wealth quintile. The use of modern contraceptives among 15-19 years of married women is about 18 % which increased with age of women (NDHS, 2012). In the last five years, teenage pregnancy has fallen by 10 %, however the progress is slow (NDHS, 2012). About 64% of young women age ≤ 20 years received antenatal care from skilled provider, which accounts for 31.5 % for older women. Meanwhile, only 41.2 % of women ≤ 20 years delivered baby in health care facility. The reasons identified for not delivering at the health care facilities were excessive cost, closed health care services, lack of transportation, lack of trust in health care (regarding the qualities), decision of husband, security concerns, not necessary and not customary. Among these a major cause was not necessary which accounts for 62 % followed by distance of health care facilities (14%). In mid-western region the main cause is transportation barrier. Regarding the postnatal care, 48 % of women of same age group received postnatal check-up within 2 days after giving birth and in mid-western region it was 39.2% (NDHS, 2012).

Administratively, Nepal is divided into 5 development regions, which is further divided into14 zones and 75 districts, 58 municipalities, 3915 village development committees (VDC) and about 3600 wards. Municipalities are referred as urban and VDCs as rural areas (NDHS, 2012).

Dang, the research site lies in Mid-western Development region (Terai region) of Nepal. The total population is 552, 583 according to census 2011. The number of adolescents
(10-19 years) is 143,026 with 73,998 (about 26%) females (CBS, 2012). It has 31 (Village Development committees) VDCs and 4 municipalities with the area of 2,955 square kilometers. The district headquarters lies in Ghorahi. Tulsipur is another main city in Dang. There are health care facilities established in every VDC of the district with one sub-regional hospital, one zonal hospital, two eye hospitals, one Ayurveda Hospital and eight private and communities hospitals (DDC, 2016).

The study was conducted in four VDCs namely Hekuli, Shreegaon, Dhanuri and Urahari. According to 2011 household census, the total population of Dhanauri was 9,433, Hekuli (9,206), Shreegaun (6,985) and Urahari (12,862) (CBS, 2012). The VDCs consists of majority of “Tharu” population with Dhanuri (3849), Hekuli (5751), Shreegaun (2588) and Urahari (5659) (CBS, 2014b).

The prevalence of child marriage decreased from 61 % in 2006 to 53 % in 2011 in mid-western region (UNFPA, 2012b). Among a total of 280,500 married population of Dang, age at first marriage for 1170 below 10 years, 27, 980 married between 10-14 years and 157,462 married between 15 – 19 years of age (CBS, 2012). According to the 2011 National Census, 157,432 people in Dang had married while they were ages of 15 -19 and 103, 467 of them were girls. Many child marriage cases in the district go unreported, which makes difficult for the law enforcement agencies and other concerned authorities to intervene (K.C., 2016).

2.1 Health Care System in Nepal

Department of Health Services (DOHS) is responsible for delivering the preventive, promotive, diagnostic and curative health services throughout the country. Based on this, Sub-Health Post (SHP) is first contact point for providing the basic health care services at the grass root level. The health system works on the hierarchical way by providing the referral services. The referral point starts at SHP to HP, to Primary Health Care Centre (PHCC), to district, zonal, sub-regional and regional hospitals, and finally to tertiary level hospitals in Kathmandu. Additionally, at the community level Female Community Health Volunteer (FCHV), Traditional Birth Attendant (TBA) including the PHC outreaches clinics and EPI (Expanded program on immunization) clinics act as connecting point between the community people and sub-health post (NDHS, 2012).

Overall, the government health care services in the country are delivered by 2,247 SHPs,
1,559 HPs, 208 PHCC/HC, 78 district/other hospitals, 10 zonal hospitals, 3 sub-regional hospitals, 3 regional hospitals, and 8 central level hospitals (MOHP, 2013/2014). In Urahari and Dhanuri there is one sub-health post (SHP) each, Hekuli has one health-post (HP) and Shreegaon consist of one Primary Health Care Centre (PHCC) (USAID, 2011). Rapti zonal and Rapti sub-regional hospital, private health care facilities and a number of medical clinics provide the health care facilities in Dang. Privatization of the health sector along with public health started in 1991 with the establishment of private hospitals, nursing homes, and private clinics. The extension of the private health care occurs mainly in the urban areas (profit oriented), which occupies 3 % hospital beds in Mid-western region of the country (RTI, 2010).

2.1.1 Free Health Care Services in Nepal

From January 2008, essential health care services were free to all population through health-post and sub-health post up to hospital level with 25 bed limits. Under this, the charges for registration, outpatient, emergency and inpatient services or the essential medicines are free (Karkee & Kadariya, 2013). However, the private health sector has largely become preference of people despite the high costs for services (Karkee & Kadariya, 2013). Along with free essential health care services, Nepal Government introduced Aama (mother’s) program under reproductive health morbidity prevention program. According to revised Aama program FY 2069/70 (2012/2013), the four components (DOHP, 2012/2013) included under this services are:

1. Safe Delivery Incentive Program (SDIP) includes cash incentives started in July 2005. For an institutional delivery a cash payment of Nepalese Rupees (NRs) 1,500 in mountain, NRs. 1,000 in hill and NRs. 500 in Terai region are provided following delivery
2. Free institutional delivery care, started mid-January 2009
3. A cash payment of NRs. 100 is made to health worker for home deliveries
4. A cash payment of NRs. 400 is provided to women on completion of four ANC visits at the 4, 6, 8 and 9 months of pregnancy following institutional delivery
3 METHODOLOGY

This chapter includes the description of research methodology utilized in the fieldwork, explanation of research site and sample chosen for study. Further, it includes reflexivity, data analysis along with ethical issues considered and dissemination of the results.

3.1 Research Design

Qualitative methodology broadly deals with the concept of research that uses descriptive data of people’s own written or verbal words and the observed behavior (Fossey, Harvey, McDermott, & Davidson, 2002). The use of qualitative research method in health-related and healthcare issues associated with social and cultural dimension enables the researcher to provide a descriptive explanation of meaning, experiences and views of the participants (Z. Q. Al-Busaidi, 2008).

The study was designed to understand the perspective of early-married women, their understanding of health and reasons for not seeking health care services. A qualitative design method thus helps to explore scenario from the perspective of key informants and individuals involved in this practice. The views of participants help to understand how people see the things that are occurring. The qualitative methodology can further be used to explore health beliefs, health-seeking behaviors and choices to gain new knowledge and understanding of complicated realities (Kielmann, Cataldo, & Seeley, 2011). The maternal health care use being poor among early-married women along with poor health outcomes (Godha et al., 2013), the study aims to gain deeper understanding and looks for perceived adaptive suggestions for health care utilization and improving the health condition.

3.2 The Study Sites and Participants

3.2.1 Study Sites

The study was conducted in mid-western region, Dang district, of Nepal. It was selected as a study site purposively as the literature showed that the child marriage prevalence was high in mid-western region (UNFPA, 2012a). A local NGO in Dang District was contacted with the help of co-supervisor. Based on raw data provided by organization, presence of child marriage was found, after which it was decided to choose field site of study.
Four Village Development Committees (VDCs), namely Hekuli, Shreegaun, Dhanuri and Urahari were selected based on the information provided by a local organization and availability of participants. Initially, I took some time for understanding the village layout and become familiar with its infrastructures. Informal communications with villagers, especially women, helped in understanding their lifestyle, daily activities and how they spend their time. Also, I was spending some time in a local clinic run by non-government organization (NGO) and had conversations with people visiting there by introducing myself as a student researcher. As soon as research sites were selected, the social mobiliser working in each respective VDC was contacted to get further information about research participants for the study.

While travelling to each of the villages, I was accompanied by staff member provided from a local NGO working in the community, as a research assistant. I accessed each of the sites by riding a motorbike with research assistant, by walking or by using the public transportation. These travelling enabled me to understand better the transportation difficulties and challenges during the daily lives of the community people in these areas. The research site was in village area, which means although there was accessibility of road, transportation facilities were not easily available. People would preferably use motorbikes as a common means of transportation. Otherwise, they had to walk at least thirty minutes to one hour to reach the place accessible to public transportation. The health post was located at walking distance of half an hour to one hour where only basic health care services were available.

In addition to this, I come to realize that in selected communities of the study, prevalence of Chaudhary and Tharu ethnic groups (Dalits) was majority population. For this reason, the literature review was modified by necessity.

3.2.2 Research Participants

a. Women Participants: In-depth interviews (IDI) were held with thirteen women participants who were married before the age of 18 years and having at least one child or pregnant. The present age of participants was from 17 to 20 years so that they would be able to share their recent experiences of using health care services. This would also help to represent the current scenario of health care for them. One participant who had
miscarriage was included in the study although she was neither pregnant nor had a child, because her experiences married as a child and present age as 20 years was relevant. At each selected VDCs one focus group discussion was conducted with the participants from six to eight in number in a group. The selection criteria for participants in FGD were same as in IDI.

**b. Key Informants:** In-depth interviews were conducted with ten key informants in the community. It included school headmaster, health post in-charge (Health Assistant), and social workers, social mobilisers and female community health volunteer (FVHV) who were working at government level and involved in non-governmental organizations working in the community. The social worker from non-governmental organizations were found to be active in the community in the sector of providing services and creating the awareness program. They were willing to participate in research interview when they were told about research objectives while some health care staffs working in the government sector were reluctant to take part in the research and put forward their views openly.

**3.3 Triangulation:**

Triangulation is a method of maintaining validity of a research by the use of more than one method of data collection techniques on the same topic including variety of samples. Meanwhile, it provides an opportunity of acquiring different dimensions of the same subject matter (Kielmann et al., 2011; Morse, 2015).

In-depth interview (IDI) and focus group discussion (FGD) among early-married women regarding their health-seeking behavior and IDI with the key informants regarding their perceptions of these women’s care-seeking enriched the quality of data collected on particular issues. The respondent sources were also varied including women who were pregnant, women who had already given one or more birth and key informants were health post in-charge, school headmaster, and social mobiliser working in government and private organizations. In addition to this, selection of four different VDCs for data collection increased the strength of data collected representing variation in study sites.
3.4 Research Assistants

It was not possible to conduct a fieldwork in short time frame without the assistance of a local person who would provide orientation of the village area. Therefore, research assistants were hired on request to head of an NGO in the particular locality. Two social workers, as research assistants, were provided based on their time feasibility to assist me. Due to the restrictions in financial budget, it was not possible to hire research assistant trained in social science and research, however they thoroughly understood their roles and works they had to perform. Having worked in the local community, they had thorough information about research site and probabilities for identifying the research participants. It was easier to make them understand the research objectives as they were working in same field of promoting women’s welfare and promotion of health in local community. They oriented and showed me the research sites on the planned date. They verbalized understanding of their roles as note taking during the interviews and FGDs, which was performed very well. As research assistants were from the local community and experienced in the community field, their suggestions while talking with the participants were appreciated. She would occasionally speak and add related questions to lighten up the subject matter. This made participants comfortable as she had positive impact in the community because of her involvement in social welfare work and it accelerated the discussion and she immediately realized what her roles.

3.5 Sampling And Recruitment

Purposive sampling was applied to recruit the participants for study. The intentional selection of participants provides basis for collection of rich information related to subject area of the study (Patton, 1990) and maximum variation in research participants (Kielmann et al., 2011). Upon arrival to the research site, I contacted director of a local organization working at community level in Dang. The research project was explained to her along with the specific criteria of research participants. As the village was completely new to me, research assistants helped me to identify the research participants based on research criteria. Meanwhile, she also mentioned about safety issues of a researcher while walking in the evening time, being a female and new person in the community. The participants were contacted initially with the help of the social mobiliser working in the particular VDCs. Apart from this, research participants who
already participated in the study were asked to provide information about any women of
same category who could be willing to participate in the study following snowball or
chain sampling (Patton, 2002). All the potential participants were explained about the
purpose of the study with detail explanation of the informed consent and having them
signed it if they were interested to participate in the study.

A place for focus group discussion was identified in each village based on time and
distance suitability for the research participants. To ensure the homogeneity in research
participants (Kielmann et al., 2011), they were placed in groups with similar age and
background so that they would freely discuss their experiences especially about family
planning, pregnancy, delivery and post-pregnancy period. The participants induced each
other to speak on research topics, as the conversation was not always spontaneous. After
the completion of each FGD, one or two participants were asked if they were willing to
speak again separately with me participating in in-depth interview whenever possible.
Two of them from the focus group agreed to participate in in-depth individual interview.
The participants were also approached by talking with them at the spot, where they were
engaged in their daily activities in their homes. The expected participants were identified
and ensured by asking the age of the married women who looks comparatively younger,
made or breastfeeding. Surprisingly, some of the participants were readily available to
talk choosing suitable location for the conversation. In contrast to this, when we asked
mother-in-law and father-in-law, if they would allow their daughter-in-law to
participate, they completely denied to allow to participate explaining that there were
plentiful of houses where I could go and talk.

The potential participants were informed about interview and focus group discussion a
day earlier wherever possible and again confirmed on the day of actual interview with
signed informed consent. One of the interviewee’s inabilities to understand the subject
matter and objectives of study created an environment that she did not want to
participate in the study, for which she was explained again. However, her decision not to
participate was respected.

The key informants were approached with the help of local organization where they
helped me to locate offices and sites where I could have an opportunity to talk with them
and some of the key informant provided reference about particular person in the village.
Some key informants agreed to take part in the interview in their work places, in village areas and at their home.

3.6 Pretesting and Changes in Interview Guide
Pretesting with initially developed questions was performed with one focus group and one interview with key informant to bring the necessary changes in interview guide. Transcription was done and sent back to the supervisor. After receiving the feedback, necessary modification was done and a final interview guide was prepared (see appendices 8-10). A pilot interview was conducted to make the suitability of interview guide, probing and follow-up questions with opportunities to have self-reflections by reviewing notes, transcribing and listening to the recorded tape.

3.7 Data Saturation
The total number of participants was determined during data collection period when saturation occurred (Morse, 1995). The data collection was stopped when data adequacy was realized to develop an understanding related to the findings and objectives of research (Morse, 1995). The “Teej” festival during my stay and the arrival of the big Nepalese festival “Dasain and Tihar” halted the participants to participate in the study to some extent. Therefore, I believe some new information might have come with further recruitment of the participants.

The total number of the participants in the study was forty-eight. Out of this, thirteen young women participated in in-depth interviews, twenty-seven were included in the focus group discussion and ten key informants participated in in-depth interview.

3.8 Data Collection Methods
Data collection was done with a set of predefined questions developed based on the objectives of study. Open-ended questions were used with areas to be covered such as questions related to health care and illness, family planning use, antenatal examination, delivery situation and postnatal care, and violence. Probing questions helped the participants to talk freely about their experience and increased the richness in the subject matter (Patton, 2002).
3.8.1 Focus Group Discussion

Focus group discussion involves the group interaction, which aids in exploration of people’s experiences and knowledge (Dahlgren, Emmelin, & Winkvist, 2007). With the group of participants, a wide variety of concepts can be covered within a short period. The participants who are reluctant to participate alone in the study are stimulated to talk in a group. In addition to this, the cost effectiveness nature of this method has been highlighted along with deeper understanding of the topics which people are uncomfortable or dishonest to talk about (Kielmann et al., 2011).

Total four focus group discussions (FGDs) were conducted in each VDC. Although FGDs is favored with group where the participants are strangers (Patton, 2002), practically, in the group all members were not unknown to each other. In one of the FGDs, the participants themselves uncovered that they were stepmother and daughter in relation, as father of that girl had married a woman who was very young. Being a small village, it was hardly possible to expect that participants do not know each other.

The researcher with help of social mobiliser identified all the participants for each FDG. It was ensured that varied participants are included based on caste and ethnicity and educational background. The majority of them were underprivileged considering the research site is in rural area. Before arriving at designated place for discussion, it was ensured that research assistant understood how FGDs would be carried out and the principal researcher is a facilitator for discussion.

While conducting FDG, it was discovered that all the participants were not active during the discussion; some were responding more like one to one interviews and answering the questions and participated less in discussion while others were discussing within themselves and arrived into a new topics for discussion. This might have happened due to variation in the group where sometimes few participants were dominating. The factors small age and their ethnicity background might have also influenced some of the participants to speak less. Being aware of this factor, I explained the participants to contribute equally in discussion and put their views. Each of the FGDs had explored new information on subject matter and is found to have crucial value during fieldwork and analysis part.
All the discussions lasted from 45 minutes to 1 hour 15 minutes. The FGDs were conducted in a space provided by VDC office, Health-post and local organization. The separate space was managed to maintain privacy, and it was also applicable by distance to arrive at the venue. The chosen venue, however, might have created queries in the participants, for which I explained that particular organization do not have any concern in my study. The discussion was carried while some of the participants were breastfeeding and some accompanying their children. This, sometimes, broke the natural flow of discussion as the children were crying in between discussion. I tried to avoid this distraction in the subsequent discussion but it was not possible for the participants as they said there is nobody to look after their children. Later, I realized this was not distracting the participants, which was perceived by researcher.

3.8.2 In-Depth Interviews

The qualitative interview provides deeper understanding of social issues that are relevant to health care. It helps to examine the perceptions, beliefs, and motivation of an individual on certain issues including sensitive matters, in which one to one communication is important (Gill, Stewart, Treasure, & Chadwick, 2008). As the main purpose of the study was to explore the facilitators and barriers for using health care services from the perspectives of user “early-married” women, it was decided to conduct in-depth interviews with the potential participants.

In-depth or unstructured interview being flexible in nature and its suitability to talk about sensitive topic provided rich and relevant data (Kielmann et al., 2011). It was essential when exploring the young women’s perceptions and experiences while seeking the health care services for their intimate health problems. This approach of data collection allowed me to explore participant’s perception, experiences and knowledge with thorough understanding and explanation of reasons for seeking and using the health care services.

The participants were invited to participate in interview in their preferred location. The venue selected ranged from participant to participant which were a room in their house, social mobiliser’s home, space front and back of their house, in a workplace as shop, and
in a space provided by the organization where I was staying. All of the locations were chosen by participant themselves where they could talk freely with privacy maintained away from their family members and other members of the community. All of the participants were comfortable to talk and discuss their view with me. Although the mother tongue of the participants was different compared to mine, the universal use of “Nepali” language between participants and researcher made circumstances comfortable. After they have agreed and we arrived at the location, some participants expressed their anxiety regarding the interview, as they had never participated in such conversations. The participants were reassured and convinced again mentioning that it is a natural conversation where they have to share their experiences and views. The note-taking environment influenced some of the participants where they were waiting until the note taking process is finished. In this case, the participants were re-informed that they do not have to wait for this to be over and they could speak at their natural pace.

The interview with key informants was more in natural flow with pre-determined schedule and location where their restrictions to interruptions and privacy were highly managed by participants themselves. It was either room of their working places, inside their house, or office of organization where I stayed. The interview with key informants ranged from 20 minutes to around 47 minutes. A few interviews were short where the participants in KII restricted further elaboration and quickly completed the conversation. Due to the time constraints, undertaking of repeated interviews was not applicable and thought was impractical (Richards & Schwartz, 2002) when the participants were busy in their daily schedules. Multiple interviews with the same participants could have provided a deeper understanding and new themes might have emerged. With the implication of thematic interview guide, I asked questions to the participant with follow-up questions. Probing was done whenever required to obtain the information as it elicits participants to provide holistic information and their viewpoint.

3.8.3 Data recording procedures and Transcription of the interviews

The audiotape was used for recording data while carrying out the interviews, which was coupled with note-taking, in case audiotaping failed to record the information (Creswell, 2013). The recorded verbatim allowed me to listen to interviews and focus group
discussions repeatedly and helped me to ensure that transcriptions were done correctly (Patton, 2002). Research assistants took note for the interview; one was assisting me in focus group discussion while other in in-depth interview. The notes included date, time, venue and short background description of the interview participants. The facial expression and non-verbal body cues were included whenever possible. The participants were informed about the audiotaping of the conversation. Although the participants verbalized the understanding of tape-recorder and agreed for recording, it was demonstrated to ensure that all of them understood it. They were informed that interviews would be deleted from recorder after the completion of study and it will not be shared with anyone except the researcher and supervisors. The presence of the recorder seemed not to affect the discussion as participants were speaking freely. The possibility that the subjects might not discuss the most sensitive matters while using recorder was, however, taken into consideration, which could not be avoided. The recorded interviews were copied in the personal computer of the researcher. All the interviews and focus group discussions were tape-recorded and the verbatim transcribed by me. Some of the transcriptions were done during the fieldwork while some were transcribed after the completion of fieldwork.

3.9 Data Analysis
After each interview and discussion, the thoughts that appeared were written maintaining a logbook, which consists of interview setting, reflection on the informal conversation before and after actual interviews and discussions. The transcriptions of some interviews and discussion were done while staying in the field helped in the development and re-construction of interview guides and identifying of the potential emerging themes.

Both interview and focus group discussion were carried out following interview guide prepared before and redesigned during fieldwork. The questions were modified to increase the level of comfort to the participants, especially when the participants were shy to speak. The main themes of the interview guide were designed to explore the experiences of the participants in health care settings during the antenatal check-up, during delivery, postnatal period and while using family planning services and also how
they decide to use services that they have been using and what were the basis that they choose private or government health care services.

I translated the initial interview guide from Nepali to English, which was sent to co-supervisor with the Nepali script, who could read both of the languages. This was done to ensure the translations and interpretations were done compatible with the original words expressed by the respondents. The clarification between supervisor and me assured common understanding of the interview transcripts.

The question guides were reconstructed during the data gathering time as necessary after the preliminary analysis with different ways of asking the questions and exploring the new themes. For example: “How do you care for you own health?” was often confusing for some of the participants and they would not speak. I replaced the question “For what purposed do you go to the health care services?” The questions helped to break the silence and led the floor into discussion.

For analysis, Malterud’s systematic text condensation strategy was used which consist of four main steps; construction of preliminary themes from data collected by identifying associated and disassociated themes, themes converted into codes by identified meaning units, with subsequent condensation from constructed codes to meaning unit following re-contextualization of data into the formation of descriptions and concepts (Malterud, 2012). I read and re-read all the transcripts produced from interviews and discussions along with summaries derived from it to gain the overall overview of talks given by the participants. Having gone through the transcripts line by line, I developed preliminary themes. Using the Hyper-research software, I generated the meaning units from which the codes were generated.

### Analysis process

<table>
<thead>
<tr>
<th>Meaning Units (Selected)</th>
<th>Themes (Selected)</th>
<th>Codes</th>
<th>Categories</th>
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</thead>
<tbody>
<tr>
<td>“not usual to eat many fruits”</td>
<td>Concealing health problems thinking it as normal</td>
<td>Care for health and competing responsibilities</td>
<td>Perceptions of health, illness, pain and childbirth</td>
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<tr>
<td>“even after the pregnancy, I did not think about the light or heavy work, I was doing every”</td>
<td>Lack of Nutritious diet</td>
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<td></td>
<td>Treatment not sought for minor illness</td>
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<td></td>
<td>Female perform domestic work</td>
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<tr>
<td>Work</td>
<td>No time to go for check-up</td>
<td>Mean time of first birth</td>
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<tr>
<td></td>
<td>Uterine prolapse, miscarriage due to heavy work</td>
<td>Impacts on the health of the child</td>
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<td></td>
<td>Expected role to become mother</td>
<td>Adolescent pregnancy</td>
<td></td>
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<tr>
<td></td>
<td>Lack of decision making capacity</td>
<td>Inadequate weight</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inadequate weight</td>
<td>Repeated sick of children</td>
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</tr>
</tbody>
</table>

| “my husband didn’t agree to use the family planning devices. Mother-in-law and father-in-law also would not agree if we were not having baby after marriage” | Exceeding a year of marriage | Use of the family planning services |
|      | | Experiences in using reproductive health care services |
|      | | Antenatal period and care |
|      | | Delivery experiences |
|      | | Postnatal period care |

| “It was becoming more than 1 year that I got married so we decided to have baby... I do not feel any discomforts and it is not about happiness. One should have at least one baby” | Exceeding a year of marriage | Use of the family planning services |
|      | | Experiences in using reproductive health care services |
|      | | Antenatal period and care |
|      | | Delivery experiences |
|      | | Postnatal period care |
|      | | Lack of care and trust |
|      | | Unexpected response |
|      | | Prolonged stay in hospital |

| “I went for check-up once during first pregnancy and didn’t go for antenatal visit in second pregnancy” | Exceeding a year of marriage | Use of the family planning services |
|      | | Experiences in using reproductive health care services |
|      | | Antenatal period and care |
|      | | Delivery experiences |
|      | | Postnatal period care |

| “I knew about the antenatal check up but I need one little baby” | Exceeding a year of marriage | Use of the family planning services |
|      | | Experiences in using reproductive health care services |
|      | | Antenatal period and care |
|      | | Delivery experiences |
|      | | Postnatal period care |

| “I only knew about the second pregnancy after 5 months. | Exceeding a year of marriage | Use of the family planning services |
|      | | Experiences in using reproductive health care services |
|      | | Antenatal period and care |
|      | | Delivery experiences |
|      | | Postnatal period care |

| “Even if they come, they call from distance they don’t come to house to explain everything. “Even if we had the labor pain, they do not come to visit” | Exceeding a year of marriage | Use of the family planning services |
|      | | Experiences in using reproductive health care services |
|      | | Antenatal period and care |
|      | | Delivery experiences |
|      | | Postnatal period care |

| “they kept me in the hospital for 6-7 days” | Exceeding a year of marriage | Use of the family planning services |
|      | | Experiences in using reproductive health care services |
|      | | Antenatal period and care |
|      | | Delivery experiences |
|      | | Postnatal period care |
| "there was power cut-off. They even didn’t turn on the generator" | Hospital infrastructure | Concepts of Home Delivery |
| "If it is possible I want to delivery at home" | Desire to have home delivery | Shyness and Discomfort |
| "Woman feels difficult to the share these problems to male health care personnel as they are scared of being touched by a man and to show their inner part” | Avoid institutional delivery | |
| in hospital, they will insert the hand | Unavailability of female health care provider | |
| They do check up in front of many people from the village. | Discomfort for examination | |
| Privacy | | |
| “it was because of spirits and supernatural power” | Belief towards supernatural power | Choices of health care made and Behavior |
| “My mom took me to the private hospital” | Preferences towards private hospital | |
| “sacrifice chicken as told by the healer” | Trust on religious healers | Health care seeking |
| “started using the neem leaves, it is getting better” | Use of other treatment options | |
| “managed to travel with the help of motorbike it took about one and half hour to reach there” | Difficulties in traveling | Transportation and distance |
| “took me to the Koholpur hospital” | Health care facilities in city area | |
| Travel to another district | | |
| “opening time is not suitable for a woman who needs services” | Staff Training | Informant’s suggestions for improving health |
| Accessibility | | |
| Awareness program | | |
3.10 Reflexivity

The position and background of researcher overall have the influence on direction and framework of the study, the methods selected to find out results and way of delivering conclusions (Malterud, 2001). The researcher expressed this realization in methodological point reflexivity. Although being from the same country and culture and having insight into the situation of local people, the site was chosen in a rural area with a completely different ethnic background explicitly separates me from research location and participants. However, the relationship with participants was established when the researcher spoke the same language and understood their expressions. The point that I am from Nepal and speak Nepali language strongly supported women to speak with me. It was an additional advantage for me that I could describe fieldwork and its objectives thoroughly to them. At the same time, recognizing fact that I do not belong to their community might have influenced their response to questions. Keeping this in mind, I developed and improved my rapport with participants by spending time with women of villages and involving in general conversations and group gathering and meetings with their permissions. One factor that I had to consider was that the villagers would think me as a rich and educated girl from the capital city Kathmandu and who has been to abroad. I entered in a rural community where most of the people living in the village consider me different from them. As this was expected, I dressed up in descent attire “Kurta Suruwal,” which was usually accepted by local people and presented myself as a student researcher who came to conduct a study. In addition to this, I came to know that other students from the other parts of the country have been there for their study purpose related to agriculture, which was benevolent for me to explain that my study is in the different field compared to previously visited students. I was aware that I was residing in an organization working for the women’s welfare, would alter the perceived role of mine. In one hand, it may have permitted the participants to express their opinions without hesitation. On the other hand, it may have restricted them to speak against such organization, as a staff of the organization was accompanying me. I had to build trust and rapport with them that their views would be
confidential, and I was an independent research student not having any concerned
towards activities of particular organization. I was staying there just for my fieldwork.
In Nepali society, women feel uncomfortable to share their problems with males
especially related to reproductive health. Being a female helped me to develop the
rapport with the women participants, but the age factor, the women participants
comparatively smaller in age than me, may have a negative influence while interviewing
them.
The awareness of researcher that they do not rely on the developed tool, rather they
themselves is a key instrument (Creswell, 2013) in whole the research process reduces
the subjectivity bias in study. My previous professions as a health care worker and my
experience working in the community field favored my initial approach to research
participants and research site. It enabled me to speak more effortlessly with participants.
The participants who were willing to talk with me, assuming that I could solve their
problems were explained my role as a student researcher. However, proper advice was
provided to them if they had any queries after interview sessions were over. In addition,
research assistants accompanied me while walking around the village created an
environment that I was a trusted individual in the community. Nevertheless, I had to
work more carefully to ensure that my knowledge in the related field would not alter
inference drawn or interpretation of views of the respondents.

3.11 Discussion on Methodology
With the escalating demand for qualitative research in the area of health care with social
and cultural dimension (Zakiya Q Al-Busaidi, 2008), Reynolds emphasized the
importance of maintaining quality within the research outcomes and prioritized quality
maintaining principles while carrying out whole research process (Reynolds et al.,
2011). Guba talked about trustworthiness to be maintained following the description of
four key aspects namely, credibility, transferability, dependability and confirmability.

3.11.1 Credibility
Guba described credibility as maintaining the internal validity of study which deals with
the “truth” factor to demonstrate trustworthiness (Guba, 1981). Leung defines validity in
qualitative research as “appropriateness” of tools, process and data, whether the
developed research question is sensible to draw stated outcome, appropriateness of chosen methodology along with valid sampling, data analysis, results and conclusions for the sample in given settings (Leung, 2015).

This study explains the context of study sites, sample selection purposes and processes to ensure its compatibility with the research questions. The use of triangulation aided in adding the credibility to study as it provides different perspectives of seeing the same phenomenon (Zakiya Q Al-Busaidi, 2008). Use of different methods of data collection and different sample to answer the same research questions added validity to study.

The questionnaire themes were modified following the feedback from supervisor after conducting a pilot FGD and interview and transcribing them. In order to develop trust and good working relationship between researcher with research assistant and study participants, more than a week was spent in the village by communicating with them and explaining my purpose of being in the village (Kielmann et al., 2011).

Before data collection was started, research assistants were selected, explained and trained about their roles and tasks (Kielmann et al., 2011). They were included in preliminary FGD and interview to ensure that research assistants understood the concept and objectives of the study along with their roles during data collection period. Feedbacks such as maintaining notes, keeping the FGD environment calm were provided. Further, they were asked if they had any difficulties in understanding their tasks.

3.11.2 Transferability

Transferability is external validity or generalizability which deals with the applicability of the study (Guba, 1981). A detailed description of the study (Shenton, 2004) was done in order to develop foundation and proper understanding of the study. This provides the basis for the researcher to decide whether the findings from research report is comparable in similar situations or whether the study can be transferred in other circumstances.

3.11.3 Dependability

According to Shenton, the idea of dependability in qualitative terms is ensured by the clear and detail description of comprehensive information at each stage of the research
process enabling the future researcher to repeat the study to find out same result if necessary (Shenton, 2004).

The main objective of study was to explore factors affecting the use of health care services among early-married women in rural VDCs of Nepal. I believe the qualitative method chosen was consistent with the purpose of the study as it aims to explore the perceptions and views of women’s experiences and key informants who are residing in research site and have close observation. Along with this, the data were gathered with focus group discussion and in-depth interviews; with the variability in the background of key informant participants maintained the dependability of the study. The effectiveness of study process was discussed with the supervisor and own perception of overall flow of the study was presented in the reflexivity.

3.11.4 Confirmability

Shenton again for maintaining quality of the study describes confirmability is concerned to objectivity of the researcher and is maintained by presenting the actual views and experiences of participants in findings of the study rather than the perspectives of the researcher (Shenton, 2004). To minimize the bias from the position of researcher, triangulation in data collection techniques was maintained (Shenton, 2004). Along with this, the transcribed data were shared with supervisor along with the results concluded from study. The discrepancies were removed and corrected with the suggested changes from supervisors in the interpretation of results.

3.12 Analytical Framework

Health belief model (HBM) in the present study has been used as a framework design to describe an idea of health-related behavior of early-married women and their perception towards medical care.

3.12.1 Health Belief Model

Health belief model (HBM) illustrates that health related behaviors and health services uptake of an individual is associated with socio-psychological aspects of decision-making. The individual’s readiness to take action for health condition in HBM is described in constructs of perceived susceptibility, perceived severity of the health condition, perceived benefits to taking actions, barriers and cues to action (Irwin M
Rosenstock, 1974). A meta-analysis of health belief model demonstrated that HBM is socio-psychological theory, which is linked with individual’s health associated decision making (Harrison, Mullen, & Green, 1992). Using health belief model as a framework helps in better understanding of the health related actions of early-married women regarding their health care seeking behavior. This helps to define how they perceive their health condition and whether it is directed towards preventive measures and curative actions.

The constructs of the HBM as illustrated by Rosenstock (Irwin M Rosenstock, 1974) are as follows:

**Perceived susceptibility:** It is the beliefs of an individual towards chances of sufferings from the conditions and it varies between the individuals.

**Perceived severity:** It is the condition when an individual sees seriousness of health condition and assumes it deteriorates and creates difficulties in associated life factors as job, family life and social relations.

**Perceived benefits:** Believing susceptibility and seriousness of a health condition, the individual takes action but the course of action may incline in any direction. However, the action is assumed to have beneficial side to reduce the “perceived threat.” The action is believed to be best among the alternatives available to them.

**Barriers to take action:** Meanwhile even believing benefits of particular action, the individual may not take action due to the obstacles, being inconvenient, expensive, unpleasant, painful or upsetting. The potential barriers may prevent a person from taking the desired action. The intention of willing to take action and strength of potential barrier determines whether the behavior is likely to occur or not.

**Cues to Action:** This variable was added to HBM to indicate triggering factors based on right health beliefs (I. M. Rosenstock, 1966) that stimulate the occurrence of action. It is believed that particular action is directed to alleviate perceived susceptibility and seriousness of the illness. The triggers responsible for action come from the stimulus. The “cues to action” in health might be internal as symptoms or external as media, interactions and social influences (Irwin M Rosenstock, 1974).
HBM was originally constructed targeting researcher who seek to understand reasons for not taking preventive measures to promote the health (I. M. Rosenstock, 1966). HBM is used in the studies related to health behavior (Harrison et al., 1992). Corner and Norman (Conner & Norman, 2005) illustrated Health belief model could be applied in the research that is related three broad areas:

i. Preventive health behaviors: It consist of health promoting behaviors (diet and exercise) and health risk behaviors (smoking, vaccination, contraceptives)

ii. Sick role behaviors: It includes sticking to the advised planned therapy

iii. Clinic use: visiting physician for various reasons

The objective of the study is to find out the facilitators and barriers of the health care utilization among the early-married women. As the usage of services are based primarily on the perception of an individual, the constructs of Health Belief model has been used to draw the assumptions regarding the health care use by early-married women. The interpretation has been made to develop an understanding of concepts.
3.13 Ethical Considerations

Before approaching research field, ethical issues to be considered while conducting the study were closely examined. Council for International Organizations of Medical Sciences (CIOMS) in collaboration with World Health Organization (WHO), have made it very clear that all human subjects involved in research should be dealt following the ethical principles of respect for persons, beneficence, and justice (CIOMS, 2002).

Public health research is different from biomedical and clinical research regarding ethical consideration. Qualitative methodology is considered as less threatening on an individual level as there is implied interaction between the researchers and informants for the purpose of understanding real world of the informants (Dahlgren et al., 2007). The study was carried out following ethical guidelines from Council for International Organizations of Medical Sciences (CIOMS) based on Declaration of Helsinki, International Ethical Guidelines for Biomedical Research Involving Human Subjects (CIOMS, 2002) and World Medical Association Declaration of Helsinki Ethical Principles for Medical Research Involving Human Subjects (WMA, 2001).

Before the study began, research protocol was submitted for comment, guidance and approval to concerned research ethics committee “Nepal Health Research Council” (NHRC) in Nepal. After feedback and corrections in some elements of protocol, study was ethically approved to carry out in respective site Dang and a respective population of study (see Appendix1). Having not required approval from Regional Committees for Medical and Health Research Ethics, Norway (Appendix 3), the study had gained permission for storage of information through Norwegian Social Science Data Services in Norway (Appendix 2). All the approvals were obtained before the conduction of fieldwork.

3.13.1 Informed Consent and Assent Form

Council for International Organizations of Medical Sciences (CIOMS) guideline 4, defined informed consent as a competent person’s decision to participate in a research after receiving and understanding necessary information; without any coercion, undue influence or inducement or intimidation. Informed consent enables individual to choose freely and favor the individual’s autonomy (CIOMS, 2002). For young, children, adults
with mental and behavioral disorders and persons who are unfamiliar with medical concepts and technology, independent ethical review of research proposal must be done for additional safeguard. Informed consent should be obtained according to legal requirements and cultural standards of community in which the intervention is carried out (CIOMS, 2002).

The women participant from age 18-20 years provided consent independently to participate in the study. The participants who were not competent enough to take decision to take part in the study signed Assent form. Some of the participants were 17 years, who were considered as child, took assent after explanation of purpose of the study. In these cases, permission from husband or mother-in-law was obtained with the initial approval from the participant.

The information on consent and assent form was written in English and translated into local Nepali Language. The individual participant signed informed consent by reading through the written content or after taking clarification information from the researcher. Although all the participants were literate and could write their names, most of the women participant asked me to read what was written in consent paper, finding it lengthy and difficult to read fluently by them. In this case, I read the informed consent thoroughly while summarizing its main themes. Some of the respondents were provided with a copy of informed consent to take home before interview, which they could read at home and sign it when they were willing to participate in study. It not only allowed the participant to make free choice and protect them (Richards & Schwartz, 2002), but also aided in maintaining the rigor of the data collected. Enough and convenient time was taken for explanation and opportunities to ask questions to the participants.

For key informants, there were not any hindrances in getting informed consent, as they were more willing to participate and understood context of the study. The individuals were informed about their right to withdraw consent at any time without reprisal. The information sheet and researcher contact details was provided to the research participants. Informed consent and assent form are presented in Appendices 4-5 and 6-7 respectively.

The participants had to walk a long way for the interview, so they were provided with lunch after conversation and discussion was over, where some preferred to eat there,
while some wished to take it home with them. However, they were informed about it only after the discussion was over, to ensure that this did not influence their involvement in the study.

3.13.2 Vulnerability
The CIOMS guideline 13 defined vulnerable persons as those individuals who are relatively (or absolutely) incapable of protecting their interests. Thorough logical explanations are required to involve them in the study considering rights and welfare of these groups (CIOMS, 2002). Nepal, being a male dominated society, there might be a risk for young married women to involve in the study, where they are not allowed to make an independent decision. Among teens and young women, their husband and mother-in-law have much influence in decision-making process regarding the access of maternal health care (Upadhyay et al., 2014). The lack of decision-making capacity might have affected women participation and result of the study. Young married girls are less powerful and suffer from physical, sexual and psychological violence (K. Santhya, 2011), which might lead to potential harm by participating in the study. To avoid this vulnerability, the participants were involved with permission from participant and if necessary permission from the family members was sought.

3.13.3 Risks and Benefits
The potential risk and benefits were considered while conducting a research involving the human subjects (CIOMS, 2002; WMA, 2001). As the study was qualitative in nature and exploring the views, perceptions and experiences regarding the use of reproductive health care services from participants, there was not any physical harm associated while participating in the study. Also, there were not specific direct benefits to the participants but they might take the discussion as of value for them and influence each other in health care seeking practices by participating in the FGD. Few participants verbalized this in the end of some discussions. It is important to have understanding about health care needs of married adolescent and young women and barriers to reach them. The result from research may be utilized, as a reference, by some organizations working in the particular village while dealing with health care needs of early-married women in particular community. Identifying the barriers and facilitators could provide the new
dimension to work while dealing with their needs. Likewise, there were not potential direct risks for participating in the research project. However, the respondents might have been disturbed emotionally while retrieving information from their past experiences. It was stressful for participants to talk about their pain and experiences regarding illness or loss of their children or husband and their painful experiences during pregnancy, delivery and postnatal period. At that time, I listened to them carefully allowing time to recover from their emotions and showed sympathy and empathy. Moreover, I realized that I was taking their valuable time, as they were busy with their household work and for the upcoming festival. The participants were informed that they do not need to talk about anything, which creates distress while participating in the study. The benefits of this study were overbalancing the risks that were likely to occur, which justified the purpose of study.

3.13.4 Confidentiality and Storage of Data
The matter of confidentiality and maintaining privacy of all participants is highly recommended to develop a mutual understanding through trust as well as to preserve the ethical standards in a flawless research (Baez, 2002). The confidentiality and privacy of data generated after interviews and focus group discussions were stored safely in a personal computer of the researcher, which was further protected by a password. The access of data including tape-recorded was shared only to the individuals involved in research; outsiders were out of reach of the collected data. The field notes were only accessible to me. Anonymity was maintained on the transcripts of material/data. All data were kept without mentioning the name or any recognizable factor of the participant. It was highly essential to maintain privacy of collected data because most people in a small village know each other. The culture of gathering together and having talks was common among women, which might limit the privacy of data especially collected during the focus group discussions. The study was about the reproductive health care seeking behavior of the young married women, which is also being a sensitive topic, confidentially was highly required. Interviews and discussions were conducted in a designated place where privacy was heightened. The participants were also informed and requested to maintain confidentiality of the matters discussed especially in FGDs by not having conversation about other participants in village and community after they
leave the discussion room. The research assistant accompanying me understood the matter of confidentiality having worked in the women’s issues in the same village, and I also requested her to maintain it. Furthermore, the participants were informed about the anonymity of the data collected before initiating each interview and discussion. All the data generated during the study will be destructed after the completion of thesis.

3.14 Dissemination
As a partial requirement of fulfillment of M. Phil International Community Health, the result of the study will be delivered at the University of Oslo. A summary of research will be disseminated to Nepal Health Research Council (NHRC) and to the authority of the community in Dang where the research was conducted. Being the main researcher I also intend to submit the result in an article to a peer reviewed journal for publication.
4 FINDINGS
The finding section includes the description of views derived from research participants, both early-married women and key informants of the community. The data obtained from in-depth interviews and focus group discussions are combined to shape the results of the study. The quotes are used to present the views of participants in their own words without any alteration and these are assigned to respective respondent.

4.1 Socio-demography of the participants

4.1.1 Profile of key Informants Interviewed
The key informants participated in the interview ranged from various professional backgrounds. They were selected from four VDCs of Dang District who were linked directly or indirectly to adolescent girls and early-married women and their health in their profession.
Health service: Health-post In-charge (worked for 15 years)
Health post: Female community health volunteer (worked for 10 years)
Local NGO: Social mobilizer (worked for 8 years)
Local NGO: Social mobilizer (worked for 3 years)
Local NGO: Department of Head (worked for 2 years)
Government Department: VDC officer
Government Secondary Level School: Headmaster
Local NGO: In-charge officer (worked for 5 years)
Community: Community leader
Government: Human Right officer (worked for 15-16 years)

4.1.2 Profile of early-married women
The age at marriage of women participated in the study started from 13 years of age. The present age varied from 17 to 20 years; most of them were 19 and 20 years of age and five of the participants were 17 years of age at the time of data collection. The husbands’ of all the women participants was comparatively one to three years older. Economically they were not stable. For this reason, the husband of most women participants has been abroad (India, Qatar) for earning money, as it was time for them to bear the responsibilities. Some were engaged in labor work in the city area of the Dang
district and few were engaged in agricultural work. Mostly, women in the community were seen working in the farming field.

The participants already had one-two children by the age of 20 years, few participants were pregnant with first baby and one participant was pregnant with second baby. One participant had her miscarriage and did not have any child.

Most of the participants had mobile phone and some of them verbalized they use it to listen news and FM radio. All the participants were living in houses made up of brick and mud, with tin or tile roof. Drinking water, toilets and electricity facilities was available to all the participants.

Among total thirty-eight women participants, most participants did marriage by themselves by eloping away. Parents married four of the participants forcefully without their consent. The causes mentioned were influence from friend’s circle, exchanging the phone number and influenced by husband before marriage. Most them were studying at secondary level of education and left education after marriage. Two participants continued education after giving birth to babies.

I observed everyday norms and activities around the community for understanding local people’s lifestyle. Mostly women were engaged in daily domestic works and in farming in fields. Having cattle at home was common to all the participants. Cutting the grasses and carrying them over the head was seen among the girls and women. Waking hours to reach the destination was easily accepted in the community. News about someone eloped away from another village to this village was heard few times when the social mobiliser were talking. It was a norm that parents would marry them when they have eloped away from home and the community accepted it. One of the marriage happened during my stay in the field.

4.2 An Overview of Main Findings

The overall result of study reflected various facilitators and barriers that influence the health care use among early-married women in communities of Dang. The thoughts and experiences expressed by each participant are individualist and unique. However, the overall picture from these expressions is presented with identification of common themes that influence the general and reproductive healthcare seeking behavior. The whole finding is divided into four heading followed by sub-headings. They are:
Perception of health, illness and symptoms of childbirth, experiences in using health care services, determinants of health care accessibility and utilization, and key informant’s suggestions for improving status of early-married women.

Most participants identified health as an important factor and choose to receive services on the basis of their beliefs and availability. However, the health care was minimal during antenatal, delivery and postnatal period, which impacted the health of both mother and newborn. The use of family planning devices before the first birth is uncommon. Furthermore, the barriers were distance and transportation unavailability to health care, economic factor, verbal abuse from health care provider and shyness and discomforts. The facilitators were shared and own experience of health care use, independent decision making capacities and positive attitudes towards health care facilities. The informant’s suggestions were practical and based on their experiences.

4.3 Perception of Health, Illness and symptoms of childbirth

Nearly all the women participants in the study showed consciousness about their own and children's health and sought for the treatment options available to them. When the women participants discussed about the perception towards their health, most of them related health care with the cleanliness of surroundings and their body such as washing and cooking and eating nutritious diet. However, two of the participants expressed their unmet need of the nutritious food. The inadequacy of food during the time of pregnancy was revealed.

"Usually, fruits should be bought at this time (pregnancy); here they (family members) didn't bring for me. I didn't eat or drink milk or other stuffs available in the market; I managed with the foods from home"- TRANS 10 (17 years married, present age 20 years)

"It is not usual to eat many fruits in the Chaudhary caste"- TRANS 12 (married at 17 years, present age 20 years, one miscarriage)

Furthermore, the participants explained when the particular members in the family were sick, the decision to go to the health care services were done, in majority, by the husband or mother-in-law or father-in-law.
"I didn't decide it by myself. Her father called me (from abroad) and told me to go to the hospital by walking slowly and then I went." TRANS 5 (Married before 18 years, one child)

However, one woman mentioned she decided everything by herself, if somebody got sick as they were already separated from the joint family.

"My husband usually gets ill more than me and I have to take him for the treatment and the medicines. When I get sick, there is nothing much, I have to tell him to do, like treatment and all... it is hard for me... my husband is not aware of my health and I have to tell him to take me for treatment" TRANS 2 (Married at 14 years, Present age 20 years, 2 children)

According to the key informants, early-married women compared to adult women do not have knowledge about taking care of their own and children's health. In addition to this, their physical incapability and weakness was described as a reason for this. They are not matured enough to be responsible compared to the adult women. Further, it was suggested in KII that the early-married women were the isolated population and left behind in the community having the limited access to the health care facilities.

"These are the group of women who reach less to the health posts because our society has not been able to change. The parents have a different perception of their children, those who have done early self-initiated marriage. They are left to manage their life by their own as they have chosen to get married on their own. The lack of understanding has left them far behind." REC 5 (key informant, community leader)

As explained by two key informants, the reproductive health issues are private and confidential among the women. A woman may not seek care considering the particular reproductive health problem and symptoms appears only among group of the women involved in sex works. The feeling of insecurity that they would be identified as a sex worker would overwhelm them.
"They are afraid that people might think of her as a sexual worker because they think this kind of problems usually happens to the sex workers. They feel insecure and do not reach up to the health care services" REC 1 (Key informant, District officer local NGO)

These all explanation gives the overview that varied perception exists in health care among the participants in the study.

4.3.1 Care of health and Competing Responsibilities

The finding of the study in the community of Dang district suggested that perceived roles of the women were to remain in the house and to perform the household activities. Most of the female participants verbalized that overload of the household works prevented them from caring for their health during pregnancy. While they have to perform all the work at home, they have little time to care for their own health.

"Doctors had told me not do the heavy lifting, not to carry the heavy water but I used to carry it. There was nobody at home, my mother-in-law was always quarrelling insisting me to work with my husband”- TRANS 4 (married at 15 years, present age 20 years, one miscarriage, one child at present).

The women bounded by the household responsibilities were not able to deny the work even at the time of their pregnancies. One participant said when they talk about the rest mentioned in the health care facilities during the antenatal examinations; the mother-in-law takes it as an excuse for not working and the doctors were in their position only to earn the money. Another participant said it was common for all women in the community. Furthermore, some participants in FGDs expressed the overload of household work in the village prevented them taking care of their health and there were no options for them that they could run away from it. Other participants in the discussion agreed with the views of this respondent.

“if we say so (about rest), then we are told that the particular person is working in the same condition (pregnancy), why shouldn’t I? If all the family members from the home understand these things, then it will be the value of this talk”- FGD 1
“even after the pregnancy, I did not think about the light or heavy work, I was doing every work.” - FGD 2

“it’s the same, we have to carry the water and carry the heavy loads. Carry the grasses and woods; to feed the cattle, we have to be able to do everything.” - FGD

"while we are staying in a village, there is nothing much about taking care of the health. We have to work. We all have cattle at home. If we are rearing them, we have to work. We have to work in every possible way" - FGD1

The women participants mentioned that they could not arrange time to visit the health care facilities while they were busy in finishing the household works.

"After getting married we don't care much about our health. The caring attitude of own health is very minimal. We are very busy at doing the works. Being a daughter-in-law, we have to perform all the household works. Because of all these, we rarely care for our health". - FGD3

This view was congruent with the expressions of most key informants. One of the reasons for women’s difficulties in receiving the services as mentioned by the key informant was that there is time mismatch between the opening hours and women seeking the health care services. As the priority was given to the work, they were busy in performing the work. By the time they finished work, the health care facility would be closed. Because of this situation, they might not have time to consider and take care of their health.

"Almost all of the adolescent, early-married women goes to the health posts, they have very limited access to hospitals and private clinics. They have to finish all the household work before they can visit the health-post like handling children, food and everything. After finishing the household work they start to go for health-post and the time they reach there, the health posts are closed. Health
care personnel just walk away. So there is a condition where these women travel again and again to health-post but do not get the services." REC 1 (Key informant, District officer local NGO)

The women in the community prioritize the work completion compared to their health. Being married at very small age and with all the responsibilities towards the household works and their children, most of the participants in key informant interview (KII) indicated the early-married women were unable and not willing to take care of their health.

**Existing Health Problems in women**

The participants reported various health problems as consequences of excessive work that they had to perform. Problems related to uterus and other general body pain were mostly discussed among early-married women as a consequence of giving birth immediately after marriage followed by heavy work during the postnatal period. Two participants in the study shared their experiences that they had already suffered from uterine prolapse in their early second decade of life.

"After 15 days (after delivery), I had to carry the barley sacks to get it beaten. Because of that, part of the uterus came out. There were nobody at home, my mother-in-law and me, only five members. We had to work fast. I had to do everything, so the uterus came out" - FGD 4.

A participant explained about her difficulties in daily life due to uterine prolapse. Although she sought for treatment, she did not recovered and she mentioned about further mentioned about difficulties to get it recovered.

"(...) when I am walking without wearing the underwear, it is little difficult; I feel something has covered there (private part). I am planning to get the treatment for this, I also have pain in the lower abdomen, but when I go for the treatment they said the condition is good. There are not any problems. " TRANS 2 (Married at 14 years, Present age 20 years, 2 children)
“they may have reproductive health problems during that time. They may have infection, uterine prolapse and fistula and other problems.” - REC 8

Miscarriage was also one of the issue among the participants, where few participants expressed they suffered from miscarriage.

"I was told not to work too hard and carry the heavy lifts but this is not applicable at home, being a daughter-in-law I had to do all the work. And the bleeding was seen continuously." - FGD 3

" in every health care facility they used to tell to take adequate rest and not to carry the heavy lifting, but as soon as arrive at home, I had to do all the works." - FGD 3

"At that time I had miscarriage and my baby was wasted.... I had miscarriage at three months pregnancy. And second time I got pregnant with my second son. At that time also I had many difficulties. I had to take injection of rupees five thousand to increase the growth of the baby... I went to Nepalgunj and received injection" - TRANS 4 (married at 15 years, present age 20 years, one miscarriage, one child)

Few participants mentioned about prolonged labor pain. For instance, one woman mentioned she was taken to the hospital after having labor pain for three days.

4.3.2 Meaning of First Birth

All the participants in the interview had adolescent pregnancy, as soon as get married, without using family planning methods, in order to save and show their fertility capacity. It was not only her, the whole family members, husband including the mother-in-law and father-in-law were not in the favor to postpone the first pregnancies when the women got married.

"(...) my husband didn't agree to use the family planning devices. Mother-in-law and father-in-law also would not agree if we were not having a baby after
marriage. They insisted me to have a baby” TRANS 3 (Married at 14 years, present age 17 years, two children)

"..the men would not agree on these things. I told my husband that I wanted to postpone the pregnancy for 2 to 3 years, as my age was very small. But he scolded me for this… I told my husband that I would do the abortion of the baby. He then gave me the warning; if anything will happen to the baby then I could not go back his home. So I didn't do anything and I gave the birth to the baby” TRANS 6 (married at 16 years, present age 17 years, I child)

" we both (husband) decided together and I had to ask my mother-in-law anyway. My mother-in-law said that I couldn't do that. If you become pregnant, you have to give birth. From then I have not used any services”- FGD1

Priority to health of a girl was not given when she was expected to deliver a baby soon after marriage.

4.3.3 Interpretation of Pain

There were some participants who visited the local health care facilities for the problems like leg pain, hand pain and fever which were considered as minor illnesses. Women participants did not consider it as severe to receive any treatment for these kinds of pain.

"I am not receiving any treatment for this. It gets better when I have massage with the oil" TRANS 7 (woman married at 16 years, present age 19 years, one child)

"I go to the health post. Some simple fever is recovered by itself, if its severe I go to the hospital and take the medicines and sleep"- TRANS 11 (married at 17 years, present age 20 years, one miscarriage)

In addition to this, one of the participant explained having abdominal pain was a common problems among women and was perceived as minor problem.

"its common to have some problems related to health like having the abdominal pain"- FGD 1
Other participant expressed symptoms, as vomiting was a common problem to all women at the time of pregnancy due to which the participant did not reveal about it when she visited the health care facilities for antenatal examination.

"I told about all other things, but I didn't tell about this (vomiting) to them. I heard this happens to everybody. So I thought it is useless to say this."- FGD1

Further, health care seeking at the time of labor pain was usually done when the pain became severe. Participants considered mild pain or initial pain as normal during the labor pain, and many did not recognize it as labor pain until it became severe.

"I started having pain, and the pain was on and off. And I thought it was abdominal pain only, and I told nothing to anybody. And in the evening I started to have severe pain. And I told I have pain at 2 a.m., and they called the ambulance and took me to the hospital"-TRANS 7 (woman married at 16 years, present age 19 years, one child)

A woman or the family member tends to seek the care when the intensity of the pain is intolerable, during which the health care facilities were sought lately.

"I was taken in about 3 days (in health care facility), the condition of the baby and the mother was worst, about to loss life. There in the hospital, I was scolded for coming late and then I told, the family members from home were not taking me and how could I come. I was the person having the labor pain so I could not come . I delivered the baby but the condition was not good and then they kept the baby in something, in oxygen, then the baby survived hardly. . In the village the people would not consider for the mild pain, and ignore the pain that nothing will happen. They would think that they might deliver the baby here. The hospital is taken when there very difficult emergency pain"-FGD 3

"The woman also tells about the labor pain only in the condition that they cannot tolerate the pain anymore at very last moment." REC 1 (Key informant, District officer local NGO)
A woman described she would go to the health care facility for the antenatal examination when she suffer from abdominal pain.

"I used go when I had abdominal pain and any other problems. They used to give the advice, if the baby doesn't move; we have to go to the nurse. We ask that what had happened the baby is not moving. The nurse might say the condition like if the baby is small" - FGD2

Pain severity was an important factor for using the health care services.

4.3.4 Impacts on the Health of a Child

The health of the baby was discussed several times by the women participants in the study. It was expressed the hospital stay was extended because health condition of the baby was not good when it was born.

"The baby was kept in ICU in Lucknow (India). The mother was in Ghorahi (Dang); only the baby was taken there. They were saying the baby will be better, but later they told the baby could be alive or dead. The doctor suggested avoiding more expenses. Then the baby was brought home for "Nwaran" (name ceremony). The day after this ceremony, the baby died. The baby was not able to breathe properly and not suck the mother's breast milk" - FGD2

“My baby was kept in ICU, we had to take the baby in Koholpur (neighboring district). The baby was born in zonal hospital, but the baby was weak and did not suck the breast milk. Then we took the baby in Koholpur with the ambulance and was kept in ICU for seven days” - TRANS 6 (married at 16 years, present age 17 years, one child)

“They (health care providers) asked if they can keep the baby in ICU as the baby is not able to suck the milk. I told them, my son is sucking the milk but there is no milk…. he used to cry a lot, when he was just born... he used to cry a lot” - TRANS 12 (married at 15 or 16 years, present age 19 years)
The problem that the children of the participants get repeatedly sick was mentioned in the talks with women participants.

“they (children) are getting sick from time to time. The elder daughter had jaundice previously. But she has recovered now”- TRANS 2 (Married at 14 years, Present age 20 years, 2 children)

“She is having wound in the head and she does not let me sleep the whole night (looking at the baby). I have taken her 2 times for the examination in the hospital and the health post. It was about to heal but it is infected again. I am giving her the medicines and they have prescribed the ointment also”-TRANS 8 (Married at 15 years, Present age 18 years)

Woman participant and key informant both mentioned the problems in the expression of breast milk and inadequate milk to feed the child after delivery of the child.

"There was no formation of the breast milk after the baby was born. They suggested feeding the baby, so that there will be formation of milk. Although I tried to the feed baby, there was no milk. He didn't suck the milk for four days"- Trans 12 (married at 15 or 16 years, present age 19 years)

"they may have problem of breast milk expression, and formation and they do not have enough milk for the child”- REC 8 (Key informant, Social mobiliser, NGO)

In the study, a few participants mentioned about low birth weight of baby.

“Then they kept me there (in health facility) for 24 hours as baby was of only 2kgs in weight”. - FGD 1

“I took my daughter there to examine her wound, they told me to feed “Balvita” – “supplements” to my daughter. It is in the tablets and they told me to mix it with the rice. They told my daughter in very small, although she had reached the age of one year and she also do not have the enough weight”.- TRANS 8 (Married at 15 years, Present age 18 years)
Some of the participants mentioned the baby was born before the expected date of the delivery for which the problems in the health of the baby occurred.

“I was pregnant 3 months later (after marriage) in the month of Bhadra (July/August) and born in the month of Baisakh (April/March) in 8 months.” - TRANS 6 (married at 16 years, present age 17 years, one child)

Therefore, the condition of a child born from a mother at adolescent period is likely to influence the health of the baby.

**4.3.5 Experiences of Violence**

The interview with the key informants revealed that physical violence was common in child marriage resulting into the consequences as divorce and polygamy. It was mentioned divorce in the Dang district was rising among the early-married women after having children. It was indicated some women at the age 20 years already having three children were left by her husband. This situation could make them more vulnerable.

"The thing is they marry, and later after one two years they become matured and they have problem with understanding each other and then they want to get divorced... They marry and sometime the husband leaves the girl when she is pregnant, and they even do not have registered their marriage. And there will be no base to provide justice to them." - REC 4 (Key informant, NGO In-charge)

Furthermore, the violence environment at home inhibited the women in the decision-making capacity in order to visit the health care services.

“Those who have family issues and arguments, where there is no peace home environment, they cannot decide on their own. They have issues like for what reasons she has to go when we are fine even we didn't go for check up.... she is now 17 years old, she delivered the baby at the age of 14 years, and she has one daughter. Her husband didn't allow her to stay at home... he beats her... The mother-in-law also doesn't treat her good and beats her " - REC 8 (Key informant)
“the husband is not supportive and women with victim of domestic violence are not going to the health care facility”-REC2 (Key informant, In-charge local NGO)

Many women participants considered it as usual to have disputes and conflicts at home mainly with husbands and other family members. Most of the women participants talked about the verbal violence from husband and mother-in-law. Inabilities to perform the household work were the reason for most of the participants.

“it is common to have some fights and discussions at home. Sometimes husband might not agree on what the wife has said. It is also same with the mother in law. It is not always sure to have good at home. Sometimes it is common to have fights with everybody”- FGD2

"here (husband’s home) I am scolded a lot. I always want to cry. I was married at very small age. I am scolded a lot"- TRANS 8 (Married at 15 years, Present age 18 years)

“Even I got married at very early age, I used to do the all works. But even after that they would not be satisfied with me. They used to scold me”- TRANS 2 (Married at 14 years, Present age 20 years, 2 children)

“in my husband’s home, my mother-in-law used to shout all the time. I never replied her back. My husband used to say that I do not reply her back, she will shout and shout and get tired and will be quiet. My husband used to shout at her when he heard her shouting at me but I never replied her back. Instead I used to cry, but don’t speak to her. I used to sit and cry loudly but I didn’t replied back anyone”-TRANS 4 (married at 15 years, present age 20 years, 1 miscarriage, one child)

A participant indicated she had suffered from violent environment at home, and the issue was whether the participant to become pregnant or not.
"Previously, we used to have fight because of issues related to having baby or not"- TRANS6 (married at 16 years, present age 17 years, one child)

Another reason for the existence of violent environment was a habit of the husband of women participants that they would be a binge alcohol drinker and beat wife if she asked him not drink too much. For this reason, a few participants were beaten where they decided to stay quiet rather than making further arguments. Verbal arguments were common as explained by the participants.

“Previously I used to have some fights with my husband, he used to drink alcohol a lot. I don’t drink and we used to fight for this reason. Our family brothers were separated with the property distribution and then we had lots of loans to pay then he had to go abroad”-TRANS 5 (Married before 18 years, one child)

“it is very common that everybody is taking alcohol in today’s world. The main reason to have fights between the husband and wife is alcohol…. I don’t like he drinks. Even mother-in-law and father-in-law scold me that my husband is drinking the alcohol. I suggest him not to smoke or drink; only those who are wise understand it. He argues with me that he has not used my money or property from my parents…I think that is the main cause for the husband and wife to fight”- FGD 1

Few participants also mentioned physical violence.

“Sometimes, it happens. When I ask him not to drink, he beats me. Sometime when we have fights, I feel very restless and I think what can I do to have every thing good”- TRANS 12 (married at 15 or16 years, present age 19 years)

“the husbands drink the alcohol and come to fight. They marry at small age and do not use any family planning methods and babies are born in less spacing interval. After having many children, it is obvious to have problems at home and the issue for the fights arises at home. The children have demands, which cannot be fulfilled, and discussion arises”- FGD 3
One of the participants in FGD explained the reason for fights and disputes were related to polygamy.

“my husband has married to three women. I am the third one. She is the daughter of the first wife (indicating another participant). He sometimes stays with one, sometimes with the other; it’s the habit of the men…. there is not a single day that there is no fight between us…He beats everyone.. It is like get beaten and sit quietly. There are no other options ”- FGD3

The women participants in the study easily accepted the violence from their husbands.

4.4 Experiences in using reproductive health care services

The experiences of women participants while using family planning services, antenatal, delivery and postnatal care provided a significant support to the findings of the study.

4.4.1 Use of family planning services

The use of family planning methods was not common among women participants before birth of the first baby and they were more likely to give birth within first to second years of marriage. The reason for immediate pregnancy was linked with the time period of marriage. Exceeding period of a year or more was considered as late time to become pregnant by the participants in the study.

"It was becoming more than 1 year that I got married so we decided to have baby... I do not feel any discomforts and it is not about happiness. One should have at least one baby"- TRANS 1 (Early married, present age 18 years, pregnant eight months)

Key informants presented the same view.

"When women do not deliver within 2 -3 years, the family starts to talk about it. They do not give the pressure. They are concerned about reasons why she didn't give birth. They start to think she cannot give birth" REC 8 (Key informant, Social mobiliser, NGO)

One participant who was married at the age of 17 years, after having one miscarriage was distressed when she was not able to become pregnant immediately for the next
baby. She was seeking treatment options to become pregnant soon when she was only 20 years.

"I think about why didn't I have the baby. It would be better if I had the baby. I keep on thinking about these things if I am sitting alone. When would I have the baby?" - Trans 11 (married at 17 years, present age 20 years, one miscarriage)

A married woman (a girl) was not expected to use the family planning devices before the birth of a first child. The belief that use of family planning devices lead to complications for becoming pregnant was found to be widespread among women participants in the study.

"usually, it is a risk of not having the baby after use of family planning methods before first pregnancy. After having done the marriage, the thinking is that it is not necessary to use it (laughs). After the baby is born, temporary methods are used." – FGD3

With this regards, the girl who was married early becomes pregnant with their first baby as soon as possible within a year leading to adolescent pregnancy in child marriage. The reasons identified for immediate pregnancy was influenced by number of factors. Firstly, they do not have adequate knowledge about the use and means of the family planning methods that they can postpone the pregnancy. Even when the family planning devices are used, some of them use it not having the knowledge about it. Further, participants preferred the advice from the experienced women in term of family planning use and it was suggested not to use family planning methods before the first pregnancy, as they were afraid about the consequences of difficulties for being not pregnant after its use. Most of them used the family planning methods only after first pregnancy. In addition to this, the decision to use the family planning devices was dependent on the decision of the family members such as husband and mother-in-law. Few women participants demonstrated autonomy, but they tend to use it only after having the first baby. Even after the first pregnancy, the decision was often done with the permission from husband. The misbalanced concept between the lack of decision-
making powers in a young married woman and what she should do influenced in making contacts at the health care points.

Also, men were usually not concerned and not likely to take the responsibilities in using the family planning methods.

"Even the devices (condom) which are meant to be used by men, should be taken by the women to use it for husband and advice them to use it." REC 1 (Key informant, District officer local NGO)

"They (care provider) also told about the other methods. There is also Dhal (Condom), but my husband didn't know how to use it, and I had to save myself from being pregnant. That's why I used the injection" TRANS 2 (Married at 14 years, Present age 20 years, two children)

When discussing use of family planning methods with the key informant among early-married women, one participant suggested using the alternative methods of the family planning if the particular method of family would cause infertility.

"It is said, if the pills are taken it will cause the infertility, but they can use other means of family planning methods."  REC 3 (Key informant, FCHV)

After giving birth to the first baby, the participants were concerned about using the family planning methods as they suffered from the first pregnancy, which was expressed both by the key informants and the women participants.

"After first (baby) they know about how hard it is to take care of the child and about the problems they suffer. After that they use the temporary method of family planning. They think about having other child when one child is grown enough"- REC 8 (Key informant)

Family planning was a topic generally not discussed openly by the women, where some of the women hesitate about its discussion and laugh indicating that they were not open for its discussion. For example: the word used about the family planning devices like "condom" was even difficult to bring it into discussion, even though they have been
using it. The reason that male uses it might have influenced their perception. However, few participants were very open to discuss about it. Furthermore, the findings showed that although the use of family planning devices is secret talk between the husband and wife, it is usually influenced by shared ideas with the women in the village who have experiences. It would be the mother-in-law, neighbors, and experts as social workers.

"I am using injections...I got advices from the seniors and friends from the neighborhood. They told what will happen if I do that... Previously, I used to go Gaurigaun; it is far from here. Later I went to the WOREC clinic... It would take almost 1 hour to walk there or it would take at least 45 minutes from here" - TRANS 10 (17 years married, present age 20 years)

"I knew about it (family planning) from before also when I went for training when I was adolescent in WOREC. And I come to know about it while talking with friends, that it is necessary to do after marriage. After marriage also, I asked to those who are married that which one is better for family planning methods." - TRANS 13 (married at 17 years, present age 20 years)

The use of the family planning methods is not common before first birth because of the lack of trust for it was found in the study.

4.4.2 Antenatal Period and Health Care
Most of the key informants considered pregnant woman at small age were immature physically and mentally and did not have knowledge about caring for herself and baby during pregnancy. This view was similar to thoughts of women participants as they described their experiences in discussion.

One participant described that she knew about her first pregnancy very late and went late for the antenatal examination and from this experience she came to know about the examination months for the second pregnancy.

"I come to know about first pregnancy after six to seven months" TRANS 9 (Married at 17 years, present age 20 years, had child and pregnant with 1 ½ months)
"In the previous days, nobody knew in the home that I was pregnant and later when she knew about it (mother-in-law), she told me to go for check-up. My husband was not at home; he was abroad. My mother-in-law was at home and she gave the permission to go for the examination. Sometimes we used to go together, sometimes by myself" - TRANS 10 (17 years married, present age 20 years)

"When I was pregnant, I did not know about my pregnancy. I asked my sister-in-law if I am pregnant because I did not had my menstruation cycle. She told me to go for the examination. We went together for the examination and with the urine examination I come to know about my pregnancy" - FGD2

Furthermore, common motivators for seeking health care facilities during the time of pregnancy were information and suggestions provided by experienced women in the community or suggested by relatives. However, inconsistencies were found during antenatal examinations varying from at least one visit to visits more than four times as mentioned by women participants. KI in the in-depth interview supported that the visit for antenatal examination is only one or two times.

When a participant had second pregnancy, she did not have time for the antenatal visits, although she had information about it. The reason explained was that she had to take care of first baby as well. At the same time, experiences in health care facilities during first pregnancy also determined the possibilities for the next visits.

"And I did same for my daughter but I didn't go for the check-up. I completed both injections at once when I was pregnant with daughter but with son I went for twice. That's it. I went for check-up once during first pregnancy and didn't go for antenatal visit in second pregnancy" - TRANS 3 (Married at 14 years, present age 17 years, two children)

Regarding the health care suggestions received during the antenatal visits, for almost all the participants who visited for the antenatal examination, similar suggestions were
provided by the health care provider as not to carry the heavy loads, which was a common practice among women in village community of Dang.

"they (health care provider) say I should not carry heavy things, I have heard about this. In food they talked about eating the green vegetables, pulses, lentils"-TRANS 1 (Early married, present age 18 years, pregnant eight months)

"to take care health, it is advised not carry the heavy weights. It is not good to carry water. It is necessary to take care of your own health. It is not good to do difficult works"- FGD1

Also, reason participants mentioned, for not completed their antenatal examination during the pregnancy, was preterm delivery.

"When I was pregnant I went for the examination. I went when the pregnancy was three months, 7 months and I was planning to go in 8 months.... I delivered the baby in 8 months"-TRANS 6 (married at 16 years, present age 17 years, one child)

"it was three times (antenatal examination). It is actually four times that I had to visit. For the first time it was when I was pregnant I went at four months, then six and eight months.. The baby was born when it was eight months "-TRANS 13 (married at 17 years, present age 20 years)

Although the participants mentioned about the antenatal care and antenatal visits, it was not satisfactory on the basis of recommended visits and care to be received by a pregnant mother.

4.4.3 Delivery and Postnatal Period Experiences
Some of the participants expressed a level of satisfaction with health care services, however most participants were not happy with health care facilities during and after the delivery.

"I felt bad when I had delivered my baby, the nurses left without doing the stitch in some area, which causes bleeding and again the stitch were done 2 or 3 times. }
That has happened to me"- TRANS 4 (married at 15 years, present age 20 years, 
imiscarriage, 1 child)

The expectation was not met when they reached health care facilities. The experiences 
were described as below.

"As soon as I delivered the baby, there was power cut-off. They even didn’t turn 
on the generator. We stayed in the light of mobile. The mosquitoes were biting 
the baby. I was scared. I felt that what kind of hospital is this; they are not even 
using the generator. We were just talking within ourselves that they did not turn 
on the light. It was a feeling of relief only in the morning. There were many huge 
mosquitoes"- TRANS 12 (married at 15 or 16 years, present age 19 years)

"... during the stay, there were a lot of mosquitoes biting. The whole body was 
not feeling well, as I was a new postnatal mother. I had severe pain in my hands 
and legs"- TRANS 6 (married at 16 years, present age 17 years, I child)

The participants also talked about extended length of stay in health care facilities 
because of the complications during delivery.

"They said the wound (perineal area) is very severe one and they kept me in the 
hospital for 6-7 days and then after that we came back home."- TRANS 8 
(Married at 15 years, Present age 18 years)

"after the birth of my daughter I was there (in health care facility) for four days. 
There, it was necessary to clean the wound, so I came home after four days"- 
TRANS 9 (Married at 17 years, Present age 20 years, one child and present 
pregnant)

The way of examination during the delivery was also described as irritating to the 
participant.

"The main thing that I didn't like about them they were inserting the hands 
frequently (in private part). I asked my mother to say them not to insert the hands 
regularly as I cannot withstand the pain but they used to do it frequently and
Furthermore, participants felt alone during labor pain when the male member was not allowed to stay in the room in health care facilities.

"When we reach in the hospital, they send my brother outside the room, and I had to stay there alone. They just left me there on the bed. Nobody came to see me, and they only came when I was about to deliver the baby. They didn't come when I was having labor pain" - TRANS 10 (17 years married, present age 20 years)

**Concepts of Home Delivery:**

Among the women participants, it was discussed that the outcome and experience of the first birth generally considered as the reference for a woman whether to have the next delivery at institution or home. Few participants expressed that better option for them would be to deliver at home when they were giving birth at small age. The experience in the hospital at the time of first delivery was the basis for the decision for second delivery.

Few participants delivered at home without the assistance of the skilled attendant in the community.

"I also delivered the baby at home. I was working all morning...and in the evening I delivered the baby...the labor pain was for not so long. Nobody was aware at home that I was having the labor pain" - FGD 3

In a focus group discussion, it was said that cases of normal pregnancy could be delivered at home. This view was congruent with the view of the few key informants mentioning that villagers had idea that normal delivery without any complications could be done at home. The key informant deemed this as a problem in one of the in-depth interview:

"The people still are not aware that they have to go to hospital for delivery. They believe it is good to deliver at home when the pregnancy is normal." - REC 1 (Key informant, District officer local NGO)
Also, KII thought that home delivery would occur in rare unplanned cases when some delivers easily at home although they do not suggest having deliveries at home.

"Among 18 to 20 delivery cases in Dhanauri VDC, sometimes one or two cases are delivering at home. Last month's case, they had called the ambulance, but when the ambulance reached there she had already delivered" REC 6 (key informant, Health post In-charge)

Thus, the participants were concerned about lack of care from health care provider; others were not satisfied with the procedures, physical structure of the care facilities during their stay in hospital. Few participants also delivered at home.

4.4.4 Verbal Abuse and Neglect by Health Care Providers

The results showed that some of the participants were not satisfied with the harsh language used by health care provider and being critical about their age of marriage and pregnancy, which was a potential barrier for the visit to health care facilities. A participant explained she did not wanted to go back to the facilities in case she is scolded again for her immediate second pregnancy.

"They had already scolded me for first pregnancy at very small age. I was furious at that time. If I had gone for the check-up for second pregnancy, they would even scold me very badly. That is why I didn't go for check-up. They speak in loud voice and don't respect. Who would do it if one knew everything? If I had known everything, I would not be pregnant. They speak badly." TRANS 3 (Married at 14 years, present age 17 years, two children)

The participants felt bad about the way they are dealt and being scolded for marrying and pregnant at small age.

"It was difficult experiences as it was my first baby. The doctor shouted at me and said it is not only you who deliver the baby; you elope away at the age of 17 years, and you women are looking for your rights. The doctor was scolding me. And I was not in the position to feed the breast milk. I had wound in my body, and I was in severe pain, my body was aching... The doctor was scolding and my husband he couldn't give any explanations and reasons. He was quiet. And my
mother in law also couldn't speak. The doctor came, scolded me, and went back. Then it was over."- FGD 1

A key informant also highlighted the behavior of health care provider, which varies in government compared and private health care facilities.

"The behavior of the health care personnel is also creating the problem for women to use the services. The same doctor if providing services in his clinics, they deal in a proper manner and speak politely and provide the good service. In the government health care services, the same doctors behave differently, they become surly and unfriendly" REC 2 (Key informant, In-charge local NGO)

One of the women participants in focus group discussion expressed her lack of knowledge about the expectation of the health care provider regarding her age when she visited the health care facilities as below.

"The doctor from there also scolded me. I didn't know that I had to keep the age above 18 years in the card. They did not provide me the advice here about it (health post). At that time I kept 17 years in the card. He shouted at me as soon as he saw my age there in the card. He shouted that it is not the age to get married and give birth at 17 years, what is it about women's right? At that time my mother-in-law and husband was quite and did not speak a word"- FGD1

"The doctor told her, little harsh, it is not possible, only 2 point (cm) mouth of uterus is open now. The people from there scolded. I feel like they are very mean and so things for their benefits. When I saw this misbehavior from the doctors, I was thinking and I delivered my second baby at home."- TRANS 3 (Married at 14 years, present age 17 years, two children)

The verbal actions of the health care personnel in the hospital setting had influenced the place of preference for the delivery as explained by woman in focus group discussion. One of them mentioned she was not satisfied with the doctor's perception and being judgmental about her age at health care facilities. Thus, lack of support from health care
provider indicated the probabilities of avoiding health care use among this group of women.

4.4.5 Shyness and Discomfort

Shyness and discomfort were linked with the gender of the health care personnel, behavior of the health care personnel in the health care settings and age of the participant itself. Even when the women go to the health care facilities, they were shy when the health care provider was male. The hesitancy among the early-married women for the health examination during pregnancy was because of shyness and discomfort and they hide reproductive health problems was revealed from key informant interviews.

"One of our students studying at grade 6 or 7 got married, and she left the education. She married at very small age and became pregnant at very small age. They feel discomfort and also afraid to go for the examination as they think somebody might tell them that they got pregnant at very small age, and they are shy." REC 7 (Key informant, Headmaster, Government secondary school)

"They go with one problem, and they say they have a headache, which is easier for them to tell and bring the wrong medicine. Older women are going to health-post easily after delivery also, but these early-married women are very shy to go." REC 2 (Key informant, In-charge local NGO)

Our study found that women were comfortable to share about their reproductive health problems to the female health workers. In the interview, it has been told by the key informant that the female patient tends to hide the actual reproductive health problems to male health care workers and mention about the general pain like a headache, which did not existed. The health assistant in the health-post also verbalized this happened during his working experience. The lack of the female health care provider was issue mentioned by most of the key informant.

"And even when she reach there, they cannot clearly mention the problem as most of the time there are male health care provider. There is a problem of examination, as woman feels difficult to the share these problems to male health care personnel as they are scared of being touched by a man and to show their
inner part. In health-post, there is not suitable environment for woman and the treatment is also not up to the diagnosis level. "REC 1 (Key informant, District officer local NGO)

"Still many women are not able to go to the health care facilities. And even though they go to the health care services, they come up with different problems instead of the problems they have. They find it difficult to share the problems to the male health care provider. There are also women who have not still been to the health care services."-REC 9 (Key informant, Social mobiliser, NGO)

According to key informant, the women are not open to talk about their health and illness related to sexuality because of shyness, embarrassment and discomforts.

"They cannot say that they have uterine prolapse, and they have wound (in private part), they cannot say they have white discharge. Instead, they say I have a headache and come with different medicine when they see the male doctor"

REC 8 (Married at 15 years, Present age 18 years)

Further, the women participants were concerned about the privacy, which was not maintained in the nearest health care facilities. This was the reason that they choose to go to the private health care facilities in the city area.

"Because of the shyness. They do check-up in front of many people from the village. In Binod’s clinic, they take in the separate room" TRANS 1 (Early married, present age 18 years, pregnant eight months)

A participant explained the reason for favoring home delivery was shyness and discomfort. Further, the experiences shared by others influenced the perception towards health care.

"In hospital, they will insert the hand (private part) ... They do whatever they want. If it is possible I want to deliver at home... I have heard they do many things, what ever they like. Last time my sister said she experienced discomforts because of the shyness and I also don't want to go because of the discomforts
Being pregnant for the first time was also discussed as a reason for the shyness and discomfort. In the first antenatal examination, they take somebody to go with them, later they go by themselves. In addition, sometimes the participant expressed, they hide the condition of their pregnancy until it became noticeable and visible to others. This thought expressed by the women participants were in line with the views of the experts in KII. Two participants expressed that they didn't tell about the pregnancy condition until it became noticeable and visible to others, it was because of their shyness.

"Although I knew about the need of having the examination and taking the injections while I was studying, I was avoiding it. There was a feeling of shyness within me." - TRANS 10 (17 years married, present age 20 years)

Additionally, minority caste and ethnicity was linked with the shyness and discomforts. This led to an issue that they were not heard, and their problems were not listened.

"The women from here (village) like Dalits, Janajati, Chaudhari are not comfortable to go and talk to the male, they are very shy and unable to speak with them. They hardly go and try to speak with them, but these women are not listened what they said." REC 1 (Key informant, District officer local NGO)

4.5 Determinants of Healthcare Accessibility and Utilization

The health care seeking practices of early-married women was linked with transportation, their knowledge level, the information they have, their beliefs, economic situation, how independent they were in decision-making capacities and their previous experience in health care facilities.

4.5.1 Distance and Transportation

The huge barrier in the villages of Dang District was the inexistence of proper transportation. The commonly used means of transportation in the community was bicycle and motorbike, which was used especially by the male members of the
community. The local/public vehicle use was very rare because of its unavailability or few services.

For the antenatal examination the choices of the transportation facilities were varied and difficult in relation to the distance. Most of the women had travelled either by walking or in bicycle with the husband. Some expressed they had walk up to 2 hours to reach the facilities in the city area.

“The hospital is in the market area and we have to reach there. We went there by walking so it took us 2 hours to reach there”- TRANS 5 ((Married before 18 years, one child)

Furthermore, during the time of giving birth most of the women traveled to the health care facilities by calling an ambulance. It was difficult when the ambulance would not come in time or called lately. Two women shared their experience of travelling by motorbike during the labor pain.

"It was the time of Dashain festival, so everybody was in holidays. It was not easy to get the ambulance at that time. On top of that, it was raining all night. At that time anyhow (during labor pain), we managed to travel with the help of motorbike. My brother and uncle came and they managed to take me. It would be faster if we could get the ambulance. But we did not manage to find the one. We went through the motorbike, it was raining, may be it took about one and half hour to reach there”- TRANS 10 (17 years married, present age 20 years)

The known people in the village who have the motorbike helped or the health care provider in the nearest facilities was asked for this. The difficulties with the transportation were also highlighted in KII during his experience because he found difficulties to refer the delivery cases in emergency situation. Realizing this fact, people would go to the city area rather than coming into the health post.

"(...) the way is opposite to them to go to the health post and to the hospital it is straight way... The option would be to carry them or using the motorbike to take to the health post. So the most important thing we need is ambulance."- REC 3 (Key informant, FCHV)
Similarly, a participant traveled using the rickshaw (three wheeler cycle) when it was not possible to find other convenient means of transportation to travel. One of the KII respondents explained he had travelled using his motorbike in the city area to send an ambulance to receive a woman in the village. Although one of the VDCs in study had free ambulance services to the members of that VCD, women were traveling to other health care facilities due to the geographical location of the health post as explained by health post in-charge.

“Even after the free facilities of ambulance, delivery cases are inadequate. The antenatal check-up is satisfactory. Our health post is also not at appropriate location according to the geographical aspect. From that place it is better to go there rather than coming here and there is also the facility of vehicle; here no facility of vehicle.”- REC 6 (key informant, Health post In-charge)

Distance and lack of transportation to health care facilities were the hindrances to utilization of the health care facilities among the women participants in the study.

4.5.2 Decision-making capacities

The women participants in the study were empowered to decision-making when they were separated from the joint family. Only two of participants explained they independently decided to use the family planning methods realizing more pregnancies would create difficulties to them.

One of the participant expressed she used family planning methods “norplant” implantation without consulting her husband.

“I didn’t ask anybody about this, when keeping the Norplant. I told them, that day, I was going to my mother’s house and I went to the hospital and had the implantation and I came here after it was healed... When I went to the hospital they explain me about different methods and ask me to choose which one I want. I decided by myself and choose to have implantation”- TRANS 5 ( Married before 18 years, one child)

The other women explained she managed everything including taking her husband for check-up as her husband get ill repeatedly.
4.5.3 Role of Economic Status/ Caste and Ethnicity

The treatment sought for an illness was connected with the economic condition of the family and husband of the participants. Further, the participant expressed difficulties to seek care when she gets ill and she had to take the loan for the treatment.

"Even if I get ill, I have the problem of money. When I get seriously ill, my husband will take me for check up"- TRANS 2 (Married at 14 years, Present age 20 years, 2 children)

Further, excessive expenses were also explained because of the unexpected complications in the health condition of baby at the time of delivery.

"I had a lot of expenses at hospital. The expense was almost like sixty to seventy thousand rupees. For me there was not much expenses, it was all for this child. The transportation cost was five thousand for going there and five thousand for coming back."- TRANS 6 (married at 16 years, present age 17 years, 1 child)

Despite expensive treatment in private health care facilities, women go there because of the good behavior of health care provider explained by a key informant.

"In private health care, every medicine is to be bought. For the women who do not have sources of income, the medicines are very expensive although they provide very good service. If somebody gets sick, they have to sell their whole property. It may be because of money, they behaved politely in private clinic. In government, the same people do not have good behavior and they also refer the patients to come to their own clinic." REC 2 (Key informant, In-charge local NGO

This was reiterated by the women participant that services in private sector were good although they had to cover the expenses by taking loan.

Minority caste and ethnicity were identified as a potential barrier for approaching the health care facilities in the community. Along with this, their small age and economic background increases their vulnerability.

"It is obvious that small aged women are discriminated. In our society, the patients are treated according to the family background. If the person is rich and has high status, then she is viewed differently. The one from a poor background
like Dalits, Janajati, are behaved differently. On top of that, adolescents are more vulnerable; they are humiliated and treated differently"-REC 1 (Key informant, District officer local NGO)

"And where there is majority of Dalits and Janajati (less privileged ethnicity), though the health-post is near, the numbers of people taking the services are few."
REC 6 (key informant, Health post In-charge)

4.5.4 Enforced communication and shared experiences among women

Some of the women participants explained they used family planning services and went for the antenatal examination as suggested by the experienced women in the community. The information were shared among the women in the community after using it, which would be used as a reference to contact the health care services when needed. The experienced females in the community often suggested for antenatal examinations when a woman become symptomatic as vomiting, headache, dizziness and history of stopped menstruation.

"I went to the zonal hospital for the examination. One woman, she lives nearby, came to give me the iron tablets and she told me to go for the antenatal examination in the zonal hospital"- TRANS 8 (Married at 15 years, Present age 18 years)

"I am 19 years now... And I became pregnant... I started to have vomiting after two months of my pregnancy. And then I come to know about my pregnancy. It was "didibahini"- "elder sisters” from village told me to go for the examination"- FGD 2

Some expressed they did not have information about family planning methods when they were children and they were just married (indicating themselves).

"Children (indicating all participants) do not have ideas about the methods of family planning: even I didn't know."-FGD 3

The spacing between the first birth and second birth was varied among the participants. Most of them used family planning methods after first baby is born, while some had
second baby immediately. The shared experiences about difficulties after having many children motivated them to use family planning methods.

One of the key informants expressed that women would have done permanent means of family planning at the age of 20 years.

"Many of them have already done minilap at the age of 20 years even though we say them not to marry at the age of 20 years. The situation is even like that they have given birth at the age of 13 to 14 years; when they reach 18 to 20 years they already have almost have 2 children" REC 6 (key informant, Health post In-charge, HA)

Further, from own experience a participant come to know about the further antenatal examinations in second pregnancy.

In the second pregnancy now I know about everything that in which month what I have to do"- Trans 9 (Married at 17 years, Present age 20 years, one child and present pregnant)

The health action took place usually from the shared experiences among the women members in the community or from their own previous experiences.

4.5.5 Positive Attitude towards Health care Facilities and its Use

The positive hope expressed by the participants during the visit to the health care facilities could be the facilitators to visit the health care facilities in present and in future. Some of the participants expressed positive perception towards the health care facilities. The feelings of safety and security of health at care facilities were presented during the talk with the participants.

"I feel it is good. When I take my child to the hospital, this helps to give the encouragement. There is a hope that they will be able to do something for him"

TRANS 10 (17 years married, present age 20 years)

Most of the participants were in favor of visiting the hospital for the delivery.

"it is usually good to go to the hospital when giving birth to the baby. There are some problems existing while giving birth to the baby. There is a risk of
"complication for losing the life... that is why I feel it is good to give birth in the hospital"-FGD 3

The suggestion provided by the health care professionals such as social worker at the community level encouraged the women participants to visit the health care services. Additionally, the choice of the facilities was done by the shared experience among the women who had used the services previously. The women used health care facilities when the users in the village suggested them that the particular health facilities provided good care and facilities. Service quality was important to the participants.

4.5.6 Perceived Benefits: Monetary And Incentives

Most of the women participants in the study were not aware of the cash benefits and incentives for antenatal examination and delivery unless they received the money from the health care facilities after having delivered baby in the hospital. However, key informants repeatedly talked about this. Some participants explained the difficulties they faced to receive the money after having delivered in health care facilities.

"I had the antenatal card but I had done check-up for one time only, so they gave only 500 rupees. But the process was very difficult, as the doctor was not signing the paper. We were in rush to come back home; my husband was running here and there. I feel like that 500 rupees only, which was given like for the beggar. We told if you are not giving the money, we will go to the senior doctor, and then only they gave 500 rupees with so much difficulty. Then we took the money and come back home."- TRANS 3 (Married at 14 years, present age 17 years, two children)

"We heard they wouldn't give the money and later we didn't go although they had asked us to come receive the money."- TRANS 6 (married at 16 years, present age 17 years, one child)

In addition, some participants who knew about monetary benefits and had frequent antenatal visits also expressed that they did not receive the full money that they were supposed to receive.
"As I was going for check-up time-to-time, I come to know they provide the money also if everything was correct in card. But I don't know something was wrong in one place so they gave me less money, only four hundred rupees after the delivery of the baby; the actual amount was one thousand rupees"-TRANS 5 (Married before 18 years, one child)

Even after receiving money participants were not sure about the purpose of money provided. Two of participants gave some money from it to the women who washed their clothes in the hospital when they were asked to pay for it.

"I went there by own expenses. Later they gave me thousand rupees after the birth of the baby. I don't know if it is for the transportation expenses or for the food expenses."- TRANS 4 (Married at 15 years, present age 20 years, I miscarriage, one child)

The KII participants explained women do not receive the monetary benefits from the health care facility when the budget in facilities was inadequate.

"They are not provided with the money they are supposed to receive at the facilities. I am talking about the five hundred rupees after giving birth in the hospital. I have heard, it is because of the lack of the money, but they take the phone number to give it later. However, the women do not receive the money. The situation is worst"- REC 3 (Key informant, FCHV)

Few other key informants explained the women were not receiving the money because the women were not visiting the health care facilities as required or scheduled four antenatal visits.

4.5.7 **Choices of Health Care**

When discussing about the use of health care services during the illness or any reproductive health situations, many women had the preference to go to the health care facilities. Participants had sought multiple services from various health care facilities varied between the government services, private facilities, NGO Clinics and the traditional healers. Some of them tried to use the available health care options
simultaneously to compensate services they used in order to ensure the safety of own
and their child's health.

**Primary (local) and secondary and tertiary (distant) health care**

Mostly women went to city area for seeking treatment when not satisfied with local
health care services and resources at facilities in community level were inadequate.
Sometimes they had traveled to the neighboring district Nepalgunj that is 115 km for
driving which takes approximately 3 hours to reach there.

"... In the zonal hospital they did not do anything, and just asked to walk only.
But I was not able to walk and they used to shout at me that I am not walking.
And later I told them, if I have to walk, I would not stay here and travel back to
home. They told only 1 cm uterus is open... Then they (family members) took me
to the Koholpur hospital."-TRANS 8 (Married at 15 years, Present age 18 years)

In in-depth interview, women participants also mentioned that medicines provided in
nearest health care facilities did not get cure, due to which they choose to go to the city
areas seeking for multiple heath care providers. The participants moved from one health
care facility to other in cases when they did not get proper treatment.

"(…) The family members took me to the health-post. I was kept in the Baghmare
health post for 4 to 5 hours…. There, my baby was not born. When I was not able
to give birth, I was taken to Ghorahi (city area) hospital. Then when I reached
the hospital; I gave birth in almost after 1 and 1/2 hours."-FGD2

The respondent in KII expressed similar view that women would not trust care provided
at nearest services or when the services were free. It was also mentioned that the
resources in health-post were not adequate to provide the services. Furthermore, a key-
informant in IDI mentioned that although free essential and reproductive health care
services are available at the community-based health care services, the quality were not
maintained. Further, carelessness nature in the health care providers was also discussed.

"In government, the services are free of charge, and there is a lot of carelessness
and lack of responsibilities"- REC 1 (Key informant, District officer local NGO)
The facilities in the health-post were not adequate for which the services were sought in the city area.

"if any complication occurs, it cannot be managed here but there (city area) is the facility of caesarean section and can manage any complicated cases” REC 6 (key informant, Health post In-charge, HA)

"(...) from here we went to the city area, there I come to know that the uterus is not open. Then we went to Ghorahi; there they said the uterus is opened to 4 cm. They told that there are not the facilities of surgeries. Then I was taken to Koholpur in the hospital. The day we reached I delivered the baby ay 10 pm in the night."- TRANS 9 (Married at 17 years, Present age 20 years, one child and present pregnant)

It was clear that the participants were obliged to choose advanced level of health care facilities.

**Government (local) and private health care**

The participants described that they had visited various health care facilities during labor pain and illnesses. One of the participants described her experiences that she delivered in private health care facilities although her initial approach was government healthcare facilities.

"I was having (antenatal examination) in the zonal hospital. When we went there they returned us by saying that months were not completed to deliver. They told the stool is infected. We had no idea whether to return back home and nobody was there to talk about it. We were only two, mother-in-law and I. My pain was becoming intense and then we went from rickshaw to the private ones” – TRANS 13 (married at 17 years, present age 20 years, studied grade 12

One woman perceived government healthcare facilities serve in the cases of delivery and choose to go the private health care facilities for other illness to receive good care.
"The government one is for delivering the baby. It is usually the private ones we go for other illness. May be the services are good in private ones"- TRANS 9 (Married at 17 years, Present age 20 years, one child and present pregnant)

The same thought was explained in a KII.
"if it is related to delivery period, postnatal period, or family planning methods, the use of facilities is common in the government sectors like health posts, zonal hospital, and sub-regional hospital. For other conditions like fever and other diseases, people go to private sector" REC 7 (Key informant, Headmaster, Government secondary school)

Alternatives to modern health care facilities

a. Traditional healers:
The participants expressed their beliefs on witchcraft and supernatural powers for the cause of ill health to themselves or to their children and difficulties experienced during delivery situation. One woman stated that she had difficulty while giving birth at hospital and she gave birth after sacrifice of a chicken in her village by healer when she was still in the hospital. With any difficulties while delivering the baby, the participants would refer to it as due to the supernatural power or witchcraft, which required the healing from the traditional healer.

"My mother went to the healers for me and sacrificed chicken as told by "Guru" – "the healer". He did the prayers for me and I delivered baby immediately at 2 pm on Friday" TRANS 2 (Married at 14 years, Present age 20 years, two children)

Further, a participant related cause of pain to some supernatural power.
"till now I have some pain to my hand and legs. But it is said, this is due to "bayu"- supernatural power. It must be because of that"- TRANS 7 (woman married at 16 years, present age 19 years, one child)

Sometimes the loss of baby was also linked with the supernatural power.
"When we had an examination by the traditional healer, he said she is made suffered by "naag" (snake), because of which she had a spontaneous abortion."
She does not have the baby now. It was her first baby, and her husband is abroad now. She doesn't have the baby now." FGD 2

It was also expressed that the baby would be taken to the hospital after healer completed the healing processing for illness or removes the affliction from child.
"baby is afflicted by "rahu"-"supernatural power." Now the baby is not well..then we went to the traditional healers, he told the baby has been ill because of "rahu." I had not known about this before. He recently helped to get rid of it... we have not taken baby to the hospital. First, he will complete his processing to get rid of “rahu”, and then we will take him to the hospital.”
TRANS 6 (married at 16 years, present age 17 years, I child)

“We sought for the healers, if he (baby) has suffering from witchcraft, but also it didn’t worked. I don’t know the reason why he was crying a lot. When I remember that moment, I feel it is better not to have the baby. It was very difficult”- TRANS 12 (married at 15 or 16 years, present age 19 years)

"Sometimes going to the "Dhami" and "Jhankri"- (the traditional healers) and if it does not work with it then we visit the hospitals"- TRANS 9 (woman Married at 17 years, present age 20 years)

From this beliefs and expression it could be seen that the justification of ad health was related to some supernatural power and healing are to be done by healers.

b. Use of “Neem plant”
Use of mixture of “Neem plant” and water to control the infections in cases of uterine prolapse was mentioned in a key informant interview. The use of neem plants with water for the conditions not treated in the hospital was emphasized.
"For itching and white discharge, they (NGO clinic) teach about usage of neem plant and water in the private part as a treatment. The cases of STIs, which are not recovered in hospitals and clinics have been relieved by using neem and
water. We have many cases like this which has been fully treated". REC 1 (Key informant, District officer local NGO)

One women participant in the IDI mentioned the same treatment, which was used by her to get the symptoms relieved when she suffered from uterine prolapse.

"I used to go clinic in "Padha" and later X (social mobilizer) told me about the treatment with 'neem' leaves. When I started using the neem leaves and water to clean the private area and it is getting better. But when I am walking without wearing the underwear, it is little difficult; I feel something has covered there. I am planning to get the treatment for this." TRANS 2 (Married at 14 years, Present age 20 years, two children)

This shows various approaches were made by the participants in the study to relieve the symptoms and to treat the bad health conditions.

4.6 Informant’s suggestions for improving health status of early-married women

Most key informants in the interview indicated lack of awareness and inadequate accessibility of the information among early-married women. They described the responsibilities towards creating and disseminating the information regarding the specifications of the services provided in the particular health care facilities. The strengthening of this sector was also advised. Furthermore, the effective awareness campaign in the community was recommended by involving the male members from the same family while educating the female. The reason explained was Nepal being a patriarchal society; the voices of the most of the women would not be heard and counted in the family. Also, men would be able to learn about the experiences and effects of the early pregnancies if they were involved. Furthermore, organization of the programs such as street role-play involving and covering the houses in the community was recommended.

The awareness program should focus on the adolescent girls and boys including the methods of family planning and explanation of uncertainties about early pregnancy. The information about the family planning methods was to be provided to both the married husband and wife. Along with this, providing the information about not giving birth before the age of 20 years was recommended.
"If they get the information together, even they are married; she could be pregnant after they reach the appropriate age, 20 years. Many deliver within the same year they get married in 15 – 16 years, some at 17 and some at 15 years. At that time child is giving birth to child" REC 8 (Key informant, Social mobiliser, NGO)

As frequently mentioned by most of the women participants and key informants about the behavior of the health care personnel, it was suggested that training sessions are to be provided to the health care provider while dealing with these vulnerable group of women. The improvement in the behavior of the health care provider was recommended.

"Not only working as staff, but also having the feeling of social services, good communication skills, speaking in soft voice" REC 8 (Key informant, Social mobiliser, NGO)

Importantly, it was reiterated that the government should take the responsibility towards the reproductive health of particularly these group of women. Many respondents in KII had a view that the policy implementation was a problem regardless of the existence of laws and the policies regarding the provision of health care.

"...in practice, the services are not easily accessible. In Dang district specially in the villages; there is not suitable environment to receive the services easily..." REC 2 (Key informant, In-charge local NGO)

Further, separate and trained health care providers and separate space to maintain the privacy for the adolescent group was recommended in order to increase the accessibility and utilization of the services to them. Increasing the services for young and adolescent group was suggested or a day could be separated as a check-up day for them in the health-post. Also, opening and closing time of the health care services in the government health sector were not coinciding the time visited by these women to the health care facilities. Therefore, it was recommended to extend the opening hours of services provided with provision of the health care provider; may be by increasing the salary of health care personnel.
"Nepal government is running the services from 10 am to 2 pm, which is not the suitable time for the women. The women have to perform various tasks from the time she wakes up like cooking, cleaning etc. The time she completes the work would be 12 to 1 p.m. and the health posts are usually far, so all of her time are spend on these things. So when she reaches the health posts, they are almost closed. The opening time is not suitable for a woman who needs the services. So it is compulsory for the government to run the services from 10 a.m. to 5 p.m. in the evening." - REC2 (Key informant, In-charge local NGO)

Likewise, to improve the overall health condition of women, the use of the preventive and problem-focused intervention was recommended. The inclusion of a chapter in school curriculum at secondary level related to effects on reproductive health from child marriage and adolescent pregnancy was suggested in order to create the awareness. Likewise, it was also suggested to have the facilities of ambulance in each health-post so that people could rely on the quick and referral services when needed. Decentralization of the services at the periphery of the country would benefit in the effectiveness of program. Therefore, the programs should target the people at the grass root level.

The support and special care from the family members to the early-married women were suggested as they were at a small age and also dependent member of the family. The interaction programs regarding the regular health examination were recommended for these women at the government level and other organizations involved in this sector. Empowering the women in decision-making, so that they would be able to make the decision regarding the choice of being pregnant.

In general, the findings of this study suggested that the early-married women’s health care services utilization is impacted by numerous factors such as previous experience of health care use, decision making capacities, pain, available health care services, perception towards role of health care provider and health care facilities. The subjective factor “shyness” also negatively influenced the health care use. Overall, the perceptions among the participants were varied and individualistic. In addition to this, the suggestions for the improvement of the health care use among early married women was linked with the interventions from community to policy level.
Along with the efforts to eliminate child marriage, it is important to support the lives of young married women in Nepal, as child marriage is still one of the major problems halting the development of overall women population. Health Belief Model (HBM) used as a framework, the study attempts to identify the factors for reproductive health care utilization among the early-married women with exploration of promoters and barriers along with their beliefs and experiences in healthcare seeking process in a rural setting of Nepal. Further, the study examines suggestions from participants to improve the level of health care services use. Health Belief Model provides a skeletal framework for studies that seek to understand health specific decision-making of an individual (Janz & Becker, 1984), thus, this helps to develop an understanding of priority given to one’s health condition.

The result of this study found numerous and varied factors that influence the healthcare-seeking behavior of early-married women. The facilitators were perceived awareness of own health, motivation after using health care facilities; encouragement provided by health care personnel and enforced communication about the use health care services among the women in the community. The barriers identified were shyness and embarrassment, transportation and distance of health care facilities, qualities of services, poor behavior of health care provider (verbal abuse) and household work overload among these early-married women. Also, recommendations provided by key informants were provision of separate health care providers in a separate space, training to health care providers, supervision, and monitoring of the services provided, involving male members of the community in awareness campaigns.

This states that given the importance of these facilitators and barriers while dealing with the issues of child marriage, the health status of the early-married women could be improved.

5.1 Perceived Susceptibility

According to Rosenstock “perceived susceptibility” in HBM is one of the key descriptors that describe health care seeking behavior of an individual. Perceived susceptibility refers to the chances or risk of incurring an illness or adverse health condition. As this concept is based on the subjective perception, differences in the
thinking about the vulnerability to a health condition exist between the individuals (Irwin M Rosenstock, 1974). Likewise, the result of this study shows variation in views of the participants regarding health, health care services and its utilization.

When the question was asked, “How do you take care of your health?” then according to women participants the health care for them was the daily activities related cleanliness and sanitation of body and surrounding. With probing question, “use of health care facilities”, health care services were sought only in the condition of illness was revealed. In this case, perceived susceptibility was not sufficient for the explanation of the healthcare seeking behavior. Most of the participants in the study were unaware about their susceptibility to degradation of health condition with exposure to adolescent pregnancy. Some participants were aware of their age factor and wanted to prevent the early pregnancy but the perceived roles halt them taking care of their health. Majority of the participants were not concerned about the health consequences of early adolescent pregnancy. The study identified various reasons for why early-married women underestimated their vulnerability to degradation of their health.

5.1.1 Mistrust and lack of decision-making capacity to use family planning

Infertility or the inability/difficulty to become pregnant after use of family planning methods was one of the commonly occurred beliefs among the study participants. For this reason, most of the participants did not use family planning methods to delay first pregnancy. A multi-country study in South Asia including Nepal demonstrated the similar result that the child marriage is associated with not using the family planning methods before first pregnancy (Godha et al., 2013). The similar result was demonstrated in a study in Bangladesh (Shahabuddin et al., 2016) and India (Barua & Kurz, 2001) conducted among married adolescents. In present study also, willingness to become pregnant among the participants was intense. For instance, a participant of 20 years age, who had previous miscarriage showed her concern towards her inabilities to become pregnant despite treatment sought. This shows priority placed by an individual was not based on perceived susceptibility to a potential adverse health condition. But depends on the social and cultural constructs and role perceived for that individual. The current study showed all the participants had one to two children or were pregnant when they were ≤ 20 years, excluding one participant (who had her miscarriage) and most of
them had not used any family planning methods before first birth. The finding suggests that the perceived role of a woman as giving birth was taken into high-value perspectives compared to their health. Likewise, in a quantitative study (2009) among Indian women married before the age of 18 years and at 20-24 years at the time of study, showed child marriage is positively associated with no use of the contraceptive devices before the first child is born (Muazzam Nasrullah, Zakar, & Krämer, 2013). All women participants in the study had already given birth before they reach the age of 18 years. This is a development stage when they were still considered as a child (UNICEF, 2016a). This concluded the participants were not aware of their health risk and postponing early pregnancy by using the family planning methods; thus were exposed to teenage pregnancy, which is consistent with the results presented in various studies (Adhikari et al., 2009; Godha et al., 2013; Muazzam Nasrullah et al., 2013). Likewise, other studies found that the girls married before age of 18 years were less like to use family planning methods to prevent first pregnancy compared to the young women married at 18 years or above age (A. Raj et al., 2009; Santhya et al., 2010). Along with this, married women in the study were expected to become pregnant within one-two years of marriage which prevented use of family planning methods before first pregnancy, which is also found in other studies (Barua & Kurz, 2001; Godha et al., 2013) leaving the early-married women into a vulnerable position. The mistrust with family planning methods and perceived role of young mother prevented them from using the family planning devices. From this, need for the promotion of targeted education regarding the use and the options available on family planning methods could be highlighted.

However, during the time of data collection, most of the participants who had already given birth were using family planning methods. The capacity to use family planning methods was mostly restricted before the first birth and they lack decision-making roles. The first person to decide about family planning methods use for these women was their husband. After giving birth also the participants had to take the permission from the husband and sometimes from mother-in-law to use the family planning methods. However, after giving birth they might have been able to convince the family members to use family planning devices. This denotes although they have been using it, the
choices for them were limited between the first and subsequent births. A study in Kathmandu, Nepal demonstrated similar result that teen and young adults particularly depends on husbands regarding the health care use decisions (Upadhyay et al., 2014). The results found from our qualitative study had some similarities to findings of study conducted in Bangladesh by Shahabuddin and colleagues. Shahabuddin conducted in-depth interviews with married adolescent and key informant and focus group discussions to identify the factors influencing the decision-making regarding contraceptives use and childbearing. The finding of this study denotes low decision making autonomy regarding the contraceptive use and child bearing among the research participants (Shahabuddin et al., 2016). The similar result was found in present study among the women participants in Dang district as most of the participants in the study demonstrated lack of autonomy while deciding the use family planning methods. The decisions were usually made with the permission from husband and mother-in-law. However, only few participants used the family planning methods secretly and later informed the husband about it.

Key informant interview (KII) revealed, mostly women had to use and be responsible for family planning methods instead of men. Also, in interviews and discussion with the women participants, it was said most of the time they were responsible for using the family planning methods because they had no options to avoid pregnancy. They used contraceptive methods, which was widely used by others females in the community. This lack of limited information and choices distorts the independent decision-making capacities among the early-married women.

5.1.2 Lack of knowledge

Poor knowledge about reproductive health care and services was among the main barriers for participants in study, which prevented them from taking timely health care services. This lack of knowledge was also illustrated in as a study among Bangladeshi married adolescents (Shahabuddin et al., 2016). Some of the participants did not recognize their pregnancy status until some knowledgeable women in village suggested them for examination and the confirmation of their pregnancy.

It was only after having one or two children the participants come to know about and use family planning methods. This may be due to their first-time contacts with the health care providers during pregnancy, which was true for many participants. Alternatively,
they received information from their own experience. Most of the women come to know about the family planning methods after giving birth or unplanned subsequent pregnancy. A study conducted in Nepal presented the similar result that women with higher knowledge about the family planning methods were more likely to prevent unintended pregnancies in comparison to those who have less information (Adhikari et al., 2009). Furthermore, one of the participants explained that her husband did not know how to use a condom because of which she had to use other options of family planning methods in order to avoid the subsequent pregnancy. In addition to this, inadequate knowledge level was also demonstrated at the time of antenatal examinations. With less information it might be difficult to identify the possible vulnerabilities to them.

5.2 Perceived Severity

Another descriptor of Health Belief Model (HBM) is “perceived severity” which explains that individual would take action when there is existence of “perceived threat” of contracting an illness with further seriousness if the condition is left untreated. The perceived severity of a health condition also varies between the individuals as the dimensions of the threat thought by an individual is dependent on the knowledge level about that condition (Irwin M Rosenstock, 1974).

Most of the participants in study sought for health care services when they perceived a potential threat and when they thought there were chances of degradation of health condition. This perception was used when they sought health care for themselves, their children and husbands. The use of health care services among early-married women occurred with perceived difficulties and barriers to use them. The facilitators for the use of the health care services for them were beliefs and hope that they were and would be safe when they visit the services. A construct in HBM “perceived severity” can be applied to describe participant’s choices made for using multiple health care facilities whenever the seriousness of the illness/condition was perceived.

5.2.1 Use of multiple health care options

Antenatal, delivery/postnatal care and other illness:

The findings of study showed variation in the use of healthcare facilities while seeking care for antenatal, delivery, postnatal period and other illness. The participants sought
modern health care facilities and traditional healers when the severity of the health problem was perceived. The presence of pluralistic health care facilities in Nepal (Karkee & Kadariya, 2013) allowed participants in the study to use multiple health care facilities. The study found that choices of health care facilities were multifaceted because the quality of health care services was emphasized along with seriousness of condition. Sometimes the participants used both modern and traditional health care facilities simultaneously. Furthermore, participant’s uptake of the modern health care facilities occurred when traditional healers did not cure them. The choice of health care facilities made was complementary and compensating to each other.

In modern health care facilities also, the selection between the government and private health care facilities were dynamic. While approaching the modern health care facilities, women participants mostly choose to visit private health care facilities compared to government health care facilities. The perception of many participants was that services in the private health care are good and quick. When the health condition is severe one then approaches to private health care facilities was done regardless of difficulties.

Some of the participants approached government level health-post and sub health-post available to them. It was also perceived that local health care in the community is for minor illness and for severe one they have to go city area. This means that the severe illness is to be treated in health facilities equipped with adequate resources. In contrast to this, a study conducted in 12 districts in Nepal indicated the adolescent use of the health care services was found more in the government health care services where the services were free, accessible, and provided by skilled health care provider (UNFPA et al., 2015). However, this study had not defined married and unmarried adolescent respondents, this result might have masked differences between married and unmarried adolescent. The lack of resourceful health care facilities at local level might have created a situation to make dynamic choices among the participants. Further, it was revealed that they sought for higher level of services when the medicines from local health care facilities did not work to alleviate the illness. The participants discussed they would travel and had travelled to city area in big hospitals or private health care facilities. Moreover, if it was not recovered, they had to travel to another neighboring district where they could get advanced facilities. This shows that women were unlikely to
receive expected level of health care services in nearest health care facilities because of which they were compelled to travel distant health care facilities located in city area. Participants in the study expressed they approach local health care facilities for minor illness or skip its services and end-up taking services from hospitals in city area or another district (approximately 3 hours to travel in a local bus from the city area of Dang district). They would go to another level of health care facilities finding it difficult to get the services from the local health care facilities. This further illustrated, perceived severity to health condition might be a motivating factor that influenced health care seeking behavior of early-married women in selected communities of Dang district.

Regarding delivery of a baby, most of the participants directly went to receive health care facilities in city area. The lack of resources and facilities were cause for which they directly went to city area. For example, one of the participants in FGD talked about the unavailability of the blood transfusion facilities in the health-post, for which they preferred to go directly to city area when they had to call an ambulance. This points out that people choose to go to the private health care facilities because of the adequacy of the resources or services, which was also revealed in a study in Nepal (Karkee & Kadariya, 2013). However, the participants described that they were not satisfied with services provided even when they travelled distance health care facilities. The participants described their difficulties of hospital stay when they had stayed for prolonged time that was extended due to maternal and newborn complications. The structural factors such as electricity cut-off and mosquitoes biting were expressed. This illustration makes clear that even when they reached health care facilities realizing potential threats to a health condition, it was not sure that their expectation of health care was met.

Likewise, participant’s choices of health care facilities when their children became ill were varied. Some of the mothers tried to treat the condition by taking their children to traditional healers, while other sought for modern health facilities or both. The participants believed the medicines provided from the local health posts do not work properly, for which they take their children to get treated in private health care. The choices of the private healthcare were dependent on the adequacy and quality of the services and also on the severity of the illness/condition. Participant’s seeking of next
level of health care to get the condition treated demonstrates “perceived severity” act as a factor that influence the health care seeking behavior.

5.2.2 Pain and minor illness
Some of the participants in the study considered aggravating pain as a perceived threat to their health, for which the health care were sought. This means the health condition might have deteriorated when they seek for the services. The labor pain was sometimes unrecognized by some participants considering mild abdominal pain is normal during pregnancy. With increased pain severity only, women were likely to inform about it to significant members of the family such as husband or mother-in-law after which treatment was sought. Along with this, some family members seek treatment only when pain became extreme because family members think it is not serious and wait until severity increased. As a result some of the participants delivered at home with the help of mother-in-law while some suffered from complications although they reached the health care facility later. In contrast to this even discrete pain during pregnancy was considered need of medical care even in a low resource setting Vietnam (Graner, Klingberg-Allvin, Duong le, Krantz, & Mogren, 2013). This variation in perception of seriousness of health condition might influence the health outcome.

Further, the women participants considered headache, fever, hand and leg pain, and general body ache as minor ailments. According to them, these ailments recover with time and rest (sleep) and health care facilities is contacted if it gets severe. The perceived severity of the condition only motivates women participants to take help from health care facilities.

5.3 Perceived Benefits and Barriers
The “perceived benefits” in Health belief model (HBM) is explained as a belief of an individual in effectiveness of a behavior that takes place recognizing the susceptibility and seriousness of health problems. The individuals take action but the course of action may incline in any direction. However, the action is believed to occur towards beneficial direction and best among the available alternatives to reduce the “perceived threat” while the barriers are potential hindrances to perform the recommended behavior (Janz & Becker, 1984).
The free essential health care services and monetary benefits provided by the Nepalese government (Karkee & Kadariya, 2013; MOHP, 2012) could be the perceived benefits for the women in the community. However, the benefits provided were not necessarily perceived as beneficial with the following reasons.

5.3.1 Monetary Benefits And Incentives
Monetary benefits and other incentives provision is one of the approaches of Nepal government to increase the number of antenatal visits and institutional delivery (DOHP, 2012/2013). In this study, few early-married participants were aware of the monetary benefits they were likely to receive after the completion of antenatal visits and delivery. Those who knew about it mentioned that most of the time they find it difficult to receive money that they were supposed to get from health care facilities. Also, those who said they received money after their delivery of baby during the discussions, it was guessed by other participants that she might have knew someone close from the health care facilities. Further, a participant mentioned a reason for not going to government health care facilities was because of no relatives in the hospital. This illustrates the difficulties in receiving the incentives and money when they know nobody at the hospital and making policies and strategies is not enough.

Some of the participants mentioned they did not receive the money because of some issues in the antenatal examination card. Some other participants mentioned they received only a part of the money, as they did not complete the antenatal examinations. In addition to this, they believed they had to give some portion of that money to the attendants who washed their clothes after delivery. Furthermore, one other participant in the study mentioned she had to warn the staffs that they would go to the higher-level officers to claim for the money, after which they received the money. Some of the participants in KII mentioned lack of resources and allocated budget at a particular time have created the issues and women do not receive the money incentives. In addition, large amount of expenses in cases of the complications in pregnancy, childbirth and delivery was verbalized. In a study regarding use of health care in rural Mozambique, lack of money despite free health care services was presented (Munguambe et al., 2016). This indicated that the monetary benefits provided for antenatal visits and after delivery were not considered as a motivational factor as it supposed to be, because most of
participants did not receive the allocated amount of the money. When the perceived benefits do not turn into actuality, as a consequent in similar circumstances, women might get demotivated.

5.3.2 Role of Health care workers

The result of this study showed that health care providers were both beneficial factors and barriers for the use of available health care services. The facilitators for use of health care services for young married women were information and motivation provided by the health care professionals. Some of the participants visited healthcare facilities when social workers at community level advised them. The first contact to the health care facilities during pregnancy occurred when suggestions were provided by social workers. Along with this, the use of family planning devices after the first pregnancy was done with suggestions and services provided at health-post. The key informants also explained the role of social worker as crucial in the village to influence women to visit health care facilities. Few participants indicated they went for antenatal examination as suggested by social worker. The information provided at health care facilities when they approach services was vital for them to decide to use family planning methods. In addition to this, a perceived feeling of security in the health care facilities was expressed by some of the participants in the study. Some of the women participants said that they feel safe in health care facilities Due to these reason subsequent visits to the health care facilities were done and would be continued in future. This explains the positive role of health care professionals for influencing women in the community. Thus, one of the facilitators to use health care facilities was perceived role of health care professionals.

In contrast to this, most participants mentioned behavior of the health care providers was not satisfactory to them while using health care services. The verbal abuse of the health care provider such as scolding for being married at the small age was judgmental which was perceived as rude and a feeling of humiliation by some of the participants. This unexpected response from health care personnel at health care facilities might have created perception and environment not to seek care facilities. The unfriendly and rude behavior in health care facilities by the health care provider was also consistent with a study among pregnant adolescents in a developing context in Uganda (Lynn Atuyambe et al., 2005). In a qualitative study in Denmark among multinational samples, abuse in
health care environment was reported in a form of “dehumanization” which could impact the reproductive health outcomes of women (Schroll, Kjærgaard, & Midtgaard, 2013). The similar consequences may have occurred to our participants in the study as some of them experienced abuse in health care settings. Further, in the KII the behavior of the health care provider was connected with the government and private level health care facilities. In government level, the health care providers do not behave properly for referring the cases to their private clinics. At other times, it was their negligence that the health care providers do not appear into the health care facilities on time. Along with this misbehavior of the health care providers was mentioned at few interviews. With this unpleasant scenario, a participant might not visit the health care when needed. Violence of human rights, degradation in quality and ineffectiveness of the health care services were the consequences of violence in health care reported in a research (d'Oliveira, Diniz, & Schraiber, 2002). This finding of the study illustrates there was a perceived impediment for the participants to step to health care facilities. Overall, the varied and dynamic health care provider’s role was perceived and it was different in different health care settings.

5.3.3 Family Support and Women’s Interaction

The group interaction among females in the community was frequently seen while they were collecting water, washing dishes near pond, farming land or cutting the grasses. The experiences shared among female relatives and neighbors about immediate second pregnancy and consequences because they did not use family planning methods encouraged the women participants to use contraceptives to prevent similar circumstances. The interaction between women who are comparatively older and experienced in terms of the health care use promoted the utilization of health care among the inexperienced early-married women who have not used the services. This might be because older women are more motivated in decision making compared to younger women (Navaneetham & Dharmalingam, 2002; Heidi W Reynolds et al., 2006). Further, as the women were influenced by what was happening in their surroundings, it might be effective to create awareness frequently by simulating the consequences of similar situation in role-play or dramas.
The advices provided by the family members were crucial as well. Few participants went for antenatal examination with mother-in-law or as suggested by her. Furthermore, some participants went for antenatal examination when elder and experienced females in the community influenced them. After the appearance of pregnancy symptoms like vomiting or cessation period of menstruation, elder women in the village suggested few participants to go for check-up, after which the pregnancy was confirmed and follow-up antenatal examinations were done.

From the result of this study, it is clear that mostly early-married women from villages of Dang district visit health care facilities during the time of pregnancies for antenatal examination, for delivery and postnatal care. However, the antenatal visits were not according to recommended required number of the visits during this period. Not all the women participants had at least four visits during antenatal period. This illustrates that women participants did not receive adequate care. Likewise, a study in Pakistan also linked child marriage with reception of less prenatal care (Muazzam Nasrullah et al., 2013). This indicates although women participants had certain level of information about the visits for antenatal care, there were hindrances that prevented them from visiting services. The obstacles for them were inadequate information about health care during pregnancy, the work overload, quality of health care facilities was not met and behavior of the health care providers.

5.3.4 Home delivery

Nepal government support women’s health with skilled home delivery by providing money incentives to health care worker who assisted in home delivery (DOHP, 2012/2013). The current study found existence of home delivery in the communities of Dang, although there were possibilities for institutional delivery. However, the deliveries were not conducted in the presence of skilled health worker, rather they were attended by unskilled women like mother-in-law, a phenomenon supported in other study in Nepal (Bolam et al., 1998).

Perceived susceptibility in HBM describes health-seeking behavior, which is individualistic. The perception varies widely between individuals, whether the person is likely to suffer from particular health threat (Irwin M Rosenstock, 1974). Consistent with this explanation, few participants in FGD supported the idea that normal deliveries
could be conducted at home because threat to health risks was considered low. This might provide an interpretation that women were likely to deliver at home and support it in future and wait until complications arises in health of mother and baby. In a study in Pakistan, Nasrullah presented similar result that child brides were likely to deliver at home (Muazzam Nasrullah et al., 2013). Also, decision to visit health care facilities was not solely dependent on women participants. For instance, a woman participant was taken to hospital when she was not able to give birth after three days of labor pain. It was explained that she could not do anything when she was not taken to health care facilities. Whether to seek health care was not in the opinion of sufferer. Instead the surrounding people, mainly family members influenced it. This could be explained based on health belief model as barriers to action for better health and actions might not occur even though women perceived the action would be beneficial.

5.3.5 Shyness and discomfort
Another factor that was identified as a barrier was shyness and discomfort leading to embarrassment. This was addressed in KII when discussing how the early-married women consider for their health. Being married at a small age and lack of awareness was the key description for this nature of early-married women. The physical and psychological immaturity of women married at adolescent period (Maharjan et al., 2012) and huge changes in developmental stage of their life may have impacted their emotions. Besides this, lack of female health care providers was mentioned as a cause of shyness. Some of the key informants also mentioned display of the private body part to the male health professional during the examination might be an essential barrier for examinations. The embarrassment related to sexual health found among married adolescents in a study in India (Barua & Kurz, 2001) might also be compatible to our study results.

5.3.6 Perceived gender role
Women’s role was limited to household activities, which was perceived by women participants and supported by key informant participant in the study. The heavy work they had to perform were carrying grass for cattle, water, barley sacks and others. They were not in the position that they can avoid any work. Similarly, child marriage is done
to support household activities were reported in a study conducted involving 15 districts from Nepal (Maharjan et al., 2012). The health risk was not perceived while they had to perform work as their responsibilities and compulsion. This acceptance of the perceived responsibilities put them in a health risk especially during pregnancy, delivery and postnatal period.

The daily activities of women in the community were also explored. They were engaged in domestic works and farming from the early morning to evening. It reflects that women participants engaged in daily household works and perform them even ignoring the health status during pregnancy and post-pregnancy. This also helps to conclude that there exist inadequate prenatal care which is consistent with the result of a study in Pakistan (Muazzam Nasrullah et al., 2013). This involvement in heavy works concludes that they risk condition of their health into degradation along with health of their baby and they might not perceive this condition as a risk.

The illness impeding household works were treated immediately was reported in a study in India (Barua & Kurz, 2001). The priorities is mostly given to the work can be demonstrated from this study, which might be true for our research participants as they mentioned they do not have time to care for their health after all the domestic chores. All the women participants considered household work as their priority and responsibility after being married and key informants in the interviews also mentioned it. As a consequence of this, health was prioritized less even healthcare workers suggested them to take precautions. Further, the trend of hiding pregnancy status in first months and continuing to work until the appearance of the first signs of labor pain was also reported in a study in Nepal (Mesko et al., 2003). Some women in the study also expressed that they did not disclose their pregnancy status until it became visible and they also continued to work until pain became severe to seek health care. The participants in this study reported major health problems like miscarriage and uterine prolapse. This illustrated that they prevented themselves caring for their health when it was required.

Together with this, key informants and women participants mentioned women in minority caste and ethnicity prevented women from taking care for their health in Tharu and Chaudhary (Dalits) community. Although caste and ethnicity were not a central
questions in the study, it appeared many times during the interviews and the discussion. It was mentioned in KII, women in Chaudhary and Tharu ethnicity do not care for their health and women participant’s experience was the same. This may be due to their underprivileged status (Maharjan et al., 2012) where they have been accepting their minority status in health. A study on maternal and child health in Nepal based on the caste and ethnicity revealed Dalits and Janajati women’s antenatal health care and delivery utilization is less compared to other groups (Pandey, Dhakal, Karki, Poudel, & Pradhan, 2013). Few women participants enlightened this where they explained inadequacy of nutritious foods during their pregnancy period. Likewise, shyness might be due to cultural viewpoint of certain caste and ethnicity in the village because it was mentioned several times that these group women are often shy to go and talk with health care professionals.

5.3.7 Transportation and Distance

Another part of the result of present study was difficulties in traveling for health care facilities among women participants. The geographical location of health care facilities and limited transportation options were barriers for them. It was expressed that participants had to walk a long distance or travel by bicycle or motorbike with husband/relatives while going for an antenatal check-up/delivery. Most of the participants traveled by calling an ambulance from distance health care facilities when the labor pain started. This was because of unavailability of easy public transportation facilities despite the availability of road facilities. This expressed difficulty of distance and transportation was a barrier in accessing the health care facilities (Onta et al., 2014). Finding of a study conducted in two VDCs of Nepal regarding the health care utilization indicated distance of the health care facilities play an important role in usage of skilled manpower in deliveries. The possibilities of occurrence of delay in reaching the health care facilities might deteriorate the health of these women (Yadav, 2010). In this study also, few women delivered at home while waiting for the ambulance to arrive. However, this might have occurred because they seek for health care facilities lately and perception of less severity of health problem might have influenced this (Irwin M Rosenstock, 1974).
5.4 Cues to Take Action

The cues to action in Health Belief Model (HBM) is a stimulus to induce the decision making process related to healthful behavior, which could be “internal” or “external” (Janz & Becker, 1984). Based on the result of this study, cues to action to visit the health facilities during the period of adolescent was limited due to the lack of knowledge about the adolescent friendly health care services among the women participants. After pregnancy, first contact with the health care facilities were made which was dependent on various internal factors as own level of awareness and external factors as information provided by social workers, interaction with the women in village, support from the family members. Most of the participants verbalized their difficulties during the delivery time, which enforced them to use the family planning methods later, which could be an internal factor.

The present study results highlighted the need of health awareness program to promote present and future health status of early-married women. Consistent with the concept “cues to action” of HBM, targeted education is required to motivate the use of the health care facilities available to them. The findings based on the view of key informants indicated implementation of the program designed for adolescent group is required because although there is existence of policies and strategies regarding adolescent friendly services, there is lacking in the part of implementation phase.

Most participants in KII believed early-married women in the community do not realize their need of health care. To motivate them to use to health care services, it is important to create awareness about preventing the pregnancy before the age of 20 years. Further, decision to go to the health care services are influenced by the family members, so it is necessary to involve them in the awareness programs for promoting the uptake of the family planning, antenatal, delivery and postnatal care services in the communities of Dang. Firstly sensitizing early-married women towards their need of frequent contacts with the health care services to minimize the potential risks is important. Secondly, empowering these women to make decisions regarding their choice of giving birth at appropriate age. Providing appropriate training to health care providers so they become specialized to deal with vulnerable women might influence frequency of contacts made by these women.
The factors responsible for not seeking services were lack of information, work overload, shyness, and discomfort, and transportation barrier. The free health care facilities and monetary benefits and incentives availability were limited to women in government health care facilities. Most participants sought for private health care facilities for them and when their children got sick for receiving quality care. The external cues as cash incentives were not motivating the women participants.

5.5 Limitation and Strengths of the Study

The study has some of the limitations. The use of purposive and snowball sampling methods for allocating the participants in the study means we have a limited number of sample that does not allow the generalization of study results. However, since the findings of our study are similar to findings in other studies from Nepal and similar region, we have a reason to believe the results generated in this study are reliable and valid.

The findings of the study may not be applicable to other rural setting or districts of Nepal as the study was conducted within four VDCs of a district with a limited number of participants. However, a study in similar contexts regarding health care facilities might result in transferability of the study.

While conducting FGD, there was some limitation as the groups were formed based on the time suitability of available participants. Participants with a similar background might have occurred which might have inhibited the occurrence of varied views in the discussion. Furthermore, as the women of the selected community seemed to be busy in their daily household chores, this might have excluded the other possible participants in the discussion.

The limited time and resources to conduct fieldwork restricted the coverage of large areas. Due to the political instability in the western region of the country at the time of data collection (issues related to the constitution 2015), only accessible and feasible areas were selected. During the fieldwork, the security reason of the researcher was considered. Thus, choice of the research areas might not have reflected the intense rural scenario of the district, which would have provided more interesting data.

The strengths of study, however counterbalances the limitations. The qualitative nature of study help in exploring factors related to the health-seeking behavior of the early-
married women along with shared experiences. The study identified the facilitators and barriers from the perspectives and experiences of the women participants, hence enhancing the applicability of the results. The flexibility nature of qualitative study allowed acceptance of new emerging theme during the period of data collection. This helped collection of information from the participants, which was not considered to be collected before traveling to the field.

Participants from four different sites were selected purposively to ensure the variation in the participants regarding the geographical location and accessibility to city area. This might have aided in exploring the views of people from the different area, which gives variation in thoughts and themes. Along with this, perspectives of the key members of the community might give an overview of the real scenario and allowed examination of their perspectives together with the perception of the early-married women. Key informants’ agreement with the view of the women participants provides an additional supportive basis for findings of the study.

5.6 Implications of the Study

The adolescent girls and early-married women’s health are important because of the potential exposure of risk to their health. Promoting the health status of these women is crucial to maintain and upgrade the overall health status by decreasing the morbidity and mortality. More barriers than the facilitators influence the health care utilization among these populations in the study. The factors identified in the study could be used to improve the health status of women. This result, as a whole, could be applied in the planning of the probable policies and interventions to support the vulnerable women in the particular community.
6 CONCLUSION AND RECOMMENDATION

The women in present study regularly seek care for a health condition. The women participants consider taking healthcare for herself and child, however inadequacy in the level of understanding and knowledge was found. The results of the study demonstrate various factors that influenced health-seeking behavior within the examined social context. Although perceived severity was substantial, the preventive health behavior in terms of early pregnancy was not present. The factors that favor the visit to health care services were perceived awareness of own health, positive attitude towards health care facilities, motivation after using health care facilities; encouragement provided by the health care personnel and enforced communication about use health care services among women in the community. The factors that impede women’s health care services use include shyness and embarrassment, immaturity related to age, previous negative experiences of health care, transportation and distance of health care facilities, poor qualities of services, verbal abuse from health care provider and domestic work overload. The women participants and key informants expressed violence in marriage is common, which ultimately deteriorates the health of women suffered from violence. Perceived barriers masked perceived benefits and prevented in taking appropriate healthful behavior.

The information obtained from the study indicated that special considerations should be made at government level while implementing the strategies regarding adolescent health care services and a higher priority should be given to the poor and rural settings of the country. More interestingly, the study has found that most of the women participants got married by their own decision when they were studying at secondary level of education. They did marriage by eloping away. These issues should be addressed with adequate support to improve the lives of women married as child.

This study may provide valuable information for further planning and development of the strategies to address health issues of early-married women and adolescent girls. Additionally, insight into how young married women consider healthcare will help to understand and design future plans and programs to improve the health status of women married as a child in Nepal.
6.1 General Recommendation

The study is centralized on the perception of early-married women regarding their health care utilization and experiences while using health care. The identified factors that influence the use of the health care services could be applied to prevent adolescent pregnancy and promote health care.

- Improvement in the existing health care facilities at local level with the provision of proper family planning services and antenatal care could improve the overall health status of women.
- Interventions to prevent pregnancy at early age instead of waiting for the consequences.
- Implication of awareness campaign about sexual and reproductive health by engaging male community members while intervening female.
- Ensuring of relevancy of the programs conducted through interval monitoring and evaluation.
- Deduce the perceived role of a woman being pregnant immediately after marriage at the community level.
- Emphasizing hospital delivery as crucial to maintain health rather than more focus on money and incentives.
- Identifying the loopholes created in areas of monetary benefits and incentives to be received by women.
- Providing sexual health information and counseling to sexually active people; maintaining a chapter about it in secondary school level curriculum and deliver properly.
- Extending the opening hours of health care services at local level to increase the accessibility and utilization.
- Training of the health care providers while communicating with young and vulnerable people to avoid shyness and discomforts for health care use.

6.2 Recommendation For Further Research

- Since the study showed close members (husband and mother-in-law) in the family of young women participants influence overall health status women
participants, further exploration by taking the views of these members of the community would be beneficial to explore innovative themes.

- Furthermore, involvement of more participants and more focus group discussions from geographically diverse locations, such as eastern part of the country, would help to explore more varied themes because the trend of marriage before the age of 18 years are different. It would help to understand and provide basis for development of more precise planning and policies at national level.
- The differences in the government and private level of the health care facilities and health care providers illustrates potential participants could be health care professionals working in private health care facilities.
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Appendix 1: Approval from Ethical Committee of Nepal Health Research Council (NHRC)

Ref. No. 49
17 September 2015

Ms. Binita Maharjan
Principal Investigator
University of Oslo
Norway

Ref: Approval of Research Proposal entitled Exploration of factors influencing the use of the reproductive health care services among the early-married brides in selected VDCs of Dang district, Nepal

Dear Ms. Maharjan,

It is my pleasure to inform you that the above-mentioned proposal submitted on 26 July 2015 [Reg. no. 173/2015 please use this Reg. No. during further correspondence] has been approved by NHRC Ethical Review Board on 16 September 2015.

As per NHRC rules and regulations, the investigator has to strictly follow the protocol stipulated in the proposal. Any change in objective[s], problem statement, research question or hypothesis, methodology, implementation procedure, data management and budget that may be necessary in course of the implementation of the research proposal can only be made so and implemented after prior approval from this council. Thus, it is compulsory to submit the detail of such changes intended or desired with justification prior to actual change in the protocol.

If the researcher requires transfer of the bio-samples to other countries, the investigator should apply to the NHRC for the permission.

Further, the researchers are directed to strictly abide by the National Ethical Guidelines published by NHRC during the implementation of their research proposal and submit progress report and full or summary report upon completion.

As per your research proposal, the total research amount is USS. 2,525.00 and accordingly the processing fee amount to NRs. 10,240.00. It is acknowledged that the above-mentioned processing fee has been received at NHRC.

If you have any questions, please contact the Ethical Review M & E section of NHRC.

Thanking you,

Dr. Khem Bahadur Karki
Member-Secretary
Appendix 2: Approval for Storage Of Information from Norwegian Social Science Data Services (NSD)

7 Appendix 2: Approval for Storage Of Information from Norwegian Social Science Data Services (NSD)

Norsk samfunnsvitenskapelig datatjeneste AS
NORWEGIAN SOCIAL SCIENCE DATA SERVICES

Johannes Sandby
Institutt for helse og samfunn
Universitetet i Oslo
Postboks 1130 Blindern
0318 OSLO

Vedtatt: 07.09.2015
Vnr. ref: 43861/31 JKL
Dato: 07.09.2015
Dato ref.

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPlySNINGER

Vi viser til melding om behandling av personopplysninger, notatt 03.07.2015. Meldingen gjelder prosjektet:

43861

Exploration of Factors influencing the use of the reproductive health care services among the early-married brides in Nepal.

Behandlingsmottaker: Universitetet i Oslo, ved institusjonens øvrige linker

Dyktig ansvarlig: Johannes Sandby

Sted: Bista Mahara

Personvernomfordeler har vurdert prosjektet, og finner at behandlingen av personopplysninger vil være regulert av § 7-27 i personvernloven og foralt for privatpersonvernet. Personvernomfordeler vil ikke at prosjektet gjennomføres.

Personvernomfordeler tilbuddet at prosjektet vil bli avviklet i tråd med opplysningene gitt i meldingen, korrespondanse med ombudet, ombudets kommentarer og personvernloven og beherskerloven med forskriver. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen creditor i forhold til opplysningene gitt i meldingen, korrespondanse med ombudet, ombudets kommentarer og personvernloven med forskriver. Behandlingen av personopplysninger kan settes i gang.

Det vil også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.


Personvernomfordeler vil ved prosjektets avslutning, 10.06.2016, rette en henvisning angående stans for behandlingen av personopplysningene.

Vennlig hilsen

Bjørn Henrichsen

Kontaktperson: Asdun Lavlie: tlf: 55 58 23 07

Vedlegg: Prosjektorklarasjoner

Kopi: Bista Mahara, økern Torgvei 92, 0589 OSLO
The purpose of the project is to explore the factors influencing (facilitators and barriers) the use of the reproductive health care services among the early-married brides in rural Nepal.

The sample will receive written and oral information about the project, and give their consent to participate. The letter of information and consent form are somewhat incomplete, and we ask that the following is changed/added:
- Date for the end of project (given to be 10th June 2016 in the notification form)

There will be registered sensitive information relating to health.

The Data Protection Official presupposes that the researcher follows internal routines of Universitetet i Oslo regarding data security. If personal data is to be stored on a private computer/portable storage devices, the information should be adequately encrypted.

Estimated end date of the project is 10.06.2016. According to the notification form all collected data will be made anonymous by this date.
Making the data anonymous entails processing it in such a way that no individuals can be recognised. This is done by:
- deleting all direct personal data (such as names/lists of reference numbers)
- deleting/rewriting indirectly identifiable data (i.e. an identifying combination of background variables, such as residence/work place, age and gender)
- deleting digital audio and video files
Appendix 3: Letter from Regional Committees for Medical and Health Research Ethics in Norway

Joar Svanesmyr
Institutt for helse og samfunn
Universitetet i Oslo
0318 Oslo

2015/040  En kvalitativ studie av faktorer som påvirker bruken av reproduktiv helsetjenester blant tidlig gifté kvinner i Nepal

Vi viser til søknad om forhånds godkjenning av ovennevnte forskningsprosjekt. Søknaden ble behandlet av Regional komité for medisinsk og helsefaglig forskningsetikk (REK sør-øst C) i møtet 11.06.2015. Vurderingen er gjort med hjemmel i helseforskningsloven § 10, jf. forskningsetikkloven § 4.

Forskningsansvarlig: Institute of Health and Society
Prosjektleder: Joar Svanesmyr

Prosjektomtale (original):
Objectives: To identify the facilitators and barriers for the use of the reproductive health care services among the early-married brides in Nepal Methods: Qualitative methods will be used consisting of Focus group Discussion (FGDs) and in-depth semi-structured interviews (IDI). Study sites and Participants: The study will be conducted in the Dang district of mid-western Development Region in Nepal as it has high prevalence of child marriage; 53% in 2011 (NDHS, 2011). For In-depth interview (total 15) the participants will be women married before the age of 18 years, currently with age 17-20 years. Focus Group Discussion (total 4 FGD in 4 wards) will be conducted with groups of 4-8 women. Participants from in-depth interview will be included in FGD. Short semi-structured interviews will be conducted with key informants in the community.

Helseforskningsloven gjelder for medisinsk og helsefaglig forskning, det vil si «virksomhet som utføres med vitenskapelig metodikk for å skaffe tilveie nye kunnskap om helse og sykdom», jf. helseforskningsloven § 2, jf. § 4.


Prosjektet kan gjenomføres uten godkjenning av REK innenfor de ordinære ordningene for helsetjenesten med hensyn til for eksempel regler for taustetsplikt og personvern. Søker bør derfor ta kontakt med enten forskerstøtteavdeling eller personvernombud for å avklare hvilke retningslinjer som er gjeldende.

Vedtak
Etter søknaden fremstår prosjektet ikke som medisinsk og helsefaglig forskning, og det faller derfor utenfor helseforskningslovens virkemåte, jf. helseforskningsloven § 2.
Komiteens avgjørelse var enstemmig.

Klageadgang
Du kan klage på komiteens vedtak, jf. forvaltningsloven § 28 flg. Klagen sendes til REK sør-øst.
Klagerfristen er tre uker fra du mottar dette brevet. Dersom vedtaket opprettholdes av REK sør-øst, sendes klagen videre til Den nasjonale forskningsetsiske komité for medisin og helsefag for endelig vurdering.

Med vennlig hilsen

Britt-Ingjerd Nesheim
professor dr. med.
leder REK sør-øst C

Claus Henning Thorsen
Rådgiver

Kopi til: Universitetet i Oslo; universitetsdirektør@UiO.no
johanne.sundby@med.uio.no
9 Appendix 4-5: Informed Consent Form in English and Nepali

University of Oslo, Institute of Health and Society

**Informed Consent Form (ICF)**

**Title:** Exploration of the influencing (facilitators and barriers) factors for the use of the health care services among the early-married brides in rural Nepal

**Date:**

**Informed Consent Form for exploration of the influencing (facilitators and barriers) factors for the use of the health care services among the early-married brides in Nepal**

This informed consent form is for women aged between 17-20 years who were married before the age of 18 years/ Key Informants in Dang District and who are participating in research.

**Name of Principle Investigator:** Binita Maharjan, Student M. Phil. International Community Health

**Name of Organization:** University of Oslo, Norway

**Name of Project and Version:** Exploration of the influencing (facilitators and barriers) factors for the use of the health care services among the early-married brides in rural Nepal

This Informed Consent Form has two parts:

- Information Sheet (to share information about the study with you)
- Certificate of Consent (for signatures if you choose to participate)

You will be given a copy of the full Informed Consent Form

**Part I: Information Sheet**

**Introduction:**

I am (Name of the interviewer), a Masters student in University of Oslo, Norway. I am doing research on the influencing (facilitators and barriers) factors for the use of the
health care services among the early-married brides in rural Nepal. I am doing research on Early Marriage, which is social practice taking place in different part of country and common in this region. I am providing you information (verbal and written) form and invite you to be part of this research. You and someone close to you have been selected as research participant, as you have been married before age of 18 years. You can talk to anyone you feel comfortable and take time before you decide to participate in the study.

This consent form may contain words that you may not understand. Please stop me when I am going through the information wherever you find trouble in understanding. I will take time to explain in more simple words. If you any questions later, you can ask me whenever you want.

**Background and Purpose of the research**

Early marriage is common in Nepal, rural community. These women need to access more health care services. I want to find the factors influencing and experiences regarding the use of health care services among early-married women. I believe you can help me by telling me your experiences on approaching health care services. The study aims to find out what changes are necessary to make easy for these women group to access health services. It is hoped that the result of the study will help and provide guidance to make future plans and take initiatives in improving the situation of early-married girls.

**Type of Research Intervention:** Participants for the research will be involved either in focus group discussion or selectively in in depth interview.

**Participant Selection:** You are invited as a participant because your views and experience can contribute much in our understating and knowledge of early married women’s approach to health care services.

**Potential advantages or disadvantages:** There will not be any particular benefit/risk to the participants involving in the study. You will be compensated for the transportation expenses or any other indirect costs linked with participation.
**Confidentiality:** The information that you have provided will not be shared with anyone outside of the research team. Your name will not be recorded on the information you provided; instead they will be marked with acronyms. The information collected will be private, protected by password and locked up with lock and key. The information will be destroyed after the completion of the study.

**Voluntary Participation:** The participation in the study is voluntary. It is your decision to participate in the study. If you wish to participate you can sign the consent on the final page. If you change your mind later, you can stop and can discontinue the participation without stating any particular reason even if you had agreed earlier.

If you wish to withdraw your consent from the study or if you have any queries you can contact the contact as follows.
Principal Investigator: Binita Maharjan Contact information: Mobile number (9843303071) or binita.maharjan@studmed.uio.no

This proposal has been reviewed and approved by Nepal Health Research Council, Ethical Review Committee (ERC), which is a committee whose task it is to make sure that research participants are protected from harm. If you wish to find about more about the ERC contact:

Name: 
Address: 

Telephone number:

**Procedures**

**Focus Group Discussion:** If you wish to participate, the discussion will take place in a group of 6-8 persons with similar experiences. Researcher herself will guide the discussion. The questions regarding your experiences on accessing and using health care services will be asked and time will be given to share your knowledge. You do not have to share any experiences that you are uncomfortable with. The entire discussion will be tape recorded, but no one will be identified by name in the tape recorder. We will ask the participants in the group not disclose the information outside the group discussion.
However, we cannot ensure that the participants will not share information from the discussion.

**Interview:** The participant will sit in interview with the researcher herself. We can choose a comfortable place for interview according to need. The questions regarding your experiences on accessing and using health care services will be asked and time will be given to share your knowledge. You do not have to share any experiences that you are uncomfortable with. The interview will be tape-recorded.

**Duration:** The research takes place over 3 months in total and researcher may contact you 2 – 3 times during this period if necessary.

**Criteria for participation:**

- Women who were married before the age of 18 years
- The current age of the women should be between 17 – 20 years
- The women should either be pregnant or have at least one child

**Contact with participants:** The main researcher will have contact with all the participants.

**Schedule:** The time and location will be chosen suitable to the participants who agreed for participation.

**The responsibility of the participant:** It is the responsibility of the participants to attend the discussion or interview on agreed time and place.

**Changes to study plan:** The participant will be informed as soon as possible if any changes in the information about the study arise, that might influence the participation’s willingness to take part in the study.

**Compensation:** Reimbursement for the transportation costs to travel to the site where interview or discussion will take place will be provided to the participant.

**Right to access and right to delete your data and samples:** Upon your agreement to the study, you are entitled to decide what information given by you to be included in the study. You are further entitled to correct any mistakes in the information registered. If you withdraw from the study, you can demand that the data to be deleted, unless data have been already included in analysis and used in scientific publication.
**Information about the study:** A summary of the study will be provided to the concerned authority in the VDC/Municipality. Participants are entitled to receive the information about outcome of the study.

**Personnel:**

**Principal Investigator:** Binita Maharjan, M. Phil. International Community health, University of Oslo. Contact Information: +4748663474 (Mobile); binita.maharjan@studmed.uio.no

**Supervisor:** Dr. Joar Svanemyr, Independent consultant on sexual and reproductive health and rights (SRHR) with a focus on adolescent SRHR, child marriages, and unsafe abortions. Contact Information: +4791550028 (Mobile), joarsv@online.no (Email)

**Co-supervisor:** Dr. Poonam Rishal, PhD Candidate, Department of Public Health and General Practice. Contact Information: +9779849205290 (Mobile) poonam.rishal@ntnu.no (email)
Part II: Certificate of Consent

I have been invited to take part in research about factors influencing the use of health care services among the early-married women in Dang District, Nepal.

I have read (or verbally informed about the research project) and received a hard copy of the research information. I have has the opportunity to ask my queries about it and I have been answered to any questions to my satisfaction. I consent voluntarily to be a participant of this study.

Print Name of Participant__________________

Signature of Participant ___________________ or Thumbprint of participant

Date ___________________________ Day/month/year

Statement by the researcher/person taking consent
I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands that the participant will be included in interview or group discussion.
I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of this ICF has been provided to the participant.

Print Name of Researcher/person taking the consent________________________

Signature of Researcher /person taking the consent___________________

Date __________________________ Day/month/year
Consent form for Focus Group Discussion (FGD)/ In-depth Interview (IDI) in Nepali

समुह छलफल/ अन्तर्वार्ताको लागि सुचित सहभागत पत्र:

अनुसन्धानमा सहभागी जनाउनको लागि अनुरोध

प्रस्तुतभूमि र उदेश्य:

म २०७१ साल देखी नर्वेमा पढाई गर्ने ढिबी अनुत्तरगत पर्ने आवश्यकता हो। यो अनुसन्धानले १८ वर्ष भन्दा मुनिका विभाजित महिलाहुँबी उपवार्ता तथा सेवाहरूले उपयोग पुर्बाधिकार बारे अनुसन्धान गर्ने उदेश्य रहेको छ। यो अनुसन्धानले १८ वर्ष भन्दा मुनिका विभाजित महिलाहरूले स्वास्थ्य केन्द्रहरूमा जानु अथवा नजनुका करणहरू पत्ता लगाउन कोशी गर्दछ।

यो खोजमा कहुनछ?

यो खोजमा तपाईले १८ वर्ष भन्दा मुनिका विभाजित महिलाहुँ घार देखी सातको समुहमा (अथवा अन्तर्वार्तालाई) बसेर आफुले स्वास्थ्य संस्थासँग जानुका लागि र जानु भएपछि अनुभवहरू छलफल गरुने छ। यहाँ छलफल भएका कुराहुँ मैले लिपिट र रेकोर्ड गर्ने।

कुनै नाफा र हानि?

यो अध्ययनमा सम्बन्धित सहभागीहुँदै कुनै पनि विभेष फाईवा/ हानि हुनेछ।

तपाईले विक्रेतालाई सुचना कै हुनछ?

तपाईले विक्रेताको जानकारीहुर सबै गोपय राखिने। तपाईले पूर्वान मगरे जानकारी अनुसन्धान टिम बाहिर कोहीसंग साझा हुनेछ। तपाईले नाम रेकर्ड मा पुर्योग हुनेछ। तपाईले विक्रेताको जानकारीहुर पासवर्ड दुवा सुरक्षात र ल्याउन राखिने। अध्ययन पूरा गरेपछि जानकारीहुर नष्ट गरिने।

सवैधानिक सहभागिता

यसै अध्ययनमा सहभागिता लिने अथवा नलिने तपाईको आफ्नो निर्णय हो। तपाई सहभागी गर्न चाहनुकै भने तपाई अन्तिम पृष्ठमा सहभागी साइन गर्न सक्नुहुन्छ। तपाईले पछि आफ्नो मन
परिवर्तन गर्नुभयोभने, तपाईं यसलाई रोकन सक्नुहुन्छ। तपाईले पहिले सहमति दिए पनि खास कारण नभिनक नभिनक सहभागितापनुभन्दा बन्द गर्नु सक्नुहुन्छ। तपाईं अध्ययनमा आफ्नो सहमति झिक्न चाहनुहुन्छ भने वा तपाईलाई कुनै पनि पश्चात छ भने छ भने निम्नानुसार सम्पर्क गर्नु सक्नुहुन्छ:
प्रशान्त अन्वेषक: बिनिता महर्जन संपर्क जानकारी: मोबाइल नम्बर
(९८४३३३०७१) वा (binita.maharjan@studmed.uio.no)

सहभागीलाई लगि परमाणपत्र
मलाई बाहेर जिल्ला, नेपालमा भएको १८ वर्ष बन्ना मुनिका बिखिरहेका बीच स्वास्थ्य हेलिटियर निवासी भएको उपयोग पर्यावरण कारण बारे अनुसन्धान भएको लिन निम्नलिखित गरीएको छ।
मैले पटेट (वा मौखिक) रुपले अनुसन्धान परियोजना भएको जानकारी पाएको छ र सहमति पत्रको एक हस्ताक्षर र विवरण पर्याप्त गरिएका छ। मलाई नबुझेका पश्चात छोड्नु सोधन मीका विद्युक्त गर्नुसहित बिद्युक्तको छ र मैले पश्चात छोड्नुसँग संबंधित प्रश्नहरूलाई जवाब सन्तुष्ट रुपमा भएको छ। म यो अध्ययनमा सहभागी हुन सुविधा सहमति पुर्दछु।
सहभागीको नाम __________________
सहभागीको हस्ताक्षर __________________ वा आठा छाप
मिति __________________ दिन / महिना / वर्ष
शोधकर्ता / सहमति लिने वृत्तित्व द्वारा विवरण:
मैले यस खोजको भाग लिनको लागि सहभागीलाई यस पत्र भएको जानकारी राम्रो पढ़े बुझ्नु गर्नु हुनुहोस्।
मैले यस पत्रको लागि सहभागीलाई यस पत्र भएको जानकारी राम्रो पढ़े बुझ्नु गर्नु हुनुहोस्।
मैले यस पत्रको लागि विवरण दिने तथा वृत्तित्व द्वारा सहमति राम्रो पढ़े बुझ्नु गर्नु हुनुहोस्।
यस पत्रको एक परतल र सहभागीलाई पुर्दछु गरीएको छ।
Appendix 6: Assent Form in English

University of Oslo, Institute of Health and Society

Informed Assent Form for Children/Minors

Informed Assent Form for women at 17 years who were married before the age of 18 year

Name of Principle Investigator: Binita Maharjan, Student M. Phil. International Community Health

Name of Organization: University of Oslo, Norway

Name of Project and Version: Exploration of the influencing (facilitators and barriers) factors for the use of the health care services among the early-married brides in rural Nepal

This Informed Assent Form has two parts:

- Information Sheet (gives you information about the study)
- Certificate of Assent (this is where you sign if you agree to participate)
You will be given a copy of the full Informed Assent Form

Part I: Information Sheet

Introduction

My name is Binita Maharjan, a Masters student in University of Oslo, Norway. I am doing research as a student on the influencing (facilitators and barriers) factors for the use of the health care services among the early-married brides in rural Nepal. I am doing research on Early Marriage, which is social practice taking place in different part of country and common in this region. I am providing you information (verbal and written) form and invite you to be part of this research. You and someone close to you have been selected as research participant, as you have been married before age of 18 years. I have spoken to your guardian about the research and you will be signing the consent if you want the take part in the study. If you are going to participate in the research, your guardian also has to agree. But if you do not wish to take part in the research, you do not have to, even if your parents have agreed. You can talk to anyone you feel comfortable and take time before you decide to participate in the study.

This consent form may contain words that you may not understand. Please stop me when I am going through the information wherever you find trouble in understanding. I will take time to explain in more simple words. If you any questions later, you can ask me whenever you want.

Purpose: Why are you doing this research?

Early marriage is common in Nepal in rural community. These women need to access health care services more. I want to find the factors influencing and experiences regarding the use of health care services among early-married women. I believe you can help me by telling me your experiences on approaching health care services. The study aims to find out what changes are necessary to make easy for these women group to access health services. It is hoped that the result of the study will help and provide guidance to make future plans and take initiatives in improving the situation of early-married girls.

Choice of participants: Why are you asking me?
You are invited as a participant because you are married as a child that under the age of 18 years. In addition, your views and experience can contribute much in our understanding and knowledge of early-married women’s approach to health care services.

**Participation is voluntary: Do I have to do this?**

The participation in the study is voluntary. This means it is your decision to participate in the study. If you wish to participant you can sign the consent on the final page. If you change your mind later, you can stop and can discontinue the participation without stating any particular reason even if you had agreed earlier.

If you wish to withdraw your consent from the study or if you have any queries you can contact as follows.

**Principal Investigator:** Binita Maharjan  
**Contact information:** Mobile number (9860469712) or binita.maharjan@studmed.uio.no

**Examples of question to elucidate understanding:** If you decide not to take part in this research study, do you know what your options are? Do you know that you do not have to take part in this research study, if you do not wish to? Do you have any questions?

**I have checked with the child and they understand that participation is voluntary.**

**Procedures: What is going to happen to me?**

If you decide to participate in the study you have to do the following.

**Focus Group Discussion:** If you wish to participate, the discussion will take place in a group of 6-8 persons with similar experiences. Researcher herself will guide the discussion. The questions regarding your experiences on accessing and using health care services will be asked and time will be given to share your knowledge. You do not have to share any experiences that you are uncomfortable with. The entire discussion will be tape recorded, but no one will be identified by name in the tape recorder. We will ask the participants in the group not disclose the information outside the group discussion. However, we cannot ensure that the participants will not share information from the discussion.
Interview: The participant will sit in interview with the researcher herself. We can choose a comfortable place for interview according to need. The questions regarding your experiences on accessing and using health care services will be asked and time will be given to share your knowledge. You do not have to share any experiences that you are uncomfortable with. The interview will be tape-recorded.

Examples of question to elucidate understanding:

Do you have any other questions? Do you want me to go through the procedures again?

I have checked with the child and they understand the procedures.

Risks: Is this bad or dangerous for me?
There will not be any particular benefit/risk to the participants involving in the study. You will be compensated for the transportation expenses or any other indirect costs linked with participation.

I have checked with the child and they understand the risks and discomforts.

Benefits: Is there anything good that happens to me?
There is not particular benefit to the participants involved in the study. But this research might help us to find what changes are necessary to make easy for these women group to access health services.

I have checked with the child and they understand the benefits.

Reimbursements: Do I get anything for being in the research?
Reimbursement for the transportation costs to travel to the site where interview or discussion will take place will be provided to the participant.

Examples of question to elucidate understanding: Can you tell me if you have understood correctly the benefits that you will have if you take part in the study? Do you know if the study will pay for your travel costs and time lost? Do you have any other questions?

Confidentiality: Is everybody going to know about this?
The information that you have provided will not be shared with anyone outside of the research team. Your name will not be recorded on the information you provided; instead they will be marked with acronyms. The information collected will be private, protected by password and locked up with lock and key. The information will be destroyed after the completion of the study.

**Example of question to elucidate understanding:** Did you understand the procedures that we will be using to make sure that any information that we as researchers collect about you will remain confidential? Do you have any questions about them?

**Sharing the Findings: Will you tell me the results?**

When we are finished the research, I will sit down with you and your parent and I will tell you about what we learnt. I will also give you a paper with the results written down. Afterwards, we will be telling more people, scientists and others, about the research and what we found. We will do this by writing and publishing in journal if possible.

**Right to Refuse or Withdraw: Can I choose not to be in the research? Can I change my mind?**

You do not have to be in this research if you wish to not participate in the study. No one will be disappointed with you if you say no. It’s your choice. You can think about it and tell us later if you want. You can say "yes” now and change your mind later and it will still be okay.

**Who to Contact: Whom can I talk to or ask questions to?**

If you wish to ask any questions regarding the study and participation or if you have any other queries you can contact as follows.

Principal Investigator: Binita Maharjan Contact information: Mobile number (9860469712) or binita.maharjan@studmed.uio.no)

If you choose to be part of this research I will also give you a copy of this paper to keep for yourself. You can ask your parents to look after it if you want.

**Example of question to elucidate understanding:** Do you know that you do not have to take part in this study if you do not wish to? You can say No if you wish to? Do you know that you can ask me questions later, if you wish to? Do you know that I have given the contact details of the person who can give you more information about the study?
**Information about the study:** A summary of the study will be provided to the concerned authority in the VDC/Municipality. Participants are entitled to receive the information about outcome of the study.

**Principal Investigator:** Binita Maharjan, M. Phil. International Community health, University of Oslo. Contact Information: +9779860469712 (Mobile); binita.maharjan@studmed.uio.no

**Supervisor:** Dr. Joar Svanemyr, Independent consultant on sexual and reproductive health and rights (SRHR) with a focus on adolescent SRHR, child marriages, and unsafe abortions. Contact Information: +4791550028 (Mobile), joarsv@online.no (Email)

**Co-supervisor:** Dr. Poonam Rishal, PhD Candidate, Department of Public Health and General Practice. Contact Information: +9779849205290 (Mobile) poonam.rishal@ntnu.no (email)

**PART 2: Certificate of Assent**

I understand the research is about finding the influencing (facilitators and barriers) factors for the use of the health care services among the early-married brides in rural Nepal. I have read (or verbally informed about the research project) and received a hard copy of the research information. I have has the opportunity to ask my queries about it and I have been answered to any questions to my satisfaction. I consent voluntarily to be a participant of this study.

**Only if child assents:**

Print name of child ___________________

Signature of child: ___________________

Date: ______________ day/month/year

**If illiterate:**

I have witnessed the accurate reading of the assent form to the child, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.
Print name of witness (not a parent)_________________ AND    Thumb print of participant
Signature of witness __________________________
Date __________________________
    Day/month/year

I have accurately read or witnessed the accurate reading of the assent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given assent freely.

Print name of researcher___________________
Signature of researcher___________________
Date __________________________
    Day/month/year

Statement by the researcher/person taking consent
I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the child understands that participant will be included in interview / group discussion.

I confirm that the child was given an opportunity to ask questions about the study, and all the questions asked by her have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of this assent form has been provided to the participant.

Print Name of Researcher/person taking the assent________________________
Signature of Researcher /person taking the assent __________________________
Date __________________________
    Day/month/year
Copy provided to the participant ________ (initialled by researcher/assistant)

Parent/Guardian has signed an informed consent ___Yes   ___No _____(initialled by researcher/assistant)

11  Appendix 7: Assent Form in Nepali
सन्तु छलफल अनुसंधानको लागि सुरुचि सहमति प्रतिकृति
अनुसंधानमा सहमति जनाउनको साथि अनुरोध

पृष्ठभुमि उद्देश्य;
मा २०७६ साल देखि नै माछिका पत्रिकाहरूमा चूको। यो खोज संग सदी चालौतीहरू चिन्ता अनुसंधान नै आवश्यकता हो। यो अनुसंधानमा १७ वर्ष मन्दरा मुनिका विवाहित महिलाहरूको स्वास्थ्य सेवाहरूको उपयोग प्रभावित कर्क बारे अनुसंधान गर्न उद्देश्य सङ्ग्रहान्तर गराएको। यो अनुसंधानमा १८ वर्ष मन्दरा मुनिका विवाहित महिलाहरू स्वास्थ्य केन्द्रमा जानु थापा मन्दरा कराउनको र पताका लगाउन ब्रह्महरू गरेको देखि।

यो खोजमा कै हुन्छ?
यो खोजमा तपाईंको १८ वर्ष मन्दरा मुनिका विवाहित महिलाहरू माझेको देखि नातको समुहमा (अभ्यासक अनुसंधान) बस्ने आफ्नो स्वास्थ्य संस्था जानकारी लागि र जानु भएको तपाईंको अनुसार छलफल गरिनुहोस्। यहाँ छलफल बस्ने कुलहरूले लिपिन्छ र रकम गरिनुहोस्।

कृपया नापा र हामी?
यो अध्ययन समाप्तिको सहभागीहरूसँगै कुनै पत्र उपलब्ध पाइन्छ / हामी हुनेछ।

तपाईंले दिनको सूचना के हुने?
तपाईंले दिनको जानकारीहरू सङ्क गोपन रखिन्छ। तपाईंले फ्यान गरेका जानकारी अनुसंधान टीम बाहिर कोहिल्लो साँझाहुनेछ। तपाईंले नाम र सङ्क गरेका पत्र गरेन। तपाईंले दिनको जानकारीहरू पत्रबाट टवारा सुरुवात र लक गरेको जानिन्छ। अध्ययन पूरा गरेकहरू जीनेकोले गरिन्छ।

स्वास्थ्यको सहभागिता
यहाँ अध्ययन सहभागिता जिन्दै का नथाले तपाईंले अपनै निर्णय हो। तपाईं नहाइनु भने चल्नुभएको भने हुने। तपाईं अनुसार गर्ने सहभागिता निर्णय हुन्छ। तपाईंले भन्ने हामी दिन पत्र खाल खान सक्षात्कार कर्ण सहभागिता हुन्छ। तपाईंले सहभागिता दिन पत्र खान सक्षात्कार कर्ण सहभागिता हुन्छ।

प्राधान्य अन्वेषण
बिहिता मलाई भनिन्छ। संस्करण जानकारी: भिहिता मलाई भनिन्छ।
सहभागिको लागि प्रमाणपत्र

माझं दातां जिल्ला, तेनग्नाला भाईदाखों १६ वर्ष भरत भुलिकडे विवाहित महिलाहरू वीच स्वाभाविक हेतूविधार सेवाहरूको उपयोग प्रमाणित कारक बारे अनुसंधान भरने लिए निर्धारित गरिएको छ।
मैरे पत्र (या मौलिक) सनले अनुसंधान परियोजनाबाट जानकारी प्राप्त गरेका छौर र सहभागी पत्रको एक हाई प्रतिलिपि पान सरकाय । माझाँ नन्द्रेदार पुलिस सुरक्षा वैमंडल दिइएको छ र मैरे भ्रमणहरूको ज्ञाप समस्याको स्वदेश दिइएको छ। मैरो अभ्ययणमा सहभागी हुन सक्छ आफ्नो सहभागा पदन गरेका छ।

सहभागीको नाम ____________________
सहभागीको हस्ताक्षर ____________________ या अधिक छाप

मिती ____________________ दिन / महिना / वर्ष

यदी अलिंकित भवन:
मैरो उपर्युक्त ध्रुवमा, १६ वर्ष भरत भुलिकडे महिलाहरू लागि, सामाजिक परिस्थितियो र समस्यामा बाधित देखि विवेकितालाई यस अनुसूचिकाले वादमा पल्लव सोधा माउंट दिइएको प्रति। उनलाई उस अनुसूचिकाले भाग राखापन निर्देशन निर्देशको बिस्मिल दिइएको छैन भने पुष्टि गरेका छ।

सात्त्री को हस्ताक्षर ____________________ या अधिक छाप

मिती ____________________ दिन / महिना / वर्ष

शेखावतार / सहभागी दिने व्यक्ति द्वारा विधान:
मैरो यस वोङ्मा भाग दिने लागि सहभागीको नाम यसू पनि एउटै जानकारी रामभरी पदेखो बुझिएको छ। मैरो नामात अनुसार सहभागी समस्त युगापन अथवा अन्यतरम भाग दिन पनि भनेर जानकारी दिइएको छ।
सहभागीको अवयवमा वारेना परिस्थितियाँ सम्बन्धित दिइएको प्रति, र सहभागीको सौंप्यात्तिक सर्व प्रतिको वस्तु र मैरो नामात अनुसार ज्ञाप दिइएको प्रति। व्यवहारित सहभागी दिइएको कृपया बल प्रयोग गरिएको छैन भने पुष्टि गरेका छौर र सहभागीको खुलेकर र स्वेच्छा दिइएको छ।

यस सहभागी नामको एक प्रतिलिपि सहभागीको उपाधि परिवर्तन गरिएको छ।

शेकावतार / व्यक्तिको नाम ____________________
शेखावतार / व्यक्तिको हस्ताक्षर ____________________

मिती ____________________ दिन / महिना / वर्ष
12 Appendix 8 Interview Guide: English

Interview Guide

Background information:

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your age?</td>
<td></td>
</tr>
<tr>
<td>How long have you been married?</td>
<td></td>
</tr>
<tr>
<td>Who do you live with?</td>
<td></td>
</tr>
<tr>
<td>What is your husband’s age?</td>
<td></td>
</tr>
<tr>
<td>Which type of house do you live in (earth, concrete)?</td>
<td></td>
</tr>
<tr>
<td>Do you work?</td>
<td></td>
</tr>
<tr>
<td>Is your husband working?</td>
<td></td>
</tr>
<tr>
<td>What are the sources of income in your family?</td>
<td></td>
</tr>
<tr>
<td>Do you have electricity, water seal toilet; do you have TV and radio in your home?</td>
<td></td>
</tr>
</tbody>
</table>

In-depth interview (IDI) / focus Group Discussion (FGD)

- How do you consider your health?
- For what purpose do you go to the health care services?
- Have you had any health problems recently?
- What did you do when you fell ill/had pain/needed help the last time?
- Has your child/children had health problems? If so, what did you do?
- Are there specific the health facilities available for young women in this community?
- If yes, have you visited it?
- How do you decide to go for health care services?
- What do you think about the facilities available in the health care services?
- For what kind of problems do you seek for the health care?
Reproductive Health:

- Did you go for antenatal care services during your pregnancy?
- If yes, how many times you visited for the health care facility when you were pregnant?
- How did you decide to go/not to go the health services?
- Where did you deliver your first baby, at hospital or traditional birth attendant?
- Did you have any discomforts related to transportation while reaching the health care facility for delivery?
- How long did you stay in health facility after delivery?
- Do you have to pay for the medicine and for services in health care facility?
- What did you think about the services provided and staff’s treatment in the hospital?
- Will you go the health facility next time when you are pregnant?

Family Planning:

- Are you using any contraceptive methods now?
- Did you use any method of contraception before pregnancy?
- Who and how it is decided that which type of family planning method you should use?
- Have you discussed about the family planning with your husband and family members?
- Did you talk about family planning with health care provider before and after the pregnancy?

Violence

- What do you think about violence at home?
- Have you experienced any kind of violence at home?
- What you do for that?
In-depth interview (IDI): Key informants:

- What do you think about the perception of early-married women about their need of health care services for?
- How do you feel about the local services in the community for early-married women?
- What are the factors influencing the use of health care services among early-married girls are?
- Please share your ideas about the obstacles for using/approaching health care services.
- What will be the possible options to increase their use of health services?
Interview Guide in Nepali:

पर्न्छ आफ्नो जानकारी कार्यक्रमलाई यसै तरिकामा जानालाई कसलाई र अन्य लागिने कसलाई नै?

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- In-depth interview (IDI): For key informants:
  - तपाईंले स्वास्थ्य कामी संग गर्ने भएको भएको विवाह (अन्तिम विवाह) भएका महिलाहरूले आफन्छ स्वास्थ्य हरिविवाहको आवश्यक बारे समझाउ गर्नु भएको छ?
  - तपाईलाई १८ वर्ष भन्दा पहिला विवाहित महिलाहरुको लागि समुदायको अपवाद स्वास्थ्य सेवाहरूले कार्य केही लगाउनुहुन्छ?
  - १८ वर्ष भन्दा पहिला विवाहित महिलाहरुले स्वास्थ्य सेवाहरुको उपयोग गर्नुका कारण कैंस भएको हुन्छ?
  - तपाईंले विवाहमा १८ वर्ष भन्दा पहिला विवाहित महिलाहरुले स्वास्थ्य सेवाहरुको उपयोग गर्नुका कारण जानेको छ?
  - यी महिलाहरुले स्वास्थ्य सेवाहरुको उपयोग कृतिदृष्टि गर्नुको सम्बन्धी विवरण कैंस भएको हुन्छ?

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