COUNTRY MONITORING REPORT: NEPAL

THE STATE OF THE REGION REPORT ON SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS: ICPD +30

BARRIERS IN ACCESSING CONTRACEPTION OF CHOICE AND SAFE ABORTION SERVICES AMONG YOUNG WOMEN

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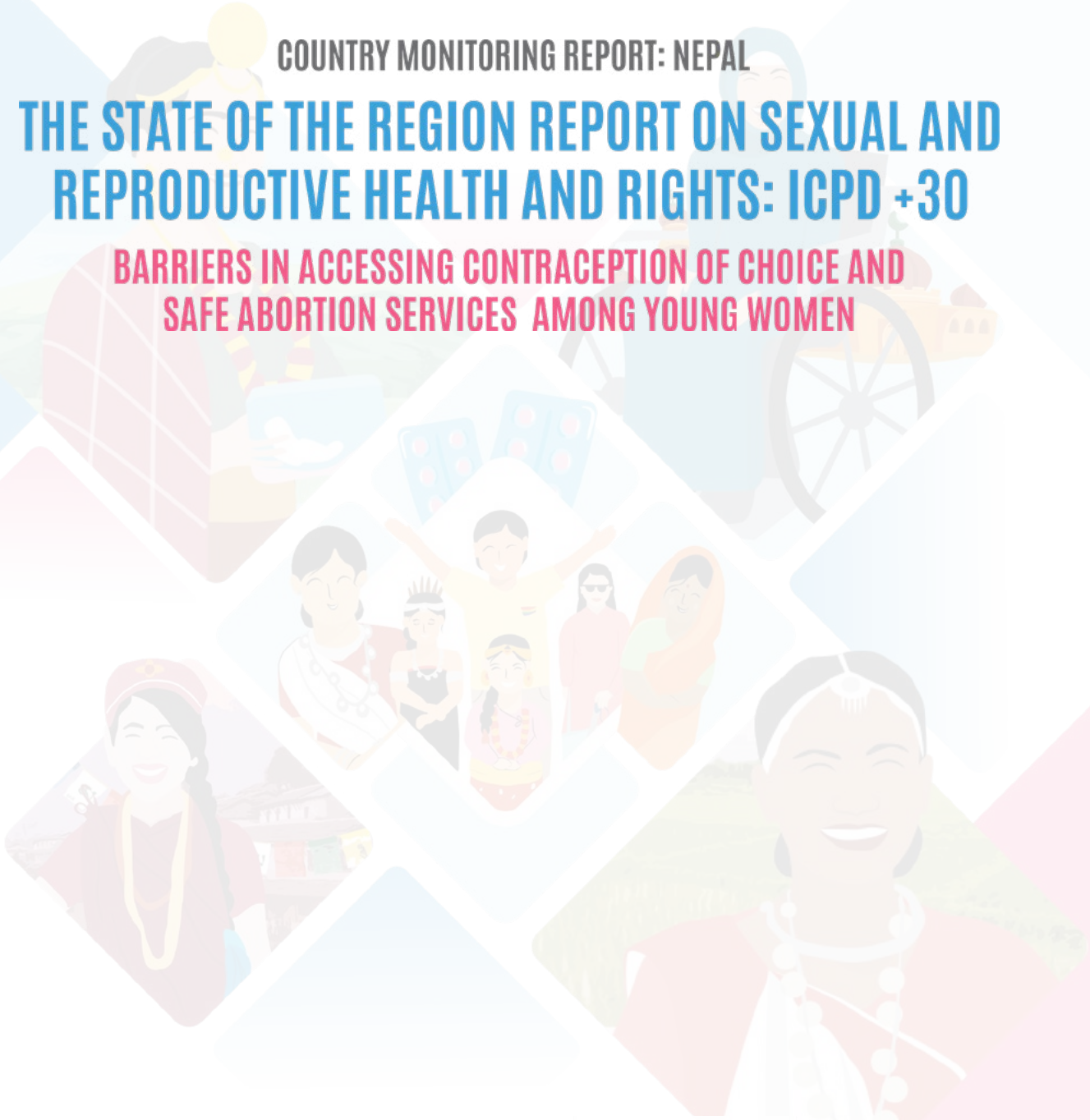

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Krishna Kumari Waiba
Chairperson
Beyond Beijing Committee

EXECUTIVE SUMMARY

Nepal, with a population of 2.9 million, has made commendable strides in Sexual and Reproductive Health and Rights (SRHR), supported by progressive policies and international commitments. Notable achievements include significant reductions in maternal mortality and improved contraceptive prevalence. However, challenges persist, particularly in contraception and safe abortion services. The monitoring report delves into barriers hindering young women's access to contraception and safe abortion, emphasizing the need for nuanced, community-specific approaches.

Despite achievements, concerns arise from a stagnant modern contraceptive rate, persistent unmet family planning needs, and high rates of unwanted pregnancies. Disparities across regions, age groups, and social strata demand targeted interventions. The report advocates for collaborative initiatives between the government, stakeholders, and communities to address gaps, dispel misconceptions, and advance SRHR in Nepal.

The qualitative approach employed Focused Group Discussions (FGDs) and In-Depth Interviews (IDIs) in diverse districts across five provinces, capturing insights into barriers faced by women aged 15-49. The sample, representative of various demographics, included unmarried and married women, Health Section Representatives, and Safe Abortion/Family Planning Service Providers. Ethical considerations were prioritized, ensuring confidentiality and informed consent.

The findings, derived from ten FGDs and ten IDIs involving 109 participants, reveal multifaceted challenges at organizational, community, and individual levels. Organizational barriers include shortages of trained service providers, budget constraints, infrastructural inadequacies, and inadequate services for persons with disabilities and adolescents. Community-level barriers involve marital status biases, socio-cultural stigmas surrounding abortion, and limited decision-making autonomy. Individual-level challenges include a lack of knowledge, persistent myths, refusals to use contraception services, and financial constraints.

Despite these challenges, opportunities exist, such as favourable policies, public-private partnerships, local SRHR projects, and a shift in societal perceptions. Addressing barriers while leveraging opportunities could improve access to reproductive health services in Nepal. Privacy concerns, stigma, and provider-client interaction challenges at the individual level reinforce reluctance to use public health facilities. Community-level barriers, such as socio-cultural stigmas and limited support structures, highlight deeply ingrained challenges. The report identifies opportunities for improvement, emphasizing favourable policies, public-private partnerships, and local government initiatives. Recommendations encompass diverse aspects, urging the government to uphold international human rights commitments, allocate resources for accessible services, and address diverse population needs through credible data and tailored programs. Stakeholders are encouraged to support community awareness, advocate for empowering policies, and engage marginalized communities through various channels. The study concludes by emphasizing a comprehensive, collaborative approach to overcome identified barriers in Nepal's sexual and reproductive health landscape, aligning with global frameworks and commitments. Recommendations involve multi-stakeholder partnerships, inclusive policies, and increased awareness, contributing to the goal of universal access to contraception and safe abortion services.

LIST OF ABBREVIATIONS

ANC	: Antenatal Care
BBC	Beyond Beijing Committee
BPfA	: Beijing Platform for Action
CAC	: Comprehensive Abortion Care
CEDAW	: Convention on the Elimination of All Forms of Discrimination Against Women
CRPD	: Convention on the Rights of Persons with Disabilities
CRC	: Convention on the Rights of the Child
CSOs	: Civil Society Organizations
CSE	: Comprehensive Sexuality Education
ECP	: Emergency Contraceptive Pills
FCHVs	: Female Community Health Volunteers
FGD	: Focus Group Discussion
FP	: Family Planning
GoN	: Government of Nepal
ICPD	: International Conference of Population and Development
IDI	: In-Depth Interview
IUCD	: Intrauterine Contraceptive Device
MA	: Medical Abortion
MDG	: Millennium Development Goals
mCPR	: Modern Contraceptive Prevalence Rate
NDHS	: Nepal Demographic Health Survey
PNC	: Postnatal Care
PoA	: Programme of Action
PWD	: Persons with Disabilities
SDG	: Sustainable Development Goals
SMRHR	: Right to Safe Motherhood and Reproductive Health
SRHR	: Sexual and Reproductive Health and Rights

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CHAPTER 1. INTRODUCTION

1.1 Background

Nepal is a landlocked country in South Asia with a diverse population of 2.9 million.[1] The female population comprised 51.1% compared to 48.9% male population. Young population aged 15-24 make up 24% of the total population in Nepal.[2]

Nepal is one of the countries with progressive laws and policies to ensure the Sexual and Reproductive Health and Rights (hereinafter 'SRHR') of the population.[3] The government of Nepal (hereinafter 'GoN') immensely supported the creation of a positive environment for empowering women and making their voices heard. Moreover, the commitment made by Nepal in 1994 at the International Conference of Population and Development (hereinafter 'ICPD') accelerated the advancement of assuring the right to sexual and reproductive health. The landmark Programme of Action (hereinafter 'PoA') adopted at the ICPD transformed global thinking on population and development issues and developed an agenda putting human rights at the centre including empowering women and girls and addressing inequalities as well as the rights of individual women and men.[4] Additionally, Nepal has also committed to ensuring SRHR through the ratification of different conventions including the International Covenant on Economic, Social and Cultural Rights (hereinafter 'ICESCR')[5], the Convention in the Elimination of All Forms of Discrimination Against Women (hereinafter 'CEDAW')[6], the Convention on the Rights of the Child (hereinafter 'CRC')[7], the Convention on the Rights of Persons with Disabilities (hereinafter 'CRPD')[8], and committing to Beijing Platform for Action (hereinafter 'BPfA') Millennium Development Goals (hereinafter 'MDG') as well as Sustainable Development Goals (hereinafter 'SDG'). Nepal has also committed to FP2030 aiming that every individual and family will lead a healthy, happy, and prosperous life, fully exercising their sexual and reproductive health and rights.[9]

Nepal has also expressed its full and unreserved support for the Nairobi Global Commitments to achieve three zeros: ending violence against women and children, early and forced marriage, ending preventable maternal deaths, and ending unmet need for family planning including investment in young people's SRHR and Comprehensive Sexuality Education (hereinafter 'CSE')[10] that will ultimately support to meet the SDGs by 2030.

The Constitution of Nepal has guaranteed the right to safe motherhood and reproductive health as a fundamental right.[11] The Right to Safe Motherhood and Reproductive Health Act (hereinafter 'SMRHR Act') 2018 has also ensured the right to safe motherhood and reproductive health services including access to contraception and safe abortion services.[12] Similarly, the Public Health Service Act 2018 has also ensured the right of every citizen to obtain free basic health services for contraception, abortion, and reproductive health.[13] Hence, the government has been providing these services free of cost at all levels of health facilities. Further, different technical and management guidelines such as; safe abortion service management guideline 2021, Adolescent Friendly Health Service Operationalization Guideline, 2022, and Disability Friendly SRHR Service Guideline 2023 has been developed to ensure that contraception and abortion service are made accessible, available, and affordable and of delivered with optimum quality.

Nepal has made remarkable progress in the different indicators since the ICPD PoA 1994 commitments. The maternal mortality ratio has reduced to 151 per 100,000 live births in 2023 as compared to 660 per 100,000 live births in 1995.[14] The births attended by skilled health personnel have increased to 80% in 2022 as compared to 10% in 1996. The total fertility rate has decreased

from 4.6 in 1996 to 2.1 in 2022.[15] The adolescent fertility rate has decreased from 127 in 1996 to 71 in 2022.[16] The modern contraceptive prevalence rate has increased to 43% in 2022 from 26.0% in 1996.[17] Similarly, the unmet need for y planning has slightly dropped from 24.6% in 2006 to 21% in 2022.[18]

Although the country has made significant progress on the different indicators, endless efforts are still necessary to further strengthen the accessibility, availability, affordability, and quality of these services and to get better achievement by 2030. According to the Nepal Demographic Health Survey (hereinafter 'NDHS') 2022, the median age at first marriage is 18.3 years among women in Nepal. The modern contraceptive prevalence rate (hereinafter 'mCPR') was stagnant at 43% in 2011, 2016, and 2022.[19] The unmet need for family planning is declining continually but slowly from 27% in 2011 to 24% in 2016 and 21% in 2022. Similarly, the family planning demand satisfied by modern methods is only 58%. One of the studies from Nepal shows that around 862,199 pregnancies occur every year in Nepal and more than half (53%) of them are unwanted. Around two-thirds of unwanted pregnancy ends in abortion whereas more than half (52%) of such abortion is conducted unsafely or by unauthorized health provider. Similarly, 58% of the women are still unaware of the legalization of abortion in Nepal.[20] Only limited health facilities, i.e. 19.2% have the availability of safe abortion services.[21] Moreover, 5% of the total maternal death is due to different complications of abortion.[22]

Regarding the utilization pattern of these services, there are disparities in accessing the services among different age groups, provinces, geographical areas, and marital statuses.[23] The modern contraceptive prevalence is lowest among the adolescent group (14.2%) followed by the age group 20-24(24.9%), 25-29(37.4%), and 30-34 (45.3%). The Gandaki province has the lowest mCPR (35%) followed by Madhesh province (41%), Lumbini province (43%), and Koshi province (44%). These provinces have the highest unmet need for family planning. Similarly, unmet need is highest among currently married adolescent (31%), Dalit (26%), Muslim (25%) women, and less educated women from rural areas. Teenage pregnancy is highest in Karnali Province (21%), followed by Madhesh Province (20%), and lowest in Bagmati Province (8%).[24] Similarly, 1 in 10 maternal deaths are among adolescent mothers.[25]

The situation and challenges of family planning and reproductive health services in Nepal have been an ongoing concern. Still, decision-makers and policymakers at all levels of government including pertinent stakeholders consider family planning and abortion as population control programs even after 30 years of ICPD PoA. There is that has resulted in budget cuts in family planning programs leading to a shortage of commodities and services. There are limited trained human resources especially after the adjustment of the human resources as a result of the federalization of Nepal. Moreover, the fear of side effects of modern family planning methods, and lack of access and/or affordability due to familial and religious beliefs/myths/misconceptions were identified as perceived barriers to family planning and abortion service utilization.[26] There are several pressing issues concerning sexual and reproductive health rights that must be addressed.

In this context, this monitoring report aimed to identify the status and barriers at an individual, family, organization, and policy level to access family planning and safe abortion services among women of reproductive age (15-49) in Nepal post 30 years of ICPD commitment. This monitoring report will also help in identifying different ways to address these barriers and recommend the government and stakeholders to increase the accessibility and availability of family planning and safe abortion services.

1.2 Objectives

1.2.1 General Objective:
To identify barriers to accessing contraception of choice and safe abortion services among young women

1.2.2 Specific Objective

i. To assess individual-level barriers to accessing contraceptives and safe abortion services
ii. To identify barriers faced by young women from marginalized population including women with disabilities to access contraceptive and safe abortion services.
iii. To explore organizational-level barriers to accessing contraceptive and safe abortion services.

CHAPTER 2: METHODOLOGY

2.1 Report Design

This monitoring report used a qualitative approach employing Focused Group Discussion (hereinafter 'FGD') and In-Depth interviews (hereinafter 'IDI') to get holistic information from the respondents.

2.2 Target Area and its Justification

This data was collected from five districts; Sunsari, Dhanusha, Kavrepalanchowk (Kavre), Baglung, and Dailekh from the five different provinces of Nepal, representing both urban and rural settings of two different ecological regions.

Table 2.1 : Detailed Description of Targeted Areas

S.N	District, Province	Target Areas	
		Rural	Urban
1	Sunsari, Koshi		Dharan Sub-Metropolitan City
2	Dhanusha, Madhesh	Laxminiya Rural Municipality	
3	Kavrepalanchowk, Bagmati		Panchkhal Municipality
4	Baglung, Gandaki		Baglung Municipality
5	Dailekh, Karnali	Dungeshwor Rural Municipality	

These target areas were selected on the basis of modern Contraceptive Prevalance Rate (mCPR) and unmet need of Family Planning as seen in the National Demographic Health and Survey (NDHS) 2022 report. Moreover, these districts were selected to capture a diversity of religious, geographic, socio-economic, and socio-cultural contexts for different castes and ethnicities across the country.

Table 2.2: mCPR and Unmet Need for Family Planning

	mCPR (NDHS 2022)	Unmet need of FP (NDHS 2022)
National	43%	21%
Koshi	43.5	18
Madhesh	40.5	21
Bagmati	44.6	16
Gandaki	35.1	28
Karnali	45.9	23

2.3 Target Population

The target population for FGD included two different groups of married and unmarried women of reproductive age group between 15-49 years. The respondents were representative in terms of religion, ethnicity, and geographical location. There was the participation of persons with disabilities and people from marginalized and vulnerable communities.

Similarly, for IDI, the Health Section Representative of the selected municipality and Safe Abortion or Family Planning Service Provider from a Government Health Facility were included in the monitoring report to understand the institutional barriers that affect service utilization among women of reproductive age.

Table 2.3: Description of Targeted Participants

S.N.	FGD	IDI
1	Unmarried young women	Health Section Representative of the selected municipality
2	Married young women	Safe Abortion/Family Planning Service Provider from a Government Health Facility

2.4 Sampling Technique and Sampling Size

The purposive sampling method was used to identify the key informants for FGD and IDI. In each selected province, two FGDs were conducted. The participants were identified by the BBC's focal network member organization of the respective provinces. Altogether ten FGDs were conducted, out of them five FGDs were conducted among unmarried women, and five FGDs were conducted among the married women of reproductive age group.

Similarly, five IDIs were conducted, with Health Section Representatives of the selected municipality, and five IDIs were done with Safe Abortion or Family Planning Service Providers from different Government Health Facilities of the selected area. So, in total ten IDIs were conducted. The details on the number of respondents included in FGD and IDI are shown in the table below.

Table 2.4: Numbers and Details of Targeted Participants

S.N.	District, Province	Focused Group Discussion (FGD)		In-Depth Interview (IDI)	
		Unmarried Young Women	Married Young Women	Health Section Representative	Safe Abortion/ Family Planning Service Provider
1	Sunsari, Koshi	9	14	1	1
2	Dhanusha, Madhesh	10	11	1	1
3	Kavrepalanchowk, Bagmati	12	17	1	1
4	Baglung, Gandaki	8	10	1	1
5	Dailekh, Karnali	7	11	1	1
	Subtotal	46	63	5	5
	Total	**109**		**10**	

2.5 Data Collection Tools and Techniques

The information was gathered through FGD and IDI techniques by using standard FGD and IDI guidelines. Data collection tools were developed by reviewing the different relevant literature. The tools were first developed in English, discussed among the team, verified, and validated among young women of the targeted age group. The tools were then translated into Nepali to collect the data. The report team themselves were involved in collecting the data. Each FGD and IDI lasted for an hour and a follow-up visit was done as needed.

2.6 Ethical Consideration

Approval for the monitoring report was received from each municipality before initiating the data collection.

Respondents were explained about the background of the monitoring report and data collection procedure before the FGD and IDI. Informed consent was taken for their participation and recording of the discussion in written form. The FGD and IDI were conducted at nearby schools, health facilities, and local government offices in secure areas and the information provided by the respondents was made confidential. Personal identifying information was not recorded in transcripts. Consent forms, audio recordings, and transcripts were placed in a secured space with access from only authorized persons.

2.7 Data Management and Analysis

The collected qualitative data were audio recorded, transcribed, and translated into English language. The information provided by the respondents was then coded thematically and entered into the framework. The framework was reviewed by all team members to identify key themes and sub-themes and the relationships between the themes.

2.8 Validation and Sharing

After drafting the report, a consultative workshop was organized among various relevant CSOs and youths, diverse in terms of age, ethnic background, caste, religion, representing persons with disabilities, sexual and gender minorities and different geographical areas. The findings of the monitoring report were shared among this group and validated through interactive discussions, which further provided an outline and basis for developing strong recommendations for the report.

2.9 Limitations

Since the data collected is qualitative, which helps in exploring and understanding the ideas, opinions, and issues but cannot be generalised to the entire population. The participants may not have disclosed the actual experiences that they have lived related to learned knowledge and behaviours regarding abortion and contraception experiences due to the stigma attached to it.

Participants from diverse ethnic groups speaking different languages other than the Nepali language were included to represent diverse voices. To minimize errors in the information interpreters from the same community were mobilized.

CHAPTER 3: RESULTS

3.1 Socio Demographic Characteristics

Table 3.1 provides a comprehensive insight into the socio-demographic characteristics of the target participants (n=109). The age distribution shows a varied representation, with 30% below 20 years and 70% above 20. Ethnically, diversity is evident, with Janajati (Indigenous Peoples) as the largest group (44.95%), followed by Dalit (19.27%), Madhesi (19.27%), and Khas Arya (13.76%). Smaller percentages represent Kirat, Muslim, and Christian communities. Religiously, Hinduism prevails at 95.40%, with 2.75% following Islam and 1.83% adhering to other faiths such as Christianity and Kirat. In terms of education, respondents exhibited varied academic backgrounds, with 32.10% having highest level of formal education up to grade 10, 44.95% completing grade 11 and 12, 9.17% holding a Bachelor's degree or above, and 13.76% reporting no formal education. Marital status distribution shows 57.80% married and 42.20% unmarried respondents. Geographically, 21.10% of the respondent represent Koshi Province, 19.27% from Madhesh Province 2, 26.61% Bagmati Province 3, 16.51% Gandaki Province and 16.51% form Karnali Province. The socio-economic setting encompasses both rural (35.78%) and urban (64.22%) participants, enhancing the diversity of the sample and providing a sturdy foundation for understanding their socio-demographic characteristics.

Table 3.1 Socio-demographic Characteristics

	Variables	Frequency (n=109)	Percentage (%)
Age Group	<20	33	30%
	>20	76	70%
Ethnicity	Dalit	21	19.27%
	Janajati	49	44.95%
	Khas Arya	15	13.76%
	Madhesi	21	19.27%
	Kirat	1	0.91%
	Muslim	3	2.75%
	Christian	1	0.91%
Religion	Hindu	104	95.40%
	Islam	3	2.75%
	Others (Christian and Kirat)	2	1.83%
Highest Level of Education	Class 1 to 10	35	32.10%
	Class 11 and 12	49	44.95%
	Bachelors and above	10	9.17%
	No Formal Education	15	13.76%

	Variables	Frequency (n=109)	Percentage (%)
Marital Status	Married	63	57.80%
	Unmarried	46	42.20%
Provinces	Koshi	23	21.10%
	Madhesh	21	19.27%
	Bagmati	29	26.61%
	Gandaki	18	16.51%
	Karnali	18	16.51%
Socio-Economic Setting	Rural	39	35.78%
	Urban	70	64.22%

3.2 Barriers to Contraception and Safe Abortion Services

Contraception and safe abortion services are essential for reproductive health, yet numerous organizational barriers hinder their accessibility, especially for young women. These challenges encompass a shortage of trained service providers, stemming from the transition to a federal structure, as well as budget limitations, inadequate infrastructure, and shortages of commodities. Additionally, issues like the absence of disability and adolescent-friendly services, privacy concerns, and behavioral challenges posed by service providers compound the difficulties faced by young women. The lack of governance structures and limited information dissemination channels further aid in exacerbating these barriers. The subsequent paragraphs delve into a detailed discussion of the organizational barriers identified in the monitoring report.

3.2.1 Organizational Barriers

i. Lack of trained service providers

The majority of health section representatives and service providers emphasized the impact of inadequate human resources with proper training on the unavailability of contraception and safe abortion services at health facilities. Notably, there is a prominent absence of second-trimester abortion services, even in referral hospitals. Several key informants highlighted that the shift from a unitary to a federal government structure led to a significant number of trained service providers being reassigned to managerial positions, resulting in a shortfall of professionals directly involved in service provision. This organizational change has contributed to the observed scarcity of trained personnel offering essential reproductive health services.

"Currently, we do not provide all five temporary methods from any health facility in our municipality. We only provide four of them. IUCD was provided by one of the health facilities but the service provision was discontinued as the only trained service provider has left…We are not able to provide the service even though women here seek IUCD service"

-Health Section Representative, Dailekh

"We used to provide abortion services for up to the second trimester in case of rape and incest. But now, we do not have a trained medical doctor to provide this service for 2-3 years. We also don't provide other family planning services. However, we provide MA and CAC services."

-Service Provider, Baglung

"This is the only government health facility providing safe abortion service in Dharan."

-Service Provider, Sunsari

"Training is provided by the provincial government to all the health service providers. But the training has not been provided to our health service provider working at our municipality."

-Health Section Representative, Dhanusha

ii. Lack of budget

Insufficient budget allocation emerged as a significant barrier to accessing contraception and safe abortion services, alongside a lack of information within the community. Key informants underscored that the local government allocated limited funds to health, with SRHR services receiving the lowest priority. Moreover, they emphasized the lack of awareness and sensitivity among local decision-makers regarding the importance of contraception and safe abortion services. This dual challenge of limited financial support and inadequate awareness poses barriers to the provision of essential reproductive health services in the community.

"Not much budget is allocated for health and education. The budget for health has not even reached to 2-3% of the total budget…They don't emphasize on anything other than buying medicines. We also made a tentative budget for SRHR services, but it was difficult for us to get the budget as requested."

-Health Section Representative, Dailekh

Furthermore, a major concern was expressed about the reduction in the budget for contraception by policymakers, resulting from a perceived decline in population. Instead, key informants shared that there have been initiatives to promote population growth.

"Talking about the budget, health has not been prioritized by the municipality…They focus on roads and things like that…The municipality focal person says that population is decreasing now and there is no need to invest in family planning program…Instead, they are providing incentives to promote population growth. Few municipalities are providing various packages as incentives to those who give birth to two children."

-Health Section Representative, Baglung

The key informants also expressed their inability to reach all individuals in the community due to budget constraints

"We have also presented the budget to the health department addressing issues on adolescents, reproduction, safe abortion, and family planning. There was a problem because they allocated low budget…Information could not be provided to everyone as there is limitation for the participation for only 25-30 people. Budget is fixed for certain programs. Those who were included in the program have more knowledge while other get knowledge through books or newspaper."

-Health Section Representative, Dhanusha

iii. Inadequate infrastructure and shortage of commodities and equipment

The majority of the respondents shared that inadequate infrastructures, commodities and equipment are barriers to accessing services, affecting the comfort of the service seekers. Limited space in health facilities was specifically mentioned as one of the issues contributing to discomfort during service provision.

"Even though these are listed institutions for safe abortion service, we are not able to operate the service due to the lack of tools and equipment...I am a trained service provider, but due to lack of separate room and other various equipment, our service is not operational till now... We are providing 4-5 services from one room. So physical structure has affected us the most."

-Service Provider, Dailekh

"There is shortage of the commodities here. There are 20 wards in Dharan but Dharan health post is the only one centre that provides abortion services"

-Service Provider, Sunsari

The participants also expressed that women tend to seek services from private facilities or medicals when these services are not available at government health facilities.

"If family planning commodities are not available in health post, we go to the pharmacy to buy it."

-Married, 30, Indigenous, Sunsari

However, a few of them also shared that they do not have any issues related to commodity shortages as they have a good coordination with federal level and provincial government in regarding the supply of commodities.

"We don't have any problem related to equipment or supply of commodities. We ensure the supply of necessary commodities on the basis of the monthly report."

-Health Section Representative, Baglung

iv. Lack of friendly services for person with disability and adolescents

The lack of disability-friendly and adolescent-friendly services at health facilities poses a barrier for persons with disabilities (hereinafter 'PWD') and adolescents seeking access to services. Participants in the FGD expressed that these services are neither user-friendly nor easily accessible, hindering their utilization in times of need. Individuals with disabilities noted the additional difficulty caused by service providers' behaviour towards them. Key informants also pointed out that unfriendly physical infrastructures, the distance of health facilities from PWD residences, and geographical constraints further limit their ability to utilize healthcare services. However, there was a difference of opinion among key informants regarding whether health providers engage in discriminatory behaviour towards individuals with disabilities.

"I am a blind woman. Persons with disability who are illiterate do not know how to use the family planning methods so they get pregnant. For most of us, it is very difficult to use family planning methods like pills. It has colour to indicate but not practical for us as we cannot see the indication."

-Married, 30, Indigenous, Blind, Sunsari

"Though they have lost their vision, they also need contraceptives. It is more difficult for them. It makes it more difficult due to the health worker's behaviour towards us them at the hospitals."

-Married, 22, Indigenous, Baglung

"Our health facilities are not built in a disability-friendly and youth-friendly way but we are working on it. PWD come to the health facilities for family planning services. Flow of the PWD is comparatively low as they are unable to visit health facilities. PWD also need the family planning services but due to the difficult geographical structure it is difficult for them to reach the service centres. However, the behaviour of health worker is equal and non-discriminatory towards everyone including PWD."

-Health Section Representative, Baglung

However, the key informants added that there are a few programs initiated at the local level to address the issues of PWD. Nevertheless, they emphasized that there is still a lack of prioritization of PWD's SRHR.

"Even if PWD wants to get services, they are not able to. Now, they have started building disability-friendly toilets, but other services are not provided yet…There are no specific programs or provisions related to family planning services for person with disability…"

-Health Section Representative, Dailekh

Similarly, due to unavailability of a separate room and lack of friendly service for the adolescent, they typically face difficulties in accessing healthcare services.

"A separate facility to provide contraceptives services for adolescents and unmarried girls is needed but the services are being provided to everyone from a common place."

-Unmarried, 19, Dalit, Dailekh

v. ***Lack of privacy and confidentiality***

The lack of privacy and confidentiality at the public health facilities emerges as a significant barrier, particularly for unmarried women seeking services. Participants expressed fear that service providers or community members might disclose their sought services to their parents and the community, negatively impacting their societal image. Participants noted that providers often inquire extensively about their marriage and spouses to confirm their marital status. Privacy and confidentiality, especially for abortion services, were highlighted as more concerning issues than those related to contraception as contraceptives could be easily purchased from local medicals contrary to limited places performing abortion. Women strongly expressed a lack of confidence in public health facilities regarding privacy, leading them to prefer private institutions.

"As the person from medical shop recognizes us, they will surely visit our home and tell our parents that we went there seeking family planning service. They will then spread the talk about the unmarried woman who came to the medical to get family planning services. The people in the society will prohibit others from interacting with her since they think her act might influence other girls to engage in similar activities and behaviour."

-Unmarried, 20, Dalit, Dailekh

"They go to places that are far for abortion services as they want to keep it a secret. It is a matter of their prestige."

-Married, 30, Madhesi, Dhanusha

"I won't go to nearby health post to uptake those service, I prefer health institution that are far away from here."

-Unmarried, 18, Madhesi, Dhanusha

"Nowadays, people chose private health facilities like clinics, health centres, pharmacies over government health facilities because they have to wait very long for registration and check-up. They also fear about their confidentiality being breached. Though the FP services are provided free of cost from government health facilities, they still prefer to visit the private clinics and pay the fees due to easy access to services."

-Health Section Representative, Baglung

Despite the service seekers claiming otherwise, service providers asserted that they maintain privacy and confidentiality and follow their professional ethics. The statements of service providers and seekers contradicted each other concerning the assurance of privacy.

"We maintain the privacy as stated in our code of ethics. It is a matter of their rights, which we know we must respect."

-Service Provider, Baglung

vi. ***Behaviour of the service providers***

Most of the FGD participants revealed that the misbehaviour of service providers towards service-seekers has created barriers for them to access contraceptive devices and safe abortion services. Instead of receiving proper counselling for the services they are seeking, they have been treated inappropriately, disregarding client confidentiality. FGD participants expressed that they were unable to receive good counselling while at the health facility for the service, and instead, they encountered bad behaviour from the service providers.

"Nurses (service provider) are not supposed to yell at service seeker, they need to address their problem generously."

-Unmarried, 18, Dalit, Dailekh

"We discuss about the method of contraceptives to be opted at home and request for the preferred service at the health facility accordingly. They (service providers) still try to ensure the service chosen has come out of family consensus. They also ask about clients husband before providing service."

-Married, 28, Chhetri, Dailekh

"Yes, unmarried women are treated differently. Service providers become judgemental towards unmarried people, while married people were treated normally."

-Unmarried, 21, Chhetri, Baglung

To avoid such behaviour of service providers, some women even opt for unsafe methods.

"There is a problem for unmarried women. Some of them abort the foetus using abortion medicine. When they go to health facility, they are pressurized to tell their husband's name which becomes very problematic for the women."

-Married, 37, Dalit, Sunsari

vii. Lack of policies

A few key informants shared that the change in policy in federal Nepal has led to a shift in national guidance for program implementation. However, they highlighted that the local government has not yet developed guiding documents for implementation, which are yet to be formulated. This absence of local-level policies and their implementation concerning the enlistment of safe abortion services has constrained the expansion of such services. Additionally, key informants expressed concerns about the lack of proper recording, reporting of data, and monitoring of services provided by health facilities.

"Previously, we used to provide safe abortion training to service providers and the health facility would be enlisted by the Ministry of Health. Now it is stated in the national guideline that the municipality will be taking over that responsibility. We are yet to develop a related policy guideline. There is no issue with the enlistment of the facility but we have a problem in the documentation problem. There are no records of service users from private health facilities. We are trying to promote public-private partnerships. But one of the main issues is that all clinics are not listed as safe abortion service yet."

-Health Section Representative, Dailekh

"There are total 7 institutions providing family planning services but medical abortion are provided through only two of them. There is no other trained health worker except me."

-Health Section Representative, Dhanusha

Despite legalization, there are places performing abortions illegally. Due to the continuous flow of patients in government health facilities resulting in long waiting periods, women are forced to seek services from private facilities, and medical stores or adopt any other illegal ways to get it done.

"Safe abortion is not legal in the private medicals but women are getting services from illegal places…This is a referral hospital and we get 4000-5000 cases so the waiting period to get any services is very long. If family planning and medical abortion services cases were specifically handled at some other places rather than in general, it would be easy for us to prioritize those cases."

-Service Provider, Baglung

"The process is a bit long at the health post, so we receive services from private health facilities during emergencies and get services from government health facilities at other times."

-Unmarried, 20, Chhetri, Dailekh

vii. Limited source of information on SRHR services

It was acknowledged that Female Community Health Volunteers (hereinafter 'FCHVs') have made significant contributions in disseminating information on SRHR at the local level. Additionally, mother's groups have been mobilized to share relevant information. However, the participation of mothers in these group meetings is limited and only those who participate become aware about the services. Key informants emphasized their specific focus on marginalized communities, but contradicted it by stating that only the people living nearby the health facilities are in access to the information and services while communities such as Dalit are being deprived of any such information. Unfortunately, local levels are not effectively utilizing various media channels for information dissemination, relying primarily on FCHVs. FGD participants reported receiving information from schools and their families. However, some mentioned that information from families was restricted to menstruation topics.

"We have been disseminating information through FCHVs only. They say that the information is shared during the mother's group meetings so that those who need the services can go and get them. But many of them might not even know about this information because they were not present during the meeting."

-Health Section Representative, Dailekh

"We had conversations only on menstruation but not about pregnancy. There is no special person who would provide such kind of information. There are FCHVs in our village but their job is to provide polio drops"

-Married, 28, Indigenous, Baglung

"I read about women's health when I was studying but they don't teach anything about abortion"

-Unmarried, 22, Muslim, Baglung

"Information are provided to the communities which are near to the health centre. Dalit community are mostly deprived of such information"

-Health Section Representative, Dhanusha

viii. Lack of proper counselling services

Several key informants highlighted that inadequate counselling to the service seekers constitutes a significant barrier impacting the use of the SRHR services. Such a situation not only deteriorates the quality of the service provided by a government facility but also negatively impacts the perception of the service seekers. The health professionals however emphasized the need for improved counselling to enhance the overall quality of service provided.

"After the abortion, some come back saying they are pregnant again because they did not receive proper counselling on family planning "

-Health Section Representative, Dailekh

"We are eager to provide quality service, but it depends how the patient perceives the quality care provided by me. The patient might be feeling stressful, time consuming, they might not be feeling satisfied then the service provided by us might not be quality service."

-Service provider, Baglung

3.2.2 Community Level barriers

i. Marital status

Marital status emerged as a significant barrier to accessing services and the information, particularly in the context of SRHR. It was shared that married women find it easier to access SRHR services, especially for FP and abortion services compared to unmarried women and girls. A negative preconceived notion persisted within the community and among the service providers regarding unmarried women seeking contraception or safe abortion services. This biased perception was identified as a prominent barrier for unmarried young women.

"If they get pregnant before marriage, it will be difficult for them to survive in the society. Parents would scold them, would not let anybody to talk with them and isolate them from others."

-Unmarried, 18, Madhesi, Dhanusha

"Society is not against abortion service but if any unmarried woman gets an abortion, people would criticize it. The families also do not allow to get abortion."

-Health Section Representative, Dailekh

Married women appeared more at ease discussing issues related to SRHR, whereas, unmarried women seemed reluctant to engage in such discussions. It was also observed that adolescent or unmarried individuals are not engaged in the government-led SRHR programs.

"Unmarried women fear that their family member might find out about their abortion while married women talk openly without hesitation."

-Service Provider, Sunsari

"I think the main objective to include adolescent in mother's group is to provide them with basic information about family planning devices and abortion but they usually don't include adolescents or unmarried women,"

-Unmarried, 20, Dalit, Dailekh

ii. Socio-cultural Stigma

Socio-cultural stigmas heavily influence the utilization of abortion services more than contraception services. Most informants shared about abortion being perceived as a sin, particularly within certain religious contexts where it is even considered unacceptable to have an abortion. Some acknowledged that women are compelled to undergo abortion under certain circumstances, but the societal stigmas surrounding abortion lead to feelings of guilt among women. Certain participants in FGD shared that women hesitate to access abortion services due to the negative perception of the community.

"Woman do not want to have an abortion. Even our religion restricts from getting an abortion but women are compelled to undergo abortion. The women who had an abortion also feel like they made a mistake by getting an abortion ..."

-Service Provider, Baglung

"In our Muslim religion, whether it is a son or a daughter, no one should abort a child. It is considered a gift from God".

-Unmarried, 22, Muslim, Baglung

"People who have had an abortion and their acquaintances have such a negative attitude towards abortion. "

-Married, 23, Dalit, Christian, Dailekh

Although the community associates abortion with stigma and shame, there is a prevailing practice of sex-selective abortion in favouring sons over daughters.

Though all female participants in the FGD were against the concept, the sex-selective abortion was found to be evident.

"Why should we abort a girl. It is good to give birth to girl child."

-Married, 38, Marginalized, Kavre

The respondents shared that couples despite having multiple pregnancies still expect a male child. If they already have daughters from the previous pregnancies, the couple identify the sex of the foetus and undergo abortion if it is a girl. An interesting finding is that some community people also get an abortion based on the astrological beliefs in the hope of having a son.

"If a woman already has two daughters, and gets pregnant again, she will continue the pregnancy only if it is a boy otherwise, she will get an abortion."

-Health Representative, Dhanusha

"Those who have two daughters, if they conceive girl again, they abort in Janakpur."

-Married, 23, Madhesi, Dhanusha

"There was a couple in my neighbourhood…They had three daughters. The husband is an astrologer and he made his wife abort the fourth child saying that he would not have a son until he reaches the age of 32."

-Health Section Representative, Dhanusha

One of the key issues identified for the sex selective abortion was dowry system and the male dominated society we live in.

"Parents have to pay 10 to 50 lakhs as a dowry to the groom and because of this nowadays people don't want daughter, so they choose to abort."

-Married, 30, Madhesi, Dhanusha

"Some might choose to abort a girl child, as we live in a society where people prefer son"

-Married,28, Chhetri, Dailekh

But there was an interesting finding that, if they already have a son, abortion happens despite the sex of the foetus.

"If they already have male child, they might abort if they find out they are having another son."

-Married, 28, Chhetri, Dailekh

However, it was also found that there are legal actions taken against the sex selective abortion.

"Yes, I have heard of it. Doctor and patient both got arrested who wanted to abort after identifying the sex of the foetus"

-Married, 30, Madhesi, Dhanusha

iii. *Lack of autonomy in informed decision making and lack of support from partner and family*
Many participants and key informants expressed that lack of support from their partners and family has affected the utilization of SRHR services. In FGDs, respondents shared that their ability to decide and accept the use of contraceptive methods depend upon the approval of their husbands or partners and families.

Women face multiple challenges in selecting contraceptives based on their own preferences and may even experience violence for seeking such choices and services.

Women face multiple challenges in selecting contraceptives based on their choice and may even experience violence for seeking such choices and services. There is a concern that others might perceive women's contraceptive use as an indication of extra marital affairs, further adding to the difficulties women encounter in making personal reproductive health decisions. Additionally, women fear that if they disagree with their husbands' choices, their spouse might consider marrying someone else.

"There are many challenges we face to access the services. When we ask for abortion pills, the husband tortures and even beats us...I used to use depo but when my husband started doubting, I stopped using depo."

-Married, 40, Indigenous, Sunsari

"Yes, in both cases whether married or unmarried, they ask to bring the partner for consent or guardian to take decision."

-Unmarried, 19, Chhetri, Sunsari

Some also mentioned that the limited availability of contraceptive options in the market for women, and especially for men, restricted their choices.

"There is only one contraceptive option for boys and that's condom, the other is permanent vasectomy, the option is less, so women have to do it."

-Unmarried, 20, Indigenous, Baglung

3.2.3 Individual level barriers

i. *Lack of knowledge about the services*
Most of the participants in the FGD have come to know about some of the contraceptive devices through their friends, books, CSOs and FCHVs. However, they were not adequately informed about all contraceptive devices and their availability at health centres. Unmarried women, people from marginalised communities and those in rural areas were comparatively more vulnerable to lack of access to such information. The majority of the them were unaware of the legalization and other government provision related to abortion.

"I don't have much knowledge (about contraceptive device), I just know few names like depo, condom, pills"

-Married, 25, Chhetri, Dailekh

"If there are such provisions (legalization of abortion), the government should keep us informed. I've heard that if a pregnancy is normal, it can be terminated up to three months. Beyond this period, it will be difficult to abort and this might also affect the health of the woman. I am not aware of the legal action."

-Married, 26, Indigenous, Baglung

"There is no problem in the coverage of the services in the urban areas. The lack of awareness on contraceptives and services has directly affected the safe abortion service in the rural areas."

-Service Provider, Baglung

"Level of awareness depends upon the caste that they belong to. Dalit community have lower level of awareness (about contraceptives and safe abortion) in comparison to other castes."

-Health Section Representative, Dhanusha

Moreover, some unmarried participants in the FGD shared that they did not have the necessary information on contraceptives and safe abortion services before marriage.

"Mother's group organize the meeting every month. The attendees are usually married women. We don't bother participating in the meeting because we are not yet married and we don't feel the need for such information."

-Unmarried, 19, Dalit, Dailekh

ii. Myths and misconceptions:

Respondents discussed about various myths and misconceptions related to safe abortion and contraceptives that prevailed in the community. The most common misconceptions were associated with the use of IUCD and implants. Some individuals expressed their concerns about the movement of the implant and IUCD to other parts of the body. Additionally, a few of them shared about experiencing some side effects after using certain contraceptive devices.

"Some people say that IUCD can reach to the heart and other organs."

-Service Provider, Baglung

"I heard that women should not do heavy work while using implant as it might shift to other part of the body and cause pain and discomfort. That's why most women do not use it ...People in community have negative perception toward women who undergo abortion."

-Married, 28, Chhetri, Dailekh

"I have used one of the contraceptive devices. I started having diarrhoea after its use, so, I opted for minilap."

-Married, 30, Madhesi, Dhanusha

Likewise, according to participants, people of the community perceive abortion as a shameful act, while a few also accepted it as normal as a childbirth..

"Abortion is throwing a baby."

-Married, 30, Dalit, Dailekh

"It is shameful act to get pregnant before marriage, hence, such things are usually kept confidential"

-Unmarried, 18, Dalit, Dailekh

"In my understanding, safe abortion is normal just like childbirth, and care for the mother is needed like in childbirth with proper food and rest."

-Unmarried, 18, Dalit, Dailekh

Furthermore, some of the participants of IDI expressed concern that an increased focus on abortion service might decrease the uptake of contraceptive services. They also discussed community perceptions regarding the availability of emergency contraceptive pills, suggesting that it may lead to an increase in illegitimate sexual relationships.

"We think if we focus on safe abortion services, contraceptive uptake will get decreased. We have implemented emergency contraceptive pills program but people think this will increase the unsafe sexual activities. However, we are raising awareness in people that ECP reduces possibility for unintended pregnancy."

-Health Section Representative, Baglung

iii. Refusal to use Contraceptive Services

Controversial statements were made by women and key informants regarding the refusal of family planning services by some women. A few informants also shared that some women refuse to use any form of contraception services but find it convenient to opt for abortion instead. Additionally, some respondents expressed their preference for traditional methods over modern methods contraception. This choice might be influenced by the limited contraception options available and the fear of side effects associated with modern contraceptive methods.

"They take abortion medicine but they refuse to use temporary methods. More unmarried women refuse to use contraception."

-Health Service Provider, Sunsari

"I used pills previously, but it caused me pain in the stomach. Therefore, I am currently using depo."

-Married, 21, Chhetri, Dailekh

"Typically, we will choose condoms because they have fewer side effects and reduces the risk of diseases. The use of medicines leads to issues like headaches. It also affects menstruation."

-Unmarried, 17, Marginalized, Kavre

Typically during sexual intercourse, male partners often prefer not to use condoms and instead opt for the withdrawal method. One of the unmarried respondents shared that;

"I have heard from my sister that men ejaculate outside vagina during intercourse to avoid pregnancy. Most of them prefer withdrawal method rather than using condoms. That should be done by a boy, not a girl."

-Unmarried, 22, Muslim, Baglung

Respondents also shared that the spouses of migrants do not use any methods of contraceptives.

"We do focus on counselling but many women say that her husband is leaving for abroad within 1/2 days and refuse to use temporary method."

-Health Service provider, Dailekh

iv. Financial barriers

The key informants from the health facility shared that contraception and safe abortion services are provided free of cost from the health facility. However, the people of the community still prefer to seek services from private clinics.

"Yes, it is free. For medical abortion, we provide the medicine to the client and we receive 800 rupees from the government for providing this service."

-Health Service Provider, Dhanusha

"Money is the main obstacle and they fear of loss of prestige."

-Married, 38, Marginalized, Kavre

"It is hard for people who don't have money to access the services from public health facilities."

-Unmarried, 18, Madhesi, Dhanusha

3.3 Opportunities

Several opportunities were also identified to address these barriers and facilitate easier access to safe abortion and contraception services.

i. Favourable policies and laws

The key informants conveyed that the government has established favourable policies and programs to provide safe and quality SRHR services at all levels. They also added that the government has integrated SRHR services into basic health services and offering them free of cost irrespective of an individual's marital status.

"Yes, services are provided easily to unmarried women, we don't have the right to ask about their marital status. We provide the services in privacy with confidentiality. It is their right and we must respect that. This is a protocol created by the government under the program of Safe Motherhood. Everything under the program like ANC, vaccination for children, PNC, delivery, safe abortion service is free of cost."

- Service Provider, Baglung

"Services will be provided whether she is married or unmarried"

-Health Section Representative, Dhanusha

The FGD participants also believed that women have the right to access these services.

"Services are provided at the health post as the right of all women. The health facility is open to everyone."

- Unmarried, 16, Dalit, Dailekh

ii. Public Private Partnership

Collaboration between the government and private agencies was identified as an opportunity to expand services and enhance accessibility for diverse women in the community. It was observed that women tend to prefer private health facilities over government ones, although the family planning and safe abortion services are provided free of cost from the government health facilities, especially due to privacy and confidentiality issues. Key informants at the local level are actively engaged in collaborations with private clinics for the expansion of services as well as to ensure quality with the support of health-related projects. The local governments are developing policies to provide training to the private service providers to expand the services and also providing training on recording and reporting of the services to collect data in the national information system.

"Health post does not open on Saturdays but medical or pharmacy are always open. That's why collaboration with private health facilities can be done especially for the emergency services."

-Unmarried, 18, Dalit, Dailekh

"In the hospitals, we have to stay in queue for a long time but in medical, it is easy to pay and get services."

-Married, 18, Indigenous, Baglung

"We think if we expand the service by collaborating with the private clinic, it will help in service expansion. The private ones are also approaching us to work with them...Until now, we are providing the services from 6 government owned health institutions only. But now, we have made a policy to provide training to the private providers with the coordination and coordination of project. We are also providing them training on recording in the government information system. It is not possible to provide the service through the government system only"

-Health Section Representative, Dailekh

"Now we are coordinating with a national project that is supporting to provide training on family planning services as well as sex education to the private clinics as well as pharmacy including the training on the recording and reporting in the national information system."

-Health Section Representative, Baglung

"There are local level governments which should monitor private health institutions strictly and take action things. There are projects which is providing SRH training to service providers from private clinics."

-Health Section Representative, Dharan

iii. SRHR related project/program implementation at the local level

The key informants indicated that various organizations are supporting local governments in expanding SRHR services and awareness programs. These organizations have advocated for public-private partnership modality to expand the services and provide training to service providers.

"Now we are in touch with one of the organizations which is providing the training related to depo and providing sex education. They are also planning to provide the report of private clinic and medical to the local level."

-Health Section Representative, Baglung

FGD participants also shared that they have actively participated in and benefitted from various awareness programs conducted by these organizations

"When I was a teenager, VSO organized a training program related to these topics. I was trained and got the opportunity to be a peer educator. After the training I don't feel hesitant or shy anymore."

-Unmarried, 23, Chhetri, Baglung

"People from other organizations taught us about these topics while we were in school"

-Unmarried, 18, Dalit, Dailekh

ii. Initiation from local government

Different initiatives have been undertaken by the local government to enhance SRHR services. Few key informants mentioned the promotion of adolescent and disability-friendly services. The local government had also prioritized SRHR services during COVID-19 pandemic, distributed free sanitary pads as per the provision of the Government of Nepaland established women's network to strengthen consultation and counselling services.

"This year we managed to conduct the orientation program for adolescents to school teachers, hospital management committee members, health workers and FCHVs. Our motto is to make health services adolescent-friendly. We are planning to develop four health institutions as adolescent-friendly"

-Health Service provider, Dailekh

"Programs such as free pad distribution is conducted in schools for adolescent girls"

-Unmarried, 16, Dalit, Dailekh

"So local level is planning to gather the data of the labor/worker regarding the types of work, working year, marriage year...We are creating awareness among achool students through the teachers in coordination with education board and also through FCHVs at community level.

We also conduct radio programs to provide information."

-Health Section Representative, Baglung

iii. Multiple methods for information sharing

It was observed that people at the community level are receiving SRHR information through various means and media. While FCHVs played a significant role in disseminating SRHR-related information to women in the past, presently, women have better access to information through social media and the internet, facilitating easier access to SRHR-related information.

"The people of this area have good education and everyone has received sex education and information related with safe abortion and legalization of abortion. Such education is provided through schools using various medias, health facility staffs, Female Community Health Volunteers, Community Health Nurses and through Mother's group."

-Service Provider, Baglung

"It is awkward to talk about such topics (related to SRH) but we have search engines in our hands like google to search information. However, we cannot rely 100% on the internet, we have to consult someone."

-Unmarried, 23, Muslim, Baglung

"Firstly, I will search on the phone and then ask the doctor later. The doctor will provide correct information. I got the information on how to use contraception or how to have a baby,"

-Unmarried, 18, Madhesi, Dhanusha

iv. Gradual changes in the perception

Some participants held different perception and attitude towards SRHR services. In the FGD, participants expressed the belief that all the men and women should have access to SRHR service and information when needed. Key informants noted a gradual change in people's attitude, becoming more accepting of abortion and FP related services.

"Earlier Muslim community did not use contraceptives but now the situation has changed and those women also visit seeking the services."

-Health Service Provider, Dhanusha

"I know few partners who have consent for sex and contraceptive methods."

-Unmarried, 18, Madhesi, Dhanusha

"People who have received it (contraceptives) takes it normally. But others think this is not a normal to all."

-Married, 30, Indigenous, Sunsari

However, majority of the people were found to be against the sex-selective abortion.

"Why should we remove a girl child. It is good to give birth to girl child."

-Married, 38, Marginalized, Kavre

"Once my daughter-in-law had conceived a girl child, so our family member decided to have an abortion. But I didn't let them abort because a girl is a Goddess Laxmi for me. The baby was born but died after a few days because of illness."

-Married, 30, Madhesi, Dhanusha

Respondents suggested that awareness programs should be more frequently conducted at schools and at the community level.

"I think that awareness should continue instantly. People's behaviour and understanding can be changed only after giving continuity"

-Health Section Representative, Kavre

CHAPTER 4: CONCLUSION & RECOMMENDATIONS

4.1 Conclusion

This monitoring report comprehensively explores the intricate challenges faced by young women in Nepal regarding access to contraception and safe abortion services. Delving into barriers at individual, organizational, and community levels, the report highlights nuanced impediments necessitating targeted interventions accounting for diverse demographic factors. Organizational barriers, such as shortages of trained personnel, budget constraints, and infrastructure inadequacies, demand strategic planning for optimized resource allocation. At the individual level, privacy concerns, particularly affecting unmarried women, pose challenges, requiring improvements in provider-client dynamics through training and awareness campaigns. Community-level barriers, including socio-cultural stigmas, demand effective interventions like community dialogues and efforts to challenge harmful norms. Opportunities for improvement, such as favorable policies and collaborations, are identified, leveraging Nepal's commitment to sexual and reproductive health. The report underscores the need for a comprehensive, collaborative approach, prioritizing awareness, education, and community engagement to address barriers and align with global frameworks. Insights are valuable for policymakers, healthcare providers, and advocacy groups working towards a more equitable and accessible system.

4.2 Recommendations

1. Uphold the commitments to international human rights obligations and implements accessible services for all populations, with a particular focus on reaching harder-to-reach communities.
2. Allocating ample resources and empower the workforce to deliver accessible, high-quality, stigma-free contraception and safe abortion services for diverse women, girls, and individuals in need.
3. Effectively address diverse population needs, generate credible, disaggregated data concerning intersectional factors linked with access to contraception and safe abortion services and for the development of tailored plans and programs.
4. Emphasize the need for increased investment in evidence generation, focusing on research to introduce a variety of contraceptive methods and ways of accessing safe abortion services for every individual, irrespective of their diverse intersecting identities.
5. Provide substantial support to youth and adolescent networks, enhancing their meaningful engagement in policy-making, design, planning, and implementation of SRHR services.
6. Push for the establishment of essential monitoring mechanisms capable of enforcing compliance with laws and ensuring effective implementation of SRHR services.
7. Establish effective coordination mechanisms and multi-stakeholder partnerships across various government levels, emphasizing the fortification of public-private collaborations for delivering quality SRHR services.
8. Integration of updated comprehensive sexuality education into school curriculums and programs, ensuring accurate information on bodily rights and autonomy through collaboration with relevant stakeholders.
9. Diverse use of media platforms tailored to the needs of diverse young individuals, ensuring accurate and comprehensive information on SRHR, coupled with continuous monitoring and evaluation.

Recommendations for Government:

1. Address the shortage of trained service providers by reevaluating the impact of the federal structure shift and ensuring trained personnel are actively involved in service provision.
2. Increase budgetary allocation for SRHR services, emphasizing contraception and safe abortion, and raise awareness among local decision-makers regarding their importance.
3. Invest in improving infrastructure, commodities, and equipment to enhance the comfort of service seekers, specifically addressing limited space in health facilities.
4. Develop and implement policies and initiatives to make SRHR services more disability-friendly and adolescent-friendly, addressing issues related to physical infrastructure and discriminatory behavior.
5. Enhance privacy and confidentiality measures, ensuring service providers are trained to maintain confidentiality and uphold professional ethics, especially for unmarried women.
6. Develop and implement local-level policies and guiding documents to support the expansion of safe abortion services, with a focus on recording, reporting, and monitoring mechanisms.
7. Improve information dissemination on SRHR services using various media channels effectively, encouraging media, schools, and community platforms to reach a wider audience.
8. Prioritize improving counseling services through training programs for service providers, ensuring proper and effective counseling for contraception and safe abortion.

Recommendations for Service Providers:

1. Conduct behavioral training programs for service providers to address reported misbehavior, emphasizing client confidentiality, respectful treatment, and effective counseling.
2. Proactively ensure privacy and confidentiality during service provision, implementing practices that instill confidence in service seekers, particularly unmarried women.
3. Enhance counseling services to address the reported lack of proper counseling, equipping service providers with the necessary skills for comprehensive and empathetic counseling.
4. Emphasize adherence to professional ethics among service providers, reinforcing commitment to privacy, respect, and client-centered care.
5. Collaborate with local government initiatives and organizations to improve SRHR services, participating in public-private partnerships to expand service accessibility.

Recommendations for Stakeholders:

1. Support and participate in community awareness programs on SRHR services, collaborating with local initiatives, government efforts, and organizations to disseminate information.
2. Advocate for policies and initiatives empowering individuals, particularly women, to make informed choices about SRHR services, encouraging community discussions and dispelling social stigmas.
3. Ensure information reaches marginalized communities by actively engaging with FCHVs and implementing diverse communication channels, including social media.
4. Encourage and support partnerships between the government and private agencies to expand SRHR services, promoting collaborations that enhance service accessibility.
5. Advocate for the development and implementation of local-level policies addressing SRHR services, emphasizing proper recording, reporting, and monitoring mechanisms.
6. Promote gender-sensitive programs addressing the unique needs and challenges faced by women in accessing SRHR services, emphasizing inclusive and non-discriminatory healthcare.

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ANNEXES

1. Abortion Story: Anonymous

Pseudonym: Ganga
Age: 30
Location: Janakpur

Ganga, a 30-year-old married woman from a Maithil Brahman family in Janakpur. She has completed her graduate studies and is a homemaker, dedicating her time to raising her two daughters – an 11-year-old and a 6-year-old.

In 6 months, Ganga got pregnant twice and did USG for sex determination of the fetus. Both times, the sex of the fetus was determined as a female. Thus, Ganga got an abortion both times. The primary reason behind these decisions was the family's persistent desire for a son. Despite her educational background and awareness of safe abortion practices through social media, radio, and television, Ganga found herself succumbing to familial and societal pressure.

The procedures involved the administration of medications such as mifepristone and a D and C (dilation and curettage) surgery at a private clinic in Janakpur, performed by a registered gynaecologist. Both the service provider and health institution were listed in the abortion service provider list.

The abortion surgeries were minor, lasting approximately 30 minutes each. She was discharged after 24 hours. Ganga experienced a smooth recovery, receiving the necessary medication for wound healing and infection prevention. She took some days off to rest and adhered to the prescribed post-abortion care. and with the prescriptions for healing the wound and prevent infection.

Ganga, well-informed about legal abortion timelines, recognized the importance of seeking safe services. Her family, particularly her husband, supported her throughout the process. This also played a crucial role in making informed decisions regarding abortions.

At present, Ganga leads a normal life, seemingly unaffected by the physical aspects of her past abortions. However, the lingering societal and familial expectations for a son occasionally bring about mental and psychological pressures, leading to moments of sadness. Despite these challenges, she manages her daily routine with resilience and strength.

2. Abortion Story: Anonymous

Pseudonym: Kiran
Age: 25
Location: Dhanusha

Kiran is a 25-year-old from the Yadav community. She has completed her high school and currently works as a primary school teacher. She was married 6 years ago and has 2 daughters aged 6 and 5.

Kiran underwent an abortion for the first time. After getting pregnant, a sex determination test revealed that the fetus was a female, leading the individual to choose abortion in the desire for a son. The decision to undergo an abortion was entirely personal.

The abortion procedure, including the administration of 200 mg Mifroprostone followed by 400 mg misoprostone and a D and C (dilation and curettage) procedure, took place in a government hospital in Janakpur. Both the service provider and the health institution were listed on the abortion service provider list. She was discharged after 24 hours. She was prescribed medication for wound healing and infection prevention.

Kiran was well-informed about safe abortion services through social media, radio, and television. She also had a good understanding of legal abortion timelines.

Her husband and other family members, including the mother-in-law and relatives, were supportive of the safe abortion decision. The minor surgery lasted around 30 minutes, and the recovery period was smooth, with no complications. Following a few days of rest and the timely consumption of prescribed antibiotics, she resumed daily life and worked without any complications.

3. Abortion Story: Anonymous

Pseudonym: Asmita
Age: 23
Location: Janakpur

Asmita, a member of the Gupta caste, had been married for 4 years. She has completed her high school and is a homemaker. She has 2 children, a 3-year-old daughter and an 8-month-old son.

Asmita found that she was pregnant for the third time. However, the pregnancy was unplanned. Considering the challenges of caring for a breastfeeding infant and the desire for family planning, she and her husband decided to undergo a medical abortion.

She chose the government provincial hospital in Janakpur to receive a safe abortion service. The service provider and health institution are listed in the abortion service provider list.

The abortion was performed through the administration of Mifroprostone (200 mg) followed by misoprostone (400 mg). Additionally, a D and C (dilation and curettage) procedure was performed to ensure the safe removal of uterine tissues post-expulsion.

The entire process lasted for about 30 minutes, was deemed safe, and Asmita was discharged after 24 hours. Following the abortion, Asmita took the prescribed medication, including antibiotics, calcium, and iron, for healing and infection prevention.

Asmita had acquired information about safe abortion services through various channels such as social media, radio, and television, as well as counselling from health workers. She was supported by her husband and her mother-in-law throughout the process.

Post-abortion, Asmita took the necessary time to rest and recover, adhering to the recommended antibiotic medications. At present, she is doing her day-to-day chores without any complications.

4. Abortion Story: Anonymous

Pseudonym: Ritika
Age: 18
Location: Janakpur

Ritika, a young woman belonging to the Dalit community, got married at the age of 18, just nine months ago. She had formal education until class 10. 2 months after the marriage, she found out that she was pregnant for the first time.

Ritika did a USG as a regular check up and found that the fetus had an abnormal heart and immature kidney development during an anomaly scan. Ritika and her husband decided to abort the fetus following the doctor's advice.

She chose the government provincial hospital in Janakpur to receive a safe abortion service. The service provider and health institution are listed in the abortion service provider list.

The abortion procedure was a minor surgery done within 30 minutes. The abortion was safe and done in a good way. She didn't have any complications after the abortion She was discharged after 24 hours and was prescribed medicine for the healing of the wound and preventing infection.

Ritika had information on safe abortion services through social media, radio and television. She also got the information from the health worker through counselling.

Her husband and other family members such as her mother-in-law and other relatives also supported safe abortion. She rested for for few days and recovered by taking prescribed antibiotic medicines.

At present, she is back to her daily routine and has no complications.

5. Abortion Story: Anonymous

Pseudonym: Maya
Age: 19
Location: Janakpur

Maya is a 19-year-old unmarried girl. She has completed her high school. Maya found she was pregnant after a sexual relationship with her boyfriend. She confirmed her pregnancy through a positive result from a pregnancy test kit.

She decided to get an abortion and visited a doctor for a check-up seeking medical guidance. As she was unmarried, Maya decided to get an abortion fearing societal and familial repercussions.

Maya chose to get an abortion at a private hospital in Janakpur, facilitated by a registered gynaecologist. However, service providers and health institutions were not listed in the abortion service provider directory.

The abortion procedure was a minor surgery done within 30 minutes. She did not have any complications after the abortion. Maya was discharged after 24 hours. She was prescribed medicines for wound healing, and infection prevention, as well as antibiotics, calcium, and iron, were provided.

Maya had information about safe abortion services from social media, radio and television She also got information regarding safe abortion from health workers through counselling.

Her family members did not support her in abortion. Her boyfriend and other friends supported her during the entire process.

At present days she is back to her daily routine and has no complications.

6. Case Story: Anonymous

Pseudonym: Rani
Age: 23 years
Location: Banigaama

Rani is a 23-year-old woman belonging to the Madhesi community. She has received formal education up to class 10. Rani got married at the age of 19 and is now a mother of three children. Living in a rural setting, her movements rarely extend beyond the village, primarily engaging in agricultural work.

Rani has not used any family planning contraceptive devices up to now. She wants to stop having children, but her husband doesn't want to use contraceptives.

The primary obstacle Rani encounters is the lack of knowledge about family planning methods. She views family planning solely as a means to prevent pregnancy or birth, lacking a detailed understanding of how different methods work. Providers in her village seldom offer comprehensive advice, further contributing to her limited awareness.

Rani is surrounded by myths and rumours, particularly through her husband and friends. There is a prevailing misconception that using intrauterine contraception may lead to womb cancer, cause stomachaches, and affect the entire body negatively. Additionally, societal beliefs discourage the use of contraceptive methods such as tubal ligation for women with two or three children.

The remoteness of her village and limited infrastructure pose significant challenges. Women, like Rani, seek family planning supplies from non-clinic outlets, such as pharmacies, where condoms, Depo-Provera, and oral contraceptives are available. However, accessing intrauterine devices (IUDs) proves difficult due to their limited availability in remote areas. Rani, engaged in agricultural work, faces economic and practical difficulties in travelling to a clinic situated within the village.

Despite expressing her desires and views on family planning, Rani's ability to act on her choices is constrained by her husband's views. The husband's opinion is paramount, creating an undercurrent of unspoken threats (felt by Rani) that further limit her agency in accessing family planning services. Although her husband does not actively prevent her, his lack of involvement in the process, such as accompanying her to the health post, adds to the barriers she faces.

In conclusion, the barriers to accessing contraception in Rani are multifaceted. The lack of knowledge and misconceptions surrounding contraceptive methods, coupled with the gendered context and issues of accessibility and service configuration, collectively impede the uptake of intrauterine devices in the community. Addressing these barriers requires not only targeted education and awareness campaigns but also a shift in the societal mindset to empower women to make informed choices about their reproductive health.

Overcoming Barriers in Accessing Contraception

7. Case Story: Anonymous

Pseudonym: Shehnaz
Age: 23 years
Location: Dhanusha

Shenaz is a 23-year-old woman residing in Dhanusha and belongs to a Muslim community. She did not complete a formal school education. She was married 4 years ago and has 5 children, 4 daughters and a son. Shenaz's life revolves around her familial duties. Unfortunately, her lack of education and the dominance of her family, as well as her husband, have confined her freedom and decision-making abilities. According to her religious beliefs, she is obligated to bear as many children as God/Allah bestows upon her as a gift.

Her family members are not educated. She doesn't have freedom. She is so dominated by her family members as well as by her husband. According to her religion, she has to give birth as much as the god/ALLAH gave to her as a gift.

She perceives family planning as something that is not within the guidelines of Islam. She also noted that specific contraceptive methods that require injection, incisions or insertions, such as injectables, intrauterine contraceptive devices or implants were unacceptable to Muslim women.

In particular, Shenaz pointed out the religious dilemma associated with the use of Depo-Provera, where service providers would have to expose areas like the upper arm and buttock during administration, against the tenets of her faith. The fear of facing divine consequences after death, with God questioning the integrity of body parts sent without any scars or cuts, adds another layer to the aversion towards operations within her caste.

She emphasized that in her community, there is a prevailing trend of secrecy surrounding the use of family planning devices. Muslim women often visit service providers clandestinely, avoiding disclosure to family members. Shenaz firmly believes that God directly influences the health and birth of a child, and the act of having multiple children is seen as a way to please Allah. "We want ALLAH to be happy and fulfil our wish. We will hope that ALLAH will give children to us" She said.

Shenaz's story sheds light on the formidable barriers posed by religious and cultural norms when it comes to family planning and accessing contraceptives. These barriers not only restrict the choices available but also foster a culture of secrecy within the community. The clash between personal health decisions and deeply ingrained beliefs reflects the complexity of addressing reproductive health issues in societies where religious and cultural norms play a pivotal role. Understanding and bridging these gaps is essential for providing comprehensive reproductive healthcare that respects individual choices while acknowledging the rich tapestry of diverse cultural and religious beliefs.

This research is part of State of the Region Report on Sexual and Reproductive Health and Rights: International Conference on Population and Development (ICPD+30) monitoring initiative by ARROW. This initiative includes 13 partners and generates monitoring evidence around twenty-five years of implementation of the ICPD Programme of Action (ICPD POA) in the respective countries for advocacy. The evidence from the report is expected to inform the Mid-term Review of the 7th Asia Pacific Population Conference (APPC) in 2023 at the regional level, the national policy dialogues in 2023 at the national level, and the ICPD+30 review in 2024 at the international level.

ARROW

ARROW is a regional and non-profit women's NGO based in Kuala Lumpur, Malaysia, and has consultative status with the Economic and Social Council of the United Nations. Since it was established in 1993, it has been working to advance women's health, affirmative sexuality, and rights, and to empower women through information and knowledge, evidence generation, advocacy, capacity building, partnership building and organisational development.

BEYOND BEIJING COMMITTEE

Beyond Beijing Committee (BBC) Nepal is a feminist human rights National Network organization established after the Fourth World Conference on Women in Beijing in 1995. Currently, it has over 230 NGO members from all seven provinces.

BBC Nepal is an organization in Special Consultative Status with the United Nations Economic and Social Council (ECOSOC). It works toward the civil, political, economic, and social empowerment of women, girls, persons with different Sexual Orientations and Gender Identities, and marginalized communities to achieve substantive gender equality and human rights for all. Currently, BBC's thematic areas of work are Sexual and Reproductive Health and Rights and Bodily Autonomy, Economic Justice and Rights, and Feminist Movement and Leadership. It advocates for SRHR and the rightful space of women and youth and women CSOs in decision making. It engages and enhances the capacity of girls, youth, and women CSOs in the implementation of the Beijing Declaration and Platform for Action (BPfA), CEDAW, ICPD POA, SDGs, Human Rights Treaties, and Generation Equality.

BBC Nepal is a founder of the Nepal SDGs Forum and the Convener of Women and Girls' constituency and gender justice theme. It also functions as the secretariat of the Women Major Group for Sustainable Development in Nepal (WMG-SDN).

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