Family Planning Association of Nepal

Come Together

Strategy 2023-2028

Table of Contents

ACRONYMS AND ABBREVIATIONS 2

CHAPTER I 4

INTRODUCTION AND BACKGROUND 4

VISION 9

MISSION 9

CHAPTER II 10

CENTRE CARE ON PEOPLE 10

CHAPTER III 16

MOVE THE SEXUALITY AGENDA 16

CHAPTER IV 18

SOLIDARITY FOR CHANGE 18

CHAPTER V 20

NURTURING OUR FEDERATION 20

RESULT INDICATORS 2023-2028 21

REFERENCES 23

Acronyms and abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ASRH	Adolescent Sexual and Reproductive Health
CAC	Comprehensive Abortion Care
CBO	Community Based Organization
CBS	Central Bureau of Statistics
CPR	Contraceptive Prevalence Rate
CSE	Comprehensive Sexuality Education
CYP	Couple-years of Protection
DD	Demographic Dividend
DHI	Digital Health Intervention
DOHS	Department of Health Services
EPP/ERP	Emergency Preparedness Plan/Emergency Response Plan
FCHV	Female Community Health Volunteers
FP	Family Planning
FPAN	Family Planning Association of Nepal
FSW	Female Sex Worker
FWD	Family Welfare Division
FY	Fiscal Year
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
HPE	Health, Population and Environment
ICPD	International Conference on Population and Development
INGO	International Non-governmental Organization
IPPF	International Planned Parenthood Federation
IUD	Intra-Uterine Device
IUI/IVF	Intrauterine insemination/ In vitro fertilization
LGBTQI	Lesbian, gay, bisexual, transgender, questioning/queer and intersex
MA	Member Association
MIS	Management Information System
MISP	Minimum Initial Service Package
MOF	Ministry of Finance
MOH	Ministry of Health
MOHP	Ministry of Health and Population
MoLJFA	Ministry of Law, Justice and Federal Affairs
MOU	Memorandum of Understanding
MSI	Marie Stopes International
MWRA	Married Women of Reproductive Age
NCASC	National Centre for AIDS and STD Control
NDHS	Nepal Demographic and Health Survey
NGO	Non-governmental Organization
NGOCC	Non-governmental Organisation Coordination Committee
NPC	National Planning Commission
NPC	National Planning Commission
NSO	Notational Statistical Office
PAC	Post abortion Care
PLHIV	Person living with HIV

PMSEU	Poor, marginalized, socially excluded, and underserved
PSI	Population Services International
PWD	People with Disabilities
Q&A	Question and Answer
RH	Reproductive Health
RMNCAH	Reproductive, Maternal, Neonatal, Child and Adolescent Health
SDGs	Sustainable Development Goals
SDP	Service Delivery Point
SGBV	Sexual and Gender-Based Violence
SOGIESC	Sexual Orientation, Gender Identity or Expression and Sex Characteristics
SRHR	Sexual and Reproductive Health and Rights
STD	Sexually Transmitted disease
STI	Sexually Transmitted Infection
TFR	Total Fertility Rate
UNAIDS	United Nations Children's
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VSC	Voluntary Surgical contraception
WHO	World Health Organization
WRA	Women of Reproductive Age

Chapter I

Introduction and Background

The **Come Together** Family Planning Association of Nepal's Strategy has been developed in line with IPPF's **Come Together Strategy 2023-2028**. This is the result of a series of interactive meetings held with FPAN volunteers and Senior Management Team. The strategy is focused on sexual and reproductive health and rights as envisioned by IPPF federation.

The strategy includes a brief description on FPAN, Nepal country context, vision, mission, four pillars and associated goals, and result indicators for the next 6 years.

FPAN: Brief

Family Planning Association of Nepal is the leading national non-governmental organization specialized in providing all aspects of sexual and reproductive health and rights (SRHR). The Central Secretariat is located in Kathmandu but oversees project activities spread in 31 of Nepal's 77 districts through 28 Branch Offices.

In its more than six decade-long history, FPAN dared to stand for social justice and equity. FPAN introduced contraception at the time when talking about contraception was inviting troubles in the family and society. Birth spacing and small family norm were promoted by FPAN even before the Government introduced family planning. More importantly, FPAN passionately advocated for abortion liberalization in the society where abortion was not only illegal, but it was tantamount to committing crime prior to 2002. Now, Nepal is perhaps the most liberal society with respect to abortion in South Asia as abortion is not only legal it is also free.

FPAN is one of the NGOs in the country which comprises of more females than males in Executive Committees and the founding volunteer of FPAN was a woman in 1959 and in its history FPAN has had several women Presidents. The target beneficiaries are PMSEU which include people with disabilities, LGBTQI, sex workers, PLHIVs and key focus areas of FPAN include adolescent sexuality, CSE, SRHR advocacy, access of SRH services, empowerment of young people and women and system strengthening. Also, FPAN programme includes emergency response in humanitarian setting.

Committed to attaining the goal of SRHR for all, FPAN is a part of the global federation of IPPF. Nationally too, FPAN collaborates with the Government of Nepal and other NGOs, INGOs and CBOs working in the fields of SRHR.

Country Background

Nepal - a landmass of 147,181 square kilometres, is situated between China and India. Three distinct ecological regions - the Mountains, the Hills and the Tarai run east to west. The Mountain area in the North ranges in altitude from 4,880 meters to 8,848 meters above sea level and the area accounts for about 35% of the total land of the country. The Hill area in the middle runs from east to west, ranging in altitude from above 305 meters to about 4,880 meters and accounts for 42% of the total land of the

country. The Tarai area along the South ranges from about 60 meters to 305 meters above sea level, including some of the most fertile land in the country and accounting for 23% of the total land area. According to the 2021 population census results, about 53.6% of the total population of 29.2 million resided in the Tarai, while in the hills and the high mountain regions the corresponding figures are 40.3% and 6.1%, respectively (NSO, 2023).

The total population of 29.2 million in 2021 is composed of 8,232,181 women of reproductive age (WRA) which is higher by about 15.7% compared to the total WRA of 7,117,526 in 2011 (CBS, 2012). This calls for more demand for RH services. Nepal has made remarkable progress on health front; life expectancy at birth has increased from 54 years in 1991 (Karki, Y. B. 1992) to 70 years in 2021 (males 68 years and females 71 years, CBS. 2014); maternal mortality ratio has decreased from 539 in 1996 (Pradhan *et al.*, 1997) to 239 in 2016 (MOHP, *et al.*, 2017), and further to 151 in 2021 (MOHP & NSO, 2022) and both under-five and infant mortality rates have declined. Total fertility rate is at 2.1 per woman (MOHP, *et al.*, 2022). Despite this, health challenges remain and poor and marginalized women face more challenges in accessing healthcare, and higher risks. Reducing MMR to 70 as envisaged in the Sustainable Development Goal number 3 is a daunting task for Nepal in the next 7 years or by 2030.

In Nepal, national data on CPR for modern methods indicate that CPR has remained virtually constant since 2006 – it was 44% in 2006 (MOHP et al., 2007) but in 2011, 2016 and 2022 it has remained at 43% (MOHP et al., 2022).

Unmet need for FP among married women of reproductive age (MWRA) has only slightly declined in the last 6 years from 23.7% in 2016 (MOHP, *et al.*, 2017) to 20.8% in 2022 (MOHP, *et al.*, 2022). Demand for family planning has slightly increased from 76.3% in 2016 to 78.0% in 2022 and as a corollary to it demand for family planning that is satisfied has also slightly increased from 68.9% in 2016 to 73.3% in 2022. However, demand for modern family planning that is satisfied has slightly decreased from 56.1% in 2016 (MOHP, *et.al.*, 2017) to 54.7% in 2022 (MOHP, *et al.*, 2022).

Contraceptive use among married adolescents aged 15-19 has increased by about 5 percentage points in the last 6 years from 23.1% in 2016 to 28.2% in 2022. However, use of modern contraceptive methods among the adolescents has declined from 14.5% in 2016 (MOHP, *et al.*, 2017) to 14.2% in 2022(MOHP, *et al.*, 2022). The demand for family planning that is satisfied is very low among the adolescents; it being 48% for all methods and only 24% for modern methods.

The data on percentage of demand satisfied for modern FP methods shows that Nepal has already missed the target of reaching the SDG target of 74% in 2022 and it looks far too arduous to meet the 2030 target of 80% demand satisfied for modern methods (NPC, 2017).

High and persistent unmet need for contraception among women has important implications for reproductive health programming and planning. Women who have unmet needs for modern contraception are likely to take recourse to traditional methods of contraception such as period or withdrawal methods and their effectiveness is very low. At the same time, as unsafe abortion is common among especially the youth, it is likely that if unmet need for contraception is not addressed, increasing number of youths will end up in taking recourse to unsafe abortion. Unsafe abortion is a pressing public health concern and is a major contributing factor to high maternal mortality in Nepal (Thapa & Padhye,

2001). The government's aim of reducing maternal mortality ratio (MMR) to <70/100,000 live births by 2030 (NPC, 2017) will not be achieved when unsafe abortion persists among the youth population. As per the past 2016 survey, women aged 15 – 24 contribute 55% to age specific fertility (MOH *et al.*, 2017), and therefore, it is important to pay special attention to unmet need for contraception among the youth so that the maximum number of youths are prevented from practicing unsafe abortion.

In Nepal, domestic violence is defined as any form of physical, mental, sexual, or economic harm perpetrated by one person toward another with whom he or she has a family relationship, including acts of reprimand or emotional harm (MOL & J, 2009). Domestic violence has negative health consequences for survivors with respect to women's reproductive, physical, emotional and mental health and to that of their children. In 2011, Nepal introduced a domestic violence module which was included in the Nepal Demographic and Health Survey (NDHS) and was subsequently followed up in 2016 (MOH *et al.*, 2017).

The proportion of ever-married women aged 15–49 who ever experienced various forms of violence (emotional, physical and/or sexual violence) by their husbands declined from 31.5% in 2011 (MOH *et al.*, 2012) to 26.3% in 2016 (MOH *et al.*, 2017). Moreover, about half of women who have ever experienced any form of spousal violence have experienced violence in the past 12 months.

There is a notable variation in the type of violence experienced in the 12 months preceding the survey. From 2011 to 2016, the overall emotional violence declined from 10% to 8%, physical violence remained constant at 10% while sexual violence declined from 8% (MOH *et al.*, 2012) to 4% (MOH *et al.*, 2017) during the same period.

There was a paradigm shift in the health sector worldwide following the ICPD 1994 which zoomed in improving the health of women by enunciating sexual and reproductive health (RH) and rights in a largely patriarchal society. Nepal also committed to implement the ICPD Programme of Action to improve the health of women and children. Nepal streamlined health service infrastructure by strengthening RH services and simultaneously emphasized empowerment of women. All this has resulted in improving the health of the population particularly that of women. However, the achievements fall short of commitments made in plans, policies and programmes. Young girls and boys still lack sufficient RH knowledge, girls in rural areas get married early, the vast health infrastructure runs with few skilled health care providers, absenteeism of health care providers is notoriously present, the physical facilities are not up to the mark, the supply of commodities is always stock out and above all there is a need among the providers to change their attitude to service seekers.

With the objective of addressing every aspect of SRHR and to create an environment for every citizen – leaving no one behind and reaching the farthest behind first, FPAN has been implementing programme to address the needs of lesbian, gay, bisexual, transgender, questioning/queer and intersex (LGBTQI) too. However, the situation of LGBTQI+ is not known well although there is a claim that around 2.5 million people of gender minority live in Nepal while CBS reported 1,500 such people in its 2011 census round (The Himalayan Times, 26 August, 2019). According to the final 2021 population census of Nepal 'other gender' (sexual and gender minorities) numbered only 2,928 which is only about 0.1 per cent of the total population (NSO, 2023). Nevertheless, FPAN works for all; Hormonal and for other SRH related services are provided to both trans girl/women and boy/men.

Infertility is a disease of the male or female reproductive system defined by the failure to achieve a pregnancy after 12 months or more of regular unprotected sexual intercourse (WHO, 2018). Estimates suggest that between 48 million couples and 186 million individuals live with infertility globally (Mascarenhas MN, Flaxman SR, Boerma T, et al. 2012; Boivin J, Bunting L, Collins JA, et al. 2007; Rutstein SO and Shah IH (2004). Infertility data of this nature on Nepal is not available. However, postpartum insusceptibility is another approach to look into infertility. Besides marriage and sex within marriage, women's exposure to the risk of pregnancy is influenced by postpartum behaviour. Postpartum amenorrhoea – which is largely determined by the duration and intensity of breastfeeding – and postpartum abstinence are the two components of the length of postpartum insusceptibility to becoming pregnant. The mean duration of insusceptibility has decreased steadily in Nepal from 13.5 months in 1996 (Pradhan *et al.*, 1997) to 12.5 months in 2001 (MOHP et al., 2002), 12.3 months in 2006 (MOHP, *et al.*, 2007), 11 months in 2011 (MOH *et al.*, 2012) but slightly increased in 2016 to 11.6 months (MOH *et al.*, 2017). The mean duration of postpartum amenorrhea decreased from 12.5 months in 1996 (Pradhan *et al.*, 1997) to 11.7 months in 2001 (MOHP et al., 2002), 10.6 months in 2006 (MOHP, *et al.*, 2007), 8.6 months in 2011 (MOH *et al.*, 2012) and 8 months in 2016 (MOH *et al.*, 2017). The mean duration of postpartum abstinence declined from 5.6 months in 1996 (Pradhan *et al.*, 1997) to 4.3 months in 2001 (MOHP et al., 2002) but it then has steadily increased to 5.2 months in 2006 (MOHP, *et al.*, 2007), 6.5 months in 2011 (MOH *et al.*, 2012) and 7.5 months in 2016 (MOH *et al.*, 2017). These changes imply that women in Nepal experienced slightly shorter periods of insusceptibility to the risk of pregnancy following a birth in 2011 than in earlier years but in 2016 it slightly increased.

The National Centre for AIDS and STD Control (NCASC) maintains the vision of ending the AIDS epidemic as a public health threat by 2030. It has been monitoring the HIV and STI epidemic by collecting data from various sources, namely, (i) case reporting of HIV and STI, (ii) Integrated Biological and Behavioural Surveillance Survey, (iii) Monitoring of HIV Drug Resistance, (iv) size estimation of key populations, (v) HIV infection estimations and projections and (vi) HIV Surveillance (NCASC, 2022). Of the total estimated people living with HIV (PLHIV) (30,000), there are about 1,000 children aged up to 14 years, while adults aged 15 years and above account for 96.7% (NCASC, 2022). Gender disaggregated data reveal slightly higher proportion of men of the same age group (men aged 15 and over: 53.3% compared to women 43.3%) living with HIV than their female counterparts. HIV Incidence per 1000 population is estimated at 0.02% in Nepal in 2021.

HIV prevalence among transgender persons was 6% (NCASC 2015) in 2015 which increased to 8.5% by 2021 (UNAIDS, 2022) and among men who have sex with men, the estimated prevalence increased from 2.4% in 2015 to 5% in 2021 in the same period. Prevalence rate among people who inject drugs declined from 6.4% in 2015 to 2.7% in 2021. Prevalence rate among sex workers is reported to be 4.2% in 2021 but the rate was not known in 2015. Hence, the HIV epidemic is localized and warrants tailored programmes for high-risk groups to ensure that services are reaching those who most need them.

Comprehensive Sexuality Education (CSE), the Government claims is included in Health, Population and Environment (HPE) curricula from grades 6 to 10 but experts think HPE leaves out several important components of CSE and the way the course is taught to students is not up to the mark (TimilSina A., *et al.*, 2017). In addition, HPE which used to be a compulsory subject has been recently made an optional subject (FPAN, 2019) which means that more adolescents and youth in school will be deprived of CSE. FPAN has, however, been implementing CSE programme in formal school setting as well as in non-formal settings

such as through community clubs and local CSOs. FPAN in the next strategy period should not only continue but also expand working areas in view of the fact that the proportion of adolescents and youth aged 15-24 has increased form 19% in 2001 (CBS and UNFPA, 2003) to 20% in 2011 (CBS, 2012) and has remained so in 2021 (CBS, 2022) as well.

Every fiscal year (FY), the finance minister presents budget speech to the parliament with estimates of resources and expenditure outlays. Budget allocation for the Health Ministry of last ten years shows declining proportion of budget allocated to the health sector. In FY 2012/13, of the total annual budget of the country, the proportion of budget allocated for the Ministry of Health and Population was 5% (MoF, Budget Speech, 2013) which increased to 5.88% in the following year (MoF, Budget Speech, 2014), but since then it has been declining until 2019/20 when it was 5.11% (MoF, Budget Speech, 2020). In FY 2017/18 it was the lowest at 2.48% (MoF, Budget Speech, 2017) and 2018/19 it was 2.59% (MoF, Budget Speech, 2018). In FY 2020/21, the corresponding proportion was higher at 7.8% (MoF, Budget Speech, 2021) and in FY 2021/22 it was the highest at 8.59% (MoF, Budget Speech, 2022). However, in these years nearly 30% of all health budget was spent on COVID-19 program. For the FY 2022/23, the proportion budget for the Ministry of Health and Population has been drastically reduced to only 2% (MoF, Budget Speech, 2023). Also, fair portion of the health budget goes to infrastructure such as construction of hospitals and health facilities at the cost of providing essential drugs including SRH equipment and materials. In the far-flung areas of the country the bare health facilities that exist always lack sufficient drugs including SHR materials and human resources to provide basic health and RH services. Clearly, the MoHP is functioning with much smaller budget than it needs to implement its programs.

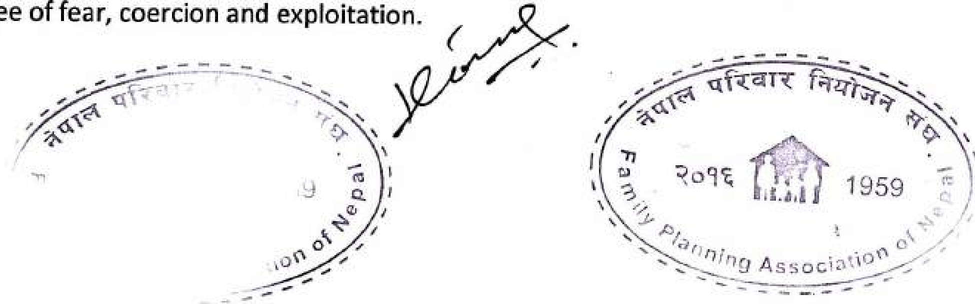
FPAN in the next six years shall be focusing on four pillars, namely, centre care on people, move the sexuality agenda, solidarity for change, and nurturing IPPF's federation as FPAN is an active member of the federation.

Vision

All Nepalese people regardless of race, colour, gender, religion, sexual orientation and gender identity, age, or disability are free to make choices about their sexuality and wellbeing without any discrimination.

Mission

Champion a volunteer movement for increased provision of Sexual and Reproductive Health and Rights by creating an environment for every citizen especially those most at risk, marginalized and under-served – *leaving no one behind* and *reaching the farthest behind first*, to lead a healthy and prosperous life of dignity, free of fear, coercion and exploitation.



Chapter II

Centre Care on People

Goal: Quality and trusted care to more people, in more places

Care is about health. It is about justice. It is about equality. FPAN delivers care in all contexts and delivers the full spectrum of SRHR. Care is FPAN's greatest asset and contribution. FPAN is devoted to the health and progress of Nepal. FPAN's care is deeply embedded in the communities and the societies.

FPAN stands up for choice and caters to people's choices along the course of their lives, in their diversity. FPAN is a proponent of care about people. Equality in care is essential. In the next six years, FPAN will expand choice, and reach more people, in more places.

Expand Choice

Choice relates to any SRHR program. For instance, in providing family planning (FP) service, choice means that clients have a range of family planning methods to choose from. Quality FP services offer different methods to suit people's differing needs – not just one or two methods. If programmes cannot provide a method or service, they refer clients somewhere else for that method.

Choice also means clients make their own decisions. FP providers help clients think through their decisions, but they do not persuade clients to make a certain choice or to use a certain method.

Furthermore, choice also means helping the client understand and remember. The provider shows sample FP materials, encourages the client to handle them, and shows how they are used. Also, the provider shows and explains flip charts, posters or sample pamphlets or printed pages with pictures. From time to time, the provider checks that the client understands.

Expanding choice is not limited to FP methods alone, it applies to provision of fertility, infertility, abortion, STIs, HIV and other SRH services. For those services that are not available at FPAN sites, FPAN partners with hospitals in districts and provinces and to formalize this FPAN has signed Memorandum of Understandings with these hospitals. Coordination is maintained with the major service providers of these hospitals. FPAN refers clients to other service centres for specialised services and keeps track of the referred clients. With the intention of making the cross-referral more effective, FPAN can review the MOUs with the district and regional level hospitals. For example, a small box can be kept in the referral centre. The staff of the referral centre drops the referral slip of the referred client in the box after the services are provided, and FPAN collects the referral slip either monthly or twice a month. This type of tracking system will be further strengthened by FPAN in the next 6 years.

FPAN will expands its offer of services with a life-cycle approach incrementally over the years. The life cycle approach to health is a concept that emphasizes on prevention and early intervention at every stage of life – intrauterine period, early childhood, adolescence, youth, middle age and old age. Outcome at one point in the life cycle might be a determinant for health elsewhere further in the cycle (Kamath, SS, 2015). The Interim RMNCAH Guideline developed by RH Sub Cluster under the leadership of the Family Welfare Division and endorsed by MoHP in 2020, has provided an opportunity to start telemedicine services to deliver RH services such as antenatal and postnatal care, family planning follow-up

counselling/consultation and medical abortion services. Since 2020, FPAN has been providing teleconsultation/counselling services which were instrumental in delivering the SRH services during the COVID-19 pandemic. The teleconsultation program has been implemented in close coordination with the Family Welfare Division at National level. In selected project districts, the programme is implemented in close cooperation with District Health Offices and public sector health facilities at the district level. The FPAN respective branches together with the concerned health authorities from the District Health Office closely monitor the teleconsultation program. In the next 6-year Strategy period, FPAN will continue and scale-up the teleconsultation services.

The proposed teleconsultation services, a 12-hour service provided by trained counsellors, will be delivered through 28 branches covering seven provinces. Necessary support will be provided to the branches for developing infrastructure and they will also be compensated for monthly telephone expenses. FPAN will collaborate with public sector health facilities and partner organisations for disabled persons, PLHIV networks, LGBTQI+ and organisations working on mitigating gender-based violence to provide tele-counselling and consultation services to clients. The Community Based Distributors such as Reproductive Health Female Community Volunteers and Peer Educators will also promote the teleconsultation/ counselling services in communities. Similarly, a consortium led by WHO with partners including FPAN, MSI, PSI and IPAS currently advocate for self-care approaches for medical abortion services. The Family Welfare Division, Department of Health Services (DoHS) is positive about self-care approach, but it will take time to change policy. However, there is provision of home-based approach for medical abortion services in the Interim RMNCAH guideline. FPAN has already piloted medical abortion services through home-based approach operational districts. FPAN proposes to scale-up the home-based care for medical abortion services. The community-based distributers will identify the need for abortion services in the community through home visits or community sessions and the accredited service providers will then provide medical abortion services at appropriate homes in the community, where privacy can be maintained.

Women in Nepal are increasingly accessing abortion service in the country and of those women who had an abortion in the last 5 years preceding the survey of 2016, most (72%) had medical abortion (MOH *et al.*, 2017) in the first trimester, that is up to 9 weeks of pregnancy. Medical abortion after 9 weeks of pregnancy is not legal in Nepal but the demand for it is high. FPAN is currently piloting 2nd trimester medical abortion service up to 18 weeks of pregnancy in its Sunsari static clinic. Based on the experiences gain from piloting, during the strategic plan period, FPAN will expand and scale up this service in the remaining static clinics which provide 24-hour delivery service.

Broaden Access

Nepal is prone to natural crises/disasters like floods, earthquakes, avalanches etc. FPAN will continue to strengthen its capacity and enhance preparedness to respond to crises and provide life-saving Minimum Initial Service Package (MISP) services. FPAN plans to create an enabling environment by advocating for inclusion of essential SRH as part of national, provincial, and local disaster response plan. FPAN will draft national level "Emergency Preparedness Plan/Emergency Response Plan (EPP/ERP)" and disseminate it amongst key stakeholders. FPAN will implement the plans too. FPAN with support of Humanitarian Team will develop national 'simulation package (SIMEx)' and sensitise all nodal officials from line Ministries/Departments, development partners, first-line responders, FPAN staff, etc. FPAN also plans to

undertake activities like 'Minimum Initial Service Package (MISP) readiness assessment' and evaluate the MA's current capacity to provide lifesaving MISP for SRH services in a crisis setting. Based on the readiness assessment, FPAN will work on identified gaps and build on the existing capacity. FPAN will continue to work closely with the CSOs led by LGBTQI, FSW, People with Disability, PLHIV and young people for developing their capacity and sensitizing them on MISP and identification of their SRHR needs in the disaster and crisis. FPAN will strengthen its supply chain management mechanism to ensure timely supply of RH kits and other consumables in crises settings. Also, FPAN plans to mobilise resources and expand its donor base for funding SRH activities in Humanitarian settings.

The conceptualisation of access to FP services or for that matter SRH services and the relationship between service accessibility and FP outcomes (e.g., contraceptive acceptance and continuation) have received considerable attention over the years by FP programme managers and researchers. However, there is little consensus as to the most appropriate way(s) to measure the concept. Although geographic proximity to service delivery point (geographic accessibility) is an important determinant of contraceptive use, the strength of the association between proximity and contraceptive use has not been as strong as might be anticipated. This weak relationship indicates that other factors might also be relevant in defining the concept of access. Foreit et al., 1978 suggest the following dimensions or elements of accessibility:

1. Geographic or physical accessibility,
2. Economic accessibility,
3. Administrative accessibility, and
4. Cognitive accessibility.

Economic accessibility refers to the extent to which the costs of reaching service delivery or supply points and obtaining contraceptive services/ supplies are within the economic means of a large majority of the target population. Economic barriers affect contraceptive use and make it difficult for contraceptive continuation.

Administrative accessibility refers to the extent to which unnecessary rules and regulations that inhibit contraceptive choice and use have been eliminated, for example, restricted clinic hours for FP services.

Cognitive accessibility concerns the extent to which potential clients are aware of the locations of service points and of the services available at these locations. For instance, a client can be unaware of the existence of a SDP, even though it is physically accessible.

To these, a fifth dimension: psycho-social accessibility, or the extent to which potential clients who desire to control fertility are unconstrained by psychological, attitudinal, or social factors in seeking out FP services. In some settings, for example, potential clients may be fearful of utilizing nearby services because of negative social stigma attached with doing so, may be wary of certain procedures (e.g., pelvic examination especially by provider of another sex), or may be unable to seek services because women are not permitted to travel alone to obtain FP services.

Thus, service accessibility is conceptualised as consisting of five elements or dimensions that constitute potential barriers that must be addressed by FP programme management to promote wide utilization of available services, that is, to "get clients to the door."

In terms of geography, FPAN reaches 28 districts of Nepal's 77 districts. But FPAN can reach more people. In Nepal too as elsewhere, systemic barriers stand in the way of health and rights. Therefore, FPAN should

do all it can to broaden access, and to reach more people who are excluded and marginalised. FPAN has been carrying out youth focused programmes and it will expand further. In an increasingly unstable work, FPAN will stand ready to deliver in crisis settings.

Further Reach

To reach further, FPAN will make the most of new technologies and digital platforms. Medical technologies are developing faster than ever. Many, especially new generations, prefer virtual interactions to human ones, also in the care they receive. Technology can be a means of cutting costs, increasing affordability, and broadening reach. Laying a foundation for the future of care, FPAN will partner with experts to invest in digital health interventions and integrate them into broader care package. FPAN will promote self-care options that inspire people to take care into their own hands. FPAN will boost the reach of its digital platforms and channels to share information and resources with those who are supported.

To mitigate the impact of the global pandemic on service delivery, FPAN is leaning into the development of and scale-up of digital health interventions and self-care approaches, including service delivery platforms that are inclusive and respect the diversity of the community they serve. Digital health interventions (DHI) adopted by FPAN serve both demand and supply functions of community engagement, risk communication, telemedicine counselling, consultations, and follow up care. FPAN will offer a range of services across digital platforms focusing on delivery of SRH counselling, contraceptive services, CAC/PAC services, HIV/STI related services, and SGBV support services. For example, FPAN has been harnessing digital innovations to accelerate de-medicalization of SRH services and promote task-sharing within the formal health system, using telemedicine as a bridge to promote safe self-care through home delivery of contraceptives with support for ongoing care. FPAN has developed CSE innovations including a TV program, song and radio program, and toll-free helpline. FPAN also developed an online quiz and video tailored for young people, and debate competition. To adapt CSE for remote use, FPAN has developed virtual training for adolescents. FPAN will scale up and continue CSE innovations through DHI intervention.

This strategy lays a foundation for the future of care. Besides other investments, FPAN will also invest in digital health interventions. Digital Health Interventions (DHIs) include the use of online and remote methods of service delivery which do not require clients to physically attend a service delivery point. This might include, for example, counselling via Zoom or WhatsApp, or a consultation using a chat service or phone calls. As long as the service delivered meets the criteria in the sexual and reproductive health service definitions and is provided through a remote and/or digital channel, it can be counted under DHIs. Note that DHIs may also be used for non-service delivery related activities but this indicator is intended to capture only cases where services are delivered.

Among the RH quality services abortion care is an important component. FPAN besides strongly advocating for abortion legalization during the late 1990s has been providing abortion services in different parts of the country soon after it was legalized in 2002.

FPAN will play key lead in the joint advocacy movement for the self-care approval. Within this strategic plan period of 2023-2028, FPAN with other partners, based on the evidence which will be generated from operational studies, will advocate that the government approves self-care management. The self-care will

be the new and cost-effective model which will be introduced in the country to access safe "self-managed" abortion which is just as safe and effective as clinician-supported abortion. The "self-managed" abortion will immensely help women who are unable to reach Service Delivery Points in person. This approach will also inspire people to take care of themselves in their own hands. In addition, FPAN is advocating for DMPA-SC self-care. Once the Government approves the self-care approach, providers of FPAN shall build capacity of client in injecting DMPA-SC.

The Total Fertility Rate (TFR) was 4.6 in 1996 (Pradhan *et al.*, 1997) and it has declined by more than half to 2.1 in 2022 (MOHP, *et al.*, 2022). The decline is attributable to increase in contraceptive use, separation of couples due to heavy outmigration of males, rise in abortion rate, change in attitude of couples for smaller family and also perhaps due to rise in infertility. However, as mentioned earlier, data on infertility is not available on Nepal. In view of apparently increasing infertility, the FPAN has initiated service centre at the Central Office in Kathmandu in an attempt to address growing infertility problem.

FPAN has been active during the times of disasters such as earthquake, fire, landslides and flooding. The humanitarian service activities are geared to providing RH and basic health services to persons especially women, children and the elderly affected by disasters. Soon after the 2015 April Gorkha earthquake, FPAN with its own and generous donors' resources mobilized staff and volunteers in several districts to provide RH and basic health services. Some 40,000 earthquake survivors benefited from this activity (FPAN, Annual Report, 2017). Humanitarian support activities in the field of SRH and services are carried out by FPAN every year.

FPAN has been working for the poor, marginalized, socially excluded, and underserved (PMSEU) communities, including sex workers, people living with HIV (PLHIV), injecting drug users, migrant workers, and survivors of gender-based violence. In the next six years too FPAN shall be continuing working in HIV integrated programmes through its well-spread district-wise care platforms.

Furthermore, FPAN shall continue to identify SGBV survivors and strengthen linkage and referral mechanism with the One-stop Crisis Management Centre located in every government district hospital.

FPAN besides providing basic RH services also delivers comprehensive SRH services integrating HIV services, through different service delivery models with focus on the poor and marginalized and socially excluded and under-served population - PLHIV, LGBTQI, FSWs, people with disabilities (PWD), young people, and people affected by disaster and crisis. In the next six years, FPAN shall make efforts not only to expand choices but also broaden access to RH services.

FPAN has a strong adolescent and youth division to conceptualize, design, develop and implement to provide care and advocate for safe SRHR of adolescent and young people, including contraception, abortion and HIV/STIs. In addition, FPAN has designed CSE guide in collaboration with the Ministry of Education, INGOs, UNFPA and other CSOs. FPAN has been implementing CSE for students in schools and also for adolescents and youth who are out of school. These programmes were carried out in all 28 branches of FPAN in the country. Given that every year, new students enter grade 6, it is of great import that CSE programme be continued in the years to come.

For implementation of data management strategy, FPAN has developed 3-year (2023-25) data management plan. Under this, in the result area Data Governance, FPAN will form data Governance Committee, update existing data protection policy. Likewise, under data quality result area, FPAN will revise SRH data set based on IPPF's new result framework.

Chapter III

Move the Sexuality Agenda

Goal: Societal and legislative change for safe abortion, comprehensive sexuality education and sexual rights

As a member of IPPF, FPAN has been promoting progressive societal and legislative changes. FPAN came into existence in 1959 with the objective of promoting contraceptive use when the society was very orthodox and restrictive; some founding members were threatened for their life (Thapa, S., 2022). During the late 1990s and until it was legalized in 2002, FPAN continued advocating for the legalization of abortion with the objective of saving women and girls from unsafe abortion and untimely but avoidable deaths (MoH, 2004). FPAN and its group of supporters along with UN agencies managed to include sexual and reproductive health and rights in the 2015 federal constitution of Nepal (MoLJFA, 2015). FPAN is strongly committed to sexual and reproductive health rights.

In the next six years, FPAN will work towards a more inclusive and feminist world. The governing bodies of FPAN at the centre and in districts are represented by at least 50 per cent females and several bodies are headed by females.

Root Advocacy

Since 2015, Nepal has become a federal nation with three tiers of governance – federal, provincial and local (MoLJFA, 2015). FPAN governance has also adapted to this type of devolution. Each tier is governed by democratically elected bodies every five years. FPAN has strong links between local, provincial, and national levels. FPAN has the potential to create opportunities for all levels to engage. Nepal is a multi-party democracy but FPAN is dedicated to holding on to its principles of quality SRHR and equity in its programme implementation.

Shift Norms

The 2015 Constitution of Nepal has made noteworthy progress in politics and legislation in terms of shifting norms in favour of female gender. Clause 84, sub-clause 8 lays down that *"at least one third of the total number of members elected from each political party representing in the Federal Parliament must be women"* (MoLJFA, 2015). This has been adhered to well by the political parties. However, societal values and behaviour to females has not changed much because daily newspapers are full of news and anecdotes of gender-based violence and atrocities. Even these days, some 50 cases of gender-based violence are reported in Nepal and highest proportion of such cases are reported in Madhesh province followed by Koshi, Lumbini, Bagmati, Gandaki, Sudurpaschim, and Karnali (Naya Patrika, 8 March 2023). Some experts think that *"women in Nepalese society are not taken as full human beings"* (Niti Aryal Khanal, *ibid*, p. 1). Nepal still needs legislative measures that can substantially reduce damaging sexual and gender norms.

Act with Youth

In view of the fact that the proportion of adolescents and youth in the total population is increasing, as mentioned earlier, it is clear that they are key drivers of change in the Nepalese society. FPAN has been

paying good attention to programmes on adolescents and youth since the turn of the century; it is now time to pay even greater attention to them. How they are schooled, what values they acquire and the opportunities made available to them determine the quality of population in all aspects of life including SRHR. In this respect, FPAN should not only continue with CSE for youth in and out of school, efforts should be made to expand this activity as much as possible. Use of digital technology – all forms of social media should be explored to reach the maximum number of adolescents and youths.

FPAN will select young influencers who have a good understanding of sexual and reproductive health and rights and are committed to promoting appropriate information and positive behaviours. They will be used to spread information on SRHR and CSE on special occasions such as Family planning day, AIDS Day through video clips. FPAN has been carrying out such activities in the past as well. FPAN will also organise Informative Q&A sessions. The young influencers will be asked to host live or recorded Q&A sessions where they answer questions about sexual, reproductive health and rights issues, providing accurate information and dispelling myths. Another event FPAN will be able to organize would be educational videos. FPAN can produce animated or illustrated videos explaining the importance of safer sex, contraceptive methods, and the prevention of sexually transmitted infections (STIs) in a relatable and age-appropriate manner involving young influencers. Still more, FPAN can conduct guest interviews. FPAN can collaborate with sexual, reproductive health and rights experts, counsellors, or doctors for interviews to discuss various aspects of SRHRs, emphasizing the significance of seeking professional guidance by young influencers.

FPAN has been working to eradicate the impacts of harmful laws and norms for many years. The Legal Code 1960 (*Muluki Ain*) of Nepal, which was frequently amended, has replaced several restrictive laws against women. The 11th Amendment of the *Muluki Ain* in 2002 has abolished the gender discriminatory laws. Women's status legally has improved because of the gender equality statute 2007 which has given complete legal rights to women in property sharing (Karki, S.,2023). All these developments have contributed to prevent, address, and respond to sexual and gender-based violence. However, as mentioned earlier, all these policy developments have not translated into practice and FPAN shall continue advocating for eradicating harmful social practices.

FPAN has been implementing CSE programme since the turn of the century. A lot has been done. Good teaching guide has been put in place. FPAN spends at least 5% of the core fund on youth-led initiatives. However, there is still a need to assess the impact of CSE and related activities by conducting robust research involving youth. The research should aim at assessing the quality and impact of CSE education in schools and among adolescents and youth who are out of school.

During this strategic period, FPAN will strongly advocate bringing changes in, at least, six national SRHR policies/Acts / guidelines. It will make efforts to make school curriculum more CSE inclusive, effectively implement School education sector plan so that CSE in formal and nonformal settings is ensured, increase national investment on FP/SRHR to address unmet needs, especially for the key and marginalized populations, extend second trimester medical abortion up to 18 weeks gestation through NGO/private sectors that are accredited to provide the service, prepare IVF policy guidelines, and amend Safe Motherhood and RH Act and Regulations.

Chapter IV
Solidarity for Change

Goal: Amplify impact by building bridges, shaping discourse and connecting communities, movements and sectors

The problems faced in the world are many, complex and interconnected. Global development agendas (such as the Sustainable Development Goals and on Universal Health Coverage) highlight the urgency of global collaboration. No sector can solve its problems alone. Only through global solidarity can we persevere. IPPF is part of an extensive system of civil society organisations and networks. Civil society catalyses collective action for people to come together, call for accountability and claim their rights.

In the next six years, FPAN along with IPPF will build bridges and forge links towards a global compact on sexual and reproductive health and rights. FPAN will support other sectors and explore synergies. FPAN will come together towards shared goals and foster solidarity for change.

Foster Strategic Solidarity & Partnerships

A number of public and private organizations are involved in SRHR, but many of them have low coverage and only a few of them are meaningfully involved in SRHR. The Ministry of Health and Population plays a key role in advancing SRHR. Some 50,000 Female Community Health Volunteers (FCHVs) of MOHP in the country play a significant role in advancing SRHR. The Ministry of Health and Population infrastructure reaches communities at the grassroots level. Besides, several other ministries also provide tertiary health services through their national level hospitals. Despite this network of infrastructure, there are still a large segment of people and communities who have limited access to the health services including SHR services. Many bilateral and multilateral agencies and local and international NGOs also contribute to advocacy works for favourable policies and legal provisions on SRHR. FPAN has been active from the early days advocating to establish or change various SRHR related policies and strategies, and its contribution to the national SRH services ranges from 15-20%. FPAN also attempts to address the special service needs of couples suffering from subfertility with IUI/IVF service, recanalization of vas, for LGBTIQ+ specialist service like hormonal & Laser service.

FPAN partners with the Government, bilateral and multi-lateral agencies, national and international NGOs for advocacy, service delivery, evidence-based learning, plans and policy formulation and implementation. This partnership has been milestones in development of SRH sector. Outside of SRHR sector, FPAN partner with forest users' groups, private institutions, banks and cooperative houses, local clubs, business houses and many others. All of them work together to meet the SRH needs of those who are most in need. The synergy of this partnership helps mitigate social injustices.

Support Social Movements

FPAN collaborates with the Government as well as CBOs to support a movement that aims to eradicate injustices and bring about equity in the society. FPAN's focus are on gender equality and promotion of SHR and rights. FPAN has organised and is continuing organizing advocacy activities for key population

groups such as female drug user, PWID, and female sex workers to ensure their rights for sexual and reproductive health. FPAN promotes these rights as human rights.

In order to strengthen partnership, FPAN regularly holds interactions with likeminded organizations through its mechanism of Non-governmental Organisation Coordination Committee (NGOCC). Issues like Marriage Equality and SRH Rights of SOGIESC, LGBTIQ are discussed to sensitize policy and opinion makers and opinion makers. This provides positive support to social movements. Movements to empower women are also organized by FPAN in collaboration with other organizations. Events like Safe Abortion Day, International Women's Day, Family Planning Day, etc, are regularly supported by FPAN.

FPAN already has a national forum dealing with SRHRs and it is a member in several government and non-governmental organizations. FPAN is in the national RH committee, National FP subcommittee, National Adolescent committee, national safe abortion committee, Provincial SRH committee, National CSE technical working committee, District RH committee, Reproductive Rights Working committee, and has good partnership with youth alliance, key population organizations, UNFPA, UNESCO, WHO and other agencies. FPAN Chairs the NGOCC since1994. FPAN works closely with the Ministry of Education, Science and Technology, Ministry of Health and Population, Curriculum Development Centre, and Universities.

- Share Knowledge

FPAN is a pioneering organization in SRHR. A number of projects have been successfully implemented and the lessons learned from them have been used for policy making. These successes and some failures need to be documented and disseminated. In this respect knowledge sharing is important. In this age of high and cutting-edge technology, FPAN can design projects for knowledge sharing first in the country and subsequently internationally. Other MAs and the IPPF Headquarters should work together to achieve this objective.

Chapter V

Nurturing our Federation

Goal: Renew our values charter, live our ideals, and unleash our collective power

Formed by eight courageous national family planning organisations, IPPF has grown in size and impact. Over 70-years, IPPF has come together and has left a mark on the world. FPAN became a full-fledged member of the IPPF federation in 1969.

Over the next six years, FPAN as a member of the Federation will adapt to a changing world; it will continue to modernise and streamline. FPAN will re-examine and reaffirm its values and assumptions. FPAN will introspect and improve its policies and action to make sure that what is said is translated into action. FPAN is always open and ready to change for the better.

Chart our Identity

As a member of the IPPF Federation FPAN is always committed to common values of the Federation. FPAN shall actively take part in developing a new membership charter during the 2023-2028 Strategy period. FPAN adheres to IPPF's philosophy which always keeps it moving forward. FPAN shall work together with other MAs to consolidate international solidarity.

Grow the Federation

FPAN shall remain a strong and committed member of the IPPF Federation. FPAN shall undertake the Governance reform to modernise the systems, structures and governance. The new structure shall encourage professionals with skills, ideas and experiences to join the movement. This will help streamline and build efficiencies.

Walk the Talk

FPAN shall live by the values it holds. FPAN is strongly committed to addressing the interconnected forms of discrimination in Nepalese society. From the inception, FPAN has been pushing for gender equality and respect for sexual diversity which it will continue more vigorously in the next six years. Since the turn of the century, FPAN has given special priority to youth leadership and it will push forward their meaningful participation in the next strategic period.

FPAN will scale up existing client-based data recording system during the strategy plan period. By the end of 2028 FPAN will expand this system in the entire Static clinics. All FPAN static clinics will have Clinic Management Information Systems including client-based electronic health records. Similarly, data management system will be strengthened to make the organization a data driven organization.

FPAN will strengthen Overall Learning and Evaluation unit and will enhance the skills of human resources of the unit focusing on research. FPAN will develop its own human resource to conduct operational studies and research during strategic plan period.

RESULT INDICATORS 2023-2028

Year wise expected result indicators for the strategic period 2023-2028 are given below:

Family Planning Association of Nepal: Proposed SP projections 2023-2028						
Indicator	2023	2024	2025	2026	2027	2028
	SP Projection	SP Projection	SP Projection	SP Projection	SP Projection	SP Projection
Expected result: 0.08 million young people completed a quality-assured CSE programme						
CSE to YP - Factored Total	9452	10891	12,550	14,462	16,668	19,212
YP Complete CSE programmes	5264	6316	7,579	9,095	10,914	13,097
YP Partial CSE	10437	12002	13,803	15,873	18,254	20,992
YP Single CSE session	3432	3947	4,539	5,220	6,003	6,903
YP Pe Educator Training	423	507	609	731	877	1,052
Expected result: 35.51 million SRH services provided.						
Total services provided	4288721	4834174	5451668	6151033	6943474	7841771
Contraceptive services	1723224	1981708	2,278,964	2,620,809	3,013,930	3,466,020
Abortion	49547	54502	59,952	65,947	72,542	79,796
Gynaecology	600568	690653	794,251	913,389	1,050,397	1,207,957
HIV/AIDS	469159	516075	567,682	624,450	686,895	755,585
Obstetric	419848	461833	508,016	558,818	614,699	676,169
Paediatric	188964	207860	228,646	251,510	276,661	304,328
STI/RTI	642408	706648	777,313	855,045	940,549	1,034,604
Subfertility	9684	11137	12,807	14,728	16,938	19,478
Urology	78236	86060	94,666	104,133	114,546	126,001
Specialised counselling	105215	115737	127,310	140,041	154,045	169,450
Oth SRH medical	1868	1961	2,059	2,162	2,271	2,384
Expected result: 2.13 million couple years of protection						
Total CYP, determined by items provided:	264424	295135	329559	368163	411476	460097
Condoms (m & f) CYP	47259	51985	57,184	62,902	69,192	76,112
EC CYP	227	272	327	392	470	564
10-year IUD CYP	16516	18167	19,984	21,983	24,181	26,599
5-year implant CYP	84921	97659	112,308	129,154	148,527	170,806
3 Month injectable CYP	30357	33392	36,732	40,405	44,445	48,890
Oral Contraceptive CYP	20265	22292	24,521	26,973	29,670	32,637
VSC (male and female) CYP	64879	71367	78,504	86,354	94,989	104,488
Expected result :0.72 million SRH services enabled	92763	102039	112,243	123,468	135,814	149,396
Expected result: Income generated locally is to $5.73 million	$576,572	$691,886	$830,263	$996,316	$1,195,579	$1,434,695
3.36 million services provided (Aged 10 - 19)	418543	481324	529456	582402	640642	704706

10 million services provided (Aged 10 - 24)	1257859	1446537	1591191	1750310	1925341	2117875
Estimated clients aged 10-19	62843	72269	79,496	87,446	96,190	105,810
Estimated clients aged 10-24	186609	214601	236,061	259,667	285,634	314,197
Estimated total clients	627805	690586	759,644	835,609	919,170	1,011,087
Number of clients served through DHI	9575	10533	11,586	12,744	14,019	15,421
Number of services provided through DHI	10800	11880	13,068	14,375	15,812	17,394
6 successful policy initiatives and / or legislative changes in support of SRHR to which IPPF advocacy contributed.	**1**	**1**	**1**	**1**	**1**	**1**
80% of IPPF's clients would recommend our services (Net Promoter score)	**70%**	**75%**	**80%**	**80%**	**80%**	**80%**
New and up-to-date systems are in place	6	6	5	5	4	4
Study/Research	2	0	1	0	1	0
0.08 million volunteers, by type	11477	12051	12653	13286	13950	14648

References

Boivin J, Bunting L, Collins JA, et al. (2007). International estimates of infertility prevalence and treatment-seeking: potential need and demand for infertility medical care. Human reproduction (Oxford, England) 2007;22(6):1506-12. doi: 10.1093/humrep/dem046 [published Online First: 2007/03/23]

Central Bureau of Statistics and UNFPA. (2003). Population Census 2001: National Report. His Majesty's Government, National Planning Commission Secretariat, Kathmandu – Nepal, June.

Central Bureau of Statistics. (2012). Population and Housing Census 2011. Kathmandu, Nepal: Central Bureau of Statistics.

National Statistics Office. (2023). Population and Housing Census 2021. Kathmandu, Nepal: Central Bureau of Statistics.

Family Planning Association of Nepal (FPAN). (2019). Annual Work program and budgets. FPAN, Pulchowk, Kathmandu.

Karki, Sushila. The Kathmandu Post. (5 March 2023). English Daily Newspaper. Thapathali, Kathmandu.

Mascarenhas MN, Flaxman SR, Boerma T, et al. National, regional, and global trends in infertility prevalence since 1990: a systematic analysis of 277 health surveys. PLoS Med 2012;9(12): e1001356. doi: 10.1371/journal.pmed.1001356 [published Online First: 2012/12/29]

Ministry of Finance. Budget Speeches of FYs 2012/13- 2023/24. Government of Nepal, Kathmandu.

Ministry of Health and Population, Nepal, New ERA, and ICF. (2022). Nepal Demographic and Health Survey 2022. Key Indicators Report. Kathmandu, Nepal: Ministry of Health, Nepal.

Ministry of Health and Population. (2002). Nepal Demographic and Health Survey 2001. Kathmandu: New ERA, and ORC Macro.

Ministry of Health and Population. (2007). Nepal Demographic Health Survey 2006. Kathmandu: New ERA, and Macro International Inc.

Ministry of Health and Population. (2012). Nepal Demographic and Health Survey 2011. Kathmandu: New ERA and ICF International Inc.

Ministry of Health, Nepal, New ERA, and ICF. (2017). Nepal Demographic and Health Survey 2016. Kathmandu, Nepal: Ministry of Health, Nepal.

Ministry of Health, National Statistical Office. (2022). National Population and Housing Census 2021: Nepal Maternal Mortality Study 2021. Kathmandu: Ministry of Health and Population; National Statistics Office, Kathmandu.

Ministry of Health. (2002). National Safe Abortion Policy. Family Health Division, Department of Health Services. Kathmandu: His Majesty's Government.

Ministry of Health. (2004). Annual Report 2002/03. Kathmandu: His Majesty's Government of Nepal.

Ministry of Health. (2005). Annual Report 2003/04. Kathmandu: His Majesty's Government of Nepal.

Ministry of Health. (2016). Safe Abortion Service Programme Guidelines 2016 (in Nepali). Kathmandu: Department of Health Services, Family Health Division.

Ministry of Health. (2021). Annual Report 2019/20. Government of Nepal, Kathmandu: Ministry of Health.

Ministry of Law and Justice. (1963). Muluki Ain, 2020 (Legal Code, 1963). Kathmandu: Ministry of Law and Justice.

Ministry of Law and Justice. (2009). Domestic Violence (Offence and Punishment) Act, 2009. Kathmandu, Nepal.

Ministry of Law, Justice and Federal Affairs. (2015). Constitution of Nepal 2015. Law Books Management Committee. Kathmandu: Government of Nepal.

National Centre for STD and HIV/AIDS Control. (2015). Integrated Biological and Behavioural Surveillance (IBBS) Survey among People Who Inject Drugs (PWID) in Kathmandu Valley, 2015, Round VI. FINAL REPORT. Kathmandu, December.

National Planning Commission. (2017). Nepal's Sustainable Development Goals: Status and Roadmap: 2016-2030. Kathmandu: Government of Nepal.

Naya Patrika. (8 March 2023). Nepali Daily Newspaper. Putalisadak, Kathmandu.

Niti Aryal Khanal. (8 March 2023). Naya Patrika. Nepali Daily Newspaper. Putalisadak, Kathmandu.

Pradhan, A., Aryal, R.H., Regmi, G., Ban, B., & Govindasamy, P. (1997). Nepal Family Health Survey 1996. Kathmandu: New ERA, and ORC Macro.
Rutstein SO, Shah IH. Infecundity infertility and childlessness in developing countries. Geneva: World Health Organization 2004.
Thapa, S. (2022). Nepal's Family Planning Program Has Come a Long Way: A Conversation with Dr. Badri Raj Pande. Europasian J Med Sci. 2022; 4:18-20. https://doi.org/10.46405/ejms.v4i0.453
TimilSina A., Gautam K., and Maskay, J. 2017. Country Advocacy Brief. Nepal Comprehensive Sexuality Education: The Way Forward. LOOM, YUWA and ARROW. Kathmandu.
World Health Organization (2018). International Classification of Diseases, 11th Revision (ICD-11) Geneva: WHO.
World Health Organization (2022). https://cdn.who.int/media/docs/default-source/gho-documents/maternal-health-countries/maternal_health_npl_en.pdf