

IMPROVEMENTS IN ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN NEPAL



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Table of Contents

SUMMARY	1
METHODOLOGY	3
WHY IS NEPAL AN EXEMPLAR COUNTRY	13
CONTEXT	14
THE FOUNDATION TO PIVOTAL PROGRAMMING : POLITICAL WILL AND POLICY	19
PIVOTAL PROGRAMS	23
BARRIERS TO PROGRESS	36
CONCLUSIONS AND RECOMMENDATIONS	38
REFERENCES	40

LIST OF ACRONYMS

AFHS	Adolescent Friendly Health Services
AFIC	Adolescent Friendly Information Corner
AFR	Adolescent Fertility Rate
AIDS	Acquired Immunodeficiency Syndrome
ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwife
ASFR	Age-specific Fertility Rate
ASRHR	Adolescent Sexual and Reproductive Health and Rights
ASRH	Adolescent Sexual and Reproductive Health
CAC	Comprehensive Abortion Care
CAGR	Compound Annual Growth Rate
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CRC	Convention on the Right of the Child
CSE	Comprehensive Sexuality Education
CSR	Corporate Social Responsibility
DACA	Decentralization Action for Children and Women
DoHS	Department of Health Service
EGH	Exemplars in Global Health
EPH	Environment, Population and Health
FCHV	Female Community Health Volunteer
FGD	Focus Group Discussion
FP	Family Planning
FSP	Flexible School Program
FWD	Family Welfare Division
FY	Fiscal Year
GATE	Girls Access To Education
GDP	Gross Domestic Product
GNI	Gross National Income
GoN	Government of Nepal
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
ICPD	International Conference on Population and Development
IDI	In-Depth Interview
IEC	Information, Education and Communication
IHIMS	Integrated Health Information Management System
IHME	Institute for Health Metrics and Evaluation
INGO	International Non-Governmental Organization
IUCD	Intra-uterine Contraceptive Device
LARC	long-acting Reversible Contraceptives
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex
LLMIC	Low- and Lower-Middle-Income Countries

LIST OF ACRONYMS

MA	Medical Abortion
mCPR	Modern Contraceptive Prevalence Rate
MDG	Millennium Development Goal
MDGP	MD in General Practice
MICS	Multiple Indicator Cluster Survey
MoEST	Ministry of Education, Science, and Technology
MoHP	Ministry of Health and Population
MoWCSC	Ministry of Women, Children, and Senior Citizens
MVA	Manual Vacuum Aspiration
NAHD	National Adolescent Health and Development
NAHDS	National Adolescent Health and Development Strategy
NDHS	Nepal Demographic and Health Survey
NER	Net Enrollment Rate
NFPS	National Family Planning Service
NGO	Non-Governmental Organization
NHFS	Nepal Health Facility Survey
NHSP	National Health Sector Program
NPA	National Plan of Action
PPP	Public-Private-Partnership
RH	Reproductive Health
RMNCH	Reproductive, Maternal, Newborn, and Child Health
SAS	Safe Abortion Service
SBCC	Social and Behavior Change Communication
SDG	Sustainable Development Goal
SFSP	Social and Financial Skills Package
SMRHR	Safe Motherhood and Reproductive Health Rights
SRB	Sex Ratio at birth
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infections
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VDC	Village Development Committee

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- The Study Team

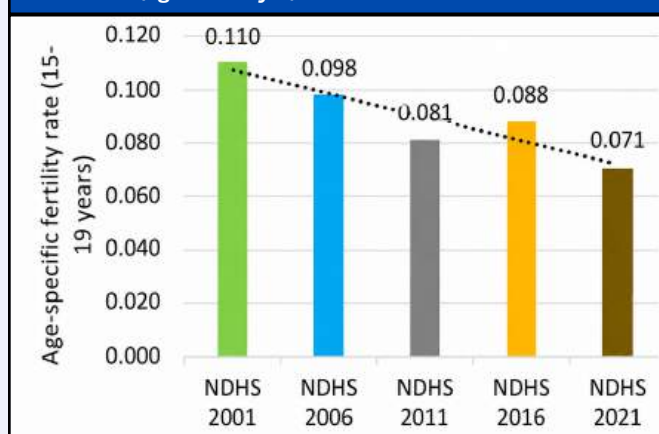
SUMMARY

- Despite various challenges, including political and civil unrest and a devastating earthquake over the past two decades, Nepal has achieved significant progress in reducing adolescent pregnancy compared to its neighboring countries and those with similar contexts.
- Nepal witnessed a 35% decline in the adolescent fertility rate- from 110 births to 71 births per 1,000 women aged 15-19 years between 2001¹ and 2022² exhibiting more significant advancement than many low- and lower-middle income countries.
- Analysis of adolescent fertility trends since 2000 indicates a significant decline between 2003 and 2009, which suggests that adolescents benefited from both reproductive and targeted youth initiatives.
- Nepal’s achievement was possible due to four key factors: (1) formulation and amendment of the constitution, laws, policies, and strategies to make them more adolescent-friendly; (2) strengthening and expansion of adolescent -friendly health services, particularly family planning, safe abortion services, and other SRH services; (3) emphasis on girls’ education and empowerment, including social and financial skills training and the introduction of age-specific comprehensive sexuality education in both formal and non-formal education; and (4) close collaboration between the Government of Nepal and bilateral and multilateral agencies, development partners, and civil society organizations in the formulation and implementation of policies and programs.

Despite an environment of political challenges—including the Maoist insurgency (1996–2006), political and economic instability (2006–2015), a major earthquake (2015), and COVID-19 (2019–2021)—Nepal has achieved significant progress over the past two decades in improving adolescent sexual and reproductive health and rights (ASRHR). In 2001, Nepal had one of the highest adolescent fertility rates—110 births per 1,000 women aged 15–19. After more than two decades, the rate declined to 71 births per 1,000 women aged 15–19. Adolescent pregnancy also decreased from 56% to 14% during the same period (through 2001 to 2022).¹⁻⁵

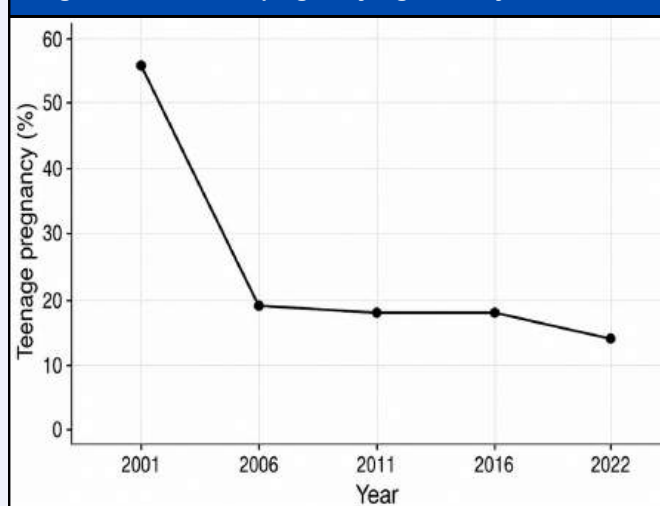
Adolescent fertility is determined by multiple factors, and in 2001 several of these factors were present in Nepal, resulting in high adolescent fertility rates. During that period, government systems were weak due to limited resources and the impact of political unrest. In particular, education and health systems were under strain. For example, access to comprehensive healthcare was limited, and abortion was strictly prohibited. Women were imprisoned for abortion.⁶ Moreover, the country had no specific programming geared toward the reduction and prevention of child marriage.

Figure 2 : Age-specific fertility rate among adolescent (ages 15-19 yrs)



In the past two decades (2002–2022), Nepal has made strong, measurable improvements in health, education, media, policy, and legislation for the benefit of adolescents. With the support of the international and national community, the Government of Nepal pursued a human right–based approach to strengthening systems through investment in health, education, socio-economic development, and media. Furthermore, by adopting a decentralized approach, the Government of Nepal not only enabled but also strengthened systems in a context challenged by rugged terrain and remotely located communities.

Figure 1 : Adolescent pregnancy (ages 15-19 yrs)



With 14% of women aged 15–19 having ever been pregnant in 2021, there remains a risk that adolescent fertility rates could increase within this subpopulation.² However, the gains of the past two decades demonstrate that Nepal now has systems in place that are integrated and contextualized to reduce adolescent fertility at the national level.

This study is part of the Exemplars in ASRHR multi-country study (Cameroon, Ghana, Rwanda, Malawi, India, and Nepal), which aims to identify positive outlier low-

and lower-middle-income countries (LLMICs) that have made exemplary progress in improving ASRHR. Positive outlier countries are those whose progress across a range of global health issues has surpassed that of other countries with comparable characteristics. Nepal has been identified as one such positive outlier in South Asia. This report synthesizes a comprehensive review of policies and programs designed and implemented to improve ASRHR over the past 20 years, alongside analysis of secondary quantitative data and primary qualitative data from Nepal.

Our research used a mixed -methods approach. In the quantitative component, secondary data were analyzed primarily using regression modeling and decomposition analysis. In the qualitative component, we reviewed key policies and programs implemented over the past two decades, engaged with national -level stakeholders and experts, and conducted focus group discussions and in-depth interviews with adolescent girls, service providers, and community -level stakeholders. Findings from the mixed-methods approach were synthesized to better understand Nepal's adolescent fertility decline over the past 20 years.

METHODOLOGY

In our study, we used a mixed-method cross-sectional study approach. Specifically, the qualitative component included: (i) a rapid review of the literature, including laws, policies, and programs targeted to improve ASRHR in Nepal between 2000 and 2022; (ii) in-depth interviews (IDs) with 30 key informants; and (iii) eight focus group discussions (FGDs) with adolescents aged 12–19 years in two municipalities across two provinces of Nepal. In addition, the quantitative component involved analysis of secondary data sources, including the Nepal Demographic and Health Surveys conducted between 2001 and 2021 and the Multiple Indicator Surveys.

During the literature review (published and grey literature), searches were conducted using databases and search engines including PubMed, MEDLINE, and Google, using search terms such as “adolescent health,” “adolescent sexual and reproductive health and rights,” “adolescent health services/programs/interventions,” “adolescent health and development,” “adolescent health policy,” and “Nepal.” Government and non-governmental portals were also accessed to obtain documents related to ASRHR. Telephone inquiries and in-person visits were conducted at relevant institutions to obtain grey literature. Published and grey literature that addressed ASRHR-related policies and programs in Nepal were included in the review.

To better understand stakeholder perspectives, we organized a two-day stakeholders’ workshop with key stakeholders. The workshop aimed to map key policies and interventions and to identify key drivers of success in improving ASRHR in Nepal. Participants included current and former Ministry of Health and Population employees, policymakers, senior officials from ASRHR-implementing agencies, experts, academics, and representatives from UN agencies who were deeply involved in ASRHR-related work in Nepal. During the workshop, participants were divided into two groups: (a) policy and laws and (b) programs and interventions. This process resulted in a list of policies, laws, and interventions implemented between 2000 and 2021 that were identified as key drivers of progress in ASRHR outcomes. Participants also identified key barriers to progress and potential strategies for addressing these challenges.

Among the qualitative methods undertaken, in-depth interviews sought to better understand the perspectives of federal-level stakeholders. A total of 16 federal-level stakeholders—including senior- and mid-level policymakers, ASRHR program managers, representatives from relevant civil society organizations and international and bilateral/multilateral organizations, healthcare providers, and youth activists—were selected through stakeholder mapping. In addition, a stakeholder analysis exercise on ASRHR in Nepal was conducted through an engagement workshop. Fourteen community-level key informants were then purposively selected based on their knowledge of and involvement in ASRHR-related policies and programs

during the reference period (2000–2021) and were interviewed using in-depth interview methods by three trained researchers. Community-level interviews were conducted in two municipalities across two provinces (Gandaki and Lumbini) between June and August 2023. In addition, eight FGDs were conducted with adolescent girls aged 12–19 years, including four FGDs with participants aged 12–14 years and four with participants aged 15–19 years. These FGDs took place in two municipalities (Bulingtar Rural Municipality of Nawalpur District and Nisdi Rural Municipality of Palpa District), selected because these areas reflected some of the highest reductions in adolescent fertility rates between 2011 and 2016.

Both focus group discussion and in-depth interview guides were initially developed in English and subsequently translated into Nepali. A technical advisory committee was formed to support the study and provided comments and suggestions, which were incorporated into the finalized tools. All interviews and FGDs were audio-recorded, transcribed verbatim, and translated into English. Analysis followed a thematic approach. As a first step, two researchers independently read transcripts and developed an initial set of codes based on the interview guides. These codes were then reviewed and modified to develop a more refined codebook. A third researcher, who was not involved in the preliminary coding, reviewed the codebook to identify discrepancies. The coding team then discussed and finalized the codebook. All interviews were coded using the finalized codebook, and content codes were grouped into major thematic categories. Data were organized, coded, and grouped into relevant themes using NVivo software. Review of policies and interventions was guided by the main research questions, specifically what Nepal accomplished in reducing adolescent fertility and how this was accomplished, as well as identifying existing barriers to further improvements in ASRHR.

In the quantitative component, we analyzed national-level secondary data sources, including but not limited to the Nepal Demographic and Health Surveys, Multiple Indicator Surveys, and Integrated Health Management Information System data, with a primary focus on abortion-related indicators over the past twenty years. These national-level data sources covered the period from 2001 to 2023. Both descriptive analyses and multivariate regression models, including event history analysis, were used. Specifically, the main aims of analyzing the secondary quantitative data were to identify factors associated with adolescent fertility, including compositional and behavioral drivers of change, as well as geographical and other inequalities. In addition, the research team partnered with IHME to conduct quantitative modeling using Oaxaca–Blinder decomposition analysis and Cox proportional hazards cohort analysis. Detailed methodologies used in these analyses are described in a separate report. These

QUANTITATIVE RESULTS

quantitative analyses complemented policy and program reviews and primary qualitative research by providing an in-depth examination of the policies and actions that explain Nepal's reduction in adolescent fertility over the period 2000–2021.

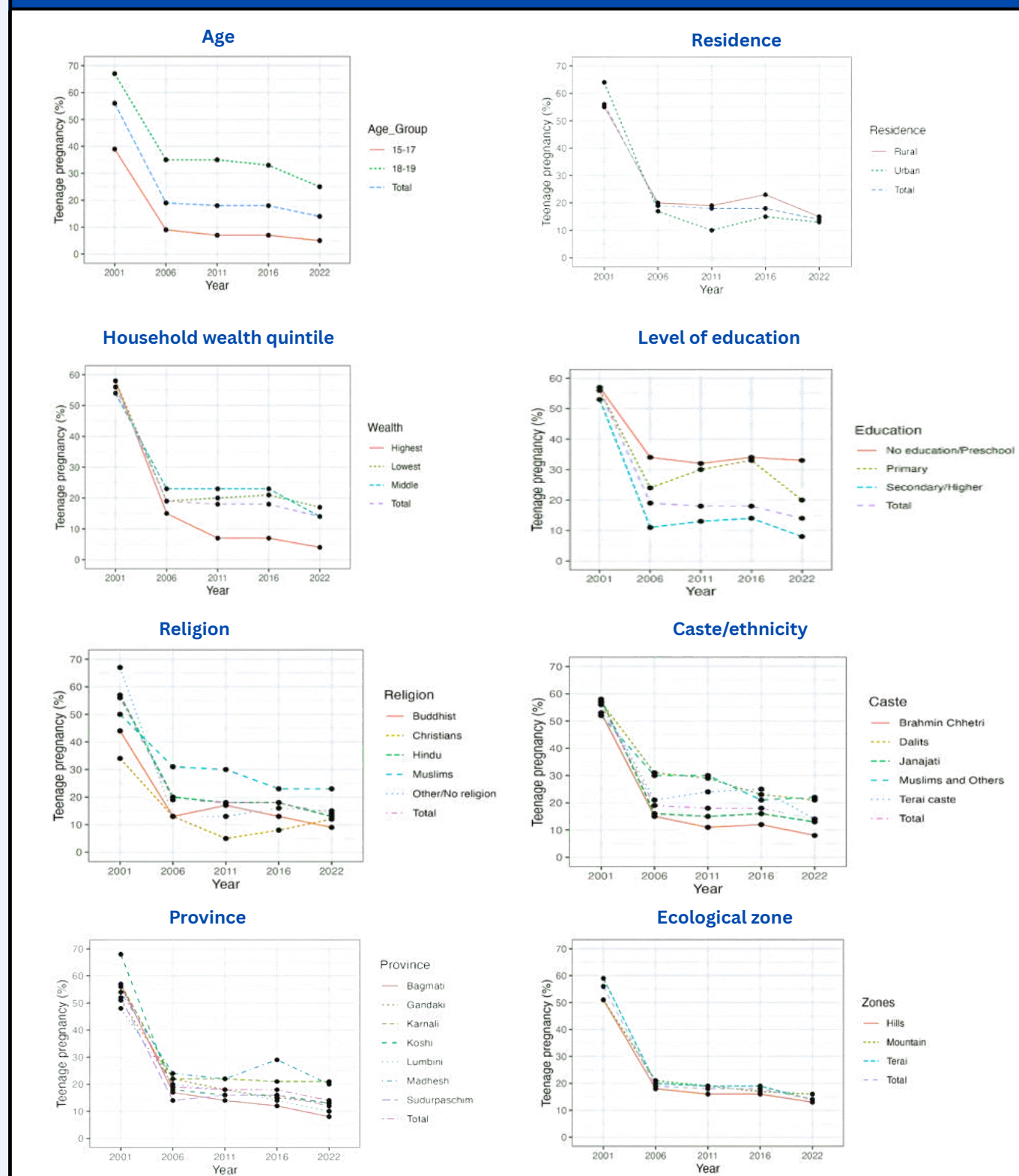
The study protocol was approved by the National Health Research Council prior to data collection.

Adolescent Pregnancy

Adolescent pregnancy has declined significantly over the past 20 years, from 56% in 2001 to 14% in 2022. Although there have been marked gains in pregnancy reduction, further improvements can be made among adolescents aged 18–19 years.

This age group experienced the highest levels of pregnancy in 2001, followed by stagnation between 2006 and 2016, and ultimately a 25% decline by 2022.²

Figure 3: Adolescent pregnancy (ages 15-19 years), by selected demographic characteristics



When disaggregated by residence, gaps in the urban-rural divide have progressively narrowed over the past two decades, with adolescent pregnancy rates of 13% in urban areas and 15% in rural areas in 2022, compared with 65% and 75%, respectively, in 2001. Moreover, when examining adolescent pregnancy by household wealth quintile, the lowest prevalence is observed among adolescents from the wealthiest households, with fewer than 10% reporting pregnancy between 2011 and 2022. Similarly, level of education is inversely associated with adolescent pregnancy, with the highest percentage of pregnancies occurring among adolescents with no education (Figure 3).

When examined by religion, the highest rates of pregnancy occurred among Muslim adolescents, which stagnated at 23% between 2016 and 2022. When examined by province, Madhesh and Karnali recorded the highest percentages of adolescent pregnancy between 2006 and 2022.

Regression analysis showed that the odds of adolescent pregnancy were lowest in 2022 compared with 2006, 2011, and 2016 (2001 NDHS data were excluded due to data limitations).

Odds were higher in Madhesh and Karnali provinces compared with Bagmati Province. Compared with adolescents from the wealthiest households, adolescents from other wealth quintiles had higher odds of pregnancy. As expected, adolescents with no education or only primary education had higher odds of adolescent pregnancy compared with those with higher levels of education. In terms of ethnicity, Dalit and Muslim adolescents had higher odds of pregnancy compared with Brahmin adolescents. (Table 1).

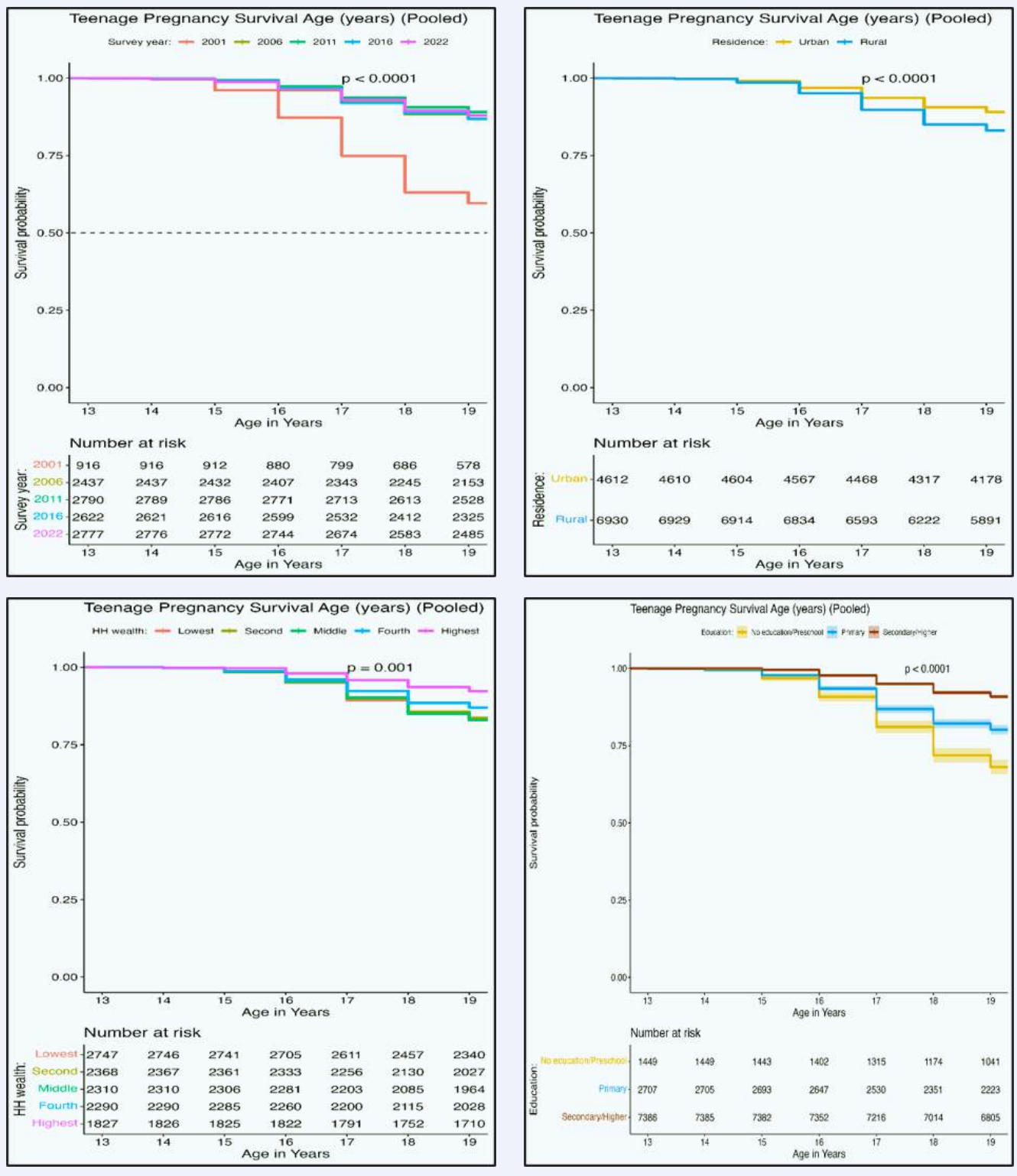
Table 1: Determinants of adolescent pregnancy (ages 15-19 years)

	COR	aOR (95% CI)		COR	aOR (95% CI)
Year			Wealth Quintile		
2022 (Ref)	1.00	1.00	Highest (Ref)	1.00	1.00
2006	1.52 (1.22, 1.89)**	1.60 (1.28, 2.01)**	Lowest	2.64 (2.02, 3.44)**	1.94 (1.41, 2.68)**
2011	1.37 (1.11, 1.68)**	1.56 (1.28, 1.91)**	Second	2.82 (2.17, 3.66)**	1.93 (1.44, 2.59)**
2016	1.38 (1.11, 1.7)**	1.86 (1.51, 2.29)**	Middle	2.91 (2.21, 3.84)**	1.95 (1.46, 2.61)**
Age group			Fourth	2.02 (1.54, 2.65)**	1.68 (1.27, 2.23)**
18-19 (Ref)	1.00	1.00	Education level		
15-17	0.16 (0.14, 0.19)**	0.14 (0.12, 0.16)**	Secondary/ Higher (Ref)	1.00	1.00
Residence			No education/ Preschool	3.71 (3.15, 4.37)**	2.52 (1.98, 3.22)**
Urban (Ref)	1.00	1.00	Primary	2.47 (2.13, 2.85)**	2.67 (2.24, 3.19)**
Rural	1.50 (1.28, 1.76)**	1.20 (1.00, 1.43)	Caste/Ethnicity		
Province			Brahmin/Chhetri (Ref)	1.00	1.00
Bagmati (Ref)	1.00	1.00	Terai castes	1.97 (1.59, 2.44)**	1.43 (1.07, 1.89)*
Koshi	1.32 (0.97, 1.79)	1.25 (0.93, 1.69)	Dalits	2.58 (2.16, 3.09)**	1.85 (1.49, 2.3)**
Madhesh	2.17 (1.62, 2.91)**	1.53 (1.08, 2.17)*	Janajati	1.32 (1.11, 1.58)**	1.26 (1.03, 1.55)**
Gandaki	1.46 (1.07, 2)*	1.36 (0.97, 1.91)	Muslims and others	2.57 (1.95, 3.39)**	1.58 (1.14, 2.2)**
Lumbini	1.29 (0.97, 1.71)	1.13 (0.83, 1.54)	<i>*Significant at 5% level, **Significant at the 1% level; COR = crude odds ratio; aOR = adjusted odds ratio. Note: Pregnancy includes miscarriage, stillbirth and abortion</i>		
Karnali	1.88 (1.4, 2.53)**	1.79 (1.29, 2.48)**			
Sudurpashchim	1.21 (0.85, 1.72)	1.11 (0.78, 1.57)			
Ecological region					
Terai (Ref)	1.00	1.00			
Mountain	1.03 (0.82, 1.29)	1.10 (0.82, 1.48)			
Hills	0.86 (0.73, 1.01)	1.10 (0.90, 1.35)			

Event history analysis sheds light on changes in adolescent pregnancy in Nepal from 2001 to 2022. Results show that a higher percentage of adolescents in 2022 than in 2001 completed adolescence without ever becoming pregnant (85% versus 60%). Similarly, a higher percentage of adolescents living in urban areas than in rural areas, and those with higher levels of education

compared with those with no education, completed adolescence without pregnancy. In terms of household wealth, approximately 93% of adolescents from the wealthiest households exited adolescence without pregnancy, compared with 83% of adolescents from households in the lowest wealth quintile (Figure 4).

Figure 4: Time to first pregnancy among women aged 15-19 years by survey year, residence, wealth quintile and education: event history analysis



First Marriage and sexual debut among Women Aged 15–19 Years

Event history analysis showed that 78% of adolescents exited adolescence without getting married in 2022, compared with 68% in 2006 (in 2001 cohort only married women were surveyed, so all married by 10 years). Moreover, 62% of rural adolescents exited adolescence without ever getting married, compared with 76% of urban adolescents. Approximately 63% of adolescents from households in the lowest wealth quintile exited adolescence without marriage, compared with 81% from the wealthiest households. A substantial difference was observed when first marriage was disaggregated by education: 29% of adolescents with no education exited adolescence without marriage, compared with 78% of adolescents with secondary or higher education (Figure 5).

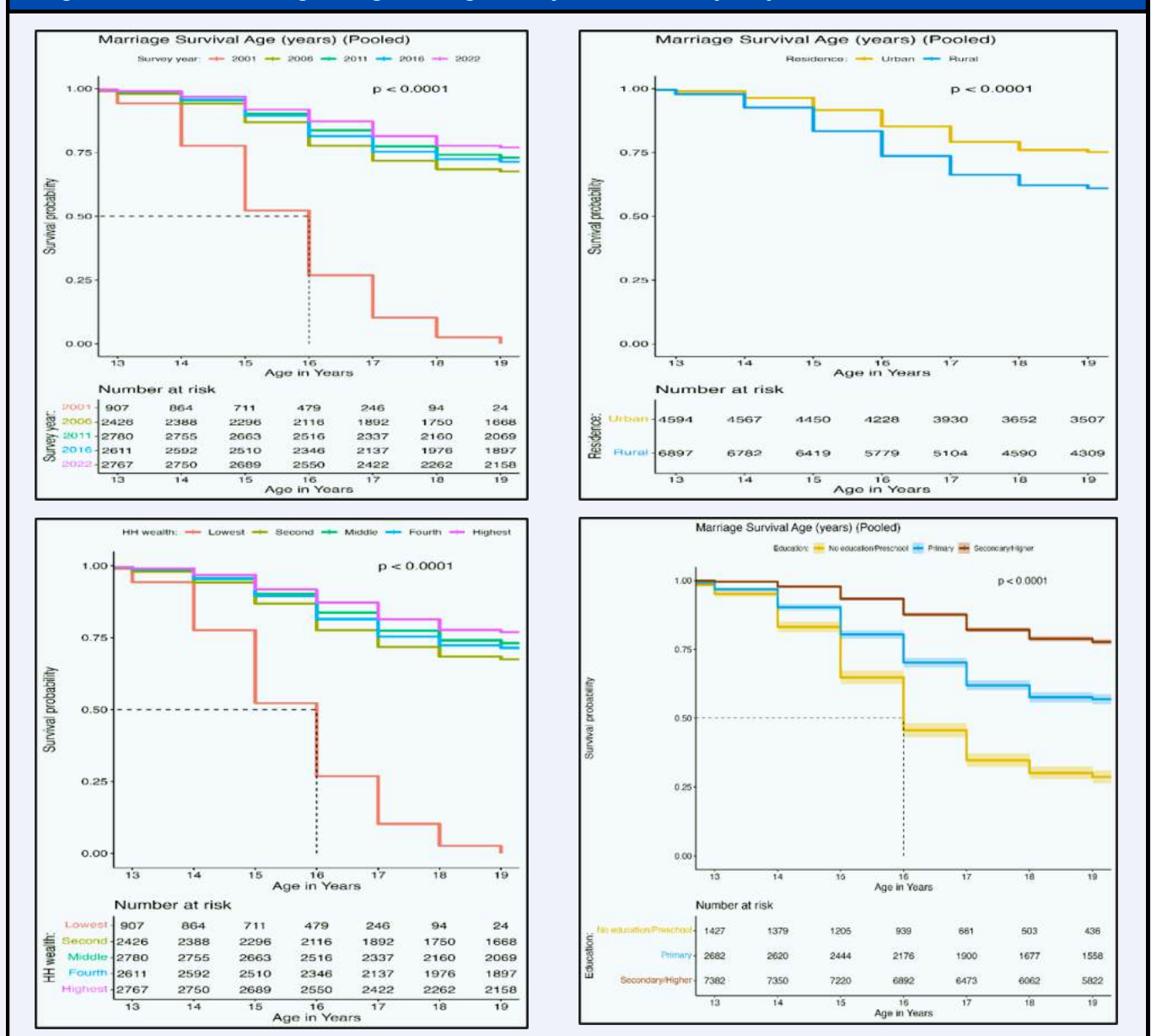
Much of the available data indicate that outside marriage is rarely reported in Nepal. For example, 67% of adolescents in 2006 exited adolescence without sexual debut, compared with 77% in 2022.²

Similarly, higher proportions of adolescents in urban areas than in rural areas (75% versus 61%), those with secondary or higher education than those with no education (77% versus 22%), and those from the wealthiest households compared with those from the lowest wealth quintile (81% versus 63%) exited adolescence without sexual debut between 2006 and 2022.

“Some adolescent girls get married at a young age. However, they don’t become pregnant for the next 4-5 years of marriage since they adopt contraceptives. Some family members are understanding and encourage their young daughter-in-law to continue studying. A senior girl in our school continued her education for three years after getting married.”

- Adolescent girl, 15-19 years, Bulintar rural municipality

Figure 5: Time to first marriage among women aged 15-19 years: event history analysis

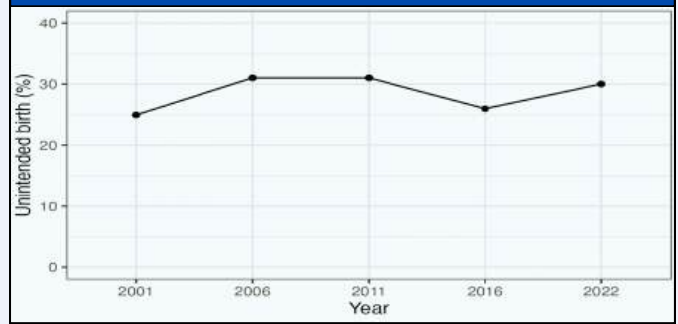


Unintended Birth in Adolescence

In Nepal, unintended birth remains an aspect of ASRHR that requires further improvement. The proportion of unintended births ranged between 25% in 2001 and 31% in 2022 (Figure 6).

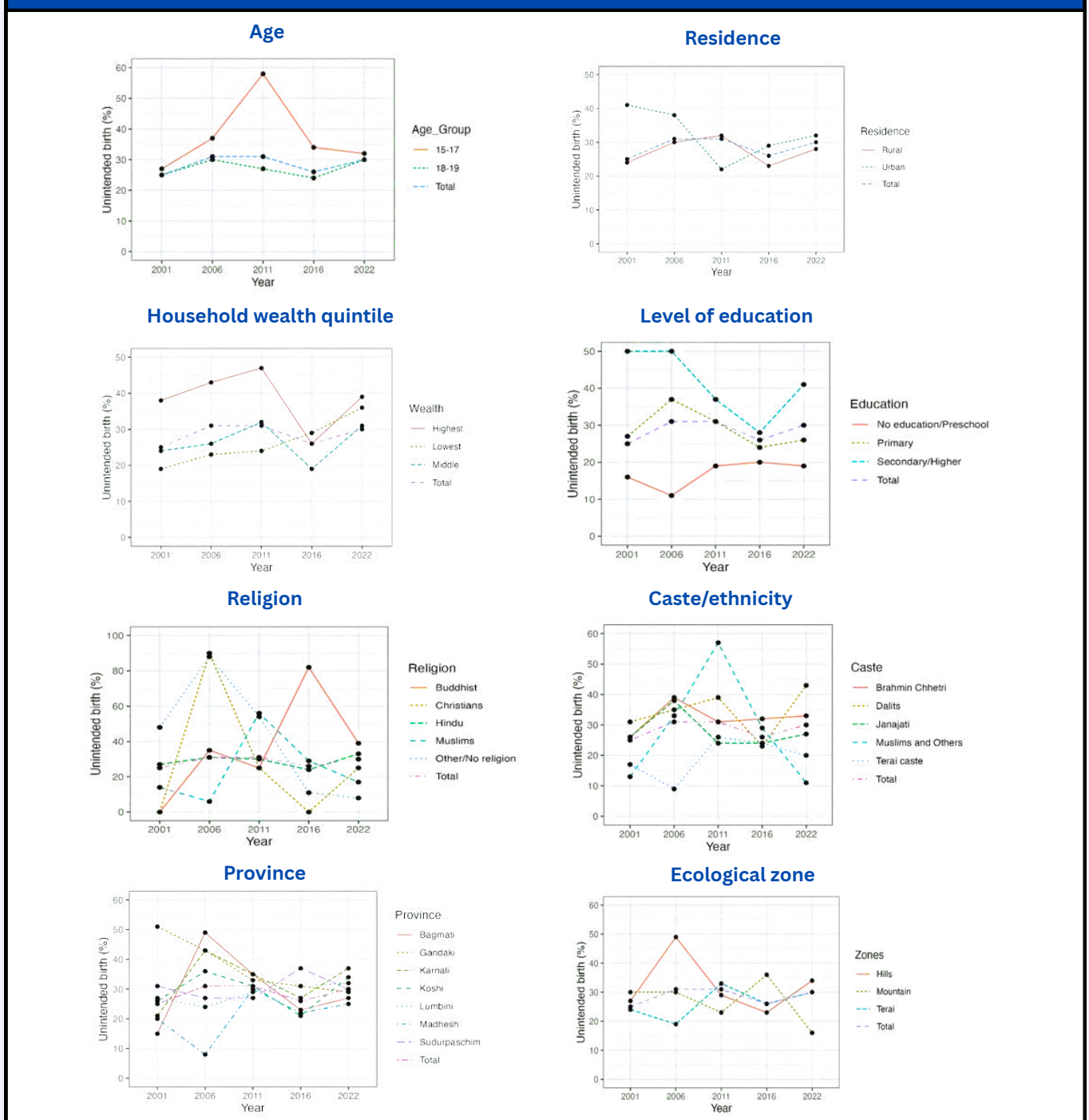
Younger adolescents in the 2022 cohort reported a lower percentage of unintended births (36%) compared with the 2011 cohort (55%). Respondents from the wealthiest households reported the highest proportion of unintended births, at approximately 40%. By place of residence, a higher percentage of urban than rural respondents reported unintended births in 2022 (32% versus 28%). Moreover, respondents with secondary education or higher reported the highest proportion of unintended births (38%). Disaggregation by religion

Figure 6: Unintended birth in adolescents aged 15-19 years



indicates that unintended births among adolescents of the Buddhist tradition were relatively high in 2022 (40%). By province, Gandaki recorded the highest proportion of unintended births in 2022 (37%), while Madhesh recorded the lowest (22%) (Figure 7).

Figure 7: Unintended births in adolescents (ages 15-19 years), by selected demographic characteristics



Although some associations between unintended births and selected background characteristics were observed in descriptive analyses, most of these associations were not statistically significant in multivariate regression analysis. For example, odds of unintended births were

not significantly different in 2022 compared with 2006. Similarly, there were no statistically significant differences in the odds of unintended births among Brahmins compared with other caste groups (Table 2).

Table 2: Determinants of unintended births among adolescents (ages 15-19 years)

	COR	aOR (95% CI)		COR	aOR (95% CI)
Year			Wealth Quintile		
2022 (Ref)	1.00	1.00	Highest (Ref)	1.00	1.00
2006	1.05 (0.68, 1.63)	0.44 (0.76, 1.87)	Lowest	0.57 (0.34, 0.97)*	0.236 (0.35, 1.29)
2011	1.04 (0.67, 1.62)	0.69 (0.69, 1.76)	Second	0.51 (0.30, 0.86)*	0.23 (0.39, 1.25)
2016	0.8 (0.54, 1.18)	0.19 (0.49, 1.15)	Middle	0.52 (0.31, 0.89)*	0.446 (0.46, 1.41)
Age group			Education level		
18-19 (Ref)	1.00	1.00	Secondary/Higher (Ref)	1.00	1.00
15-17	1.76 (1.22, 2.54)**	0.01 (1.13, 2.38)**	No education/Preschool	0.33 (0.21, 0.51)**	0.0 (0.18, 0.52)**
Residence			Caste/Ethnicity		
Urban (Ref)	1.00	1.00	Brahmin/Chhetri (Ref)	1.00	1.00
Rural	0.92 (0.67, 1.25)	0.63 (0.65, 1.30)	Terai castes	0.47 (0.28, 0.78)**	0.131 (0.34, 1.15)
Province			Dalits		
Bagmati (Ref)	1.00	1.00	Janajati	0.75 (0.51, 1.09)	0.246 (0.50, 1.2)
Koshi	0.78 (0.43, 1.41)	0.52 (0.46, 1.47)	Muslims and others	0.87 (0.44, 1.75)	0.349 (0.68, 2.93)
Madhesh	0.50 (0.27, 0.91)	0.32 (0.32, 1.42)	*Significant at 5% level, **Significant at the 1% level; COR = crude odds ratio; aOR = adjusted odds ratio.		
Gandaki	0.93 (0.50, 1.74)	0.43 (0.41, 1.46)			
Lumbini	0.72 (0.40, 1.28)	0.26 (0.38, 1.3)			
Karnali	1.00 (0.57, 1.77)	0.83 (0.51, 1.7)			
Sudurpashchim	0.77 (0.42, 1.41)	0.46 (0.42, 1.47)	Ecological region		
Ecological region			Terai (Ref)		
Terai (Ref)	1.00	1.00	Mountain	0.98 (0.59, 1.63)	0.64 (0.46, 1.61)
Mountain	0.98 (0.59, 1.63)	0.64 (0.46, 1.61)	Hills	1.39 (1.01, 1.91)*	0.98 (0.64, 1.54)
Hills	1.39 (1.01, 1.91)*	0.98 (0.64, 1.54)			

Decomposition Analysis

Using Demographic and Health Survey (DHS) and Multiple Indicator Cluster Survey (MICS) data, we examined drivers of the reduction in adolescent pregnancy in Nepal between 2006 and 2022. Nepal has a unique profile among ASRHR Exemplar countries, characterized by a low proportion of unpartnered adolescents reporting sexual activity. The analysis involved two components: an Oaxaca–Blinder decomposition analysis and a Cox proportional hazards cohort analysis. The Oaxaca–Blinder decomposition analysis enabled quantification of the contribution of changes in drivers to changes in adolescent pregnancy outcomes between 2006 and 2022. The Cox proportional hazards cohort analysis complemented this approach by better accounting for timing between the onset of drivers and outcomes. The cohort analysis also

enabled assessment of drivers not included in the Oaxaca–Blinder analysis—most notably school attendance and contraception—due to reverse causality, whereby these drivers may be influenced by the outcome. For example, school attendance may cease following childbirth, and postpartum contraceptive use may occur after birth and be supported through post-delivery care.

The Oaxaca–Blinder decomposition analysis showed that marital status, years of education, and sexual activity were the largest drivers of declines in adolescent pregnancy rates between 2006 and 2022. This analysis was limited in that it did not incorporate use of modern contraceptive methods. The cohort analysis extended these findings by incorporating use of modern contraceptive methods, including method type, and school attendance, and demonstrated that these drivers were also critical to reductions in adolescent pregnancy during the period of focus.

Descriptive Results

As a precursor to the decomposition analysis, we examined basic descriptive statistics. Nepal's adolescent pregnancy rate (in the two years prior to interview) declined from 18.0% in 2006 to 12.5% in 2022 (Figure 8). Figure 9 presents these rates among sexually active adolescents by partnership status.

Figure 8: Adolescent pregnancy rate (ages 15-19 years), including terminations, miscarriages, and stillbirths, in the two years prior to the survey, 2006-2022

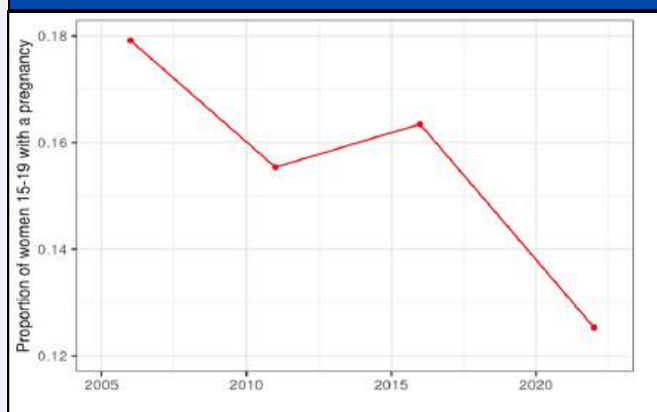
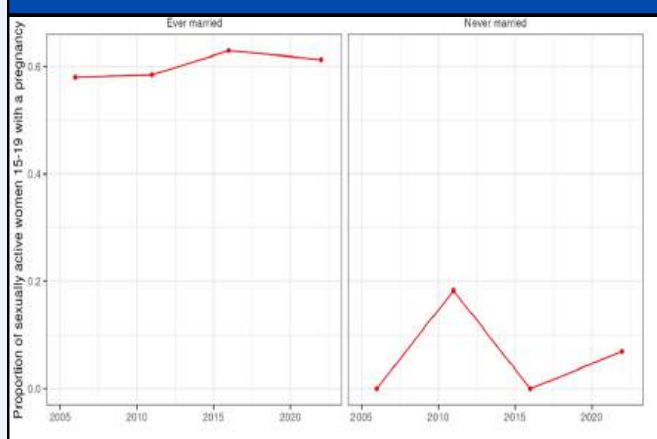
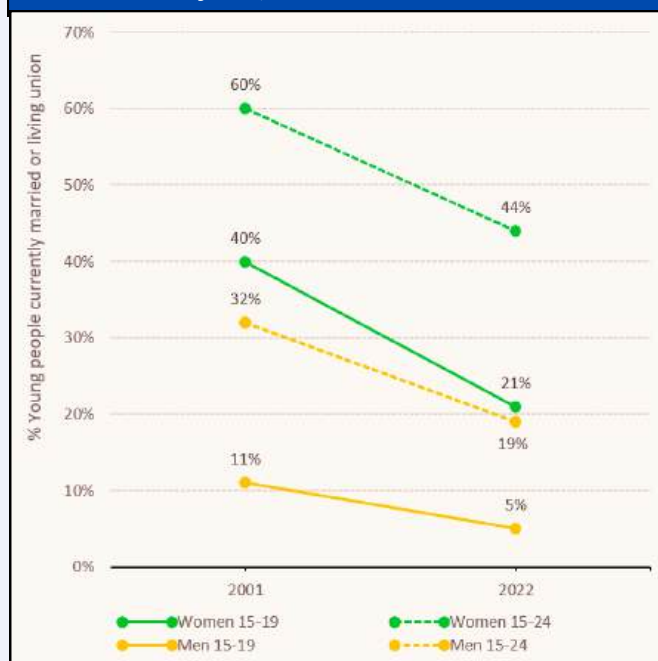


Figure 9: Adolescent pregnancy rate (ages 15-19 years), in the two years prior to the survey, among sexually active adolescents, by partnership status, 2006 - 2022



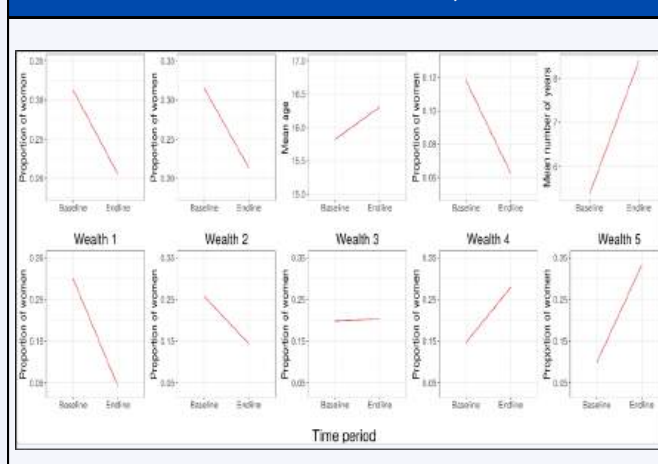
From 2001 to 2022, adolescent marriage in Nepal decreased significantly, declining from 40% to 21% for girls and from 11% to 5% for boys aged 15 to 19 years (Figure 10). Between 2006 and 2022, the proportion of adolescents reporting sexual activity declined from 31.6% to 21.3%. Adolescents who were sexually active reported a slightly higher age at sexual debut in 2022 (16.3 years) compared with 2006 (15.8 years).

Figure 10: Prevalence of marriage among adolescents and youth, 2001-2022

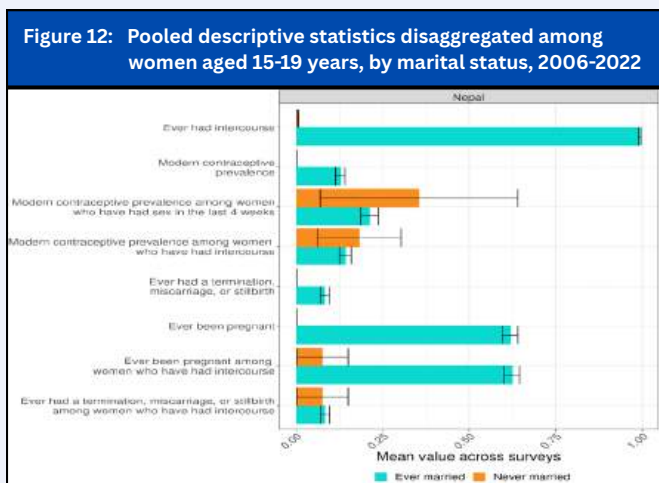


Unmet need for contraception declined from 11.8% in 2006 to 6.2% in 2022. Adolescents attained substantially more education in 2022 (8.4 years on average) compared with 2006 (5.4 years). The standard of living, measured by the distribution of households across wealth quintiles, improved over the same period.

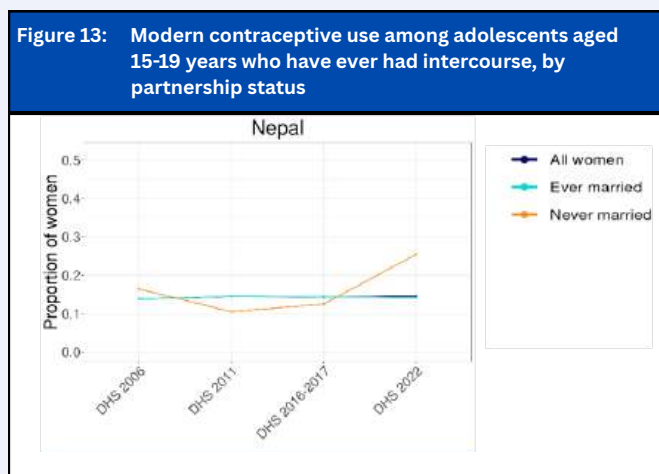
Figure 11: Changes in key drivers of adolescent pregnancy between endline and baseline, 2006-2022



We also assessed elements of contraception, considering both marital status and sexual activity (Figures 12 and 13). Modern contraceptive prevalence among adolescents who had ever been sexually active remained relatively stable between 2006 (13.8%) and 2022 (14.5%) (Figure 12).



As shown in Figure 13, pooled across all years, the percentage of never-married adolescents reporting sexual activity (0.58%), modern contraceptive use (0.09%), and any pregnancy (0.04%) remained very low.

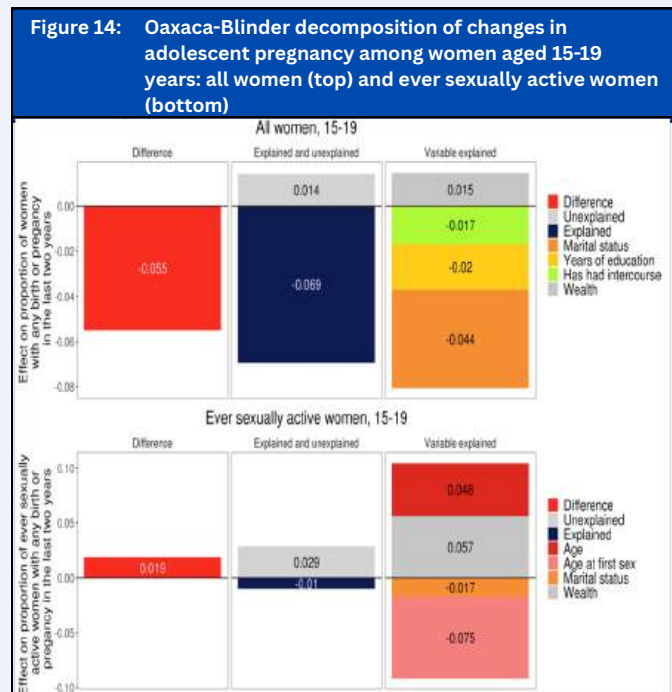


Oaxaca-Blinder Analysis

We conducted Oaxaca-Blinder analyses for all women aged 15-19 years and separately for women aged 15-19 years who reported ever being sexually active. In both analyses, the explanatory variables included age, marital status, years of education, ever having had intercourse, unmet need, and wealth quintile. Variables were selected through a multi-stage process designed to achieve parsimony and avoid bias. Covariates were excluded if they were not available in both baseline and endline datasets, introduced bias due to reverse causality, or were not statistically significant in any version of the results across countries included in the Exemplars in ASRHR project.

In the analysis of all women aged 15-19 (top panel in Figure 15), the proportion of women with any birth or pregnancy in the two years prior to the survey declined by 0.055 between 2006 and 2022, represented by the size and direction of the red bar. In the middle column, the navy bar represents the portion of this change attributable to the explanatory variables. In the third column, the contribution of each variable is disaggregated as the proportion explained by changes in the outcome multiplied by the coefficients estimated in the regression analysis underpinning the Oaxaca-Blinder decomposition. The bars in the third column do not sum to the total explained difference represented by the navy bar because only variables that were statistically significant at the 95% confidence level ($p < 0.05$) are shown. Overall, delaying marriage showed the largest association with changes in adolescent pregnancy, followed by years of education, sexual activity, and wealth.

In the bottom panel of Figure 14, focusing on women who had ever had intercourse, a smaller proportion of the change in adolescent fertility was explained by the selected explanatory variables compared with the full sample. Age at first sex was the strongest explanatory factor, followed by wealth, age, and marital status. Nepal's Oaxaca-Blinder results among sexually active adolescents were distinctive due to the very low prevalence of sexual activity among unpartnered adolescents.



The exclusion of certain explanatory variables due to mismatches between timing of drivers and outcomes—particularly school attendance and contraception—limited interpretation of findings related to contraceptive use, fertility preferences, and characteristics of contraceptive provision and motivated the cohort analysis presented in the following section.

Cohort Analysis

The cohort analysis followed adolescent women longitudinally from ages 15 to 19 years and estimated associations between explanatory variables and first pregnancy. This approach accounted for mismatches in timing between outcomes and drivers by specifying whether the onset of drivers occurred before pregnancy. Most importantly, using data from the DHS contraceptive calendar, the analysis captured contraceptive use prior to pregnancy. Findings from the cohort analysis emphasized the same drivers identified in the Oaxaca–Blinder analysis—marital status, sexual activity, and education (Figure 15). Improved measurement of education highlighted the role of completing secondary education, achieved by keeping adolescents in school. Contraceptive use, particularly long-acting methods, also emerged as a critical driver in preventing adolescent pregnancy.

Figure 15: Coefficients and hazards ratios from Cox proportional hazards regression of time to first pregnancy among women aged 15-19

	Variable	Coefficient	Hazards Ratio
Time-Fixed	Urban	0.097*	1.10*
	Education of HH head (yrs)	0.010*	1.01*
	Beating is justified	0.173*	1.19*
	Household Wealth quintile		
	1st quintile (poorest)	Reference	1
	2 nd quintile	0.262*	1.30*
	3 rd quintile	0.277*	1.32*
	4 th quintile	0.314*	1.37*
Time-Varying	5th quintile (richest)	0.209*	1.23*
	Marital status	2.51*	12.27*
	Ever had intercourse	18.60*	>1000*
	Contraceptive Use		
	No method	Reference	1
	Traditional	-1.93*	0.145*
	Modern short-acting	-2.83*	0.059*
	Modern long-acting	-20.48*	<.0001*
	Education		
	Not attending: less than secondary	Reference	1
	Not attending: completed secondary	-0.108	0.898
Currently attending	-0.249*	0.780*	

*Statistically significant ($p < 0.05$)

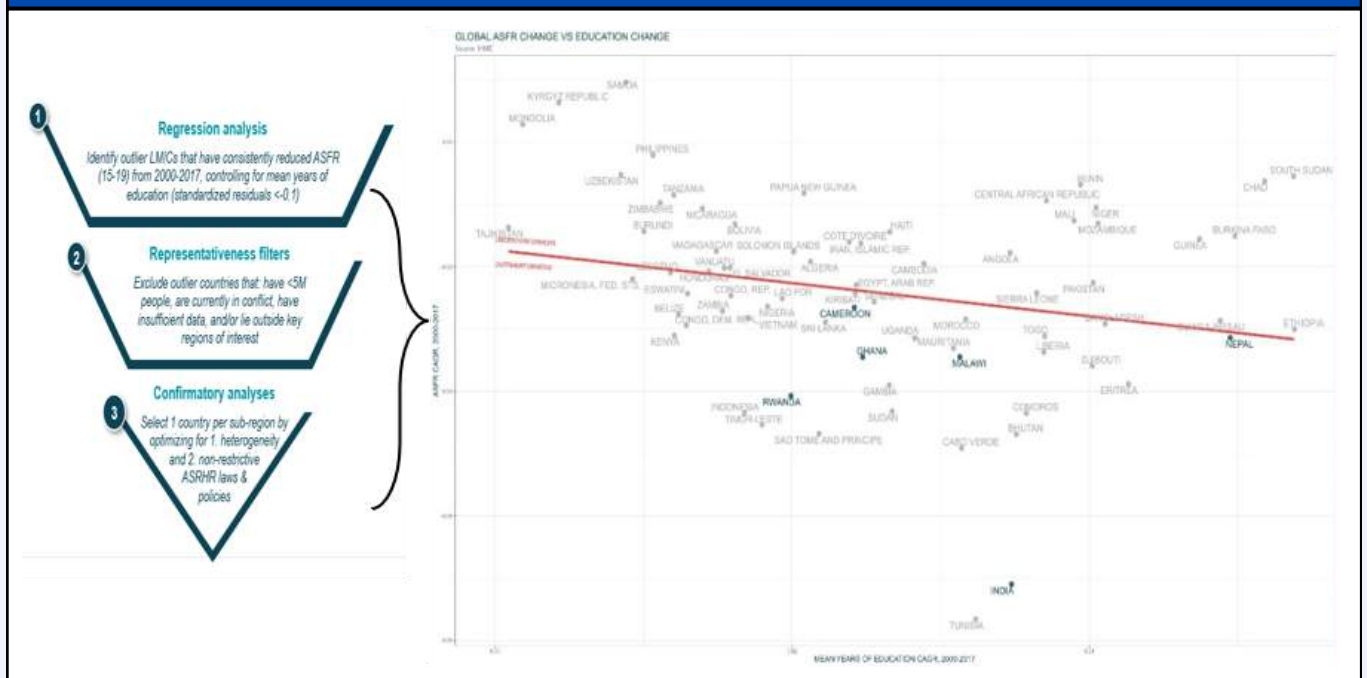
WHY IS NEPAL AN EXEMPLAR COUNTRY?

The Exemplars in Global Health (EGH) initiative identifies a relevant and practical health outcome for each topic area through consultations with subject matter experts and funding partners. EGH then selects Exemplar countries based on changes in the identified health outcome, while controlling for relevant economic measures such as gross domestic product (GDP), gross national income (GNI), or program-specific expenditures. For the Exemplars in ASRHR project, countries were selected from the World Bank’s list of low- and lower-middle-income countries (LLMICs) for 2021, with prior exclusion of countries known to be in conflict or with small population sizes (i.e., fewer than 5 million people) at the time of selection. Countries excluded due to conflict included Afghanistan, Myanmar, Yemen, Palestine, North Korea, Syria, Somalia, and Ukraine. Island countries such as Timor -Leste, Cabo Verde, and São Tomé and Príncipe were excluded due to small populations. Adolescent fertility, or the age-specific fertility rate (ASFR), defined as births per 1,000 adolescents aged 15–19 years, was identified as the outcome variable. Adolescent fertility was selected over unintended teenage pregnancy due to the availability of comparable data across all LLMICs. A linear regression

model using the compound annual growth rate (CAGR) of ASFR among adolescents aged 15–19 as the outcome variable, and CAGR of mean years of education as a control variable, was employed to select countries for the Exemplars in ASRHR project. Data for outcome and predictor variables were sourced from the Institute for Health Metrics and Evaluation (IHME) for the years 2000 to 2017. Mean years of education was selected over other potential predictors—such as GDP, GNI, human development index (HDI), and poverty rate—because it demonstrated higher explanatory power.

Countries with standardized residuals less than or equal to -0.1 were subjected to further scrutiny based on abortion laws, population size, fragility, and data availability and quality. This process produced a shortlist of countries for each geographical sub-region. At this stage, countries were selected to ensure geographical representativeness. India and Nepal were selected to represent South Asia. India had the highest residuals in the region (and globally). Nepal was selected because, in addition to being a positive outlier, it has a unique safe abortion context that provided a rich opportunity for study and for generating lessons applicable to other LLMICs.

Figure 16: Analytical approach ASRHR Exemplar country selection



Key Points

- Nepal has experienced substantial population and economic growth between 2001 and 2022 and introduced several policies, strategies, and interventions to improve overall population health, including adolescent health.
- The country observed a large reduction in adolescent fertility between 2001 and 2022, declining from 110 births per 1,000 women in 2001¹ to 71 births per 1,000 women in 2022² among adolescents aged 15–19 years, while the total fertility rate decreased by half from 4.0 to 2.0 births per woman. Additionally, adolescent maternal mortality in Nepal decreased from 253 deaths per 100,000 live births in 2000 to 152 in 2021, significantly below the global average of 192.⁷
- Nepal has made persistent efforts to prevent and manage adolescents’ unintended pregnancies at both normative and programmatic levels. While normative frameworks were critical in establishing concepts and systems to empower adolescents in reproductive decision-making—including delaying early marriage and reducing unsafe sexual interactions—and ensuring the availability of SRHR services, programmatic initiatives played a substantial role in translating these frameworks into practice.
- In recent decades, Nepal has experienced major events affecting both adolescents and the wider population, including the civil war from 1996 to 2006, the 2015 earthquake, and the promulgation of a new constitution in 2015 that established a federal structure with three tiers of government.

Political and Economic

Nepal is a landlocked country with a population of approximately 29.1 million, sharing borders with China to the north and India to the south, east, and west. Since 2001, Nepal has undergone significant political transformation. Major events affecting both adolescent girls and the broader population include the civil war from 1996 to 2006, the 2015 earthquake, and the COVID-19 pandemic from 2019 to 2021.

The armed conflict initiated in 1996 by the Communist Party of Nepal (Maoist) against the state led to a guerrilla-style confrontation, resulting in displacement and casualties. Approximately 13,000 people were killed and 200,000 displaced, representing about 1% of the population.⁸

Figure 18: Reproductive health expenditure, \$M USD (IHME)

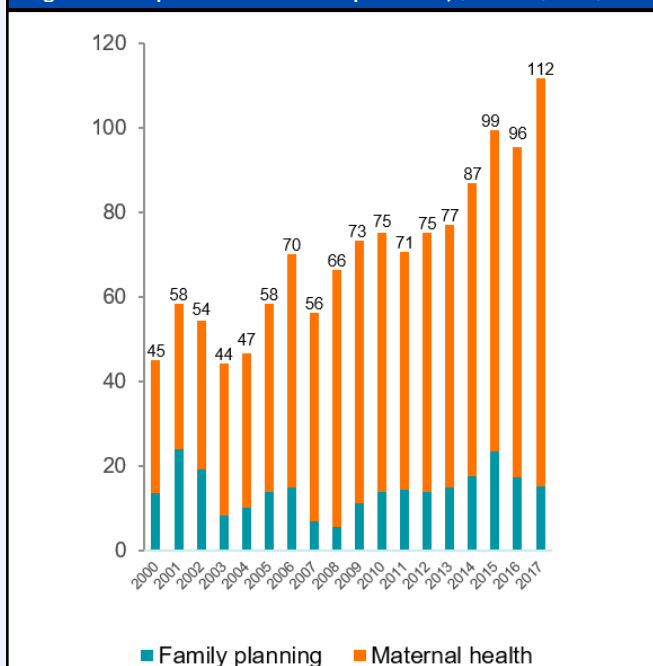
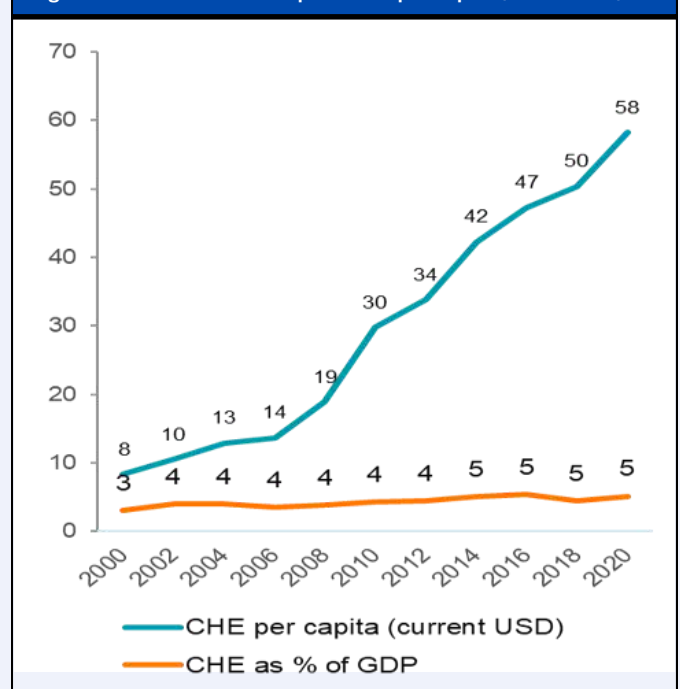


Figure 17: Current health expenditure per capita (World Bank)



The ideological nature of the Maoist insurgency contributed to the participation of a substantial number of female combatants, with reports suggesting that up to one-third were women.⁹ A peace agreement was reached in November 2006, followed by the election of a constitutional assembly in 2013. However, the 2013 assembly failed to draft a new constitution, leading to a second election in 2015 that culminated in the promulgation of Nepal’s current constitution. Under this constitution, national elections for the House of Representatives were held in 2017 and 2022.

Nepal’s gross domestic product increased from USD 6.01 billion in 2001 to USD 40.83 billion in 2022, reflecting an average annual growth rate of 3.8%.

Although Nepal's HDI score has steadily improved since 1990—advancing from the low to the medium human development category in 2016—the country ranked 143rd globally in 2021 and remained behind most South Asian countries. Nepal ranked ahead of Afghanistan and Pakistan but below the South Asian regional average HDI of 0.632. Between 1990 and 2021, Nepal's HDI value increased from 0.399 to 0.602, representing a 50.9% increase.¹⁰ During this period, life expectancy at birth rose by 13.6 years, mean years of schooling increased by 2.8 years, and expected years of schooling increased by 5.4 years. Nepal's GNI per capita increased by approximately 146% over the same period.¹⁰

With rising GDP, healthcare expenditure has increased steadily. Reproductive health expenditure has also risen, driven largely by maternal health investments. While maternal health spending increased over time, family planning expenditures remained relatively stable (Figures 17 and 18).

Nepal's life expectancy at birth is comparable to, or slightly higher than, the South Asian average. However, Nepal lags behind the regional average in mean years of education for adults (4.9 years in Nepal versus 6.4 years regionally). Similarly, average per capita income (PPP) in South Asia is USD 6,473, while Nepal's stands at USD 2,748, placing it just ahead of Afghanistan. Development outcomes are unevenly distributed across the country. In 2019, Bagmati Province (home to the national capital) recorded the highest HDI (0.66), followed by Gandaki Province (0.62). Madhesh Province recorded the lowest HDI (0.51), followed by Karnali Province (0.538). Among ecological regions, the hills outperform mountain areas and the Tarai, and urban areas have higher HDI scores than rural areas.¹¹

Despite being a lower-middle-income country, Nepal achieved a significant milestone by halving the proportion of the population living below the poverty line over the past two decades, declining from 38% in 2001 to 18.6% in 2021 (poverty ratio 8.2).¹²⁻¹⁴ However, persistent economic challenges remain, including heavy reliance on agriculture, a fragile social protection system, climate change impacts, natural disasters, and low rates of school continuation beyond grade 8. The 2015 earthquake resulted in approximately 9,000 deaths and pushed an additional 3% of the population into poverty.¹⁵ From 2019 to 2021, COVID-19 caused 12,031 deaths.

A substantial share of Nepal's labor force participates in overseas employment, with Nepali workers present in more than 100 countries worldwide. While remittances are a critical source of national income, the absentee population represents a significant demographic shift. The number of overseas workers increased from 0.76 million in 2001 to 2.2 million in 2021. Migration has had broad implications for human development outcomes, including health, food security, education, and overall living standards.

Demographic

Decreasing fertility rates, increasing life expectancy at birth, high levels of internal and external migration, a growing proportion of older adults, and an uneven distribution of the population have wide-ranging implications for economic productivity, resource distribution, and health and well-being in Nepal. The current annual population growth rate stands at less than one percent (0.93%), compared to 2.25% in 2011. The number of districts with a negative population growth rate increased from zero in 2001 to 32 in 2021. Average household size declined from 5.4 in 2001 to 4.3 in 2021. Nepal's population is highly diverse, comprising 142 ethnic and caste groups, with Brahman Chhetri and Brahmin being the predominant castes.¹⁶ The country has 124 mother languages, with Hinduism as the predominant religion (81.2%), followed by Buddhism (8.2%). The estimated disability prevalence is 2.2%.¹⁶

According to the Population Census 2021, adolescents aged 10–19 years constitute approximately 20% of Nepal's total population. The proportion of adolescents who are married exceeds the proportion who have begun childbearing, and both have declined at similar rates, suggesting that adolescent fertility may be driven largely by early marriage (Figure 19).

The median age at first marriage increased from 16.7 years in 2001 to 18.3 years in 2022, with a three-year difference between males and females (21 years for males and 18 years for females). Overall, 14% of women aged 15–19 years in 2022 had ever been pregnant, compared with 21% in 2001, indicating notable progress over time. The median age at first birth also increased from 19.9 years in 2001 to 20.6 years in 2022. Likewise, the age-specific fertility rate among women aged 15–19 years declined from 110 births per 1,000 women in 2001¹ to 71 per 1,000 women in 2021². However, approximately one in three pregnancies among adolescents aged 15–19 years are unintended, and nearly half of these unintended pregnancies end in abortion.^{17-19, 2}

Figure 19: Marital and childbearing status, women ages 15-19 (DHS)

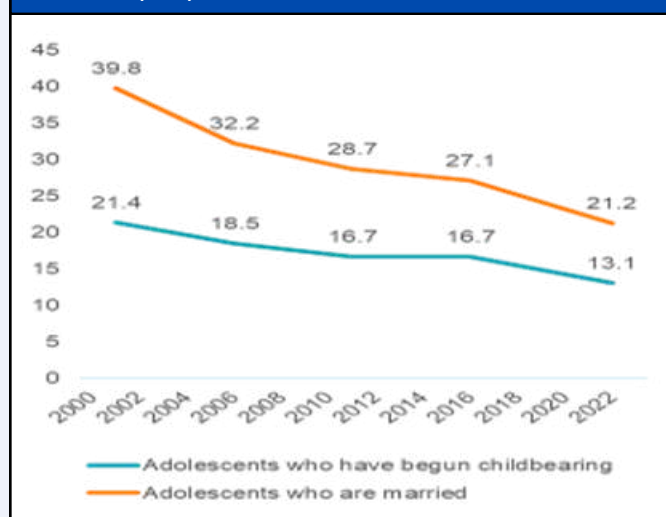
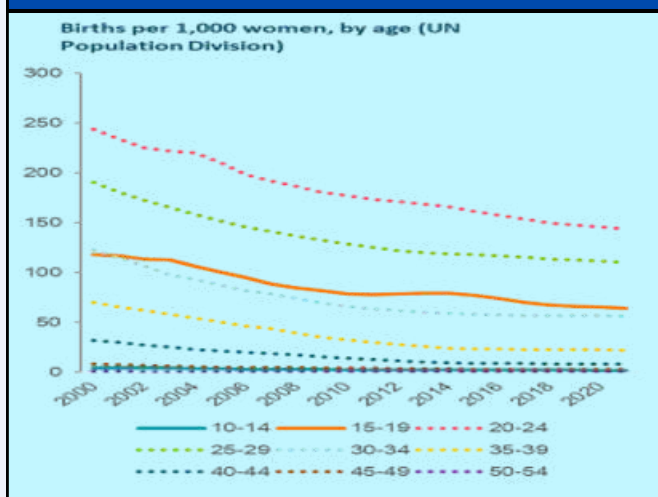


Table 3: Unintended pregnancy, abortion, and marriage (2002-2022)

	Prior	Recent
Abortion legality index	-	100 (2019)
Proportion of pregnancies that are intended	-	30%
Number of unintended pregnancies ages 15-19	-	44.9k (2017)
Number of induced abortions, ages 15-19	-	21.2k (2017)
Median age at first sex	16.7 (2001)	18.3 (2022)
Median age at first marriage	16.7 (2001)	18.3 (2022)
Median age at first birth	19.9 (2001)	20.6 (2022)

Despite progress in fertility reduction, Nepal has made limited progress in preventing violence against women and girls. Experience of any form of violence (physical, sexual, or emotional) among ever-married adolescent women was reported at 23.1%, including 9.1% physical violence and 2.0% sexual violence in 2022, with little improvement over time. Violence during pregnancy was also more common among adolescent mothers compared with women in older age groups.²

Figure 20: Adolescent's birth (2000-2020)



Despite sustained efforts to promote family planning use, uptake of modern contraceptive methods among adolescents aged 15–19 years has not improved. Unmet need declined gradually from 12.9% in 2006 to 9.6% in 2016. At the same time, use of traditional methods (withdrawal and abstinence) increased, while use of modern contraceptive methods declined over time.²

Figure 21: Percentage of women ages 15-19 experiencing violence in past 12 months

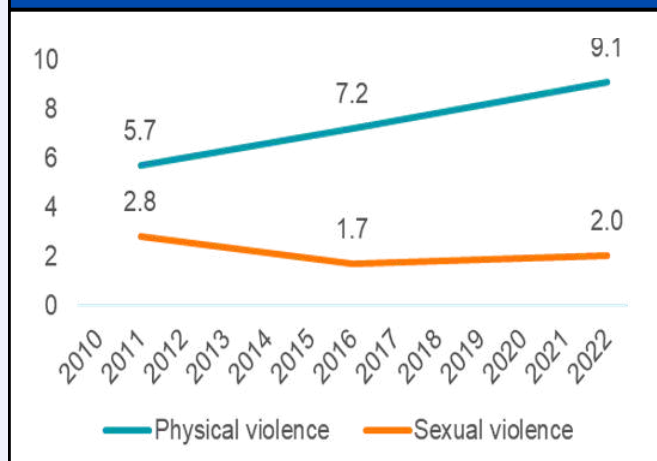


Figure 22: Demand and current use of contraception of ages 15-19

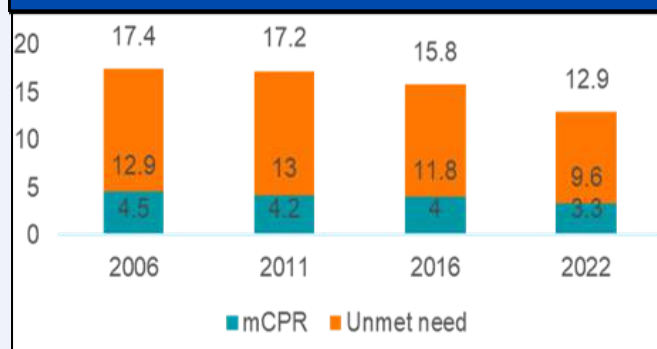


Table 4: Current use of contraception- method mix among adolescent aged

Type of contraception used	2006	2011	2016	2022
Withdrawal	0.6	0.7	2.1	2.5
Injections	1.8	1.4	1.5	1.4
Condom	1.9	1.9	1.2	1.1
Abstinence	0.1	0.3	0.3	0.5
Pill	0.5	0.8	0.6	0.4
Implants	0.1	0	0.6	0.3
IUD	0.1	0	0.1	0

Health System and Infrastructure

Following adoption of the National Health Policy in 1991, Nepal’s healthcare sector experienced notable expansion in both public and private domains. Over the past two decades, the number of public health facilities—including hospitals, primary healthcare centers, health posts, and other facilities—increased from approximately 3,424 in 2001 to about 4,300 in 2021, representing a 25% increase. This expansion reflects government efforts to improve access to basic healthcare services, particularly in rural areas.

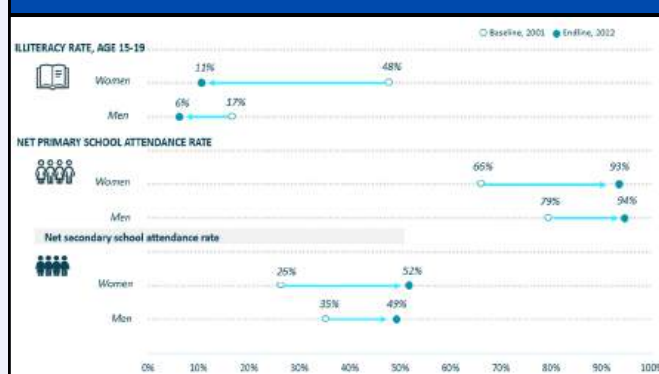
Following federalization in 2015, health service delivery responsibilities were distributed across three levels of government. The federal government is mandated to operate national and specialized hospitals, provincial governments oversee provincial-level hospitals, and local governments are responsible for managing basic hospitals and basic healthcare centers. In addition to service provision, all three levels of government implement public health programs and interventions. These structures and defined roles form the basis for implementation of strategic plans across levels.

The Government of Nepal has recognized the importance of addressing adolescents’ specific healthcare needs and has implemented initiatives to provide comprehensive adolescent health services. Through national health policies and programs, adolescent health has been prioritized as a key component of the public health agenda. One major initiative is the implementation of adolescent-friendly health services (AFHS) beginning in 2010, which expanded to more than 1,300 health facilities nationwide. AFHS aims to create supportive and non-judgmental environments where adolescents can access a range of services tailored to their needs, including sexual and reproductive health services, mental health support, nutrition counseling, and substance use prevention. Adolescent health education has also been integrated into school curricula (as an optional subject) and community outreach programs to promote health awareness and support informed decision-making. Continued investment in healthcare infrastructure, human resources, and financing—along with effective policy implementation and community engagement—remains essential to achieving universal health coverage and improving health outcomes for adolescents in Nepal.

Education

Between 2001 and 2022, Nepal experienced significant developments in its education sector, reflecting sustained efforts to expand access and improve quality nationwide. Key policies implemented during this period included the Education for All National Plan of Action and the School Sector Reform Program, which prioritized increasing enrollment—particularly among marginalized communities and disadvantaged regions—through free and compulsory education up to the secondary level. Additional efforts focused on improving education quality through curriculum reform, teacher training, and infrastructure development.

Figure 23: Progress towards closing gender gaps in education, 2001-2022



Further, outreach centers and bridge programs in Nepal have supported the reintegration of out-of-school youth, particularly girls, into formal education through sector-wide reforms and flexible pathways. Since the early 2000s, Community Learning Centers have served as local non-formal and lifelong learning hubs, resulting in the establishment of 2,151 centers across all local governments by 2019. Partnerships with international organizations and non-governmental entities supported these initiatives by providing resources, technical expertise, and innovative approaches to address systemic challenges. Median years of education among female adolescents aged 15–19 increased from 5.5 years in 2006 to 8.5 years in 2022. Secondary-level gross attendance nearly doubled between 2001 and 2022, rising from 42.6% to 81.3% among females and from 57.5% to 84.6% among males, while the median years of schooling completed by women ages 20 to 24 years nearly tripled from 3.6 in 2006 to 9.1 in 2021, compared to an increase from 7.1 to 9.8 for men during the same period.

Table 5: Status of education among adolescent between 2001-2022

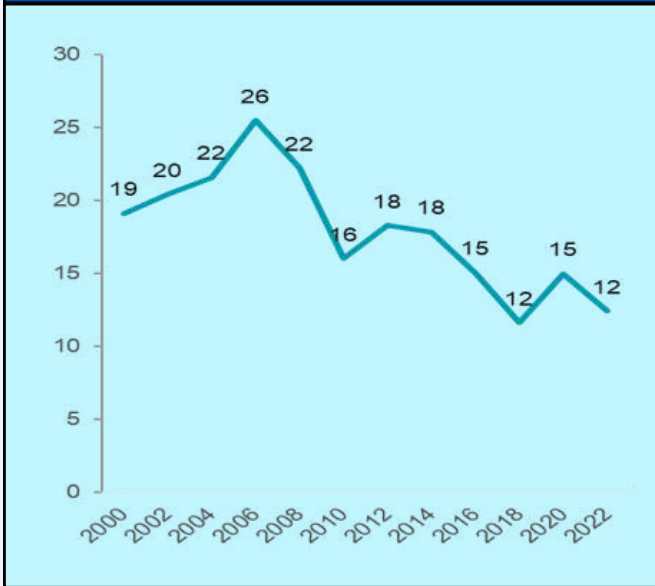
	Prior	Recent
Median year of education completed (Female, 15-19)	5.5 (2006)	8.5 (2022)
Current gross secondary school attendance rate (female)	42.6 (2001)	81.3 (2022)
Current gross secondary school attendance rate (male)	57.5 (2001)	84.6 (2022)

Despite these gains, the education sector continued to face challenges. Persistent issues included reductions in public education spending, inadequate infrastructure, teacher shortages, and unequal access in rural and remote areas. Socio-economic factors such as poverty, child labor, and gender inequality further constrained progress toward universal education. In addition, natural disasters, political instability, the 2015 earthquake, and the COVID-19 pandemic disrupted learning continuity and exacerbated existing disparities over the past two decades.

Purpose of the Study

Despite these challenges, Nepal has made noteworthy progress in addressing adolescent sexual and reproductive health and rights through policies and programs. However, to our knowledge, no systematic and rigorous study had previously documented the factors underlying this progress. Therefore, this study aimed to identify the drivers of change in ASRHR indicators in Nepal. Understanding these factors can inform scale-up of the most impactful interventions within Nepal and support replication of effective strategies in other countries with similar contexts.

Figure 24: Government expenditure on education, % of total expenditure



THE FOUNDATION TO PIVOTAL PROGRAMMING: POLITICAL WILL AND POLICY

Key Points

- Over the past two decades, Nepali policymakers have demonstrated strong political will and commitment to improving sexual and reproductive health and rights for women and girls, supported by sustained investments in education and healthcare.
- Nepal has also demonstrated ongoing commitment to international human rights treaties that protect women's and adolescents' rights, including the right to health and access to sexual and reproductive health information and services, such as the Convention on the Elimination of All Forms of Discrimination against Women and the Convention on the Rights of the Child.
- Nepal's 2015 Constitution recognized basic healthcare and gender equity as fundamental rights and reinforced these commitments through multiple acts, policies, and strategies.

Progress achieved through policies and programs addressing ASRHR needs in Nepal has been noteworthy over the past twenty years, and available data show clear gains despite ongoing challenges. At the heart of this progress is the government's sustained commitment to providing a comprehensive package of reproductive health services and prioritizing adolescent sexual and reproductive health as a key programmatic focus.

This commitment was translated into coordinated policy and programmatic actions, including expansion of national family planning programs, policy support for girls' education, legalization and free provision of safe abortion services, scale-up of adolescent-friendly health services, and integration of comprehensive sexuality education into the school curriculum. To support implementation, national AFHS standards and action plans were developed, and the Nepal Health Sector Program II Implementation Plan (2010–2015) set a target of introducing 1,000 AFHS within the public health system by 2015, resulting in coverage of approximately 25% of government health facilities. Together, government- and partner -led interventions reflect a strong health systems approach to addressing adolescents' comprehensive healthcare needs.

This domestic policy and programmatic progress were reinforced by Nepal's engagement with global commitments, laws, and development frameworks related to ASRHR, which helped align national priorities with broader population and development goals. Through these national and international commitments, Nepal has set targets, enacted laws and policies, and achieved measurable results in reducing adolescent pregnancy and early childbearing.

In particular, Nepal's alignment with international human rights obligations and global development agendas has supported sustained attention to adolescent health. The country has demonstrated this commitment through approval of key international instruments, including:

- Convention on the Elimination of All Forms of Discrimination against Women (CEDAW Convention)
- Convention on the Rights of the Child (CRC)
- International Conference on Population and Development (ICPD), 1994
- Millennium Development Goals (MDGs), 2000
- Sustainable Development Goals (SDGs)

Nepal was among the countries that adopted the ICPD Program of Action in 1994 in support of developing global policy actions to achieve gender equality and women's empowerment. Similarly, as a signatory to the Millennium Development Goals, Nepal aligned national policies, strategies, and plans to achieve MDG targets, including partial achievement of Indicator 5B (Universal Access to Reproductive Health). This progress included a reduction in the adolescent fertility rate from 119 births per 1,000 girls aged 15–19 in 2000 to 66 births per 1,000 in 2014.²⁰ In the 2010 MDG Progress Report, the Government of Nepal highlighted the importance of providing adolescents with knowledge and information on sexual and reproductive health, including a recommendation to integrate adolescent health into school curricula, as outlined in the National Adolescent Health and Development Strategy.²⁰

Global action continues as Nepal has committed to achieving the United Nations Global Agenda articulated through the Sustainable Development Goals 2030.²¹ According to SDG Indicator 3.7.2, Nepal committed to reducing the adolescent birth rate to 30 births per 1,000 women by 2030. As reported in the SDG Progress Assessment Report (2016–2019), the adolescent birth rate stood at 63 per 1,000 women, approaching the interim target of 56 per 1,000 women set for 2019.

I. Constitutional and Legislative Actions in ASRHR

During a period of political unrest and instability between 2000 and 2022, Nepal was governed by three constitutions: the Constitution of the Kingdom of Nepal (1990), the Interim Constitution of Nepal (2007), and the Constitution of Nepal (2015). These constitutions included the following provisions:

In 1990, the Constitution enabled advancement of women's participation in national development through provisions related to education, health, and employment. Although broadly framed, the 1990 Constitution laid the foundation for engagement with state policy systems to introduce legislative measures in education and health for protection and advancement of women and children.

In 2007, the Interim Constitution marked progress by recognizing children's rights and women's reproductive rights as fundamental rights. This recognition supported advocacy through public interest litigation, contributing to strengthened systems addressing child marriage and improving availability and accessibility of reproductive health services, particularly access to family planning services for adolescents.

In 2015, Nepal's current Constitution adopted the strongest commitment to women's reproductive rights and children's rights among the three constitutions. It guarantees safe motherhood and reproductive rights, as well as children's rights, as fundamental rights. This constitution broadened national laws and policies to include sexual and reproductive health and rights, education, gender equality, and youth rights within a human right-based approach. It also provided a strong normative framework for UN agencies, external development partners, and national and international organizations to initiate and strengthen programmatic interventions aimed at empowering women and adolescent girls. These provisions enabled increased advocacy and awareness regarding the consequences of early pregnancy among adolescents and their parents. In addition, the Constitution explicitly prohibits child marriage as a punishable offense and protects children from physical, mental, and other forms of harm.²²

II. Major Acts and Codes

Significant progress in advancing sexual and reproductive health and rights has been achieved through three key acts and codes, including:

- Muluki Ain (Penal Code), 2002, which legalized abortion and affirmed Nepalese women's rights to make decisions regarding fertility choices.
- Act Relating to Children, 2075 (2018), which broadened the scope of child rights in Nepal to support progress and advocacy in education, health, and overall development.
- In 2002, the legal age of marriage was increased to 20 years, provided parental consent was obtained. However, the Nepal Civil Code (2017) abolished the provision for parental consent and established 20 years as the legal minimum age of marriage.

However, the act that arguably made the greatest contribution to reducing adolescent fertility at the national level is the Safe Motherhood and Reproductive Health Rights Act (2018). The SMRHR Act and its accompanying regulations (2020) sought to guarantee, safeguard, and enhance women's reproductive health rights across all levels of government—federal, provincial, and local—through legislation as well as earmarked budgets for reproductive health services. The Safe Motherhood Act not only establishes the right of every individual to access information, counseling, and services related to reproductive health but also mandates that all safe abortion services be provided free of charge at government health facilities. Since 2020, telemedicine and self-care for medical abortion have been facilitated by additional reforms, which have also incorporated abortion as a fundamental element of ASRHR.

III. Key Strategies and Guidelines

Among Nepal's efforts toward identifying feasible, comprehensive, and sustainable solutions in adolescent sexual and reproductive health, the country recognized the importance of alignment with and acknowledgment by the Millennium Development Goals. The MDGs served as a guiding framework for key initiatives, including the National Adolescent Health and Development Strategy (NAHDS, 2008), National Strategy on Family Planning (2008), Adolescent Sexual and Reproductive Health Implementation Guidelines (2008), National Plan of Action on the Holistic Development of Adolescents (2013), and the Health Sector Program Implementation Plan (2010–2015).

The journey toward strategic approaches to reducing adolescent fertility was firmly established in 2000, when the Government of Nepal adopted the NAHDS. The strategy articulated three main objectives, including:

- Increasing availability and accessibility of information on adolescent health and development, and expanding skill-building opportunities for adolescents, service providers, and educators.
- Increasing accessibility and utilization of health and counseling services for adolescents.
- Creating a safe and supportive environment to improve the legal, social, and economic status of adolescents.

Despite challenges related to limited resources, retention of skilled personnel, and shifts in political context, NAHDS was acknowledged by the MDGs Status Report of the National Planning Commission as the key strategy guiding government and partner efforts to improve Nepal's adolescent health and development programs.²⁰ In particular, the strategy emphasized empowering adolescents with accurate, current, and age-appropriate information and skills to support safe and responsible behaviors and appropriate service-seeking.²⁰

Target populations included adolescents, service providers, parents, educators, policymakers, and the broader community, resulting in development of an information package focused on adolescent health and development, human sexuality, puberty, marriage, reproductive processes, sexual relationships, and responsible parenthood.



In 2008, the National Strategy on Family Planning explicitly acknowledged unmet need for family planning among adolescents as a key challenge. The strategy identified areas for integration with Nepal’s family planning programming and the country’s ongoing adolescent health initiatives,²² which were later reinforced by the Safe Motherhood and Reproductive Health Rights Act (2018), ensuring that reproductive healthcare services are provided free of charge at government health facilities.

Also in 2008, the Adolescent Sexual and Reproductive Health Implementation Guidelines were developed and adopted to support district-level health managers in operationalizing NAHDS. These guidelines—also acknowledged in the MDGs Status Report (2005–2015)—address adolescents’ reproductive rights in the context of access to sexual and reproductive health services and recommend youth-friendly services in health facilities, as well as community-level awareness-raising activities supported by schools and local organizations.²⁰

Abortion was legalized in Nepal in 2002, allowing abortion on request up to 12 weeks of pregnancy and up to 18 weeks in cases of rape or incest. In addition, abortion is permitted at any gestational age if the pregnancy poses a danger to the woman’s life or physical or mental health, or in cases of fetal anomaly.²³ The legalization of abortion marked a significant shift from previously restrictive laws that had led to the prosecution and imprisonment of women and their families for undergoing abortions. This legal reform aimed to address high levels of maternal morbidity and mortality associated with unsafe abortion and led to the establishment of safe abortion services across the country.

The earlier Penal Code was replaced in 2017 by the Muluki Aparadh Sanghita, which retained the same legal provisions related to abortion. In 2018, Parliament passed the Safe Motherhood and Reproductive Health Rights (SMRHR) Act, which guaranteed women’s rights

to legal and safe abortion care on wider grounds. Under the Act, abortion is permitted with the consent of the pregnant woman up to 12 weeks’ gestation and up to 28 weeks in cases of rape or incest, if the woman is living with HIV or another incurable disease, if the pregnancy poses a danger to the woman’s life or physical or mental health, or if there is a fetal anomaly. The SMRHR Act also endorsed the Penal Code by explicitly prohibiting sex determination and abortion on the basis of fetal sex.²⁴

In 2002, the Eleventh Amendment to the National Code increased the marriage age to 20 for both girls and boys, or 18 with parental consent. Further reforms reinforced a rights-based approach: the 2015 Constitution explicitly prohibited child marriage, and in 2017, Civil and Penal Codes were revised to remove the parental consent provision and introduce criminal penalties.

The goal of the National Adolescent Health and Development Strategy 2075 (2018) is to promote adolescent sexual and reproductive health. Guided by the strategy, major activities for fiscal year 2079–80 (2022–23) included expansion of adolescent -friendly health services to more than 1,300 health facilities, of which 287 facilities received certification as adolescent -friendly health facilities by the end of the fiscal year. A total of 26,912 adolescents utilized family planning services, 39,522 utilized antenatal care services, and 5,651 utilized safe abortion services in fiscal year 2079/80 (2022–23).

Regarding reproductive health morbidities, notable developments during the same fiscal year included endorsement of the Cervical Cancer Screening, Prevention and Treatment Guideline 2079 (2022) and the Disability -Friendly Reproductive Health and Safe Motherhood Service Guideline 2022. Alongside implementation of the HPV vaccination program for adolescent girls, cervical cancer screening was conducted among 160,497 women aged 30–49 years (3.4% positivity rate) and 44,794 women aged 50 years and above (2.4% positivity rate). Breast cancer screening was conducted among 30,377 women (1.7% suspected and referred), obstetric fistula screening among 10,324 women (1% suspected), and pelvic organ prolapse screening among 83,056 women (15.9% identified). With support from the Family Welfare Division of the Ministry of Health and Population (MoHP), mechanisms are in place to manage identified cases.²⁵

Aligned with the MDGs, in 2013, to commemorate the second International Day of the Girl Child and to acknowledge the focused attention required to meet adolescents’ development needs, the National Plan of Action (NPA) on the Holistic Development of Adolescents was launched. The NPA emphasized “Innovating for Girls’ Education,” with a focus on health—particularly sexual and reproductive health—alongside development of enabling and protective environments, education and skills, financial empowerment, and gender and social inclusion to support women and girls.

The Health Sector Program Implementation Plan (NHSP) 2010–2015 explicitly identified unmet need for family planning among certain groups, particularly adolescents, as a challenge to overall health sector progress. In promoting adolescents' sexual and reproductive health, the NHSP aimed to increase availability of and access to information on adolescent health and to provide opportunities to build skills among adolescents, service providers, and educators. In addition to these priorities, a key feature of the NHSP was identification of opportunities to scale up the national ASRH program through introduction of adolescent -friendly services, promotion of behavior change communication, targeted engagement of adolescents and their social environments, capacity building, and integration with the Ministry of Education to strengthen comprehensive sexuality education.²⁶

Moreover, adoption of the National Adolescent Health and Development Strategy by the Government of Nepal in 2000 was both a necessary and timely step toward addressing the Millennium Development Goals. The strategy empowered adolescents through provision of accurate, relevant, and age-appropriate information and skills, supporting development and practice of safe and responsible behaviors and encouraging appropriate service-seeking.²⁷ This was complemented by adoption of the 2008 ASRH Implementation Guidelines, which articulated adolescents' reproductive health rights in the context of access to sexual and reproductive health services and called for youth-friendly services at health facilities and community-level awareness -raising activities supported by schools and local organizations.²⁰ These key strategies and action plans ensured expanded access to family planning, contraceptives, and reproductive healthcare for adolescents, thereby contributing directly to reductions in adolescent birth rates. Moreover, improved availability and integration of information at both school and health facility levels supported adolescents in making informed decisions about their sexual and reproductive health.

Ensuring adolescents' access to reproductive health services remains a critical component of efforts to promote adolescent sexual and reproductive health and rights. This involves implementing a range of strategies to make reproductive health services accessible, affordable, and youth-friendly across the country:

- **Youth-friendly services:** Establishing youth-friendly reproductive health services that are tailored to the specific needs and preferences of adolescents. These services are designed to be welcoming, non-judgmental, and sensitive to the unique concerns of young people.
- **Contraception services:** Providing access to a range of contraceptive methods, including condoms, oral contraceptives, and long-acting reversible contraceptives (such as intrauterine devices or implants). Adolescents are educated about their contraceptive options and supported in making informed choices regarding their sexual health and family planning.
- **STI testing and treatment:** Ensuring the availability of confidential and non-stigmatizing STI testing and treatment services for adolescents. This includes screening for sexually transmitted infections (STIs), such as HIV/AIDS, syphilis, and gonorrhea, and providing appropriate treatment and counseling.
- **Comprehensive sexual health education:** Offering comprehensive sexuality education as a curriculum-based process of teaching and learning about the cognitive, emotional, physical, and social aspects of sexuality. This education aims to enable individuals to develop a positive outlook toward sexuality, make informed decisions, and build necessary life skills that support a healthy future. These programs also address issues related to consent, healthy relationships, and gender equality.
- **Safe abortion services:** Where legal, ensuring access to safe abortion services for adolescents who may experience unintended pregnancies. This includes providing accurate information about abortion options, counseling on reproductive choices, and access to safe and legal abortion procedures performed by trained healthcare providers in accordance with national laws and guidelines.
- **Geographical accessibility:** Ensuring that reproductive health services are geographically accessible to adolescents, particularly those living in rural or remote areas. This may involve establishing outreach clinics, mobile health units, or telemedicine services to overcome barriers related to distance and transportation.
- **Affordability and availability:** Ensuring that reproductive health services are affordable and available to adolescents from diverse socio-economic backgrounds. This may involve subsidizing or providing free services for adolescents, as well as ensuring that essential reproductive health commodities are consistently stocked and available at healthcare facilities.
- **Confidentiality and privacy:** Respecting adolescents' rights to confidentiality and privacy when accessing reproductive health services. This includes ensuring that healthcare providers maintain confidentiality regarding sensitive health information and create safe and confidential environments in which adolescents can seek care without fear of judgment or discrimination.

PIVOTAL PROGRAMS

Key Points

- Between 2001 and 2021, Nepal implemented a number of programs that contributed to empowering the adolescent population to exercise their sexual and reproductive health rights through multiple strategies. Among these, national family planning programs, safe abortion services, adolescent- and youth -friendly health services, and affirmative action for girls' education, including child marriage prevention, were three pivotal programmatic areas. In addition, the use of a variety of media channels, technology, and cross -cutting programming aimed at socio-economic, health, and education development of adolescents was instrumental in reducing adolescent fertility.
- National family planning programs, initiated in 1974, have continued to be strengthened over time. From 2001 onward, family planning information and services have been available to all women and girls on request, regardless of marital status, through government facilities, NGOs, private clinics, and social marketing. In addition, approximately 52,000 female community health volunteers (FCHVs) routinely engage with women of reproductive age in communities, including pregnant and lactating mothers, to provide family planning information, referrals, and resupply of condoms and oral pills. This channel was essential for accessing unmarried and out-of-school youth.
- Legalization of abortion through the amendment of the General/Civil Code (Muluki Ain) in 2002, and the Safe Abortion Procedural Order in 2003, established abortion as a women's right and laid the foundation for expansion of safe abortion services across all 77 districts. Task shifting to nurses began in 2005–2006, followed by initiation of medical abortion in 2009. All women and girls aged 18 years and older may access abortion services up to 12 weeks' gestation for any reason, regardless of marital status. The Government of Nepal made safe abortion services free of charge at all public sector health facilities, with annual budget allocations to support implementation. Beginning with one hospital in Kathmandu in 2004, approximately 1,600 public and NGO/private health facilities and about 4,500 providers were offering safe abortion services by 2021.
- The National Adolescent Sexual and Reproductive Health Program has contributed to improving adolescents' sexual and reproductive health by providing adolescent -friendly services irrespective of marital status.
- Nepal also implemented programs aimed at keeping girls in school, not only for their overall development but also to prevent child marriage. Gender parity in secondary school enrollment was achieved from 2011 onward as a result of government incentives and scholarships targeting socio-economically marginalized communities, where gender stereotypes had previously limited girls' school attendance and contributed to early marriage.

I. Adolescent Sexual and Reproductive Health and Rights

National Family Planning Program

Nepal's advances in policy and implementation of the National Family Planning Services (NFPS) supported major achievements related to ASRHR. NFPS includes nationwide priority programming of the Government of Nepal targeting men and women of reproductive age (15–49 years), including adolescents aged 15–19, regardless of marital status. Programming includes provision of long-acting reversible contraception, including intrauterine contraceptive devices and implants, as well as voluntary surgical contraception for men and women. In addition, NFPS includes regular provision of post-partum and post -abortion family planning services and micro -planning to address unmet need among hard -to -reach and underserved communities. Roving auxiliary nurse midwives support family planning service utilization through satellite clinics.

The involvement of approximately 52,000 female community health volunteers (FCHVs) in distributing pills and condoms door to door and referring adolescents and young women to health facilities for comprehensive family planning services has contributed to increased service utilization among married adolescents and youth. National family planning services have also mobilized individuals, families, and communities to advocate for and participate in dissemination of information and delivery of services within their communities. This included formation of groups where girls could learn about literacy and reproductive health, specifically targeting low-income and illiterate adolescent girls aged 10–19 years. Activities also encouraged spousal communication and joint decision-making, as well as greater participation of husbands in maternal health.²⁸

At the community level, programs raised awareness of the rights and needs of married adolescents and contributed to attitudinal shifts that facilitated adolescent access to reproductive health information and services. These activities included increased community awareness of family planning options,

improved accessibility and availability of quality services, and capacitation of outreach health facilities with medical equipment. Door-to-door family planning services provided by FCHVs improved access to health facilities and promoted contraceptive knowledge, including the standard days method (calendar method), contributing to increased contraceptive uptake and postnatal service delivery. In addition, national family planning services ensured access to high-quality reproductive, maternal, neonatal, and child health services responsive to adolescents' SRH needs, resulting in improved reproductive health knowledge, contraceptive use, and menstrual hygiene practices.

Distribution of family planning commodities through FCHVs contributes to reducing adolescent fertility through several mechanisms:

- **Increased access to contraceptives:** FCHVs play a vital role in providing family planning (FP) commodities, including contraceptives, to communities, including adolescents. By distributing contraceptives directly to households, FCHVs improve access to essential reproductive health services, empowering adolescents to make informed choices about their reproductive health and helping to prevent unintended pregnancies;
- **Education and counseling:** FCHVs often provide education and counseling on family planning methods, including their benefits, correct use, and potential side effects. By offering accurate information and guidance, FCHVs help adolescents understand their contraceptive options and make decisions aligned with their reproductive goals, contributing to lower fertility rates;
- **Community outreach:** FCHVs are trusted members of their communities and have a deep understanding of local customs, beliefs, and needs. Their involvement in distributing FP commodities enables targeted outreach and education initiatives tailored to the specific needs of adolescents and their families, helping to address cultural and social barriers to contraceptive use;
- **Referral to healthcare services:** In addition to distributing FP commodities, FCHVs refer adolescents to healthcare facilities for additional reproductive health services, such as counseling, screenings, and long-acting reversible contraceptives (LARCs). By connecting adolescents with comprehensive reproductive healthcare, FCHVs contribute to reducing adolescent fertility rates and promoting overall reproductive health and well-being;
- **Monitoring and follow-up:** FCHVs often conduct follow-up visits to ensure that adolescents are using contraceptives correctly and to address any concerns or questions they may have. This ongoing support and monitoring help adolescents overcome barriers to contraceptive use and improve adherence, ultimately contributing to lower fertility rates.

Altogether, there are 51,416 FCHVs in Nepal (46,088 in rural/VDC areas and 5,328 in urban/municipality areas).²⁹

Some local-level stakeholders interviewed highlighted the contribution of wide-ranging initiatives undertaken by municipalities to improve uptake of SRH programs. FCHVs were regularly engaged in community visits, follow-up phone calls, and reminder systems for women and adolescents. Stakeholders noted that these actions enhanced trust in SRH services, increased awareness of service availability and rights, motivated facility visits, and enabled adolescents to share concerns with providers without hesitation.

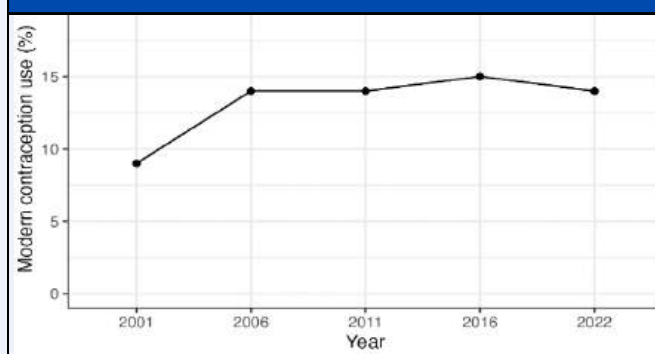
"Female community health volunteers (FCHV) have been invaluable in raising awareness within their communities, particularly among postpartum mothers and the general population. Their efforts have contributed to the development of a shared understanding and awareness among family members."

- ID 26, Youth advocate, Nawalpur

"In the previous fiscal year, particularly in 8 municipalities of Nawalpur, there has been a very high frequency of ANC and PNC visits by expecting and lactating mothers at the health facilities. This indicates that the healthcare providers had greater engagement and attachment with the local community in one way or the other. All of this might have played a role in maintaining birth spacing and increasing contraceptive prevalence rate."

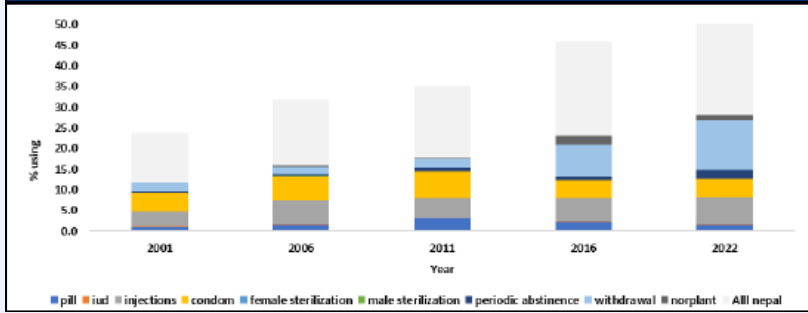
- ID 29, Local Government Official, Nawalpur

Figure 26: Trends in use of modern contraceptive methods among married adolescent girls aged 15-19: Nepal (NDHS 2001-2022)



Contraceptive Acceptance: Although the use of modern contraceptive methods among married adolescent girls aged 15-19 increased from 9% in 2001 to 14% in 2006; however, overall trends remained nearly constant (14%-15%) between 2011 and 2021 (Figure 26). Higher reliance on traditional methods, such as withdrawal (coitus interruptus), compared to modern methods contributed to stagnant modern contraceptive prevalence. As shown in Figure 27, the method mix has been dominated by traditional methods since 2016, followed by injectable contraceptives (DMPA) and male condoms. During 2001-2011, condoms were the most commonly used method among adolescent couples (Figure 27).

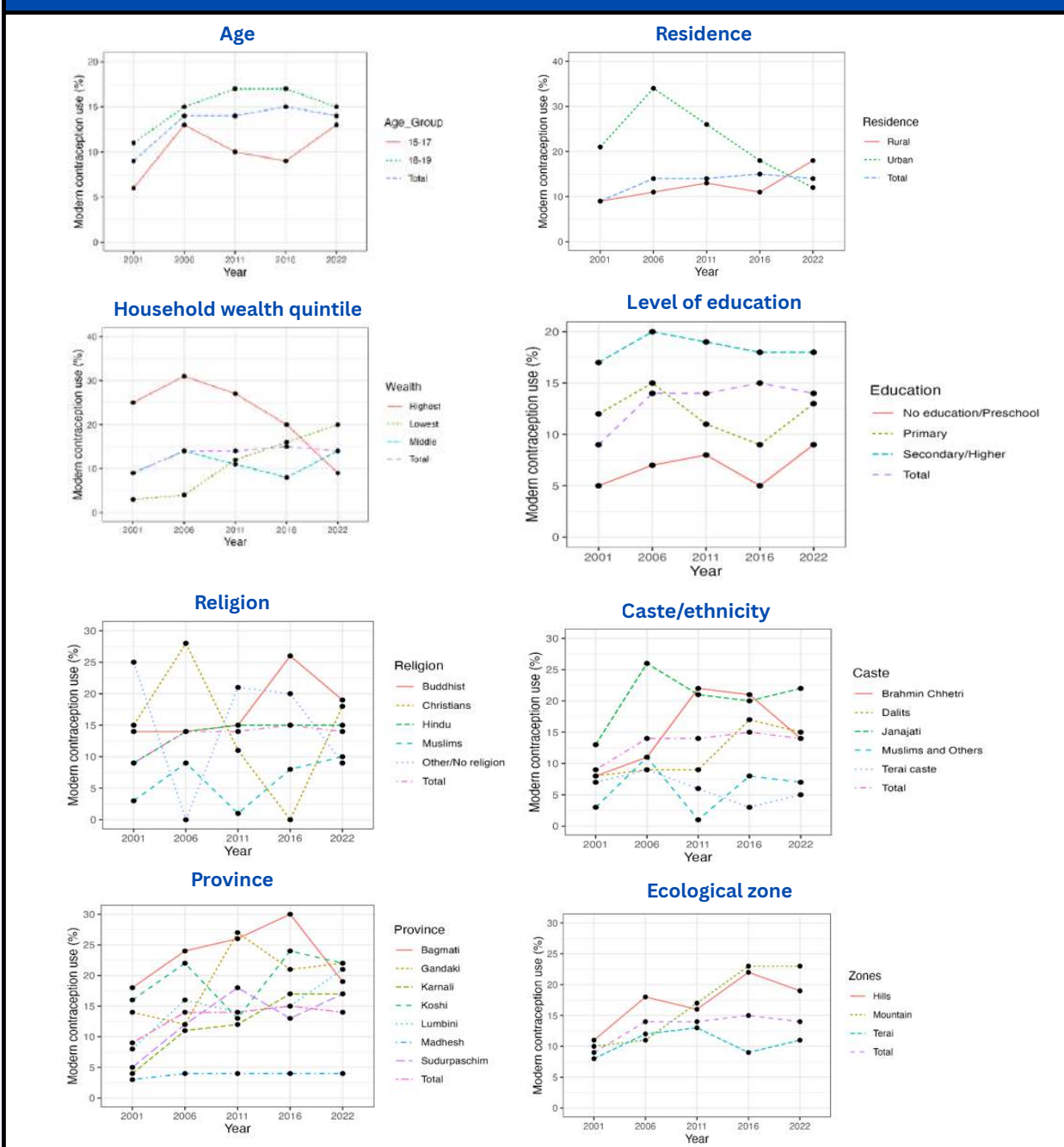
Figure 27: Method mix among women aged 15-19, NDHS 2001-2022, Nepal



"For the fertility rate reduction, maybe two programs have highly contributed without taking any credit, i.e., the family planning program and abortion services. Nepal is the first country in this region that ensured uptake of FP services even by unmarried couples. This was possible after the terminology "married" was erased from the client register form thereby making it not mandatory for the service providers to ask the marital status of their clients seeking FP service. This eventually broadened the service horizon and built a strong foundation for accessibility to adolescents as well. The expansion of family planning services helped adolescents, including unmarried pregnant adolescents, to access the services as per their needs."
 - ID 12, ASRH Expert, Kathmandu

Use of modern contraceptive methods among married adolescent girls varied by socio-demographic characteristics, including age, residence, education, ethnicity, and wealth status. Higher use was observed among older adolescents, urban residents, those from wealthier households, those with secondary or higher education, and Janajati adolescents. Higher uptake was also observed among adolescents residing in hill regions and in Bagmati Province (Figure 28).

Figure 28: Trends in use of modern contraceptive methods use among married adolescents



Multivariate regression analysis confirmed that younger adolescents, those residing in Madhesh Province, and those from the lowest wealth quintile households were

less likely to use modern contraceptive methods compared to their counterparts (Table 6).

Table 6: Determinants of modern contraceptive use among adolescents (ages 15-19 years)

	COR	aOR (95% CI)		COR	aOR (95% CI)
Year			Wealth Quintile		
2022 (Ref)	1.00	1.00	Highest (Ref)	1.00	1.00
2006	0.95 (0.67, 1.36)	1.02 (0.68, 1.53)	Lowest	0.45 (0.28, 0.71)**	0.47 (0.28, 0.81)*
2011	1.00 (0.68, 1.47)	0.93 (0.62, 1.39)	Second	0.45 (0.28, 0.72)**	0.59 (0.36, 0.98)
2016	1.01 (0.69, 1.49)	0.97 (0.66, 1.43)	Middle	0.41 (0.2, 0.66)**	0.66 (0.40, 1.09)
Age group			Fourth	0.6 (0.36, 1)	0.77 (0.46, 1.29)
18-19 (Ref)	1.00	1.00	Education level		
15-17	0.66 (0.5, 0.86)**	0.69 (0.52, 0.9)*	Secondary/ Higher (Ref)	1.00	1.00
Residence			No education/ Preschool	0.35 (0.24, 0.53)**	0.69 (0.43, 1.11)
Urban (Ref)	1.00	1.00	Primary	0.62 (0.47, 0.81)**	0.74 (0.55, 1.00)
Rural	0.69 (0.52, 0.92)*	0.81 (0.59, 1.1)	Caste/Ethnicity		
Province			Brahmin/Chhetri (Ref)	1.00	1.00
Bagmati (Ref)	1.00	1.00	Terai castes	0.31 (0.19, 0.5)**	0.61 (0.35, 1.06)
Koshi	0.72 (0.46, 1.13)	0.83 (0.53, 1.31)	Dalits	0.67 (0.45, 0.99)*	1.00 (0.66, 1.51)
Madhesh	0.13 (0.07, 0.23)**	0.21 (0.11, 0.42)**	Janajati	1.38 (1.04, 1.84)*	1.35 (0.96, 1.91)
Gandaki	0.75 (0.47, 1.19)	0.79 (0.48, 1.3)	Muslims and others	0.4 (0.22, 0.72)**	0.67 (0.35, 1.28)
Lumbini	0.57 (0.36, 0.9)	0.73 (0.45, 1.17)	Ecological region		
Karnali	0.5 (0.32, 0.77)**	0.72 (0.45, 1.15)	Terai (Ref)	1.00	1.00
Sudurpashchim	0.51 (0.31, 0.81)**	0.64 (0.38, 1.06)	Mountain	1.64 (1.1, 2.44)*	1.15 (0.72, 1.84)
Ecological region			Hills	1.8 (1.35, 2.4)**	0.98 (0.69, 1.37)

**Significant at 5% level, **Significant at the 1% level; COR = crude odds ratio; aOR = adjusted odds ratio.*

Stakeholders representing bilateral organizations and ASRH experts identified national family planning and safe abortion service programs as key contributors to reductions in the adolescent fertility rate. They emphasized the role of free family planning services regardless of marital status at public health facilities, community clinics, satellite camps, and through FCHVs. Additional contributing factors identified included increased antenatal and postnatal care visits, increased utilization of abortion services, and establishment of adolescent-friendly health services.

“For the fertility rate reduction, maybe two programs have highly contributed without taking any credit, i.e., the family planning program and abortion services. Nepal is the first country in this region that ensured uptake of FP services even by unmarried couples. This was possible after the terminology “married” was erased from the client register form thereby making it not mandatory for the service providers to ask the marital status of their clients seeking FP service. This eventually broadened the service horizon and built a strong foundation for accessibility to adolescents as well. The expansion of family planning services helped adolescents, including unmarried pregnant adolescents, to access the services as per their needs.”

- ID 12, ASRH Expert, Kathmandu

“There has been an increase in choices with temporary family planning devices, permanent family planning devices and safe abortion on the free will of women was also managed in 2060 BS (2002 AD). From there on, most of the couples do not have more than 2 children.”

- ID 29, Local government official, Nawalpur

National Safe Abortion Services

Sexual and reproductive health and rights, including provision of safe abortion services, is one of the priority programs of the Ministry of Health and Population. Since the conditional legalization of abortion in 2002, Nepal has taken significant steps to expand safe and legal abortion services across the country.

The country's new Constitution (2015) and the Safe Motherhood and Reproductive Health Rights (SMRHR) Act (2018) guarantee the right to abortion as a fundamental right for women.^{22, 25} The MoHP has developed and periodically updated regulations, strategies, and directives to implement abortion laws and expand access to safe and legal abortion services.

Expansion of training centers has enabled more clinicians to gain skills in safe provision of surgical and medical abortion, and task shifting for medical abortion has expanded the provider base by allowing trained auxiliary nurse midwives (ANMs) to provide medical abortion up to 10 weeks' gestation. Surgical abortion (MVA) was introduced in 2004, and medical abortion was introduced in 2009.³⁰ Since 2017, all safe abortion services at public sector health facilities have been provided free of charge.

As of 2021, about 4,500 clinicians (1,833 auxiliary nurse midwives, 743 nurses, 1,853 MBBS doctors, and 92 obstetrician-gynecologists and MD general practitioners) were trained.²⁹ As per government policy,³¹ ANMs are permitted to provide medical abortion services up to 10 weeks' gestation; staff nurses can provide both MVA and medical abortion services up to 10 weeks; MBBS doctors can provide MVA services up to 12 weeks; and obstetrician-gynecologists and MD general practitioners can provide abortion services between 13 and 28 weeks' gestation.

As of 2021, 1,516 facilities are accredited for provision of safe abortion services (SAS) for gestation up to 12 weeks, and 34 public and private hospitals have been accredited for provision of second-trimester abortion services. These services are available in almost all federal, provincial, and local-level hospitals and most

federal, provincial, and local-level hospitals and most outreach public health facilities, as well as in some NGO/private hospitals and clinics.³²

Medical abortion remains a highly popular method of abortion, including among adolescent girls. As evident from NDHS 2016, within the five years preceding the survey, 76% of women aged <20 accepted medical abortion for their last abortion; 16% accepted MVA; and the remaining accepted dilation and evacuation or other methods. A total of 452,940 women received abortion care cumulatively in the past five years (2017/18–2021/22), and of these, 42,361 (9.3%) were adolescents. Trends show a decline in adolescent abortion clients from 10.3% in 2017/18 to 7.3% in 2021/22, potentially due to service disruptions during the COVID-19 pandemic and under-reporting in HMIS (Table 7).

Table 7: Trends of safe abortion service utilization among adolescents (ages 15-19 years)

	Year				
	2017/18 ³³	2018/19 ³²	2019/20 ²⁹	2020/21 ³⁴	2021/22 ³⁵
Total abortion users (All)	98,640	95,746	87,869	79,952	90,733
Adolescent abortion users	10,127	10,193	8,472	6,924	6,645
% of adolescents to the total users	10.3	10.6	9.6	8.7	7.3

While both MVA and medical abortion services are available at federal and provincial hospitals (Surgical 93%; MA 96%), many local hospitals (Surgical 38%; MA 57%), primary health care centers (CAC 32%; MA 65%), and health posts (Surgical 26%; MA 49%) did not offer abortion services in 2021/22 (Figures 29 and 30)

Figure 29: Extend of provision of surgical abortion (procedure) by type of health facilities

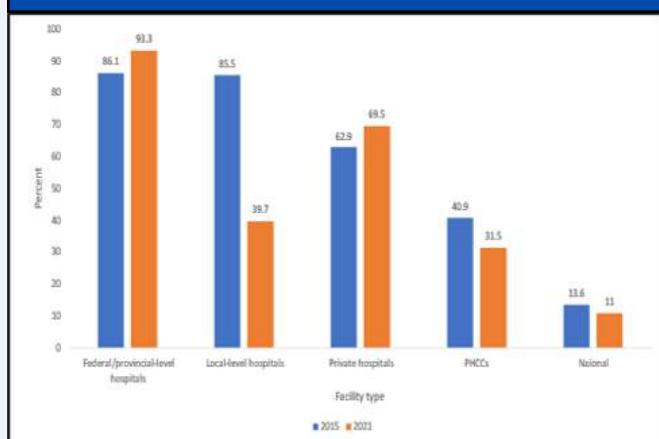
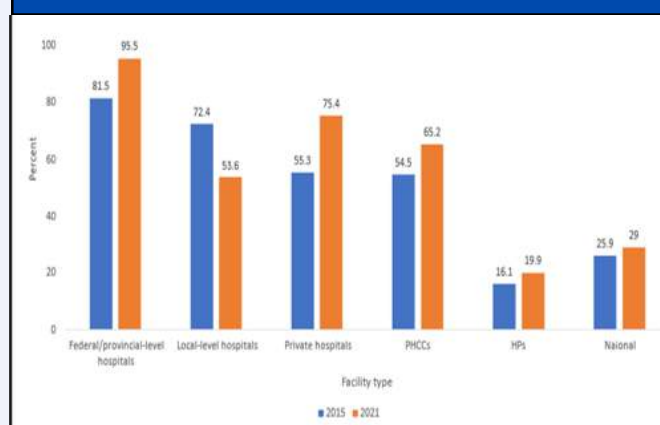


Figure 30: Extend of provision of medical abortion by type of health facilities (Not all govt. and private hospital offer MA)



National Adolescent Sexual and Reproductive Health Programs

In 2000, Nepal prioritized adolescent sexual and reproductive health rights (ASRRH) as part of its commitment to gender equality and reproductive healthcare. Implementation guidelines from 2007 established standards for adolescent-friendly services, which were operationalized through the 2010 National ASRH program. The program sought to increase availability of and access to information about adolescent health and to provide opportunities to build the skills of adolescents, service providers, and educators; increase accessibility and utilization of adolescent health and counseling services; and create a safe and supportive environment for adolescents in order to improve their legal, social, and economic status. Adolescent girls who visited health facilities did so for menstrual health and hygiene advice, to access contraception, or because friends went to the facility for an abortion. Married adolescents reported visiting for antenatal check-ups and vaccinations. Most adolescents who visited facilities stated that they were happy with health workers' behavior and assistance, while those who had not used services were concerned about confidentiality and felt embarrassed to talk to older people—whom, in some cases, they already knew—about sexual and reproductive health issues.

A similar program (Better Life Options for Youth), implemented in the early 2000s, covered more than 24,000 youth aged 10–21 years. The intervention aimed to improve sexual and reproductive health knowledge, service accessibility and quality, and supportive social and policy environments. Using a peer education approach, it created youth groups that met regularly to discuss youth reproductive and sexual health topics and established a telephone hotline counseling program. The program also worked with teachers, parents, and service providers through training and advocacy around delaying marriage and childbearing, and with the Ministry of Education to review and revise school course books and incorporate age-appropriate sexual and reproductive health material.

Adolescents and young women who had visited an ASRH facility reported high satisfaction with services, with 96% indicating they were satisfied or totally satisfied, and 100% stating they would recommend the services to family members or friends.

Youth in project areas increased their knowledge about the legal status of abortion and the facilities where safe abortion was available; 88% knew where a woman could obtain a safe abortion compared to 77% in control areas. At endline, young people were aware of the legality of abortion for married and unmarried women and also knew the gestational age limit for terminating a pregnancy.

Interaction with peer educators proved to be effective, with 88% of youth who interacted with peer educators knowing that abortion was legal in Nepal, compared to 62% of youth with no such interaction. Peer educators also reported referring 163 women for comprehensive abortion care and 3,066 male and female community members for other reproductive health services.

Health providers' knowledge on youth-friendly abortion care also improved, along with their understanding of barriers that girls and young women face in accessing such care and how to facilitate access rather than contribute to barriers.³⁶

"Legalization of abortion service in Nepal has been exemplary worldwide, also we have entered with provision of second trimester abortion as well. Also, when an adolescent visits health facility for an abortion with her guardian we do not insist to produce proof of her age if the guardian has no issue with it, we provide her the abortion service. ... Adolescents can also easily access abortion through a private clinic since there the law permits abortion for gestation up to 12 weeks. They can get MA (Medical abortion) for up to 10 weeks."

-ID 05, NGO representative, Kathmandu

Adolescent Friendly Health Services (AFHS): AFHS was intended to increase availability of and access to quality information on adolescent health and development and to provide opportunities to build the respective knowledge and skills among adolescents, service providers, and educators. AFHS also aimed to improve accessibility and utilization of adolescent-friendly health and counseling services and to create safe and supportive environments for the improved legal, social, and economic status of adolescents.

The Government of Nepal recognized the importance of providing adolescent-friendly health information and services in its MDG 2010 Progress Report and noted that it is essential that adolescents are provided with knowledge and information on sexual and reproductive health to achieve behavioral changes associated with responsible parenthood. It recommended the Ministry of Education introduce adolescent health into the school curriculum, as outlined in the National Adolescent Health and Development Strategy.

Recognizing the necessity to improve adolescent sexual and reproductive health, the Family Welfare Division (FWD), MoHP developed the National Adolescent Health and Development Strategy in 2000 and the National Adolescent Sexual and Reproductive Health Program in 2010, with AFHS as the central component. The NAHD Strategy was later revised in 2018 to address emerging adolescent issues in Nepal's changing context. A total of 1,355 public health facilities in Nepal, only 108 were accredited as adolescent-friendly health facilities as of 2020/21.³⁴

In 2015, UNFPA Nepal supported the Government (FWD/MoHP) in the certification of AFHS using the Quality Improvement and Certification Tool for ASRH. Health facility eligibility for ASRH certification was determined using the Certification Criteria Assessment Score Matrix pertaining to nine national QI standards. Out of 538 AFHS facilities established in 21 districts, only 79 facilities that met the certification criteria received AFHS certification.

A study conducted in 2017 that assessed utilization of AFHS and interviewed 528 school-going adolescents in one remote hill district (Jumla) revealed that more than two-thirds of adolescents reported utilizing AFHS in the past 12 months preceding the survey. Adolescents cited a range of reasons for their visits. Of these, the top five reasons were general illness (91%), safe abortion care (36%), family planning (35%), care for young pregnant mothers (26%), and counseling (32%).³⁷ An assessment study on the functioning of AFHS conducted in 2020 showed that a trained AFHS provider was available in almost all certified AFHS sites, and providers reported that the AFHS training they received was helpful in improving their skills.

Enhancing Sexual and Reproductive Health Services for Young Women (2012-14): This project aimed to help prevent unwanted pregnancy and improve access to safe abortion services, as well as improve the availability and quality of sexual and reproductive health services for young women. It organized a series of educational events and workshops on youth-friendly services with key stakeholders, provided training to service providers, and established a network called *Didi/Dai* (meaning “Big Sister/Big Brother”) that trained young men and women from 31 VDCs to serve as peer educators on safe abortion and other sexual and reproductive health and rights issues in their communities. These peer educators held sessions for thousands of in- and out-of-school adolescents, conducted door-to-door counseling visits, and held more than 100 street drama performances.

As program outcomes, youth in project areas increased their knowledge about the legal status of abortion and the facilities where safe abortion was available; 88% knew where a woman could obtain a safe abortion compared to 77% in control areas. At endline, young people were aware of the legality of abortion for married and unmarried women and also knew the gestational age limit for terminating a pregnancy. Interaction with peer educators proved to be effective, with 88% of youth who interacted with peer educators knowing that abortion was legal in Nepal compared to only 62% of youth with no such interaction. Peer educators also reported referring 163 women for comprehensive abortion care and 3,066 male and female community members for other reproductive health services. Health providers’ knowledge on youth-friendly abortion care also improved, along with their understanding of barriers that girls and young women face in accessing such care and how to facilitate access rather than contribute to barriers.³⁸

II. Adolescent Education

Affirmative Action for Girl’s Education

In advancing affirmative action for girls’ education, the Government of Nepal recognized the importance of integrating adolescent health into the education system through the National Adolescent Health and Development Strategy. The strategy recommended introduction of adolescent health into the school curriculum by the Ministry of Education, including review and revision of course books to incorporate age-appropriate sexual and reproductive health content. Complementary efforts also focused on providing basic numeracy and literacy education and life skills programming for out-of-school adolescent girls.

“In the past 20 years the changes in socio economic status, or education that has helped a lot. Either it is on female education or socio economics or socio-cultural change, these factors have also played major role. Among educated.... I mean to say it differs among educated and uneducated adolescents. Adolescent fertility rate differs highly among the educated and non-educated adolescents. What I mean to say is that the improvement in education sector has also contributed to the decline in Nepal’s adolescent fertility rate.”

-ID 10, NGO representative, Kathmandu

“Education has made the major impact. We can see the difference among the educated and uneducated adolescents. Next is socio economic change, family in the rural area, even reliant on remittance, think of educating their children. Of course, our strategy has helped in service expansion, people were aware of their right, including adolescent and that also played major role and next, apart from these.... Some contribution is also from migration and spousal separation. If they are not staying together there is no chance if being pregnant which decline fertility.”

-ID 10, NGO representative, Kathmandu

“Education has been a crucial factor in reducing the fertility rate, primarily through the schooling and awareness raising on SRH issues to school children. Through education, children have come to understand the potential consequences of child marriage, such as deprivation from their future careers and educational opportunities. Schools have been instrumental in imparting knowledge about the legal age of marriage set at 20 years, as well as the legal and health consequences of child marriage.”

-ID 26, Youth Advocate, Nawalpur

Improved access to education—particularly for girls—has been associated with delayed marriage and childbearing. Changes in economic opportunities and livelihoods may further influence adolescents’ decisions regarding marriage and family formation, while shifting social norms and cultural attitudes toward early marriage and childbearing have also contributed to reduced adolescent fertility rates, as communities increasingly recognize the health benefits of delaying pregnancy.

Among non-health sector interventions, education sector programs have played a particularly important role in improving adolescents' SRH outcomes. The Education for All National Action Plan (2001–2015) strengthened multiple aspects of the education system, contributing to improved enrollment and survival rates among students, including adolescent girls, and reinforcing norms around the importance of girls' education and the right to education.

Guided by national policies, schools developed sector plans and periodically updated curricula to include SRH topics. Compulsory and free education policies further improved girls' enrollment and retention. In addition, complementary initiatives supporting re-enrollment of out-of-school girls—such as the Girls Access to Education (GATE) program—helped address the needs of adolescents who had previously been excluded from schooling.

Collectively, these efforts contributed to measurable improvements in girls' participation, progression, and retention in lower secondary education, including:

- Girls' lower secondary enrollment increased from 914,090 in 2011 to 944,815 in 2015, exceeding 50% of total enrollment.
- Grade 8 enrollment among girls increased from 274,422 to 311,813 between 2011 and 2015.
- Girls' lower secondary NER increased from 69.6% to 78.9%.
- Girls' promotion rates increased from 88% to 91.8%.
- Girls' survival to grade 8 increased from 69.5% to 77.4%.

Taken together, these trends indicate that a growing proportion of adolescent girls remained in the school system for longer periods. Given the well-established relationship between years of schooling and age at marriage, these education gains have contributed meaningfully to reductions in adolescent fertility.

Peer education networks were a hallmark in strengthening affirmative action for girls' education. In particular, peer education networks disseminated relevant information, supported local health facilities for youth-friendly services, and fostered an enabling environment to increase adolescent access to and use of services. This also encouraged spousal communication and joint decision-making, along with greater participation of husbands in maternal health.

Moreover, rural adolescent girls were targeted through a project comprised of a four-week curriculum of education and empowerment workshops for adolescent girls. Workshops were facilitated by trained young women from the community who were members of low caste or marginalized ethnic groups. This, in addition to targeting adolescents in grades 6 to 9 in 47 schools (with a focus on girls), and engaging parents, teachers, and child protection structures, further supported affirmative action for girls' education. In addition, early

childhood care and education enabled free and compulsory primary education, life skills learning, adult literacy and continuing education, social equality and gender parity, and overall improvement in the quality of education.

Schools, government bodies, and NGOs at the local level were involved in addressing child marriage through community education and awareness-related programs. According to one NGO representative, schoolteachers are provided with orientation training to deliver SRH-related topics to students confidently and without hesitation, contributing to enhanced awareness of SRH matters among students. Likewise, a local-level stakeholder attributed the reduction in AFR to formation of child clubs among schoolchildren and initiatives to make schools "girl-child friendly."

"We worked to ensure girl education, school environment, improved access to education for adolescents, their retention in schools, and creating safe and comfortable spaces for the girl child to travel from home to school. As a result, there has been greater school enrollment, access, and retention of girl children in schools and their capacity to communicate their issues in the school environment without fear of judgment. Adolescent girls now can freely talk to their teachers about the topic of menstrual hygiene and pads and actively involve themselves in child clubs."

- ID 17, District level NGO representative, Palpa

"We have been ensuring to establish schools as child-friendly and developed indicators to measure if the schools are child-friendly or not. Along with that, we have also facilitated meetings of adolescent-friendly schools and conducted demonstrations on their teaching materials. About 1500-2000 teachers have been giving training to make schools adolescent friendly."

- ID 17, District level NGO representative, Palpa

Decentralized Action for Children and Women (DACAW)

Launched in 1998 by UNICEF in collaboration with the Government of Nepal, the DACAW program (1998-2010) aimed to protect children against violence, exploitation, abuse, and harmful traditional practices. Paralegal committees were established to serve as community pressure groups challenging harmful practices, raising community awareness, seeking to prevent violence, and addressing child protection problems. In addition, child and youth clubs were created to address child protection issues and engage in rights advocacy challenging various forms of violence against children, including child marriage, child labor, and child trafficking. Paralegal committees played an important role, over the program's lifetime, they managed more than 42,000, with 80% of child protection cases resolved by committee members, particularly cases of domestic and community violence against children.³⁸ Paralegal committees typically consist of 13-15 volunteer women and use legal arguments to address protection abuses. In each district they are

supported by a district resource group, which consists of lawyers and social activists who train committee members and provide consultations. An evaluation carried out by the Royal Norwegian Embassy noted that paralegal committees enhance community welfare as they address cases not openly discussed within the community or brought to the formal justice system, such as domestic violence and abuse, rape, harassment, child marriage, and property inheritance; only complicated cases are referred to the formal justice system.

The program established and strengthened child clubs in targeted areas. Clubs enabled children to get involved in decision-making that affected their lives and in community advocacy and policy influencing efforts. Child clubs at district and municipal levels advocated for the right to quality education and the need to make the school environment child-friendly and campaigned to improve health, hygiene, and sanitation and tackle violence against children. In one case, working children's clubs were established, and their network collaborated with the municipal government to increase budget allocations for children; Biratnagar municipality became the only one in the country with the target to become child friendly by 2015. In another case, child clubs from six districts in the central region prepared a convention that was submitted to the Prime Minister for provision of free and compulsory education to all children and prevention of child labor, child trafficking, and sale of children. Yet, child clubs were not fully integrated in communities and often worked in isolation. In many cases, children were not perceived and respected as positive change agents and citizens with rights.³⁹

Adolescent Reproductive and Sexual Health Program – Better Life for Youth 1999-2004

The project sought to improve the sexual and reproductive health of in-school and out-of-school youth, improve service accessibility and quality, and create a supportive social and policy environment. The intervention used a peer education approach that chose and trained adolescents to become peer educators and created a network of youth groups. These groups met regularly and discussed youth reproductive and sexual health topics. A telephone hotline counseling program was also established. The program also worked with teachers, parents, and service providers, offering training and advocacy activities around delaying marriage and childbearing, as well as with the Ministry of Education to review and revise school course books and incorporate age-appropriate sexual and reproductive health material.

The project improved knowledge, attitudes, and skills among adolescents in project schools compared to those in non-project schools: 45% of those in intervention schools had very good knowledge of changes in puberty compared to 24% in control schools; 28% had very good knowledge about menstruation and sperm development compared to 9%; and 56% had good knowledge about the adverse consequences of early childbearing compared to 34%. A larger proportion

of students in intervention schools also felt very confident about successfully convincing a sexual partner to use a condom. However, behavior changes were reported to be more limited. The project also successfully bridged gaps between adolescents and service providers and raised awareness of adolescent reproductive health issues among government officials, school leaders, and the public.

Network for Addressing Women's Reproductive Rights

This was a four-year collaborative intervention program (2005-2009) that sought to improve women's access to safe abortion and post-abortion care. Funded by the Planned Parenthood Federation of America (PPFA), this program was implemented by three national NGOs and covered 16 districts. The task included mobilizing private paramedics and chemists and linking them to safe abortion service centers managed by the government and NGOs; training service providers and offering services; working to effectively implement the abortion law and advocate legal reforms to make the law more gender-sensitive; and conducting grassroots advocacy and awareness-raising activities among community health providers, youth, married women of reproductive age, and other stakeholders about the abortion law and safe abortion services.

Child Marriage Prevention

Key drivers of child marriage in Nepal are poverty, dowry (payment of groom's price), elopement, school discontinuation among girls, and parents' feelings of insecurity for grown-up daughters. Child marriage and teenage motherhood continue to be challenges in efforts to preserve health and reduce adolescent fertility. Interventions addressing child marriage were identified at community and national levels based on the national strategy to end child marriage by 2030 developed by the Government (MoWCSC) in 2016. Specifically, at the community level, awareness was raised on the rights and needs of married adolescents and contributed to attitudinal shifts that facilitated adolescent access to reproductive health information and services. The project also encouraged debates on social norms affecting adolescent health, including child marriage. Moreover, empowerment workshops for adolescent girls were facilitated by trained young women from the community on issues of violence and safety such as child marriage, trafficking, domestic violence, and sexual abuse, awareness of existing laws, and election of a group to form a Girl Support Committee.

The importance of an enabling environment was identified at national and district levels to combat child marriage and other forms of gender-based violence through behavior change communication and social mobilization in Nepal. Specifically, this was aimed at a girls' empowerment program to impact a girl's life and her ability to exercise her rights. Adolescent girls participating in the program gained recognition at local

government and were involved in government programs. This resulted in six provincial governments and 92 municipalities developing action plans to address child marriage, and 51 municipalities allocating a total of US\$100,000 toward scaling up implementation of the Rupantaran program in their communities.

Nepal has barred child marriage, and the minimum legal age for marriage is set at 20 years for both boys and girls. The government is playing a pivotal role in prohibiting all forms of sexual violence that could potentially contribute to unwanted pregnancies.⁴⁰

Comprehensive Sexuality Education – Intra-Curricular Sexuality Education

Among key interventions, comprehensive sexuality education (CSE) played a critical role in reducing adolescent fertility in Nepal. Specifically, this included integration across multiple regular subjects such as Science, Social Studies, Environment Population and Health, Health and Physical Education, and Moral Education. In 2000, comprehensive sexuality education was incorporated into health and population education for grades 9 and 10, and in 2002 it was expanded to include grades 6 through 8, addressing topics such as puberty, reproductive health, and HIV/STI prevention, after a decade-long advocacy effort to make it comprehensive and age-appropriate. The main topics of CSE included in Nepal are SRH, sexuality, violence, sexual rights, pleasure and entertainment, diversity, and relationships. In 2014, a review by the Ministry of Education and the United Nations Population Fund called for curriculum and teacher-training reforms due to identified gaps in comprehensive sexuality education, such as limited primary-level coverage (grades 1 through 5), inconsistent age progression, and a focus on biological and prevention topics. CSE is not imparted as a stand-alone subject but is integrated into multiple subjects such as Science, Social Studies, Environment Population and Health, Health and Physical Education, and Moral Education. Recently, the Health, Population and Environment subject was made optional for grades 9 and 10 students.

Over 700 school teachers and over 500 peer educators have been trained by 123 resource persons/trainers from the Education Training Center of the Education Ministry (MoEST) on CSE. Adolescent friendly information corners (AFIC) were established and strengthened in approximately 190 public schools. Coverage of out-of-school adolescents by CSE is limited and carried out by local government through Flexible School Programs (FSP) and through development partners/non-governmental organizations. The FSP focuses on children aged 8–14 years who are primary school dropouts and encourages these children to enroll in grade 6 in the formal schooling system. It is a condensed version of the formal education curriculum and misses a large section of CSE, with content limited largely to HIV and AIDS.

“Nowadays girls speak against child marriage. If someone suggest to a girl that she of marriageable age and should get married, then she would say that anyone can go to jail if they force her to marry before the age of 20. If adolescents elope themselves then they could have been married as a child but no family arranges child marriage these days.”

- ID 21, Service provider, Nisdi Rural Municipality, Palpa

“We make sure all our adolescent boys and girls are well aware of these legal areas [related to marriage]. We tell our students to not get married before reaching the age of 20 years. We also tell adolescent girls to not become pregnant even if they get married before reaching the age of 20 years as they won't be physically and mentally mature for childbirth.”

- ID 25, School Principal, Bulingtar Rural Municipality, Nawalpur

Rupantaran – A Comprehensive Social and Financial Package

In 2014, the government endorsed Rupantaran (meaning transformation) a peer-facilitated social and financial skills package (SFSP) developed by UNICEF and UNFPA, in collaboration with the Government of Nepal. It is aimed at empowering adolescent girls 10-19 years-old especially those out of school or at high risk of early marriage through the information and skills they need, enabling them to navigate society, prevent caste-based discrimination, child marriage, and sexual violence, plan for their futures, and become changemakers in their communities. It is rolled out in more than 30 districts. The SFSP contains 15 modules in Nepali language on gender equality and human rights (including child marriage-related information), reproductive health, gender-based violence, nutrition, communication, decision making, and negotiation skills, among others, and is completed through weekly sessions over a period of nine months. Rupantaran sessions are conducted with the help of the manual, along with additional materials such as charts, stickers, and infographics, and are facilitated by a social mobilizer or facilitator. Rupantaran reached around 14,000 at-risk girls in 2023, with evaluations showing that 80% exhibited measurable improvements in sexual and reproductive health and rights (SRHR) knowledge and gender-equitable attitudes, alongside indications of delayed marriage and increased economic participation. Rupantaran modules have recently been digitalized and translated into Maithali and Bhojpuri languages as well.

Peer-to-Peer Learning on SRH

Peer education and counseling, information and education campaigns, adult peer education and youth clubs, as well as street theatre, teacher education, and provision of livelihood opportunities. The program adopted a participatory approach with youth and the community as a whole and tested the effectiveness of

the participatory approach in defining and addressing adolescent reproductive health concerns. This also included use of a peer education network to disseminate relevant information, support local health facilities for youth -friendly services, and foster an enabling environment to increase adolescent access to and use of services. Project components also encouraged spousal communication and joint decision-making, along with greater participation of husbands in maternal health. This also included a peer education approach for in-school and out-of-school youth and establishment of a telephone hotline counseling program.

In support of integration into the school system, over 700 teachers and over 500 peer educators have been trained by 123 resource persons/trainers from the Education Training Center of MoEST. AFIC corners were established and strengthened in approximately 190 public schools. Interventions included peer education and counseling, information and education campaigns, adult peer education and youth clubs, street theatre, and teacher education. This also involved use of a community -based participatory approach to improve adolescent sexual and reproductive health in rural and urban Nepal. A peer education network was used to disseminate relevant information, support local health facilities for youth -friendly services, and foster an enabling environment to increase adolescent access to and use of services. Many peer educators became champions for youth behavioral change; female peer educators became powerful role models for adolescent girls and promoted their access to basic health services. Use of a peer education approach for in-school and out-of-school youth, and establishment of a telephone hotline counseling program, enabled effective peer -to -peer learning on SRH. This also included review and revision of school course books and incorporation of age-appropriate sexual and reproductive health material by the Ministry of Education.

III. Social, Economic, and Media

Media and technology-based interventions play a crucial role in promoting sexual and reproductive health (SRH) by leveraging various platforms to disseminate information, foster positive attitudes, and encourage healthy behaviors among adolescents and young adults.

Utilizing various media platforms: Media platforms such as radio and television are widely accessible across different demographic groups in Nepal. These platforms can broadcast SRH messages, educational programs, and public service announcements to reach a broad audience, including those in remote areas with limited access to other forms of communication.

Other social media platforms like Facebook, Twitter, and Instagram are increasingly popular among young people in Nepal. Utilizing these platforms allows targeted messaging and engagement with specific demographic groups, such as urban youth or marginalized communities. Mobile applications have become powerful tools for SRH education and service delivery.

These apps can provide interactive content, quizzes, and games to engage users and reinforce learning. They may also offer features such as chatbots or hotlines for anonymous counseling and support.

Disseminating SRH information: Media and technology-based interventions facilitate dissemination of accurate, evidence-based SRH information. This information covers a wide range of topics, including puberty, contraception, STIs, consent, pregnancy, and childbirth. By utilizing various media platforms, SRH messages can be tailored to different audiences based on age, gender, cultural background, and geographic location. This customization ensures that information is relevant and culturally sensitive, increasing its effectiveness and impact.

Promoting positive attitudes and behaviors: Media and technology-based interventions aim to promote positive attitudes and behaviors related to SRH. They challenge stigma, dispel myths, and address misconceptions surrounding sexuality and reproductive health. Through engaging and interactive content, these interventions encourage discussion and reflection on topics such as gender equality, healthy relationships, and sexual rights. By fostering open dialogue, they empower individuals to make informed choices about their sexual and reproductive lives.

Popular radio program: Saathi Sanga Manka Kura *“Chatting with my best friend”*

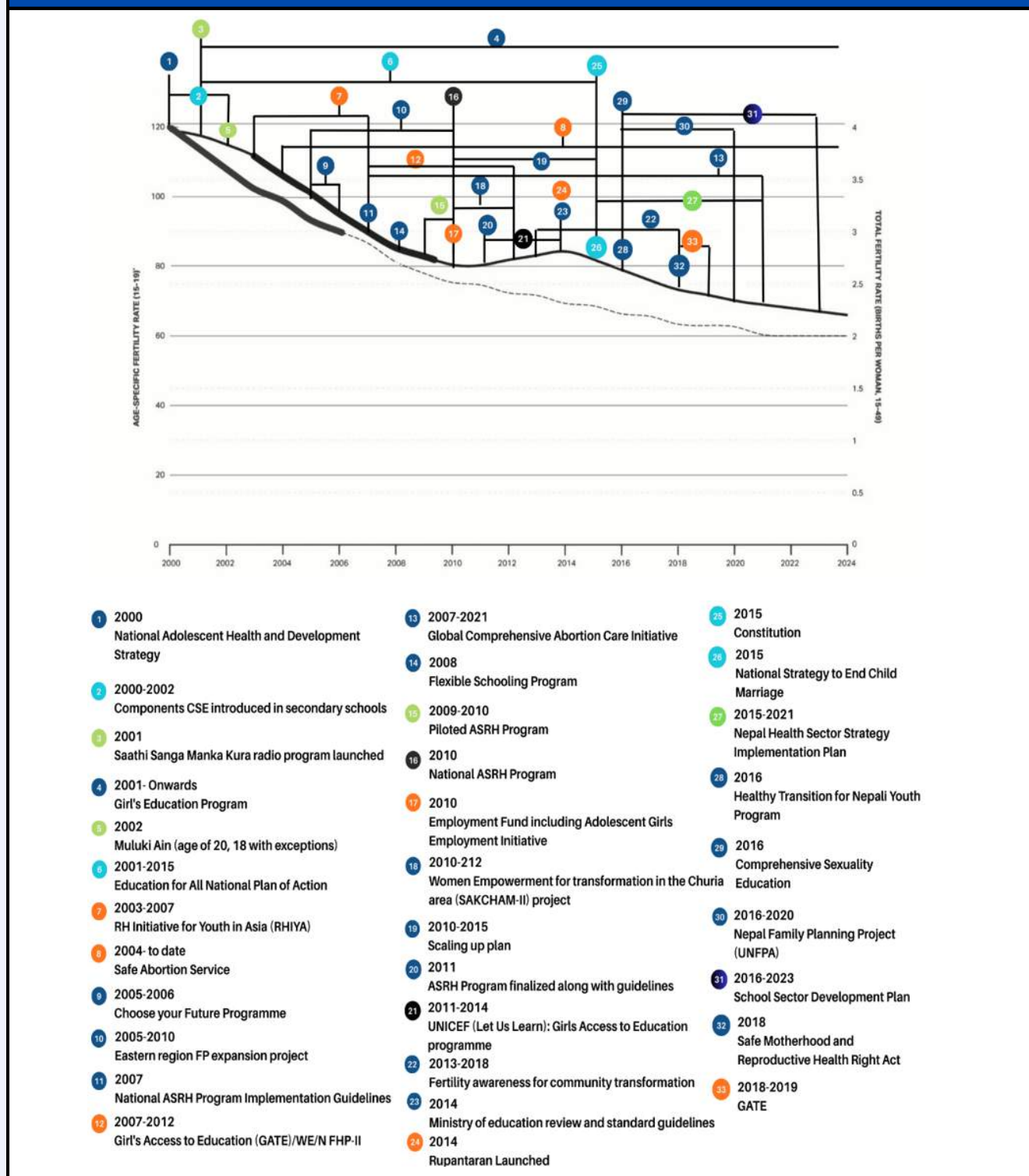
This radio drama, broadcast since 2001 as a weekly program for 45 minutes from 150 FM stations of Nepal. The show aims (i) to provide youth with information about puberty, sexual and reproductive health, peer pressure, HIV and AIDS, and education and work opportunities and (ii) to enable adolescents and young people to make informed decisions about issues that matter in their daily lives. Issues discussed focus on adolescent participation, menstrual hygiene management, love and relationships in adolescence, physical and mental health, financial literacy and livelihoods, and child protection. A study on the importance of communication initiatives for adolescent girls in Nepal noted that since its start, the program received more than 40,000 responses in which people described changes in their lives and communities after the SSMK experience. These were usually about stopping dowry, child marriage, or sexual abuse by guardians. By 2010, the program reached over 90% of young people in the country, with 5.4 million weekly listeners. Its "edutainment" storylines addressed issues like child marriage, dowry, and gender-based violence. With over 1,400 listener clubs and 3,000 to 4,000 weekly interactions.

Anonymous access to information and services:

Interactive websites, mobile apps, and toll-free hotline telephones provide a safe and confidential space for individuals to access SRH information and services anonymously. This anonymity reduces barriers to seeking information and support, particularly for those who may feel uncomfortable or stigmatized accessing SRH services in person. Counseling services offered through these platforms allow users to ask questions, seek advice, and receive referrals to SRHR services without disclosing their identity. This privacy encourages greater engagement and help-seeking behavior among vulnerable adolescents and young people.

A 2022 study conducted among 2,436 adolescents and youth (A&Y aged 10-24) in six provinces showed that more than half of A&Y own a mobile phone (59% males and 54% females), and anonymous access to the internet among them was very high—85% of male and 77% of female A&Y. YouTube (88%) was the most popular social media platform accessed by male A&Y, whereas TikTok/Like (75%) was popular among female A&Y. Other common social media platforms accessed by adolescents and youth were Instagram (26% males and 19% females), Messenger/ WhatsApp/Viber/Google Duo/Telegram (21% males and 26% females), and Snapchat (11% males and 17% females).³⁹

Figure 31: Milestone’s interventions and programs contributing progress in ASRHR in Nepal (2000-2023)



Partners contribution

Partners contributing to improving ASRHR in Nepal encompass a wide range of actors from various sectors.

Government agencies:

- Policy Development—develop policies and guidelines related to ASRHR, ensuring a legal framework that supports adolescent health and rights.
- Funding Allocation—allocate budgets for ASRHR programs, including funding for healthcare services, education, and outreach initiatives.
- Program Implementation—government-run health facilities and educational institutions provide services and implement programs targeting ASRHR.

International organizations:

- Technical Support—provide technical assistance, expertise, and best practices to strengthen ASRHR programs in Nepal.
- Funding—provide financial support for ASRHR initiatives, supplementing government and local resources.
- Coordination—facilitate coordination among stakeholders, ensuring alignment with global standards and priorities.

Non-governmental organizations (NGOs):

- Service Delivery—fill gaps in healthcare infrastructure by providing ASRHR services, especially in rural and marginalized communities where government services are limited.
- Advocacy and Awareness—advocate for policy changes, raise awareness about key issues, and promote positive social norms through community engagement and media campaigns.
- Capacity Building—build capacity of healthcare providers, educators, and community leaders to address ASRHR effectively.

Healthcare providers:

- Service Provision—offer adolescent-friendly SRH services, including counseling, contraception, STI testing and treatment, and maternal healthcare.
- Training and Capacity Building—receive training on youth-friendly approaches, confidentiality, and cultural sensitivity to ensure quality care for adolescents.

Educational institutions:

- Comprehensive Sexuality Education (CSE)—integrate ASRHR topics into the curriculum, providing students with the knowledge and skills to make informed SRH decisions.
- Safe Spaces—create safe and supportive environments where adolescents can access information, ask questions, and discuss ASRHR topics without fear of judgment or stigma.

Community leaders and religious institutions:

- Advocacy and Support—advocate for ASRHR issues, challenge harmful norms and practices, and provide support to adolescents and their families.
- Cultural Sensitivity—ensure that ASRHR interventions are culturally appropriate and sensitive to local customs and beliefs.

Media and communication agencies:

- Awareness Campaigns—raise awareness about ASRHR through campaigns, articles, TV shows, and social media platforms.
- Information Dissemination—disseminate accurate SRH information, debunk myths, and provide resources for adolescents seeking help or advice.

Youth-led organizations and adolescent networks:

- Peer Education—engage in peer education and outreach activities, empowering young people to advocate for their own sexual and reproductive health rights.
- Advocacy—they advocate for policies and programs that prioritize ASRHR and ensure that the voices of adolescents are heard in decision-making processes.

Academic and Research Institutions:

- Research—academic institutions conduct research on ASRHR issues, generating evidence to inform policy and program development.
- Capacity Building—they contribute to building capacity of researchers, policymakers, and practitioners through training, workshops, and knowledge-sharing activities.

Private Sector:

- Corporate Social Responsibility (CSR)—private companies support ASRHR initiatives through CSR programs, providing funding, resources, or technical expertise.
- Innovation—they may develop innovative solutions, such as mobile health applications or telemedicine platforms, to improve access to ASRHR services and information.

BARRIERS TO PROGRESS

Key Points

Despite the successes achieved, Nepal's efforts to reduce adolescent fertility still face notable challenges. These are partly due to existing laws and policies as well as program delivery -related challenges, while some barriers are due to rigid socio-cultural norms and harmful practices.

- Inconsistencies exist in laws and policies in defending adolescents' rights to access comprehensive SRH education, information, and services, including family planning and safe abortion, versus legal age at consent for sex (18 years) and legal age at marriage (20 years).
- Differing provisions exist in the act primarily governing abortion services (Safe Motherhood and Reproductive Health Rights Act, 2018) and the National Penal Code, 2017, which can lead to punitive actions for a woman seeking abortion care, the service provider, or both for performing an abortion in certain circumstances.
- Patriarchal attitudes and gender and social norms continue to pose barriers to attaining gender equality, non-discrimination, and respect for women's right to make decisions concerning reproductive health, despite the country's constitution safeguarding these as fundamental rights.
- Comprehensive sexuality education inducted into the curriculum under social studies/health has been made optional for grades 9 and 10 (and is not comprehensive enough in other grades), thereby depriving students in these grades of learning age-appropriate sexuality -related matters.
- Systems-based demand-side and supply-side barriers persist that prevent adolescents, including married adolescents, from utilizing ASRH services as needed.
- Limited government and non-government funding and low prioritization of adolescent SRHR and wellbeing.
- Increasing practice of prenatal sex determination and sex -selective abortion leading to highly distorted sex ratio at birth (SRB) in the past decade—114 boys per 100 girls in 2021, compared to 105 per 100 a decade ago.
- Poor coordination and functional linkage between relevant ministries such as MoHP and MoEST, which have main obligations to fulfill adolescents' rights to sexual and reproductive health and sexuality education.

I. Law- and Policy-related Challenges

- Some inconsistencies and contradictions exist in the country's legal provisions. For example, the Right to Safe Motherhood and Reproductive Health Act 2018 ensures adolescents' right to access family planning contraceptives, safe motherhood services, and safe abortion services. However, the National Penal Code, 2017 defines minors as persons below 18 years of age. Accordingly, sex with a person below 18 years is considered rape and punishable through a fine or imprisonment, or both, while provision of family planning contraceptives and antenatal/postnatal care to young mothers under 18 are acceptable acts.
- CSE topics are scattered across multiple subjects from grades 4–12. However, most CSE content is concentrated in the health/social studies subject at the secondary level, particularly in grades 9 and 10. Since health is an optional subject, many students are deprived of critical education on sexuality components.
- Differing provisions exist in the act primarily governing abortion services (Safe Motherhood and Reproductive Health Rights Act, 2018) and the National Penal Code (2017), which can lead to punitive actions for a woman seeking abortion care, the service provider, or both for performing an abortion in certain circumstances.

II. Program- and Intervention-related Challenges

- While most ASRHR-focused interventions are multi-sectoral, there have been limitations in coverage and access due to Nepal's geographical terrain (mountains and hills) and the remoteness of settlements.
- Annual number of abortions reported in the national Integrated Health Information Management System (IHIMS) tends to be far lower than the estimated annual number of abortions. Non-compliance and under -reporting from private sector SAS clinics, as well as insufficient coordination between federal, provincial, and local government bodies responsible for collation and periodic reporting of SAS data, continue to affect national IHIMS data.
- Despite achievements in ASRHR over the past two decades, systems-based demand-side (illiteracy, lack of awareness, limited knowledge about ASRH services offered, social stigma, etc.) and supply-side barriers (remote location of an ASRH facility, clinic hours, service availability, friendly and gender-sensitive providers, etc.) persist that prevent adolescents from utilizing ASRH services.
- The Government (MoHP) planned to develop 2,000 health facilities as adolescent -friendly health services and train 5,000 service providers by end of 2021. However, by end of FY 2074/75 (2017/18), only 1,331 health facilities out of 2,000 public health facilities (66%) had introduced AFHS, and only 1,768 (35%) service providers were trained from 2015 to December 2018 (FY 2071/72 to FY 2074/75).

III. Socio-cultural Barriers

- Patriarchal attitudes, norms, and gender stereotypes deeply embedded in Nepalese society continue to pose an invisible barrier to attaining gender equality, non-discrimination, and respect for women's reproductive decision-making, despite the country's constitution safeguarding these as fundamental rights. As a result, Nepal has not made much progress in preventing violence against women and girls, which poses a strong risk to ASRHR.
 - Menstrual -related stigma and discrimination, including menstruation exile practiced by certain ethnic groups and religions, force women and girls to sleep in small huts (Chhaugoth) or animal sheds and deprive them of access to nutritious and healthy food, hygienic environments, and psychological support during menstruation and immediately after childbirth. Chhaugoth is often unhygienic, exposed, unsafe, and lacking basic necessities. Menstrual restrictions and stigma, including Chhaupadi, are seen as violations of women's human rights and have been criminalized in Nepal. Chhaupadi has been illegal since 2005, but the practice often goes unheeded.
 - Driven by patriarchy, sons are highly preferred in families and daughters are discriminated against, resulting in increasing practice of prenatal sex determination and sex -selective abortion. Nepal has begun to experience highly distorted sex ratios at birth (SRB) in the past decade—114 boys per 100 girls in 2021 compared to 105 per 100 a decade earlier (2011)—with high inter-province and inter-district variation.
 - Demand -side barriers that prevent ASRHR progress include: (i) poor awareness about ASRHR, particularly abortion law and where to obtain legal and safe abortion care; (ii) insufficient, incomplete, or incorrect information shared by peers on ASRHR, preventing adolescents from full utilization of sexual and reproductive health rights; and (iii) insufficient motivation for married girls to continue education.
 - Supply -side barriers that continue to present challenges to development and full realization of ASRHR at community level include: (i) sparse distribution of AFHS and SAS facilities providing free care; (ii) insufficient number of trained health providers in public and private sector facilities, especially in remote areas; (iii) low prioritization of ASRHR by government, resulting in budget reductions and delays in accreditation of health facilities for AFHS; (iv) low availability of quality counseling, including privacy/confidentiality, on ASRHR at public outreach health facilities; (v) insufficient research, monitoring , and evaluation to ensure delivery of quality AFHS; (vi) limited number of gender-sensitive teachers at schools to teach CSE to students; and
- (viii) restrictive socio-cultural norms that perpetuate silence and taboo around sexuality, leading to inadequate understanding of the importance and quality delivery of CSE in and out-of-school; (ix) inadequate attention by government and society to meet SRHR needs of young people with disabilities, transgender/LGBTQI populations, and other marginalized groups.
- Insufficient familial and parental support for adolescents' meaningful engagement and leadership development. Developmental needs, competencies, and opportunities for skill development are often ignored, and barriers exist to adolescent participation in designing, implementing, and evaluating programs.

CONCLUSIONS AND RECOMMENDATIONS

Over the past two decades, Nepal has made significant improvements in adolescent sexual and reproductive health and rights, particularly in reducing adolescent fertility. These gains were achieved through the interaction of enabling laws and policies, sustained programmatic interventions across multiple sectors, and broader social and demographic changes that influenced adolescents' lives and choices.

A strong policy and legal foundation played a central role in enabling progress. The 1991 National Health Policy articulated a vision of a national health system that reached the rural poor with basic primary care, and adolescent health began to receive explicit priority with the development of the National Adolescent Health and Development Strategy in 2000, later updated in 2018.

Together with subsequent reforms—including the amendment of the Penal Code to legalize abortion in 2002, the National Strategy on Family Planning (2011), the National Plan of Action on the Holistic Development of Adolescents (2013), the 2015 Constitution of Nepal, the National Strategy to End Child Marriage by 2030 (2016), the Safe Motherhood and Reproductive Health Rights Act (2018), the Gender Equality Policy (2020), and costed family planning implementation plans—these policies established a rights-based framework that recognized adolescent health, sexuality, and autonomy.

With support from national and international development partners, Nepal expanded availability and accessibility of SRHR information, education, and services; strengthened knowledge and skill-building among adolescents, service providers, and educators; and worked to create safer and more supportive legal, social, and economic environments for adolescents.

At the same time, a diverse set of interventions was implemented between 2001 and 2021. These included national family planning programs, expansion of safe abortion services, adolescent- and youth-friendly health services, affirmative action for girls' education (including child marriage prevention), economic empowerment initiatives, and socio-behavior change communication using mass media and digital technologies. Although many interventions were limited in geographic coverage or reach among marginalized populations—such as Dalits, Muslims, LGBTIQ+ individuals, and people with disabilities—collectively they contributed to empowering Nepali adolescents to exercise their sexual and reproductive health and rights.

Quantitative analyses help clarify how these policy and programmatic efforts translated into reduced adolescent fertility. The Oaxaca–Blinder decomposition analysis identified increased age at marriage, higher educational attainment, and reduced sexual activity as the largest drivers of declines in adolescent pregnancy between 2006 and 2022 (Decomposition analysis identified reductions in child marriage as the largest contributor in the decline of adolescent fertility in Nepal, followed by gains in education as the second largest contributor).

The cohort analysis extended these findings by incorporating use of modern contraceptive methods (including method type) and school attendance, confirming that these factors were also critical contributors to fertility reduction during the period of focus.

Despite these gains, persistent challenges remain. Patriarchal norms continue to hinder gender equality, non-discrimination, and respect for women's reproductive decision-making. Coverage of comprehensive sexuality education remains slow and uneven, particularly due to its optional status in grades 9 and 10, and the number of outreach health facilities accredited to provide adolescent-friendly and safe abortion services remains limited. In addition, the increasing practice of prenatal sex determination and sex-selective abortion has led to highly distorted sex ratios at birth, posing a serious long-term concern.

Finally, Nepal's progress in ASRHR was reinforced by cross-cutting global commitments and partnerships. Alignment with international frameworks such as the ICPD Program of Action, the MDGs, and the SDGs helped anchor national efforts within a broader human rights and development agenda. Development partners played an important role through both financial assistance and technical support to the Government of Nepal and non-governmental actors, contributing to improvements in key SRHR indicators.

Recommendations

- Make comprehensive sexuality education (CSE) a mandatory subject for all grades in school, focusing on age-specific and rights-based content. Develop evidence-based offline and online learning materials, integrate CSE into curricula, provide teacher training, foster peer networks, and create linkages to adolescent-friendly services;
- Invest in comprehensive and age-responsive information, education, and adolescent-friendly services to inform choices about sexuality and reproductive lives;
- All provinces and municipalities should develop evidence-based comprehensive ASRH costed action/implementation plans that cover different age groups, marginal castes and ethnic groups, disabilities, LGBTIQ+ adolescents and youth, and allocate adequate annual budgets for uninterrupted implementation;
- Prioritize expansion of AFHS in remote hill locations and in communities representing marginalized populations and ensure provision of quality services, presence of gender-sensitive SRH providers, and a range of family planning and safe abortion -related information and referral services;
- Expand adolescents' knowledge on use of digital technology to enable them to access and learn about SRHR and CSE;
- Complete decriminalization of abortion to allow safe abortion access within a rights-based framework and removal of regulatory mechanisms to facilitate safe abortion services access through self-care and telemedicine approaches;
- Address gender inequality and harmful socio-cultural norms and practices, including child marriage and menstruation-related stigma and discrimination, by strengthening social support systems; ensuring girls' education through secondary school; promoting economic empowerment; and investing in flexible learning pathways that help girls remain in school through secondary education. These efforts should engage local government bodies, teachers, local entrepreneurs, religious and traditional leaders, and parents;
- Strengthen IEC/SBCC activities through the use of diverse media, technology, and cross-cutting programming that integrates social, economic, health, and education interventions. These efforts should be implemented through local governments, community-based organizations, health facilities, and FCHVs to promote legal awareness; create supportive and enabling environments for women and girls to access AFHS and SAS free from stigma and discrimination; and counter misinformation spread through social media platforms;
- Consider meaningful participation of adolescents as vital partners in program design, implementation, and evaluation by providing opportunities to have a stronger collective voice in national systems through inter-generational engagement and more coordinated and effective adolescent-responsive services so that adolescents are empowered to reach their full potential;
- Strengthen inter-sectoral coordination among concerned ministries, and also with development partners and civil society organizations, to ensure collective responsibilities in improvement of ASRHR by investing in education, healthcare (including ASRHR), life-skills, and vocational training.

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