

Access to family planning services by Muslim communities in Nepal – barriers and evidence gaps

A review of the literature

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1 Introduction

The UK Department for International Development (DFID) and the United States Agency for International Development (USAID) in partnership with the Family Planning Division of the Nepal Ministry of Health¹ have been supporting initiatives to increase access to quality family planning services to the population of Nepal. As part of this support, in 2014 DFID and USAID commissioned a series of studies to better understand the factors affecting access and use of family planning services among specific population groups in Nepal. It is known, or suspected, that these groups experience specific challenges in accessing family planning services, but the nature of the challenges and barriers are not well known or properly documented. The study groups include: migrant workers and their spouses; the urban poor; young people; and Muslim communities. For each study group the studies are expected to:

- a) Document and synthesise what is known about attitudes, practices, access to and use of family planning services;
- b) Identify any important knowledge gaps in relation to the above issues;
- c) Briefly present and describe any specific interventions or strategies targeted at the study group (or similar groups) in Nepal or in other countries (where relevant to the Nepal context) to increase access to family planning services;
- d) Provide suggestions and recommendations for follow on analysis or for interventions that it may be worth testing in Nepal.

This study focuses on the Muslim population group.

2 Background: Family Planning in Nepal

Family planning is one of the priority programmes of the Nepal Government, implemented through the Family Health Division (FHD) of the Ministry of Health (MoH). The programme aims to foster equitable access and utilisation of quality family planning services throughout the country. Reproductive health (including family planning) is a component of the package of essential health services as outlined in the Nepal Health Sector Program II (NHSP II) and should be provided free of charge.

In the Government health system, temporary family planning methods (including the male condom, pills and injectables) are provided through health and sub health posts, primary health care centres and outreach clinics, whereas IUCDs and implants are provided only in selected primary health care centres and health posts that have the required trained health workers. At the community level, Female and Community Health Volunteers (FCHVs) are expected to inform

¹ At the time of undertaking the review the ministry was still referred to a Ministry of Health and Population (MoHP). We have kept that name or the MoHP acronym just for the references.

and mobilise community members about available family planning options, and provide certain commodities such as male condoms and contraceptive pills. Permanent family planning methods (male and female sterilization) are provided only in selected hospitals and through outreach voluntary sterilization camps (VSC) to populations living far from static facilities.

Through targeting and micro-planning, these efforts are intended to raise contraceptive prevalence rates (CPR) across the country while focusing on districts with the lowest CPR and on poor and marginalised communities. Despite these efforts many health facilities do not provide the expected family planning services for various reasons, including staff shortages, lack of skills and inadequate supply of commodities. Other reported barriers include limited opening hours of facilities, high levels of absenteeism among facility staff, lack of transport to reach the facilities, and lack of specific skills among government health workers who would be expected to deliver certain services, such as fitting implants and IUCDs (Thomas 2012).

Outside the public sector, non-governmental organisations (NGOs) and the private sector (private practitioners and clinics, pharmacies and franchises from several family planning, not for profit organisations) also provide family planning services in different parts of the country, particularly in urban areas and small towns.

2.1 Progress and challenges

Over the last two decades fertility in Nepal has declined from an average of 5.1 children per woman in 1984-6 to the current level of 2.6 (Ministry of Health and Population, New ERA, and ICF International 2012²). Modern contraceptive use has increased from 26% in 1996 to 44% in 2006, reaching a level comparable to Bangladesh (48%) and India (43%) (Singh 2009). However, 2011 data indicates that the use of modern contraceptives has stagnated at 43.2% and Nepal is unlikely to meet the 2015 target of 67% contraceptive prevalence rate (Millennium Development Goal 5).

Demand for family planning exists: according to the 2011 Nepal Demographic and Health Survey (NDHS) 87% of married women would like to delay the birth of their next child or want no more children, and knowledge of contraceptive methods is universal. One of the critical explanations for the stagnation in contraceptive use is that the range of contraceptive methods is not available to all women everywhere, and not all women are making an informed choice. The range of contraceptives available is limited.³ However the reasons why many women do not use contraception and the barriers to access need to be better understood.

² For convenience, in the rest of the document this will be referred to as 'NDHS 2011' (Nepal Demographic and Health Survey).

³ Since 2001 female sterilization has been the most common modern method of contraception. Currently 15% of married women are sterilized and 9% use injectable contraceptives, while use of all other modern methods is at negligible levels. Use of

Unmet need⁴ has been consistently high among young and rural women, decreasing as wealth increases, and varying by geographic location. The 2011 NDHS shows important disparities in contraceptive use which need to be addressed, for example:

- Modern contraceptive use is 18% higher in urban than rural areas; it is 49% among married women in the highest wealth quintile, but only 26% among those in the lowest quintile.
- There are 11 districts with a contraceptive prevalence rate of less than 25% and six of these are in the poorest and most remote regions of mid- and far west Nepal.

Further analyses of NDHS data have also highlighted significant disparities among social groups, and particularly high levels of social exclusion for the Muslim minority (Bennett 2008). Muslim women have:

- The lowest contraceptive use and increasing fertility compared to all other ethnic groups (Khanal 2013, Pandey 2013, Sharma 2011, Bennett 2008).
- An unmet need of family planning of 39% compared to 27.5% among the general population in Nepal (Pandey 2013).

This raises some questions: Might Nepali Muslims have lower access and use of family planning and other health services because of their religious beliefs, because they are a minority group with specific socio-cultural characteristics, or because many of them are poor? Do Muslim communities view family planning differently from non-Muslim communities? For example, do their religious/cultural beliefs hinder the use of contraceptives or are there other factors to be considered? Assuming that there are some religious, social, cultural or economic factors that make Muslims a differentiated group within Nepal, have any targeted interventions (at service delivery, community or other levels) been implemented to overcome barriers to access and use by Muslim populations? Are there similar experiences from other countries? Finally, what interventions could be designed to address these factors?

Religion has often been mentioned as a key factor affecting access and use of family planning (particularly modern contraceptives) among Muslims. However, while religion may play a role, religion is clearly not the only factor affecting use given that Muslims from other countries use modern contraceptive methods. For example, higher levels of use of modern family planning methods have been recorded in Asian countries with large Muslim populations such as Bangladesh (54%) and Indonesia (58%), where fertility is also decreasing (PRB 2015; UN Population Division 2015).

implants and intra uterine contraceptive devices (IUCD) is increasing but remains low at 1.2% and 1.3% respectively (NDHS 2011).

⁴ Defined as the proportion of women who do not want to become pregnant but are not using contraception.

This review explores these issues using existing evidence from the national and international literature.

3 Methods

This study comprises a literature review and a stakeholder consultation among organisations working in the fields of family planning and/or migration in Nepal.

Originally, this review study was to be complemented a small research study in Rupandehi, a predominantly Muslim district in the Nepali Terai, and a number of primary research questions were developed.⁵

However, the planned research could not take place because of the fuel crisis across Nepal and the unstable political and security situation affecting the Nepali Terai, including Rupandehi.

3.1 Objectives

The objectives of the literature review are to identify and review the national and international literature on barriers faced by the Muslim population in accessing family planning services, with a primary focus on Nepal.

The literature review attempts to answer the following questions:

- What are the main differences reported in health and human development outcomes (with a primary focus on use of/access to family planning and on fertility indicators) between Muslims and the average population of Nepal?
- What are the main information gaps? Do studies from other countries shed light in relation to the differences reported?
- What is the evidence about the main factors and barriers affecting access to and use of family planning services by the Muslim population in Nepal? How does the international literature help to better understand such factors?
- What (if any) interventions have been undertaken in the context of Nepal or internationally to address the access factors and barriers identified?

3.2 Search strategy

In order to identify the relevant literature we used the following search strategy:

⁵ These included: 1) What are the barriers and facilitators to use of modern contraceptive methods among Muslim communities? What factors might increase likelihood of Muslim women taking up family planning services? 2) What role (if any) do culture and religion play in Muslim women's choices (or lack of choices) about family planning? 3) What specific family planning methods might be acceptable and feasible to introduce aimed primarily at the Muslim population? 4) Would the Standard Days Method be acceptable and feasible to introduce among the population in Rupandehi? 5) What is the nature of the relationships between religious practices, family planning and labour migration?

- Structured searches of PubMed and Google Scholar to identify peer reviewed and other published literature using a combination of keywords and phrases, including: Muslim, Islam, LMICs (and variants of the term), contraceptive, contraception, family planning, birth spacing; and terms referring to specific methods.⁶
- Reference checks of the articles and documents retrieved;
- Searches on websites of organisations working in family planning in Nepal and other websites including: the UN Nepal information platform, DFID Research for Development (R4D), and the USAID clearinghouse websites.
- Broad Google searches to ensure all angles had been covered (e.g. using generic terms such as: contraception, family planning, Nepal, Muslim).

We conducted the searches in English, and used 2000 as the cut-off point. We also approached key informants from organisations active in family planning in Nepal (listed in Annex 1) to explore key issues for this review and identify additional literature.

3.3 Outcomes of the review

Overall there is a large body of international peer-reviewed literature on the use of family planning, attitudes and barriers to utilisation among Muslim populations, although it does not always attempt to assess the specific influence of religion, or the extent to which religion is an influencing factor. Less has been written specifically on whether this is an important factor in Nepal. There are several analyses of NDHS data, including two by caste/ethnicity showing how Muslim women fare in terms of health and empowerment compared to other groups. There is also a not insignificant body of grey literature (i.e. non peer reviewed) of varied quality that touches on related issues. A key source of information was the Rapid Participatory Ethnographic Evaluation and Research (PEER) study commissioned by the Ministry of Health and Population to understand the socio-cultural, economic, and institutional barriers to accessing health services experienced by poor and excluded women and men in Nepal (Thomas 2012).

We acknowledge that adopting a health angle is a potential limitation of this review, as the issues go beyond health and development. We did not specifically search the anthropological/sociological literature (which is beyond the scope of this review), although by conducting broad Google searches we attempted to somewhat compensate for this limitation.

3.4 Stakeholder consultation

The findings of the literature review were presented and discussed at a stakeholder consultation workshop on 30 May 2016, attended by 42 participants from government and non-government

⁶ Oral contraceptive pills, IUCD, copper T, minilap, vasectomy, implant, Depo-Provera, hormonal methods, permanent methods, long term methods, withdrawal, calendar method, rhythm method, abstinence method and standard days method.

organisations (listed in Annex 2), and chaired by the FHD Director. Key points from the consultation are presented in Section 5.4 of the paper.

4 Findings

4.1 The Muslim population in Nepal: some health and human development outcomes

Muslims represent only 4.4% of the total population of Nepal (CBS 2014). They live mainly in the Terai districts of Banke, Kapilvastu, Rupandehi, Parsa, Bara, Rautahat, Mahottari, and Sunsari, with a smaller proportion living in hills and mountain districts.

Nepali Muslims are not a homogenous group: they are reported to be fragmented along ethnic, regional, occupational and doctrinal lines; Muslims are however recognised as being one of the most marginalised and disadvantaged communities in the country (UN Nepal 2013). In 2011 the poverty incidence for the Muslim population was 20.2% and the adult literacy rate 43.5% compared with 25.2% and 40.43% for the general population respectively (UNDP 2014). Muslims ranked at the bottom of the Human Development Index (HDI) with a score of 0.422 – only the Madhesi Dalit were found to fare worse with an index of 0.45. By contrast other ethnic groups have comparatively higher HDI values, e.g. the Newar (0.565), Brahmin/Chhetri (0.538) or the Hill Janajati (0.509) (UNDP 2014).

Muslims are also reported to have among the poorest health outcomes. Analysis of NDHS data from 2011 reports that:

- Muslim women have low rates of attendance for at least four ANC visits (35%) and institutional deliveries (32.9%) compared to 50.1% and 35% respectively in the general population (Bohra 2012).
- Muslim women have a higher fertility rate (at 4.9) compared to the national average of 2.6, and also compared with other ethnic groups in Nepal (Khanal 2013). Fertility among Muslims has been found to be increasing (from 4.6 in 2006 to 4.9 in 2011) (Khanal 2013), and similar results were reported in analyses of 2006 NDHS (Adhikari 2010, Mishra 2011, Bennett, 2008).

The 2008 Bennett study was the first to analyse NDHS data by caste and ethnic identity (previously avoided as it was considered a controversial topic) and as the author points out, was conducted in a context of growing recognition that women's membership of social groups is a major factor in their health and development outcomes. The findings in relation to family planning were stark (Figures 1-4).

Fig. 1: Use of any method of modern contraceptive

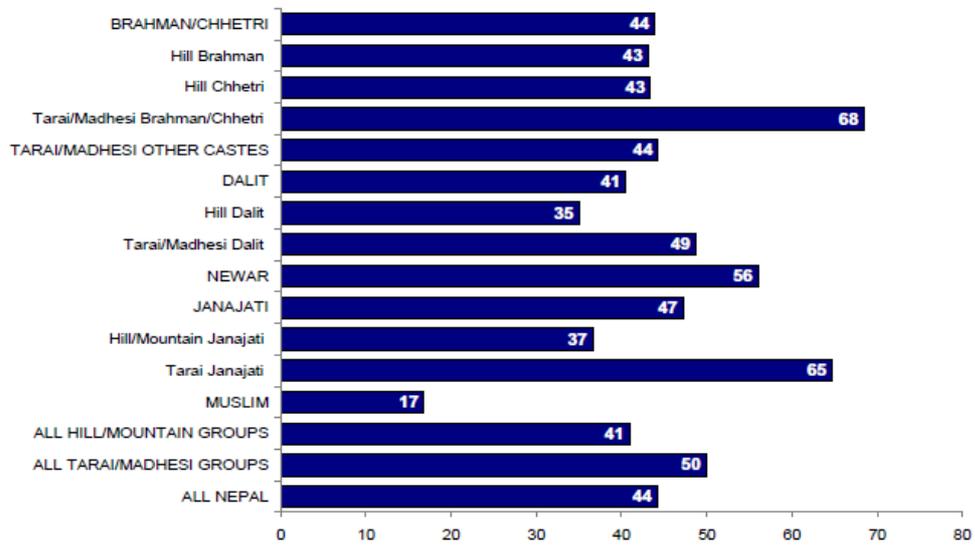


Fig 2: Percentage of women who want to limit childbearing (want no more children)

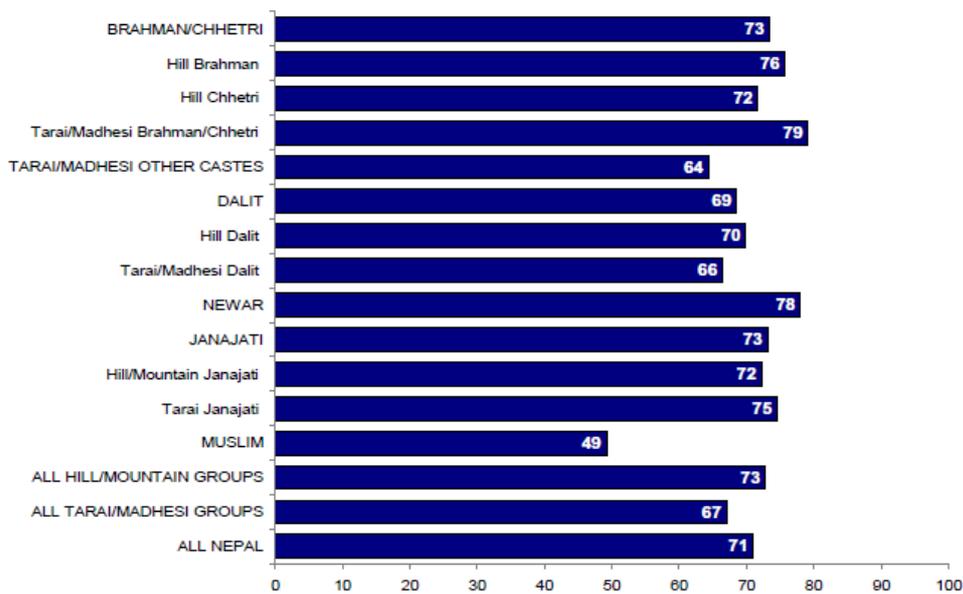
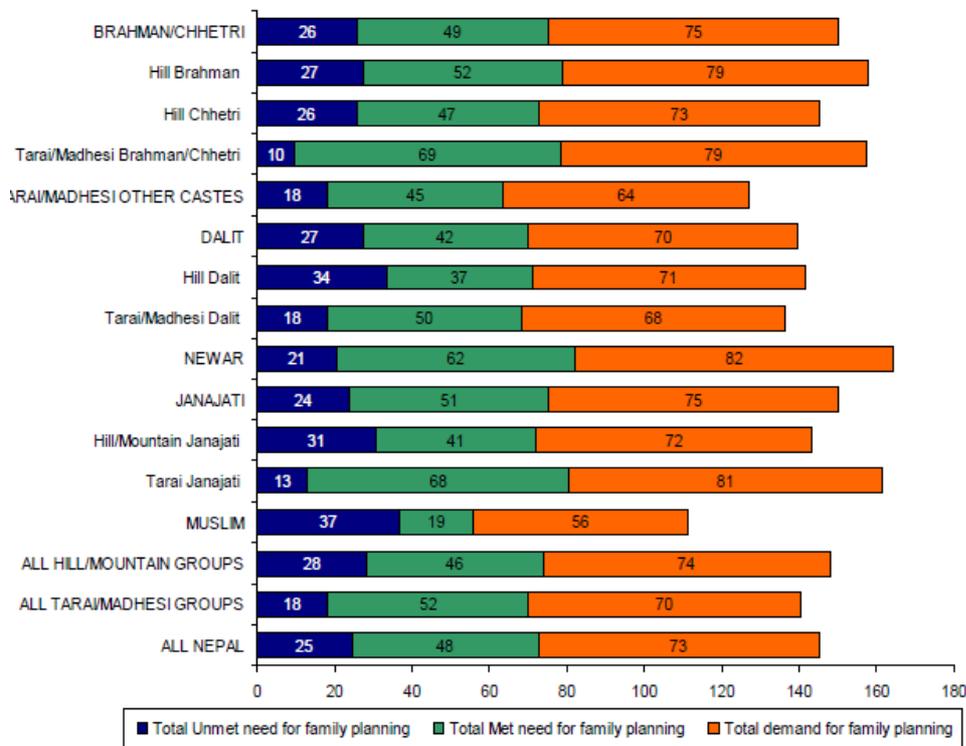


Fig. 3: Unmet need, met need and total demand for family planning



Figures reproduced from Bennett 2008.

The Bennett 2008 report made several recommendations, which we discuss in the Conclusion section.

In relation to contraceptive use specifically, analysis of data from the Nepal Household Survey 2012 found a 9.7% CPR for modern methods among Muslim women compared with 41% for other ethnic groups across rural Nepal. It also found large differences in the use of permanent methods by caste/ethnic group, with ‘Terai/Madhesi and other castes’ having the highest use (27%) and Muslims the lowest use (4%) (Mehata 2014).

Operational research found that Depo-Provera was the most popular family planning method among Muslim women in Nepal followed by oral contraceptive pills (Save the Children 2011), which is consistent with data from the 2011 NDHS.

Several studies conducted in LMICs have recorded lower contraceptive use among Muslim women compared with women from other groups. For instance, the CPR among Muslim women in India (28% in 1992 and 37% in 1998) was much lower than among Hindu women (42% in 1992 and 49% in 1998) (Mishra 2004). Unintended pregnancies among Muslim women were also

reported to be higher than among Hindu women (Dixit 2012). Another study found that Muslim women in Uttar Pradesh were 50% less likely to adopt contraception than Hindu women (Dwivedi et al. 2000). Similar results were also found in Ghana where Muslim women were less likely to use family planning methods than Christian women (Crissman 2012).

Continuity of contraceptive use has also been reported to be lower among Muslims. A study from Bangladesh found that Muslim oral contraceptive users were 1.6 times more likely to discontinue the method than their non-Muslim counterparts (Khan 2002).

It has been suggested that migration may be a factor behind the low use of family planning among certain population groups (Khanal 2013). Migration has increased over the years, and the proportion of Nepalese women with non-resident husbands increased from 26% to 32% between 2006 and 2011 (NDHS 2011). The rate of discontinuation of family planning has become a major concern for family planning programmes: husbands moving away from their homes (for any reason) has been reported in the 2011 NDHS as a major reason for family planning method discontinuation (followed by side effects, desire to become pregnant, method failure and desire of using more effective methods). A World Bank study found that Nepali migrant workers to the Gulf came from traditionally excluded populations, including Muslims, and that the probability of Muslims households having migrants was higher than the national average (46% and 40% respectively) and only lower than that of Hill Dalits (50%) (World Bank 2011).

4.2 Demand side barriers to the use of family planning

Interpretation of religious texts

As no single authority in Islam provides an exclusive interpretation of the faith, there are differences of opinion, including in relation to family planning and contraception; interpretation varies widely among Muslim communities in different countries (Roudi-Fahimi 2004⁷). The examples below are given for illustration and are not exhaustive.

In Nepal, it is reported that Muslims believe that their holy scriptures forbid male or female vasectomy, and that temporary family planning methods are contrary to religious directives (Thomas 2012). Hindus and Muslims, in particular, view children as 'a gift from God' and pregnancy is seen as a blessing to the couple and the family. Son preference also leads to multiple pregnancies, especially among Muslims (Thomas 2012). The same study reports that women are under pressure to follow religious teachings and avoid being perceived (within and

⁷ We consider this to be a good 'primer' on Islam and family planning; there are of course numerous sources on the issue but of varying quality.

outside the family) to transgress religious codes of practice, as this might bring shame on themselves and the household.

By contrast, elsewhere (e.g. among certain communities in Pakistan) there is a preference for small family sizes for economic reasons, and family planning is seen as a way to provide better resources for children (Save 2004, Naqvi 2011; Azmat 2011, Kamran 2014).

A study from Bangladesh and India (Sahu 2012) found that Muslim women with low levels of education interpreted contraceptive use as being a sin whereas Muslim women with higher education levels reported that influence of religious beliefs among the older generation was a reason for some women not using contraceptives. Some educated Muslim women from Bangalore and Dhaka reported that they considered the restriction to use contraception to be a result of misinterpretation of the religious texts (Sahu et al. 2012).

Theologians and religious leaders shape the beliefs in Muslim societies differently across the world (Roudi-Fahimi 2004). In some studies, religious leaders (imams) were reported to resist modern methods of contraception (e.g. hormonal contraceptives) in the belief that the Quran warns against using ‘unnatural’ methods of birth control, and that in using such methods a woman is killing life inside of her, rather than simply preventing the possibility of life. However elsewhere *coitus interruptus* and breastfeeding for two years after pregnancy were considered natural and ethical methods of contraception, whereas use of modern contraception was only acceptable if a pregnancy could be fatal to the mother (Zafar 2003, Keele 2005, El Hamri 2010, Azmat 2011).

Other studies from various countries report that some Muslims fear divine retribution if they use family planning services (Nishtar et al 2013b), or believe that the number of children they should have is ‘God’s business’ and that parents should not try to interfere with God’s will; the desire for large families is seen in line with Islamic teachings as it helps the family survive (Ali et al. 2004, Keele et al. 2005, Stephenson 2006, Nasir 2010, Hayat 2013).

Women’s autonomy

In South Asia there are persisting gender inequalities that limit women’s autonomy and decision making, including in relation to their reproductive health and rights. These are also reported within Muslim communities. However it is hard to disentangle issues of empowerment and autonomy from religion. For example, a study on women’s autonomy in India and Pakistan found that the influence of the social system (i.e. the specific cultural context) was in almost every case far stronger than that of religion or nationality, and that there was little support for the argument that Muslim women were disadvantaged in terms of autonomy, at least when compared to Hindu women from the same region (Jejeebhoy 2001). Another study on paired

Muslim and non-Muslim communities in India, Malaysia, Thailand, and the Philippines found that women's autonomy differentials did not account for the higher fertility, demand for more children, and less use of contraception among Muslim wives, suggesting that explanations for Muslim/non-Muslim fertility differences lie elsewhere (Morgan 2002).

In Nepal, the practice of *pardah* is reported to place strict control over Muslim women's mobility and use of space outside the home and limits communication between a married woman and men other than her husband (Thomas 2012). Limited mobility in turn can result in limited access to information on family planning as well as access to a wider range of services, which has also been reported in Nepal (PSI 2014). In Nepal, husband's approval of family planning has been shown to be a pivotal determinant of women's contraceptive use (Kamal & Lim, 2010, cited in Wang 2013).

Lack of autonomy in decision making and in accessing health services has also been found among other (non Muslim) population groups in Nepal (Thomas 2012). The 2011 NDHS shows that only 45% of currently married women in Nepal participate in decisions pertaining to health care, major household purchases, and visits to family/relatives, and further analysis of 2011 NDHS data by caste and ethnicity found that Muslim women were the least likely to participate in decision making compared to other groups (Other Terai Caste; Dalit; Janajati, Brahmin/Chhetri); indeed, Muslim women were found to be the least empowered in any respect (Tuladhar 2013; see Box 1 for more detail).

Studies from Pakistan and the Maldives also report that in Muslim communities decisions about family planning are often made by husbands and elders of the family; this is more prevalent with recently married girls or young women who have yet to prove their fertility by becoming pregnant (Nagase 2003, Zafar 2003, Sultana 2004, Gipson 2007, Azmat 2011, Farid-ul-Hasnain 2013). Giving birth to a child may increase the role of women in household decision making in certain settings (Farid-ul-Hasnain 2013). Elsewhere, in Pakistan some religious leaders emphasized that decisions about birth spacing should be made jointly between husband and wife (Azmat 2011).

Box 1: Empowerment of Muslim women and health outcomes in Nepal

A study of 2011 NDHS data was conducted to understand women's empowerment and spousal violence in relation to health outcomes of women and their children. A Women's Empowerment Index was developed using five indicators: education, owning house or land, membership of a community group, earning cash and household decision making.

When analysed by caste/ethnicity, Muslim women had the lowest level of women's empowerment: they were the least likely to earn cash; were among those with lowest

educational attainment; were least likely to be members of community groups (with Other Terai Castes); were usually not involved in household decision-making; and had the lowest levels of ownership of land or houses (with Dalit women).

In addition, Muslim women had the highest level of spousal violence (55%, compared to 20% in the Brahman/Chhetri group); were the second least likely group to make at least four antenatal visits during their last pregnancy; and immunization coverage of their children was under 60% (compared to 92% for children age 12-23 months born by all the study women).

Source: Tuladhar 2013

Women's education

The reviewed studies reported that more educated Muslim women – just like women more generally – are more likely to postpone marriage, have smaller family sizes, and to use contraception compared to less educated women (Fikree 2001, Keele 2005, Stephenson 2006, Saleem 2005, Hayat 2013). There are similar findings from Nepal. A case study on fertility and female education in a Muslim community in Sunsari district, Nepal, found that Muslim women with no education had higher fertility than their counterparts with higher education (I. Khan 2012). Another study from Saptari district reported that illiterate Muslim women had high fertility, were unaware of their reproductive rights and were very reluctant to visit health facilities (S. Khan 2010).

Again, it is hard to disentangle socio-economic status and gender inequalities from religion, and determine whether religion plays a significant part or at all, given that Nepal's Muslims are among the poorest groups in the country, and have limited access to education: in 2006, Muslim men and women without any kind of education stood at 42% and 78% respectively, as compared to a national average of 18% and 53% (Bennett 2008).

The UN Nepal country team reports on the lack of educational opportunities for Muslim girls, explaining that "Muslim girls are not sent to school if the institution does not respect religious principles, and that some Muslim girls are not attending school due to their parents' cultural and religious seclusion. Many girls drop out of formal school when they reach puberty due to the strict implementation of rules concerning school uniforms in Nepal, considered by many in the Muslim community to be un-Islamic. Some girls may continue their education through Madrasahs, where the quality of education is reportedly low, while others cease schooling. Although the government now recognises religious teaching institutions including Madrasahs within the country's education structure, educational opportunities in such institutions are not

yet on a par with the formal school system, with courses only implemented up to Grade 5 when girls are 10–11 years old” (UN Nepal 2013).

Other studies from Nepal report various reasons for Muslim girls’ lower school attendance, for example, that mainstream schools do not cater to religious needs, that they lack facilities appropriate for girls (such as hostels, proper sanitation facilities), they are not available within walking distance of the household or that it is thought that a girl’s duty is to look after household chores (Rana 2009, Haque 2013, Shrestha 2012, Parwez 2003).

Attitudes, fears and misconceptions

Some of the reviewed studies (from Ethiopia, Iran, Ghana and Pakistan) reported that Muslim women who wished to use contraception could not because of lack of support from their male partners. The studies from Ethiopia and Iran reported that some Muslim men believed that family planning was a woman’s business and they did not tend to proactively seek information or services, leaving women to struggle alone with the various barriers associated with contraceptive use (Ali 2004, Rakhshani 2005, Tilahun 2013). Other studies report that in some contexts even if men are interested in family planning for preventing, delaying, limiting or spacing births, they feel they cannot discuss such issues due to social constructs of what is their responsibility and what is ‘manly’. The same studies also reported that some Muslim men feared their wives would become promiscuous if they used contraceptives (Tilahun 2013, Sakara 2015). Where discussion of reproductive health issues in public is considered inappropriate, men and women can find obtaining family planning from stores embarrassing, as reported in a study from Pakistan (Save 2004). This issue is however not confined to Muslim populations.

Fears and misconceptions about medicines, vaccines and contraception are common, in both developed and developing country settings, and among different communities, including Muslims. Studies conducted among Muslim communities in several countries found a variety of beliefs, for example that contraceptives cause laziness, headache, weight gain and joint pains (Nagase 2003, Nishtar 2013b, Tilahun 2013), that vasectomy makes men weak, impotent and sterile (Nishtar 2013b), and IUCDs and female sterilization harms a woman’s womb (Agha 2010). However, we did not find any evidence that these misconceptions are more widespread among Muslims than elsewhere. In a study conducted in Nepal, India and Ghana, participants reported similar fears and misinformation about family planning, although some expressed fears could be often linked to real side effects and lack of information or counselling about them (Diamond-Smith 2012).

An intervention in Afghanistan showed that medical misconceptions were more important obstacles than cultural and religious barriers. However these were not insurmountable:

traditional Muslim communities rapidly accepted modern contraceptives (particularly injectables) introduced by community health workers when educated about common non-harmful side effects and correct use (Huber 2010).

4.3 Supply side barriers

We found very little evidence on supply side barriers specific to Muslim communities in Nepal, however common constraints are well known.

Cost

Research on access to health services by poor and excluded women and men in Nepal found that, independent of their caste/ethnic/religious identity, poor people cited inability to afford transport and inability to afford medicines as major barriers to family planning (Thomas 2012). In the Service Tracking Survey 2013, Muslim and Terai/Madhesi maternity clients were more likely to have received transport incentives (92% and 98% respectively); however Muslims were among those who had been asked by health workers for payment, most commonly for registration fees and medicines (MoHP & HERD 2014).

Accessibility

Availability of transport, physical distance to the facility and time taken to reach it influence health seeking behaviour and health service utilisation for any population group (Bohren 2014, Stephenson 2004). Lack of physical access can be exacerbated in certain settings where Muslim women are not allowed to leave the house unaccompanied (Stephenson 2004, Shaikh 2013).

Although the interim constitution has declared free primary health services as a fundamental right for every Nepali citizen, utilisation remains low among the least educated, Dalits, ethnic and religious minorities and people living in remote areas where various factors hinder access, including cost, transport, quality of services and inadequate supply of medicines (RECPHEC 2010). It seems likely that this situation will also affect access to family planning and its uptake.

Acceptability

The way services are provided may not be acceptable to certain population groups. In Nepal, Muslim women may not want to discuss personal issues with male doctors⁸ and, according to

⁸ This may not apply to all male doctors: informal interviews with a male Muslim doctor from Kapilvastu showed that many Muslim women attended his practice for family planning and maternal health services, which he attributed to being himself a Muslim and known and respected by the Muslim community and religious leaders from the area (personal communication from Javier Martinez).

one study, prefer not to expose their bodies to male doctors for intimate examination such as those related to maternal health and family planning (Thomas 2012).

Caste-based discrimination at health facilities has been reported (by Dalits, Muslims, and Terai Madhesi) in regard to reduced access to care, delayed care, and poor quality of care (Thomas 2012, cited in Mehata 2014), with continuing social exclusion also resulting in families not visiting health facilities to avoid potential discrimination and poor quality care (Mehata 2014). In addition, the Service Tracking Survey 2013 reported very little representation of Dalit and Muslims across all health facility staff (MoHP & HERD 2014).

4.4 Interventions

This section provides a brief overview of potential interventions to address the barriers to access to family planning services by Muslim couples. This section is intended to be illustrative, not exhaustive.

Culturally sensitive community engagement with targeted IEC/BCC

There are many examples in the health literature pointing to how clear information and culturally sensitive community interventions (which often involve religious or community leaders, men, etc.) can help overcome demand-side barriers among certain community groups. There are also several examples of community based approaches that have managed to change attitudes towards family planning and increased utilisation of services among Muslim communities in various countries. There is no reason to believe that these interventions would not overcome some of the barriers reported for Muslim women, although we found limited information from Nepal.

For example in Afghanistan, a large scale intervention provided information about the safety and non-harmful side-effects of contraceptives together with improved access to injectable contraceptives, pills and condoms. Regular interaction with community leaders, mullahs, clinicians, community health workers and couples led to culturally acceptable innovations. A positive view of birth spacing was created by the messages that contraceptive use is 300 times safer than pregnancy in Afghanistan and that the Quran promotes two years of breastfeeding. Community health workers initiated the use of injectable contraceptives for the first time. The contraceptive prevalence rate increased by 24–27% in 8 months in the project areas. Men supported modern contraceptives once they understood safety, effectiveness and non-harmful side-effects. (Huber et al. 2010). These achievements were attributed to: (i) devising family planning interventions after in-depth discussion with community leaders, both men and women; (ii) engaging women in supervising community health workers (CHWs) and organizing women's community health committees; (iii) overcoming widespread misconceptions (some inadvertently

perpetuated) by training on rare adverse effects and medical screening; (iv) creating positive, technically sound counselling messages; (v) emphasising contraceptive safety compared to pregnancy risk; (vi) educating people about birth spacing for child and maternal health consistent with Islamic teaching; (vii) involving men in contraceptive education and promotion of birth spacing; (viii) ensuring abundant contraceptive supplies; and (ix) collaborating closely with the Ministry for Public Health for approval of innovations and dissemination of findings. (Huber 2010).

A similar intervention was implemented in 20 districts in Pakistan, by the USAID-funded FALAH (Family Advancement for Life and Health) project. This project trained 10,534 health professionals to offer client-centred family planning services, which included a module that explained the Islamic viewpoint on family planning developed through an iterative process involving religious scholars and public health experts. This program led to better understanding of family planning concepts in participants and helped them to become advocates of family planning. It led to an increase in contraceptive prevalence in the project implementation districts from 29% to 38% (Mir 2013). Similar examples have been reported from comparable projects in Yemen (USAID 2007) and from other parts of the world. Specifically, involving Muslim religious leaders in the development of national family programmes has been found successful in several Muslim countries including Bangladesh, Egypt, Indonesia, Kuwait, Turkey, Jordan and Iran (as described, for example by Shaikh 2013, Ali 1998, Hoodfar 2000, Underwood 2013 and many others).

Involvement of men in family planning education

Involving men is a widely recognised approach when it comes to addressing harmful gender norms (that for example prevent women from making decisions about their reproductive health), and one that is not new to Nepal (see for example EngenderHealth 2004). Involving men in contraceptive education and promotion of birth spacing was a key element of the successful intervention in Afghanistan described earlier (Huber 2010) and has been used successfully in other Muslim settings such as Pakistan and Bangladesh (Rakhshani 2005; Stephenson 2006, Kamal 2009). In the FALAH project in Pakistan, male group meetings were widely successful, among other interventions, in changing couples' fertility intentions and practices.

It is crucial to ensure that any interventions aimed at involving men are conducted carefully to ensure that women's autonomy is not reduced, as recommended by WHO (2015).

Home visits by community health workers

In Pakistan the use of Lady Health Workers (trained married women who provide doorstep advice and supplies in their own and neighbouring communities) led to a significant increase in use of contraception (Douthwaite 2005). This approach can be successful where women have limited autonomy and mobility.

A similar intervention was initiated in 141 villages in Matlab, Bangladesh from 1974 to 1996. In this program Community Health Workers made home visits to married women every two weeks, consulted them regarding their contraceptive needs, and encouraged them to adopt contraception. Women were offered a choice of methods, and those wanting menstrual regulation or a tubectomy were referred to the local district clinic or hospital. Eighty-five per cent or more of the people in Matlab were Muslims while the remainder were Hindus. This intervention led to a decline in fertility of about 15% in the intervention villages compared with the control villages by 1982 (Joshi 2007).

Acceptability of such interventions also needs to be considered. For example, when interviewed, 78% of lady health workers in Pakistan stated that having a mother-in-law present in the house was a barrier in providing family planning counselling, as the mother-in-law would discourage family planning due to widely-held stigma against the practice, and in Uganda Community Health Workers felt that they needed increased support from community leaders in order to alleviate community stigma toward family planning (HC3 2015).

Similar approaches are already used in Nepal. Female Community Health Volunteers (FCHVs) support the delivery of health services, including information on family planning and commodity distribution. They are deployed in the mountain regions and remote districts, partly to compensate for the shortage of professional health workers (MoHP 2012a). Currently there are over 51,000 FCHVs (MoHP 2015). A survey found the lowest literacy rates among Muslim FCHVs, and that they represented Muslim members at about half their rate in the population, while Janajati and middle caste groups were represented at nearly their proportion in the population (New Era 2002). There was also some evidence that FCHVs treated Dalits and Muslims more than their proportion in the population, and the report concluded that while FCHVs may be a good way to increase service coverage for underserved groups, programmes need to be designed with this end in mind – it cannot be assumed that this will happen as a matter of course (New Era 2002).

Another project in Nepal has trained 400 voluntary women mobilisers in 50 districts to conduct communication sessions on family planning for all women, and has designed a monetary incentive scheme to keep the community mobilisers motivated. The intervention has reported

numerous successes including substantial increases in new adopters of IUCD in Kavre (more than 100%), Dhading (18%), Kailali (66%) and Kanchanpur (33%) districts (Shrestha et al 2015).

It must be noted that the examples from Pakistan and Bangladesh apply to two predominantly Muslim countries where nearly all health workers are Muslim themselves, in contrast with the situation in Nepal where the majority of FCHVs working in Muslim predominant areas are not Muslims and are therefore less familiar with Muslim traditions and the cultural or religious sensitivities of these communities. Therefore, acceptability of targeted home visits for contraception provision in Nepal would need to be carefully investigated before implementation to ensure that the intervention does not stigmatise or cause other problems for the women visited.

Social marketing

Social marketing is the use of marketing principles and techniques to 'sell' products to and influence behaviours among the target population, and has been widely used for increasing access to modern contraceptives (Lefebvre et al. 2011).

In Nepal, social marketing of contraceptives is conducted by CRS, PSI Nepal and Sunaulo Pariwar Nepal but we do not have information on how or whether Muslim communities benefit from or are being specifically targeted by this initiative. In any case, social marketing of family planning commodities targeting specifically Muslim men and women would deserve consideration as a possible intervention in the context of Nepal, particularly in locations where Muslims are a predominant or highly represented group.

Empowering women

It is widely recognised that empowering women and girls to make healthy reproductive choices requires a multisectoral approach (at all levels of programming and policy making) that addresses the socio-cultural and political issues that surround women's status. The key policy and intervention areas have been recently outlined in the Global Strategy for Women's, Children's, and Adolescents' Health 2016-2030 (2015), but there is no ready-made recipe – this requires addressing specific contextual factors.

Empowering women and addressing gender-based discrimination are also key elements of the development agenda of the Nepal government, with functions related to women's empowerment carried out by the Department of Women and Children under the Ministry of Women, Children and Social Welfare.

The study of 2011 NDHS, which concluded that Muslim women were the least empowered among all groups, also called for a range of interventions to strengthen women's agency and

ensure that women have access to livelihoods and assets – important not only for gender equality, but also likely to bring health benefits. The study recommends, among the rest, linking women to community groups, such as mothers' saving and credit groups, and further expanding the support base to women's and community networks in order to amplify the voices of women (Tuladhar, 2013).

Although it is not within the scope of this paper to address the issue of family planning beyond the health sector, we give some examples of programmatic approaches for illustration only.

In Ethiopia, the Towards Economic and Sexual Reproductive Health Outcomes for Adolescent Girls (TESFA) tested both economic empowerment and sexual and reproductive health programming among groups of girls, each receiving a different curriculum, in addition to community engagement with 'gatekeepers' (e.g. parents, village elders, religious leaders and health workers) including peer education and critical dialogue on the factors contributing to early and forced marriage. The programme evaluation found improved knowledge and use of reproductive health services, including a large and statistically significant rise in girls' use of modern family planning, as well as large gains in communication between the young wives and their husbands, decreased levels of gender-based violence and increased investment in productive economic assets, social capital and support. Although there was no evidence of a synergistic effect of combining economic empowerment and sexual and reproductive health programming, there are suggestions that girls receiving the combined package may have experienced the greatest overall gains from programme participation, showing benefits both in terms of economic and health outcomes (Edmeades 2014).

In Bangladesh the SAFE project attempted to build the social and health assets of vulnerable adolescents, addressing their vulnerability to child marriage and violence. The approach included: access to health and legal services from nearby one-stop services; interactive sessions with men, young women and girls (to discuss child marriage, violence prevention, available legal and health services, and proposed legal and policy reforms); and awareness raising campaigns in the community. Among the results, there was significant increase in modern contraceptive use that the study attributed to working with men's groups while working with female groups only showed less significant results (Naved 2014).

There are also examples of integrating family planning into non-health sector projects, for example microfinance groups that reach poor, underserved women (and attempt to empower them). An intervention targeted members of the Network of Entrepreneurship & Economic Development (NEED), a microfinance group in Uttar Pradesh, India offering family planning information as part of the health information provided through Village Health Guides. After the

intervention, family planning use among the cohort of women pre- and post-intervention increased and unmet need for family planning also fell markedly. (FHI 360/PROGRESS 2013)⁹.

5 Discussion

This section is structured around the study questions this study attempted to address (see 3.3).

5.1 Human development and family planning indicators

There is ample evidence from household and demographic surveys that Muslims present worse health and development indicators and make lesser use of public services such as health and education than the average population of Nepal. Unlike other groups, fertility rates among Muslims slightly increased between 2006 and 2011 (NDHS) and their use and access to contraceptives is among the lowest in Nepal. Limited access to education by Muslim girls and low autonomy among Muslim have been cited as key contributors to poor human development outcomes; Muslim women are reported to have the lowest levels of empowerment and the highest levels of spousal violence in Nepal.

However, all indicators should be interpreted carefully and simplistic causal links should be avoided, including the commonly cited link between low contraceptive use and the practice of Islam. In fact, the literature often links several indicators to the fact that many Muslims are poor, affected by migration or socially disadvantaged rather than to the practice of their religion.

While religion has been observed to play a role in many settings, it is the way in which the teachings of Islam in relation to family planning are interpreted that accounts for some of the differences observed. Such differences have also been found among Nepali Muslims. Other factors worth noting are the limited access to education among Muslim girls and low levels of general education in Muslim communities, which are associated worldwide with low use of contraception, as well as with broader disadvantage.

5.2 Main information gaps

We know that use of family planning among Muslims is lower than among other groups, yet the factors and barriers affecting access, use and choice of contraceptives among Muslims are less known or documented in the available literature from Nepal. In general, the literature on demand and supply side factors deriving from studies in Nepal appears limited and often superficial, with the exception of few studies based on thorough research. These information

⁹ Family planning use among the cohort of women pre- and post-intervention increased from 40% to 69% (all contraceptive methods) and 34% to 39% (only modern methods); unmet need fell from 42% of cohort members at baseline to 12% at endline. However almost half new users comprised of women reporting use of rhythm or periodic abstinence – less effective than modern contraceptive methods. The programme recognised the need to assist women transition to more effective modern method use.

gaps are a key obstacle for designing specific family planning interventions. In contrast, a substantial body of evidence is emerging from neighbouring countries, but although helpful it is often too context specific to offer readily directly applicable lessons.

It is hard to theorise about ways to bridge information gaps on the sole basis of a literature review. There seem to be three main gaps to be addressed:

1. There is a need for more sophisticated statistical analysis of NDHS data (as reported by Bennett in 2008) which should be extended to other statistical data sources such as household surveys and Multi-Indicator Cluster Surveys. Analysis should better control for the many confounding variables and identify the degree to which caste, ethnicity and regional identity actually do influence the outcomes documented (Bennett 2008).
2. Information on perceived or real demand side factors within Muslim communities is lacking. Studies tended to reference one another but few contained original empirical data about what Muslims actually believe, do, want or need. Clearly much more research of this type is needed in Nepal, but it should be gathered in ways that enable different members of Muslim communities (and women in particular) to freely express their opinions and concerns and that do not stigmatise them as ‘a problem community’.

This type of research is, by definition, time consuming and requires more advanced qualitative research skills than are possible or available through the established household and demographic surveys. It is also very different from so called ‘market research’ where ‘desire’ for specific contraceptives is gathered before the behavioural patterns and needs of the communities have been properly explored and understood. Research should be free from pre-conceived ideas about what Muslim women want or need.

3. We would also recommend specific supply side studies conducted within public and private sector family planning service providers who serve Muslim communities. The absence of supply-side studies is noteworthy. Such research is necessary to better understand whether certain reported attitudes or ‘misconceptions’ about family planning are not in fact rooted in poor service quality and other accessibility or acceptability issues.

Studies should explore, for example, the extent to which services in Muslim predominant areas are delivered by health workers (including Muslim health workers) who understand and are able to communicate effectively with their clients. We recommend primary research combining qualitative and quantitative data, while acknowledging that quantitative data originating from the HMIS is of limited or null value for research purposes given the large recording and reporting errors reported across Nepal and confirmed in recent evaluations of family planning interventions.¹⁰

¹⁰ This refers to evaluations of family planning interventions conducted as part of the project which also commissioned the literature reviews. The evaluations demonstrated that linking interventions with changes in HMIS data was not possible because of the high recording and reporting errors documented. Source: HERD and Mott MacDonald.

5.3 What interventions have been attempted or could be tested?

This literature review did not find specific interventions targeted at Muslim communities in Nepal. However there were several examples of increased recognition that access to quality health care by minority groups or in less accessible geographical areas of Nepal that deserve attention.

The need for a targeted approach has already been recognised by earlier analysis (Bennett 2008) and by the MoHP (as evidenced by commissioned research such as the PEER study). It is also expected from existing drafts that the next health sector programme will place greater focus on equity and addressing barriers that prevent specific marginalised groups from accessing services.

The PEER study (Thomas 2012) found that in addition to poverty-linked constraints, poor people experienced vulnerability related to their caste/ethnic/religious identity: “Respondents from various groups¹¹ regularly labelled themselves both by ethnic/caste/religious group and by economic/educational status, never solely by one factor, and often it was the combination of ethnicity/caste/religion, poverty, and lack of education and information which were identified as factors leading to non- and inadequate access to services” (our emphasis). So, it seems reductionist to look at these groups by religion only.

While we are unable to recommend specific interventions, other authors have emphasised several approaches that would increase the relevance and effectiveness of potential interventions. Most of these originate from the studies by Bennet (2008) and Thomas (2012 – the PEER study) (Box 2).

These studies emphasise the importance of avoiding contributing to stigma and stereotyping, and that proven interventions with high quality care are essential for Muslim women just as much as they are for other women: Muslim women should have access to the full range of methods to choose from according to individual preference – choice should not be limited because of preconceptions about what they would want as ‘Muslims’. Implicitly, these studies also stress the importance of community participation in any intervention to ensure acceptability, feasibility and local buy-in from key stakeholders, including women and their partners, but also religious leaders and other gatekeepers.

¹¹ These were: Other Backward Class, Dalit, Muslim, Brahmin/Chhetri, and Chepang (the study chose the specific terminology as the OBC group reportedly prefers to call themselves by this name).

Box 2: Recommendations from previous studies

Recommendations from the PEER study (2012)

- Work with religious leaders to:
 - inform them of the availability and benefits of health services and promote timely use of services;
 - Disseminate information from religious scripts about women’s rights and endorsement of family planning use.
- Develop appropriate targeted interventions including IEC/BCC materials for Muslim communities.
- Promote mixed mothers’ groups with Muslims and non-Muslims.
- Increase the number of Muslim FCHVs.
- Use male mobilisers to inform Muslim men about the use of family planning devices and change attitudes towards women’s use of different contraceptive options.
- Link with other social mobilisation programmes and CSOs addressing moral beliefs constraining access.
- Enhance skills of service providers so that they can provide quality services close to the community. Improve counselling skills of health providers for both motivation of couples and post-family planning acceptance advice.

Selected recommendations from Bennett (2008)

In relation to finding 1 (Dalits, Muslims, and Tarai/Madhesi Other Castes all have consistently low indicators):

- **Policy implication:** Blanket programmes designed in Kathmandu do not work for all groups. Programmes need to be designed based on deeper knowledge of the needs and conditions of different groups – and as far as possible in consultation with them.
- **Programme implication** for health and population communication programmes:
 - design messages in local languages;
 - encourage front line workers who are from the local community, speak the local language and know the local norms and concerns;
 - increase the capacity of FCHVs – and especially in Hill areas, make sure they are trained and motivated to serve Dalits as well as others.

In relation to Finding 2 (mentioning that Muslims have the highest fertility rate and also the highest level of unmet need for family planning):

- Family planning programmes should recruit and train women field workers who can communicate easily in Urdu with Muslim women and work to mobilise support for smaller family norms and contraceptive use from community and religious leaders.
- Teams developing and delivering health and family planning messages and service to diverse groups [...] need to contain members of these groups – on the ground and at the management level.

5.4 Key points from the stakeholder consultation

The findings of this literature review were discussed at a stakeholder consultation in May 2016.

Key discussion points included:

- The need to understand the patterns of uptake in different pocket areas (e.g. hill and terai; Muslims living in Muslim communities or mixed communities).
- The use of HMIS to calculate uptake of family planning among Muslim women.
- The use of digital technologies (e.g. mobile phones) to reach Muslim women.
- The need for research to understand the interplay of cultural and political barriers in relation to the uptake of family planning.

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Annex 1: Organisations approached for this study

| SN | Organisation | Date of visit | Focal person |
|----|---|-----------------------|---|
| 1 | New ERA (http://www.newera.com.np/) | 15 July 2015 | Mr. Jagat Basnet |
| 2 | CREEHPA (http://www.crehpa.org.np/) | 17 July 2015 | Mr. Mahesh Puri |
| 3 | Valley research group (http://vargp.com/) | 17 and 23 July | Only retrieved the document, could not meet in person |
| 4 | Population services International (http://www.psi.org/country/nepal/#about) | 17 and 23 July | Shazina Masoud, |
| 5 | Green Tara http://greentara.org.np/demo/) | 22 July | Mr. Amit Dhungel |
| 6 | RTI | 22 July and 19 August | Dr. Rajendra Hada |
| 7 | International organisation for Migration (http://www.nepal.iom.int/) | 22 July | Mr. Bishwa Rai |
| 8 | FHI (http://www.fhi360.org/countries/nepal) | 23 July | Dr. Neeta Shrestha |
| 9 | UNfamily planningA (http://countryoffice.unfamilyplanninga.org/nepal/) | 23 July | Dr. Shilu Adhikari |
| 10 | Family Planning Association, Nepal (http://www.familyplanningan.org/) | 23 July | Mrs Jamuna Sitaula |
| 11 | Marie Stopes International (http://www.msinepal.org.np/) | 20 August | Ms. Shilpa Lohani |

Annex 2: Consultation workshop participants

| | Name | Organisation |
|----|------------------------|-------------------|
| 1 | Dr. RP Bichha | FHD |
| 2 | Ghanshyam Pokhrel | FHD |
| 3 | Chandra Rai | Jhpiego |
| 4 | Shanti Thapa | CARE NEPAL |
| 5 | Jagadishwor Ghimire | PSI/N |
| 6 | Netra Bhatta | USAID |
| 7 | Khim Bdr. Khadka | Save the Children |
| 8 | Kanak Raj Shrestha | FHD |
| 9 | Dr. Jhalak Gautam | FHD |
| 10 | Bhakta Raj Pokhrel | FHD |
| 11 | Yuba Raj Pokhrel | NHSSP |
| 12 | Deepak Thapa | NTAG |
| 13 | Pranab Rajbhandari | HC3 |
| 14 | Minu Adhikari Khanal | FHD |
| 15 | Mohan Lal Shrestha | FHD |
| 16 | Vidya DC | FHD |
| 17 | Manju Thapa | Pourakhi Nepal |
| 18 | Kalpana Thapa | Pourakhi Nepal |
| 19 | Yogendra Prasai | New Era |
| 20 | Ashesh Regmi | FHD |
| 21 | Parshu Ram Shrestha | CHD |
| 22 | Dr. Ishwor Pd. Upadhya | NHTC |
| 23 | Dr. Sandesh Pantha | SIFPO-2 MSI/ SPN |
| 24 | Subash Shrestha | FPAN |

| | | |
|----|-----------------------|-------------------|
| 25 | Prakash Adhikari | FHD |
| 26 | Chandra Mani Dhungana | UNFPA |
| 27 | Om Khanal | FHD |
| 28 | Pankaj K. Tiwari | CRS |
| 29 | Sangita Khatri | Save the children |
| 30 | Keshu Kafle | FHD |
| 31 | Deepak Karki | PSI |
| 32 | Dr. Rajendra Gurung | NHSSP |
| 33 | Kundan Raj Acharya | HC3 |
| 34 | Ronn Hess | HC3 |
| 35 | Laxmi Aryal | WOREC |
| 36 | Dr. Beemba Shakya | CFWC |
| 37 | Dhana Basnet | FHD |
| 38 | Radhika Upreti | NTAG |
| 39 | Kunj Pd. Joshi | NHEICC |
| 40 | Manju Maharjan | CREHPA |
| 41 | Siddhi Chandra Baral | Asian Forum |
| 42 | Bimala Paudel | FHD |

(This list does not include participants from HERD)

Annex 3: Acronyms and abbreviations

| | |
|-------|---|
| ANC | Antenatal care |
| CBS | Central Bureau of Statistics |
| CHW | Community health worker |
| CPR | Contraceptive prevalence rate |
| CRS | Contraceptive Retail Sales |
| DFID | Department for International Development |
| FALAH | Family Advancement for Life and Health |
| FCHV | Female Community Health Volunteer |
| FHD | Family Health Division |
| HC3 | Health Communication Capacity Collaborative |
| HERD | Health Research and Social Development Forum |
| IUCD | Intrauterine contraceptive device |
| LHW | Lady Health Worker |
| LMIC | Low and middle income countries |
| MDG | Millennium Development Goal |
| MoH | Ministry of Health |
| MoHP | Ministry of Health and Population |
| NDHS | Nepal Demographic and Health Survey |
| NEED | Network of Entrepreneurship & Economic Development |
| NGO | Non-Governmental Organisation |
| NHSP | Nepal Health Sector Programme |
| OCP | Oral contraceptive pill |
| PSI | Population Services International |
| R4D | Research for Development |
| STS | Service tracking survey |
| TESFA | Towards Economic and Sexual Reproductive Health Outcomes for Adolescent Girls |
| USAID | United States Agency for International Development |
| UNDP | United Nations Development Programme |
| VSC | Voluntary sterilisation camp |
| WHO | World Health Organization |