Towards 2030

Monitoring Maternal Mortality and Reproductive Health in Nepal

Contributors

Authors

Satish K. Karn
Ritendra Badu
Manish Maharjan
MD. Sadik Reza Siddiki

Expert Review

Dr. Benju Koirala
Nirajan Khadka
Sushma Shrestha
Nadia Rajaram

Proofread

Yamani Khanal

Layout Editor and Designer

Sanskriti Pandey
Sukriti Tandon

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List of Acronyms

AFHs	Adolescent Friendly Health Services
AFICs	Adolescent Friendly Information Corner
ANC	Antenatal Care
CSE	Comprehensive Sexuality Education
CPR	Contraceptive Prevalence Rate
DoHS	Department of Health Services
EMR	Electronic Medical Records
ENAP	Every Newborn Action Plan
FCHVs	Female Community Health Volunteers
FGD	Focus Group Discussion
FP2020	Family Planning 2020
ICPD	International Conference on Population and Development
KII	Key Informant Interview
LGBTQIA+	**L**esbian, **G**ay, **B**isexual, **T**ransgender, **Q**ueer/**Q**uestioning, **I**ntersex, **A**sexual/**A**romantic, and other identities, representing diverse sexual orientations and gender identities
mCPR	Modern Contraceptive Prevalence Care
MMR	Maternal Mortality Ratio
MoHP	Ministry of Health and Population
MPDSR	Maternal and Perinatal Death Surveillance and Response
NDHS	Nepal Demographic Health Survey
NGO	Non-Governmental Organization
NMICS	Nepal Multiple Indicator Cluster Survey
NMMS	National Maternal Mortality Survey
NMR	Neonatal Mortality Rate
RH	Reproductive Health
SBAs	Skilled Birth Attendants
SDGs	Sustainable Development Goals
SRHR	Sexual and Reproductive Health and Rights
TFR	Total Fertility Rate
UN	United Nations
WASH	Water, Sanitation and Hygiene

Executive Summary

Nepal has made significant strides in improving maternal health and advancing sexual and reproductive health and rights (SRHR) over the past two decades. Guided by progressive sectoral policies, community based interventions, and expanded health infrastructure, the country has reduced maternal mortality, increased skilled birth attendance, and raised awareness of sexual and reproductive rights. However, these gains remain fragile and uneven, with persistent disparities across geography, gender, age, disability, and socio-economic challenges that are further exacerbated by climate-induced disasters and the ongoing impact of the COVID-19 pandemic.

This report assesses Nepal's progress toward Sustainable Development Goals (SDGs) 3.1 (reducing maternal mortality ratio) and 3.7 (ensuring universal access to SRHR services) from 2015 to 2025. It goes beyond statistics to explore the lived realities of adolescents and young people, health providers , and policymakers, identifying both systemic enablers and barriers where policy, culture, economy and institutions influence SRHR outcomes.

SDG 3.1 - Reducing maternal mortality ratio

SDG 3.7 - Ensuring universal access to SRHR services

Key Findings

1. Nepal's maternal mortality ratio (MMR) declined from 239 deaths per 100,000 live births in 2016 to 151 in 2021. However, this remains above the SDG target of 70 per 100,000 live births by 2030, with significant provincial disparities.
2. The proportion of births attended by skilled personnel increased to 81% in 2022, but coverage is still lower in remote and marginalized communities.
3. Only 55% of women have their family planning needs met with modern methods, and adolescent birth rates, while declining, remain high reflecting gaps in comprehensive sexuality education and youth-friendly services.
4. Stigma, traditional gender roles, economic hardship, limited health literacy, and health system weaknesses continue to impede access, especially for adolescents, Dalit and Indigenous groups, and those in disaster-prone areas.
5. Community leadership, peer networks, digital health innovations, and multisectoral partnerships have shown promise in expanding access and reducing inequities.

The study employed a mixed methods approach, combining qualitative analysis of national indicators with qualitative insights from Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs) involving adolescents and young people, health professionals, and government stakeholders.

To accelerate progress toward SDG 3.1 and 3.7, the report calls for:

- Increased and equitable financing for SRHR services, especially in underserved regions.
- Investment in digital health infrastructure and innovative outreach.
- Comprehensive capacity building for health providers and local governments.
- Stronger community and youth engagement in program design and monitoring.
- Enhanced coordination among government, civil society, and development partners.

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GOOD HEALTH AND WELL-BEING

Nepal stands at a critical juncture in its journey toward achieving universal maternal health and SRHR coverage. With renewed political will, targeted investments, and inclusive partnerships, the country can overcome persistent barriers and ensure that no woman, adolescent, or young person is left behind. The path forward demands urgency, innovation, and a commitment to equity-laying the foundation for a healthier, more just future for all.

Introduction

1.1 Background and Rationale for the study

With progressive sectoral policies, community based programs, improvements in infrastructure and service delivery, and international collaboration, Nepal has witnessed reductions in maternal mortality, increased uptake of family planning, and growing awareness of sexual and reproductive rights. However, these progresses remain fragile and uneven, particularly when disaggregated by geography, gender, age, disability, and socio-economic status which is further perpetuated by varying climate induced vulnerabilities and disproportionate impacts of recurring natural disasters.

The Sustainable development goals (SDGs) which was adopted in 2015 established a new global framework to guide progress on health and wellbeing, with Target 3.1 call for reduction in global maternal mortality ratio to fewer than 70 per 100,000 live births by 2030, and Target 3.7 mandating universal access to sexual and reproductive healthcare services, including family planning, education, and integration into national strategies. These targets are highly relevant for Nepal, a country grappling with the triple burden of geographical remoteness, socio-cultural conservatism, and limited health system capacity in rural and underserved areas. Despite Nepal's legal and policy commitments such as Safe Motherhood and Reproductive Health Rights Act (2018), Adolescent Health and Development Strategy (2017), Adolescent Friendly Health Service Implementation Guideline 2022 and National Family Planning Costed Implementation Plan (2015-2020), access to quality, equitable, and youth friendly SRHR services remains a significant challenge. The NDHS 2022 and DoHS Annual Report 2080/81 has revealed persistent disparities in maternal mortality and access to contraception, particularly among adolescents, Dalit and Indigenous groups and populations in Koshi and Karnali province. Furthermore, adolescents' birth rates, while declining, reflect underlying gaps in comprehensive sexuality education (CSE), community awareness, and health system responsiveness.

The urgency of this study is further amplified by the compounding crisis of recent years. The COVID-19 pandemic disrupted routine maternal and reproductive health services, increased unintended pregnancies, and exposed the fragility of service delivery systems. Additionally, the increasing frequency of climate-induced disasters-floods, landslides, and displacement has exacerbated SRHR vulnerabilities, particularly for women and girls in disaster prone areas. Political transitions and fiscal federalism have also introduced inconsistencies in local health governance and service financing, hindering uniform implementation of national commitments.

Given this context, there is a pressing need to assess Nepal's progress towards SDG 3.1 and 3.7 through a holistic, evidence-based lens. This study aims to go beyond

numerical targets to explore the lived realities of adolescents and young people, frontline health providers, and policymakers. It seeks to identify both systemic enablers and barriers at policy, cultural, economic, and institutional levels that influence SRHR outcomes. The findings are intended to inform strategic actions for accelerating equitable progress towards 2030, ensuring that no adolescent girl, young person, or marginalized woman is left behind in Nepal's development journey.

1.2 Objectives and scope of the report

Nepal's journey towards improving maternal health and advancing sexual and reproductive health and rights (SRHR) has been shaped by a complex interplay of political, social, and economic factors. Following the restoration of democracy and the signing of key international commitments such as the Sustainable Development Goals (SDGs) in 2015, Nepal has made notable progress in reducing maternal mortality ratio and expanding access to SRHR services. The adoption of the Safe Motherhood and Reproductive Health Rights Act (2018) and the Adolescent Health and Development Strategy (2017) has contributed to a more enabling policy environment, with provisions for free maternal health services, safe abortion, and adolescent friendly health programs. Despite these achievements, persistent disparities remain across provinces, castes, and age groups, and progress has been further challenged by the impacts of the COVID-19 pandemic and climate-induced disasters.

The 2021 Census highlights that a significant proportion of Nepal's population is comprised of adolescents and young people, underscoring the urgent need to prioritize their access to quality SRHR services. However, recent data from the Nepal Demographic and Health Survey (NDHS 2022) reveal that currently married women age 15-49 with 43% of women have their family planning needs met with modern methods, and adolescent birth rates remain high, reflecting ongoing gaps in comprehensive sexuality education and youth-friendly services. Furthermore, structural barriers such as stigma, socio-cultural norms, and limited health literacy continue to impede equitable access, particularly for marginalized groups including Dalit, Indigenous, and rural populations.

While Nepal's legal and policy frameworks are increasingly progressive, implementation on the ground remains inconsistent. The decentralization of health governance under federalism has introduced new opportunities but also challenges, with variations in service delivery and financing across provinces. The lived experiences of young people, women, and frontline health workers often diverge from policy intentions, highlighting the need for a more nuanced understanding of both enablers and barriers to SRHR and maternal health. Given this context, the primary aim of this report is to provide a comprehensive and evidence-based assessment of Nepal's progress and challenges in achieving SDG targets 3.1 (reducing maternal mortality ratio) and 3.7 (ensuring universal access to SRHR services) over the past decade. The report seeks to move beyond aggregate statistics to explore the realities faced by adolescents, young people, and women—particularly those from marginalized communities—while identifying systemic gaps and opportunities for transformative change.

The specific objectives of this report are:

1. Analyze trends and inequities in maternal mortality and reproductive health outcomes in Nepal since 2015 in relation to SDG targets 3.1 and 3.7.
2. Assess the effectiveness of maternal health and SRHR policies and programs at federal, provincial, and local levels focusing on service availability, quality of care, workforce capacity, and referral systems.
3. Identify key enabling factors and barriers influencing access to and utilization of maternal health and SRHR services, particularly for adolescents, young people, and marginalized populations.
4. Develop evidence-based recommendations informed by policy analysis and youth perspectives to guide national action and Asia-Pacific regional policy dialogue.

1.3 Relevance to SDG 3.1 and 3.7 in Nepal Context

SDG 3.1 (Maternal Mortality Reduction): Nepal's maternal mortality ratio (MMR) was 151 per 100,000 live births in 2022, above the global SDG target of 70. Skilled birth attendance was 80%, short of the 90% target. Despite improvements, maternal health remains a critical issue due to factors such as poor utilization of maternal health services, cultural barriers, inadequate health facilities, and quality of care challenges.

SDG 3.7 (Universal Access to SRH Services): Nepal faces significant challenges in ensuring universal access to sexual and reproductive health services. Only 43%% of women of reproductive age have their family planning needs met with modern methods (target 80% for 2030), and adolescent birth rates have improved but remain a concern. Barriers include limited knowledge, socio-cultural norms, stigma, insufficient youth-friendly services, and gaps in comprehensive sexuality education.

The large adolescent and youth population (approximately 24% aged 10-19 and 20% aged 15-24) underscores the importance of addressing SRHR among young people to meet these SDG targets. National policies have evolved to recognize adolescents' rights to access SRH services, but implementation gaps persist.

Methodology

2.1 Data Collection approaches

This monitoring report employed a mixed methods design, combining secondary quantitative data analysis with primary qualitative data collected through Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs). The approach was designed to provide a comprehensive, credible, and context sensitive assessment of Nepal's progress toward SDG targets 3.1 (reducing maternal mortality ratio) and 3.7 (universal access to sexual and reproductive health and rights - SRHR). To ensure the credibility and relevance of findings, a validation workshop with key stakeholders consisting of government personnels working in the sector, youths, CSO representatives was conducted, allowing for the triangulation of insights and the incorporation of diverse perspectives. The study was conducted from September to December 2025.

The desk review formed the foundation of the methodology, involving a systematic examination of existing literature, national surveys, research reports, policy papers, and advocacy briefs. Major national data sources included the Nepal Demographic and Health Survey (NDHS 2022), Nepal Maternal Mortality Report (NMMR 2021), Nepal Multiple Indicator Cluster Survey (NMICS 2014), and the Thematic Report: Fertility in Nepal (2021 National Population and Housing Census). These sources were chosen for their recent publication dates and comprehensive coverage of relevant indicators. For areas where recent data were unavailable, publications older than five years were considered only if they provided unique or otherwise unavailable information. Older sources (beyond five years) were included only when no recent data were available and where they provided essential contextual or trend information. Policy documents such as the Safe Motherhood and Reproductive Health Rights Act (2018) and the Adolescent Health and Development Strategy (2017) were reviewed to assess policy alignment and implementation gaps. Advocacy briefs and policy papers from civil society and youth-led organizations were included to capture non-governmental perspectives.

The qualitative component aimed to contextualize quantitative findings and explore lived experiences, system level barriers, and enabling factors. A total of four KIIs were conducted using purposive sampling. Participants were selected based on their institutional roles, technical expertise, and involvement in maternal health, family planning, and SRHR programming.

Key informants included:

1. Family Welfare Division (FWD):
    - Maternal and Child Health Section Chief
    - Family Planning and Reproductive Health Section Focal Person
2. Provincial Health Directorate (Sudurpashchim): SRHR/FP Focal Person
3. District Health Office, Kailali: Senior Public Health Officer

KIIs were conducted at federal, provincial, and local levels to capture governance and implementation perspectives across Nepal's federal health system.

One FGD was conducted with eight young people aged 20–29 years, selected through an open call and shortlisting process to ensure diversity by gender, province of origin, ethnicity, and educational background. The FGD explored youth perspectives on SRHR access, stigma, confidentiality, adolescent pregnancy, and service responsiveness.

A stakeholder validation workshop was conducted to strengthen credibility and triangulation in person and through online medium email. Stakeholders included: Government officials working in maternal health and SRHR, Youth representatives and networks, CSOs active in SRHR advocacy and service delivery. The workshop and engagement of expert through online medium enabled validation of preliminary findings, clarification of discrepancies, and consensus-building on key recommendations.

Semi-structured KII and FGD guides were developed based on:

- The Means of Implementation Framework i.e Financing, Technology, Capacity Building and Trade.
- Preliminary findings from the desk review
- Alignment with the study objectives and research questions

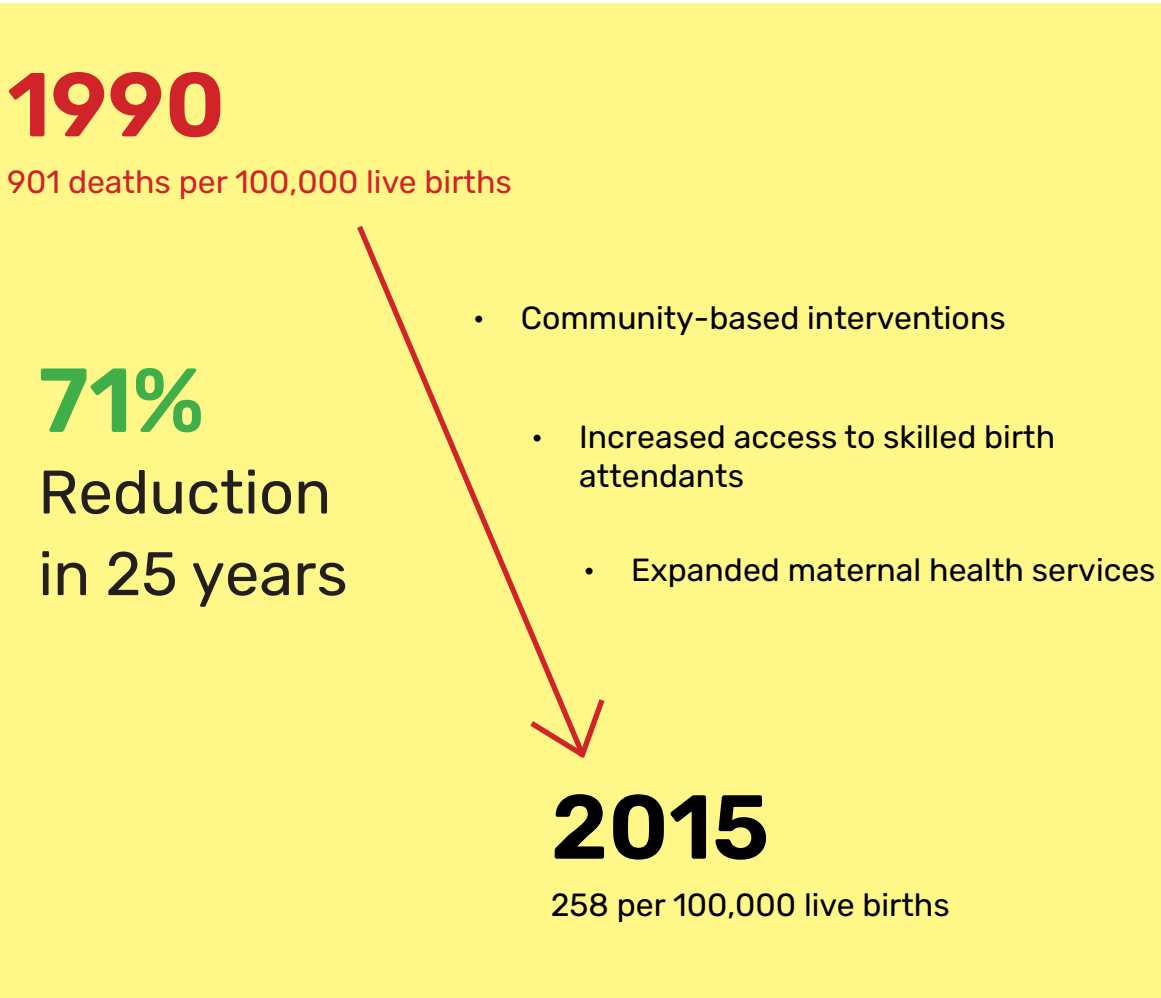
The tools were internally reviewed and refined prior to data collection to ensure relevance, clarity, and alignment with SDG 3.1 and 3.7. While formal pilot testing was not conducted, the tools were iteratively adjusted during early interviews to improve flow and contextual relevance. Qualitative data from KIIs and FGDs were transcribed and analyzed thematically. Quantitative and qualitative findings were triangulated to enhance analytical depth and validity. Where inconsistencies or data gaps emerged, additional sources were consulted, as mentioned in references section.

2.2 Research Questions

- What are the key barriers and enabling factors affecting adolescents' and young people's access to quality, youth-friendly, and equitable sexual and reproductive health and rights (SRHR) services in Nepal?
- How effectively do national health policies and programs address the SRHR needs and challenges of adolescents and youths in Nepal, in alignment with SDG-3 targets related to universal access to sexual and reproductive healthcare services?
- What has been the progress so far in reducing maternal mortality ratio and improving access to SRH services and how do young people perceive the barriers and facilitators to accessing these services in Nepal?

Status before 2015 : Pre-SDG Baseline

Before the adoption of the Sustainable Development Goals (SDGs) in 2015, Nepal had already made substantial progress in reducing maternal mortality ratio and improving reproductive health, setting a critical baseline for subsequent efforts under SDG 3.1 and 3.7. The maternal mortality ratio (MMR) declined dramatically from an estimated 901 deaths per 100,000 live births in 1990 to 258 per 100,000 live births by 2015, marking a 71% reduction over 25 years. This improvement was largely driven by community based interventions, increased access to skilled birth attendants, and expanded maternal health services, although coverage remained uneven, with only about 36% of births attended by skilled personnel and approximately 60% of women receiving antenatal care from skilled providers. Family planning services also showed progress but faced challenges, with an unmet need for contraception among 27% of married women and persistently high adolescent birth rates, reflecting gaps in access, education, and sociocultural barriers. These pre-2015 conditions highlighted the need for intensified, equity focused strategies to accelerate maternal mortality reduction and expand comprehensive sexual and reproductive health services as Nepal transitioned into the SDG era.



Analysis of Key Indicators

S.N.	SDG Target and Indicator	Baseline Data (2015)	Target Set for 2025	Current Status	Target Set for 2030
1.	**3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live birth**				
	3.1.1: Maternal mortality ratio	258[1]	99	151[3]	70
	3.1.2: Proportion of births attended by skilled health personnel	55.6[2]	79	80.1[3]	90
2.	**3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes**				
	3.7.1: Proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods	66[2]	76	55.1[3]	80
	a. Contraceptive prevalence rate (modern methods) (%)	47.1[2]	56	43[3]	60
	b. Total Fertility Rate (TFR) (births per women aged 15-49 years)	2.3[2]	2.1	2.1[3]	2.1
	3.7.2: Adolescent birth rate (aged 10–14 years; aged 15–19 years) per 1,000 women in that age group	71[2]	43	71[3]	30

1. UN Estimates (2015)
2. NMICS (2014)
3. NDHS 2022

4.1 Maternal Mortality Ratio (SDG 3.1.1)

The Maternal Mortality Ratio (MMR) is a vital indicator of the quality and accessibility of maternal health services, reflecting the overall performance of the health system. In Nepal, the MMR has declined significantly over recent years, dropping from 239 deaths per 100,000 live births in 2016 to 151 deaths per 100,000 live births in 2021, according to the Nepal Maternal Mortality Report 2021(NMMR 2021). More recent estimates from the World Health Organization (WHO, 2025) indicate a further reduction to 142 deaths per 100,000 live births, reinforcing the positive downward trend in maternal mortality. This progress demonstrates the country's ongoing commitment to improving maternal health outcomes and aligns with Nepal's pledge to reduce the MMR further to 99 by 2025 and 70 by 2030. Despite national progress, substantial disparities exist across provinces. The NMMR 2021 data show that Bagmati Province has the lowest MMR at 98 deaths per 100,000 live births, while Lumbini Province records the highest at 207 deaths per 100,000 live births. These could also be due to lack of notification and error in the recording and reporting process. The legal framework, particularly the Safe Motherhood and Reproductive Health Rights Act of 2018, has played a crucial role in advancing reproductive rights, including safe abortion services, which have contributed to lowering maternal mortality. Nonetheless, Nepal faces ongoing challenges in fully meeting the SDG target, underscoring the need to strengthen policy implementation and ensure equitable access to quality maternal health services.

An analysis of maternal deaths reveals that over 61% occur during the postpartum period (within 42 days of delivery), emphasizing the urgent need to enhance postnatal care systems, especially home visit programs that can identify and manage complications early. The report also shows that among the women who died in the post-partum period, nearly 45% of them had received three postnatal visits. As per the annual report of DOHS 2023/24, only 37.8% of mothers had received four postnatal visits as per protocol 8 ANC . Furthermore, 57% of maternal deaths occurred in health facilities, indicating that the quality and readiness of facility based care require significant improvements. This situation calls for capacity building at **Basic Health Service Centers*** and ensuring the presence of skilled birth attendants at all birth centers to provide safe and effective care.

Applying the "Three Delays" model to maternal mortality, 74% of deceased women experienced at least one delay in accessing timely and appropriate care, with 17% encountering all three delays. The first delay - seeking care affected 57% of women, often due to lack of awareness, cultural barriers, or financial constraints. The second delay - reaching health facilities was reported by 33%, reflecting geographic and transportation challenges. The third delay receiving adequate care at facilities-though less frequently quantified, remains a critical factor linked to health system capacity was reported as 40%. Additionally, nearly one-third (32%) of maternal deaths were due to non-obstetric complications,

***Basic Health Service Centers: These are the smallest public health facilities in the ward level within the health system responsible for delivering basic health services**

highlighting the importance of comprehensive management of co-morbidities during pregnancy. It was also reported that 26% of maternal deaths were due to Obstetric hemorrhage while 6% were also linked to self harm with majority occurring during pregnancy. This also shows the growing need for integration of mental health services and psycho-social counselling during ANC checkup.

Among the 611 maternal deaths analyzed in the National Maternal Mortality Report 2021 (NMMR 2021), 10.3% involved women aged 10–19 years, underscoring the vulnerability of adolescent mothers. This finding points to the urgent need for incorporating comprehensive sexuality education in the school health curriculum targeting adolescents to delay early marriage and teenage pregnancy, which are key risk factors for maternal mortality. To accelerate progress toward SDG 3.1.1, Nepal must strengthen postnatal care services—particularly home visits ensure skilled birth attendants are available at all delivery points, address geographic and socioeconomic barriers to timely care, enhance health facility readiness to manage obstetric emergencies, expand adolescent sexual and reproductive health education and services, and improve data collection and monitoring systems to effectively identify and respond to maternal death causes. Through coordinated policy efforts, health system strengthening, and community engagement, Nepal can continue its positive trajectory in reducing maternal mortality ratio and safeguarding the health of mothers nationwide.

4.2 Proportion of Births Attended by Skilled Personnel (SDG 3.1.2)

The proportion of births attended by skilled health personnel is a fundamental indicator of maternal and newborn health, as well as the overall strength and equity of a country's health system. This measure reflects not only the availability of doctors, nurses, and midwives trained to manage normal deliveries and recognize complications, but also the accessibility and quality of essential health services for women and newborns at the most critical time. Ensuring that every birth is attended by a skilled professional is central to reducing preventable maternal and neonatal deaths and achieving broader health and development goals.

Nepal has made remarkable progress in increasing the proportion of births attended by skilled health personnel over the past three decades. According to the Nepal Demographic and Health Survey (NDHS), only about 7% of births were attended by skilled personnel in 1991. This figure rose to 58% by 2016 and reached 81% by 2022, signaling substantial improvements in both service coverage and health system capacity. However, there are still important data gaps. National statistics may not always accurately capture the qualifications of all attending personnel, especially in remote areas where distinctions between skilled and unskilled attendants can be unclear. Additionally, there is limited data on home births and those occurring outside formal health facilities, particularly in marginalized and rural communities.

Despite overall progress, significant disparities persist in the coverage of skilled birth attendance across Nepal. Geographical differences are pronounced, with provinces such as Sudurpashchim reporting higher rates of skilled attendance, while Madhesh province continues to lag behind. Socioeconomic status also plays a major role: women from wealthier households, those with higher levels of education, and those covered by health insurance are much more likely to have skilled personnel present at delivery. Caste and ethnicity further influence access, with women from Terai caste, Muslim, and other marginalized communities less likely to benefit from skilled attendance. Furthermore, women who have had two or more children are less likely to use skilled birth attendants compared to first time mothers, highlighting the need for targeted interventions.

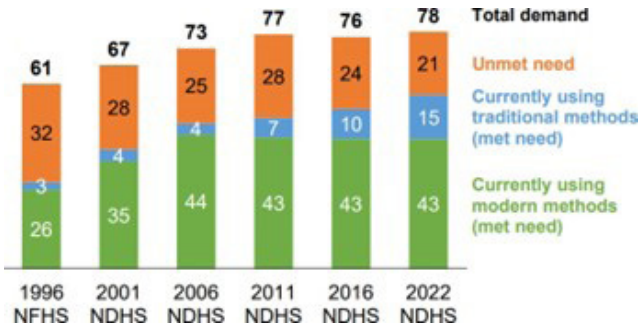
The government of Nepal has prioritized safe motherhood through a range of policies and programs over the years. The Safe Motherhood Policy, National Safe Motherhood Program, and more recent initiatives such as free delivery services and health insurance schemes have all contributed to expanding access to skilled care, especially in rural and hard to reach areas. Financial incentives and community based outreach have encouraged more women to deliver in health facilities and seek professional care. Despite these efforts, barriers remain. Physical access is still a major challenge in remote and mountainous regions, where health facilities and skilled personnel are scarce. Socio-cultural norms and a preference for home births continue to limit uptake of skilled attendance in some communities, while lack of awareness and education about the importance of skilled care further reduces demand, particularly among disadvantaged groups. Even when skilled personnel are present, the quality of care and respectful treatment can vary, which may affect trust in health services and willingness to seek care in the future.

To further increase the proportion of births attended by skilled personnel, Nepal must continue to prioritize outreach to disadvantaged and remote populations, strengthen health system infrastructure and workforce capacity, and enhance data collection to better monitor progress. Community engagement and education are essential to shift norms toward institutional deliveries and skilled care, while ongoing efforts to improve the quality and respectful delivery of services will help build trust and encourage greater use of skilled birth attendants. Ensuring that every woman has access to skilled care at birth is crucial for achieving SDG targets and for safeguarding the health and rights of mothers and newborns across Nepal.

4.3 Access to Family Planning (SDG 3.7.1)

Access to family planning is the cornerstone of sexual and reproductive health and rights (SRHR), directly contributing to improved maternal and child health, gender equality, and sustainable development. This indicator reflects the availability of contraceptive methods and services and the accessibility of accurate information, the agency of individuals to make informed choices, and the responsiveness of health system to meet diverse needs. The contraceptive prevalence rate among currently married women aged 15-49 stands at 57% (NDHS 2022) which indicates the over half of married women in reproductive age are using some form of

family planning. Of these, 43% use modern methods, while 15% rely on traditional methods. The high overall CPR reflects access to acceptance of family planning, contributing to improved maternal and child health. However, the continued use of traditional methods highlights the need for further education and access to contraceptives.



Only 14% of currently married women aged 15-19 use a modern method of family planning. The low uptake among adolescents points to barriers such as lack of information, social stigma or cultural norms. Addressing these barriers is crucial to prevent early pregnancies, which can have long-term health, social, and economic consequences. The 21% of currently married women aged 15-49 have an unmet need for family planning, meaning they want to delay or avoid the pregnancy are not using any method, the unmet need is highest among young women aged 15-19 at 31%. A high unmet need among adolescent signals gaps in service delivery, information dissemination and empowerment. Young women may face unique challenges such as lack of youth-friendly support, autonomy decision making.

Only 55% of the total demand for family planning is met by modern methods. This means nearly half of the women who wish to use family planning are either not using any method or are relying on less effective traditional methods. This indicator reveals that substantial gaps remain in ensuring that all women who want to use family planning can access effective, modern methods. Improving supply chains, service quality, and outreach especially to marginalized groups. Within the five years preceding the survey, the 12-month discontinuation rate for contraceptives was 49%. This is particularly high for pills (67%), male condoms (60%), and injectables (59%). High discontinuation rates undermine the effectiveness of family planning programs and can lead to unintended pregnancies. The leading reason—spousal separation or infrequent sex—reflects social and migratory patterns in Nepal. Side effects and health concerns also indicate a need for better counseling and follow-up services to support users in managing side effects and switching methods if necessary.

Nepal has made notable progress in expanding family planning coverage, but significant challenges persist. The high contraceptive prevalence rate is encouraging, yet the reliance on traditional methods, low adolescent uptake, substantial unmet need, and high discontinuation rates highlight persistent gaps.

4.4 Adolescent Birth Rate (SDG 3.7.2)

Reducing adolescent fertility is not just a measure of drop-down of the statistics; it is in fact an indicator of holistic provision of sexual and reproductive health services, information and rights among all without any discrimination and restrictions. Nationally, the adolescent birth rate stands at 71 births per 1,000

women aged 15–19 in 2022, decreasing from 185 per 1,000 in 2006 to 167 per 1,000 in 2011, and remained constant until 2016. This suggests that the country is making some progress in this regard. There are some data gaps in the national dataset which include: data of fertility rate for ages 10-14 was unavailable from the national records and the data does not cover all pregnancies of unmarried adolescents.

14% of women between the ages of 15 and 19 have ever been pregnant, according to data from the Nepal Demographic and Health Survey (NDHS) 2022. Ten percent of this group had a live birth, and two percent had a miscarriage. 2% of men and women had reported having sex before the age of 15. It is noteworthy that by the age of 15, 1% of women in this age group had become pregnant and 3% had gotten married. The report also highlights increasing prevalence with age, rising from 1% among 15-year-olds to 32% among 19-year-olds. Teenage pregnancy is most prevalent among Muslim and Dalit populations, and least common among Brahmin/Chhetri groups. The lowest rates of teenage pregnancy are observed in Bagmati Province and the highest in Karnali Province and among these provinces as well, rural areas report a higher rate than urban areas.

Nepal has introduced laws and policies to help reduce adolescent pregnancy since 1963 with banning marriage before the age of 20. The Adolescent Development and Health Strategy, 2000 focused on raising the legal age of marriage to reduce teenage pregnancies. In 2002, safe abortion became legally accessible for women, and in 2010, the National Adolescent Sexual and Reproductive Health Program was introduced across the public health system to ensure sexual and reproductive health. Despite this, child marriage is still common in Nepal and eventually, it continues to have one of the highest rates of adolescent pregnancy in South Asia.

Multiple intersectional factors have been reported to contribute to the persistence of adolescent pregnancy in Nepal. Girls who are out of school or have dropped out are more likely to become pregnant during adolescence. Economic conditions often drive families to consider early marriage and childbearing as strategies for financial security. Restricted availability of contraceptives, inadequate knowledge on available SRHR services and lack of comprehensive sexuality education are also some contributors in addition to deep-rooted norms that signify marriage as a means to stay reputable in the society and avoid apparent mis-happenings of choosing the spouse on their own. Besides this, more general conditions of lack of decision making autonomy among adolescents, girls and women, dependency upon the males for breadwinning and peer influence also affect early sexual activity with or without marriage. Violence, including sexual abuse, may coerce girls into early and forced pregnancies, often accompanied by early marriages. It is also important to consider the implications of criminalizing adolescent sexuality without restoring a practice and system conducive to informed decision making, along with effective implementation of adolescent focused laws and programs.

Policy and Program Effectiveness

Assessment of current national and provincial health policies and programs

Nepal has developed a comprehensive and evolving policy and program framework to improve maternal, newborn, and child health, closely aligned with the Sustainable Development Goals (SDGs) and national health priorities. A central guiding instrument is the Nepal Safe Motherhood and Newborn Health Roadmap 2030, which sets ambitious national targets, including reducing the maternal mortality ratio (MMR) to fewer than 70 deaths per 100,000 live births and the neonatal mortality rate (NMR) to below 12 per 1,000 live births by 2030. The roadmap adopts a life-cycle and continuum of care approach, encompassing adolescent reproductive health, pre-pregnancy care, antenatal, intrapartum, and postnatal services, with explicit emphasis on quality, equity, and responsiveness to diverse geographic and socio-cultural contexts. For example, improving physical access and referral readiness is prioritized in mountainous regions, while addressing sociocultural barriers and service utilization is particularly relevant in the Terai and densely populated areas.

The policy foundation for maternal health and sexual and reproductive health and rights (SRHR) is reinforced by progressive legislation, notably the Safe Motherhood and Reproductive Health Rights Act (2018) and the Public Health Act (2018), which operationalize constitutional guarantees under Articles 35 and 38. These provisions establish access to free basic health services, emergency care, safe motherhood, and reproductive health as fundamental rights. These legal commitments have been translated into multiple national programs aimed at increasing skilled birth attendance, antenatal care coverage, institutional delivery, and emergency obstetric services. Among these initiatives, the Aama Surakshya Programme represents a flagship demand side intervention. By providing financial incentives for institutional deliveries, completion of four antenatal care visits, and postnatal care alongside free delivery services and management of obstetric complications the program has contributed significantly to increased facility-based deliveries nationwide. Community-level implementation has been strengthened through the engagement of Female Community Health Volunteers (FCHVs), who play a critical role in awareness-raising, birth preparedness, distribution of misoprostol for the prevention of postpartum hemorrhage, and linking pregnant women to health facilities, particularly in underserved areas. On the supply side, Nepal has invested in expanding and upgrading health infrastructure and human resources. These efforts include strengthening health posts and primary health care centers, establishing newborn care corners, developing special newborn care units at district hospitals, and laying the groundwork for neonatal intensive care units at tertiary facilities under the Every Newborn Action Plan (ENAP). Investments in skilled birth attendant training and deployment have improved service availability; however, coverage, functionality, and quality remain uneven across provinces.

Findings from YUWA's study of National Level Policies Regarding SRHR with Gaps

and Recommendation conducted in 2022and indicate that the implementation and impact of maternal health and SRHR policies vary considerably across provinces, reflecting differences in governance capacity, financing, and coordination under Nepal's federal system. Provinces such as Bagmati demonstrate relatively stronger policy coherence and implementation readiness, supported by better resourced health infrastructure, higher concentration of skilled health personnel, and closer proximity to federal institutions. These enabling conditions have facilitated more consistent operationalization of national policies, including adolescent-friendly health services, family planning programs, and maternal health interventions.

In contrast, Sudurpashchim and Karnali Provinces face greater challenges in translating policy commitments into effective and sustained programs. Although provincial policies and annual plans align broadly with national frameworks, YUWA's analysis highlights gaps in financing, human resource availability, logistical capacity, and inter-sectoral coordination. Geographic remoteness, difficult terrain, and limited institutional capacity at local levels further constrain the reach and quality of maternal health and SRHR services, particularly for adolescents and marginalized populations. Lumbini and Madhesh Provinces exhibit mixed performance in policy effectiveness. While both provinces have incorporated SRHR and maternal health priorities into provincial policies and plans, implementation outcomes vary substantially across districts. High population density, persistent gender and caste-based inequities, and entrenched sociocultural norms continue to limit service utilization. Weak enforcement of policy provisions related to comprehensive sexuality education and youth-friendly services further reduces impact, despite the existence of supportive policy language.

Across all provinces, YUWA's study identifies a common gap in monitoring, accountability, and feedback mechanisms. While alignment with SDG targets 3.1 and 3.7 is generally strong at the policy level, effectiveness is undermined by the absence of clear implementation guidelines, measurable annual milestones, and consistent use of evidence such as findings from the Maternal and Perinatal Death Surveillance and Response (MPDSR) systemfor corrective action. Provinces with stronger coordination between health directorates, local governments, and civil society actors tend to demonstrate better service continuity and responsiveness.

In conclusion, Nepal's national and provincial health policies and programs have established a strong legal and institutional foundation for improving maternal and newborn health and advancing SRHR. Significant gains in service coverage and rights-based commitments are evident. However, policy effectiveness is shaped less by the existence of policies and more by governance capacity, equitable financing, and implementation support at provincial and local levels. To fully achieve SDG targets 3.1 and 3.7, intensified efforts are required to reduce inter-provincial inequities, strengthen quality and respectful care, institutionalize surveillance and accountability mechanisms such as MPDSR, and address persistent socio-cultural and systemic barriers. Sustained political commitment, predictable and equity-weighted financing, effective implementation under federalism, and strong multisectoral and community engagement will be critical to ensuring that all women, adolescents, and newborns across Nepal can realize their right to health.

Barriers and Enabling Factors

5.1 Findings from KIIs and FGDs

This section presents a comprehensive analysis of the barriers and enabling factors identified through KII and FGDs with young people, health professionals, and government agencies. The findings are organized across socio-cultural, economic, policy, and health system domains, and highlight both challenges and best practices that influence the program implementation and service uptake.

5.1.1 Barriers

Socio-cultural Barriers

- Stigma remains a significant impediment, particularly for individuals seeking services related to SRHR, HIV and Aids, and mental health. Many participants reported fear of being judged by their communities, which discourages them from accessing services. This is especially in context of vulnerable groups such as adolescents, unmarried women, and key populations.
- Traditional gender roles continue to restrict women's autonomy in health-seeking behavior. In many households, male members or elders are the primary decision makers regarding health care utilization. These dynamic limits women's ability to access timely and appropriate services, particularly for reproductive health.
- Deeply rooted cultural beliefs and myths about modern health interventions, such as immunization, contraception, and facility-based childbirth, persist in many communities, especially in rural areas. These misconceptions often lead to resistance, low uptake of services, and, in some cases, active opposition to health workers.
- Limited health literacy and insufficient dissemination of accurate information contribute to misunderstanding about available services and their benefits. This gap is more pronounced in remote and marginalized communities.

Economic Barriers

- The financial burden of health care, including consultation fees, diagnostic tests, medications, and transportation remains a major barrier. Many households, especially those with irregular or low incomes, are unable to afford these expenses, leading to delayed or foregone care.
- For daily wage earners and agricultural workers, the time spent seeking health services translates into lost income. This opportunity cost is a significant deterrent, particularly during peak agricultural seasons or in households reliant on subsistence labor.

- Marginalized groups, such as ethnic minorities and people with disabilities, face compounded economic barriers due to social exclusion, limited employment opportunities, and lack of targeted support.

Policy Barriers

- While national policies may be progressive, their implementation at the local level is often inconsistent. Key informants highlighted discrepancies between policy intent and actual practice, resulting in variable service quality and access.
- Health workers in several areas reported the absence of clear, up to date protocols and standard operating procedures. This lack of guidance leads to confusion, inconsistent service delivery, and reduced provider confidence.
- Both service providers and beneficiaries often lack awareness of their rights and entitlements under existing health policies, which undermines accountability and demand for services.

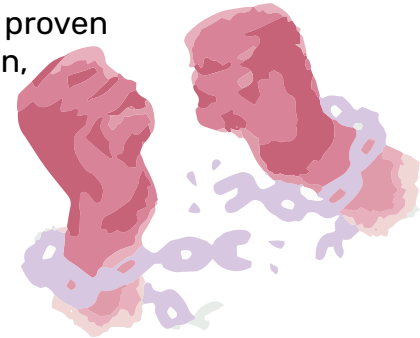
Health System Barriers

- There is a chronic shortage of trained health personnel, especially in rural and hard to reach areas, which were frequently cited. High staff turnover, inadequate incentives, and limited opportunities for professional development exacerbate these challenges.
- Frequent stockouts of essential medicines, vaccines, and supplies disrupt service continuity. Logistics in transporting supplies to remote areas have further compounded this problem.
- Many health facilities lack basic amenities such as clean water, sanitation, electricity, and private consultation spaces. Poor facility conditions negatively impact client trust, privacy, and overall satisfaction.
- Inefficient referral mechanisms hinder timely access to higher-level care, particularly for complications or specialized services. This often results in delayed treatment and adverse health outcomes.

5.1.2 Enabling Factors and best practices

Community Engagement and Participation

- The involvement of respected local leaders, religious figures, and community health volunteers has been instrumental in increasing awareness, dispelling myths, and fostering trust in health services. Their endorsement often encourages wider community acceptance and participation.
- Peer-led groups, especially among adolescents and women, have proven effective in providing psychosocial support, sharing information, and reducing stigma. These networks empower individuals to make informed health decisions and advocate for their rights.
- Regular in-service training and capacity building initiatives for



health workers have improved technical skills, knowledge, and confidence. Supportive supervision and mentorship further enhance service quality and provider motivation.

- Non-financial incentives, such as public recognition and opportunities for career advancement, have contributed to improved staff morale and retention in some settings.

Policy Support and Resource Allocation

- Where local authorities have prioritized health through resource allocation, enforcement of guidelines, and monitoring of service delivery, there has been a marked improvement in both access and quality of care.
- Integrating multiple health services (e.g., maternal and child health, immunization, nutrition) at the community and facility level has streamlined service delivery, reduced missed opportunities, and enhanced efficiency.

Innovative Outreach Strategies

- Mobile health units and periodic outreach camps have successfully extended services to remote and underserved populations, overcoming geographic and transportation barriers.
- The adoption of digital health tools, such as SMS reminders and telemedicine platforms, has improved communication, follow-up, and health education, particularly in areas with limited physical access to health facilities.

Best Practices

- Involving community members in monitoring and feedback mechanisms has increased accountability and responsiveness of health services.
- Collaborations with private sector entities and NGOs have expanded service coverage, introduced innovative approaches, and leveraged additional resources.
- Tailoring and localization of health messages and interventions to local languages, beliefs, and practices has improved acceptance and effectiveness.

These findings highlight the complexity of barriers faced at multiple levels, but also demonstrate that targeted, context specific enabling factors and best practices can significantly enhance health service delivery and uptake. Continued investment in community engagement, capacity building, and responsive policy implementation is essential for sustained progress.

Young People's Perspectives

Young people who participated in the focus group discussions (FGDs) offered candid insights into the barriers they face and the factors that enable their access to health services. A recurring theme was the pervasive stigma associated with seeking care for sensitive issues such as sexual and reproductive health, HIV/AIDS, and mental health. Many adolescents and youth expressed that the fear of being judged by peers, family members, and the broader community discourages them from accessing these vital services. This stigma is particularly acute for unmarried young women and those belonging to marginalized groups, who often feel scrutinized or misunderstood when attempting to seek help.

Traditional gender roles and limited autonomy further compound these challenges. Several young women described how health-related decisions are frequently controlled by male relatives or elders, restricting their ability to seek timely and appropriate care. This lack of agency not only delays care-seeking but also perpetuates misinformation and myths about health interventions, such as contraception or mental health support. Many participants highlighted that the absence of accurate, youth-friendly information leads to confusion and mistrust, making it difficult for them to make informed decisions about their health. Economic constraints were another significant barrier identified by young people. The costs associated with consultations, diagnostic tests, medications, and transportation can be prohibitive, especially for those from low-income families or those who rely on daily wages. Some participants emphasized that the need to miss school or work to access health services presents an additional opportunity cost, which can deter them from seeking care altogether. For youth from ethnic minorities or those living with disabilities, these barriers are often compounded by social exclusion and discrimination, making it even more challenging to access the services they need.

> ***In our society, everyone wants privacy, but it isn't maintained. That's why young people turn to unsafe options. The system still holds biases against trans people, women, and youth.***
>
> Participant P6, FGD Participant (Youth from Terai)

> ***A transgender man was mocked and misgendered by health staff during a check-up. The doctor said, "You say you're male, but you have a uterus and get your period"—in front of others. This violated all privacy.***
>
> Participant P3 , LGBTQ Youth Champion, FGD

Despite these obstacles, young people also identified several enabling factors and best practices that have helped improve their access to health services. Peer-led groups and youth networks were frequently mentioned as crucial sources of psychosocial support and reliable information. These platforms not only help reduce stigma but also empower young people to advocate for their own health and the health of their peers. Active involvement in community health initiatives

and awareness campaigns has further increased trust in health services among youth populations. The adoption of digital health tools, such as SMS reminders, social media platforms, and telemedicine, has made it easier for young people to access information and maintain follow-up care, particularly in areas where physical access to health facilities is limited. Training young people as peer educators and community health volunteers has also proven effective in building capacity and fostering a sense of ownership and responsibility for community health outcomes. In summary, the perspectives shared by young people underscore the need for youth-friendly, confidential, and non-judgmental health services. They called for continued investment in peer education, digital outreach, and community engagement to address persistent barriers and promote positive health outcomes for adolescents and youth.

Foreseeable challenges to 2030

Nepal's progress toward achieving SDG targets 3.1 (reducing maternal mortality ratio) and 3.7 (universal access to sexual and reproductive health services) faces several critical challenges that could hinder meeting the 2030 goals. A major concern is the decline in both domestic budget allocations and foreign aid, which has led to funding shortfalls for key maternal and child health programs. For instance, the Safe Motherhood Programme, credited with reducing maternal mortality by over 70% since 2000, is currently underfunded, with urgent financial gaps affecting reimbursements to hospitals and the continuation of essential services. Additionally, the suspension and reduction of foreign assistance have disrupted training, supply chains, and health services, threatening to reverse hard-won gains.

> ***If the Ministry does not develop Adolescent Health as a separate wing in this system, it will be difficult for us to meet our indicators in the future.***
>
> Participant: Family Planning & Reproductive Health, DoHS, Kathmandu

Geographic and socio-cultural barriers remain significant obstacles. Women in remote, mountainous, and marginalized communities often face limited access to skilled birth attendants and emergency obstetric care due to poor infrastructure, transportation difficulties, and entrenched cultural norms favoring home births. The persistence of child marriage and teenage pregnancies further compounds maternal health risks, especially among adolescents who lack comprehensive sexuality education and youth-friendly reproductive health services. Health facilities in many areas struggle to provide continuous cesarean delivery and neonatal care, and shortages of skilled personnel and essential medical equipment continue to undermine the quality of care.

> ***Although health is a priority for the province, funding has come down drastically due to budget ceilings. We can't run enough programs after USAID stopped working here.***
>
> Participant: Public Health Officer, Health Directorate, Dipayal, Sudurpaschim Province

Emerging challenges such as climate change, natural disasters, and social conflicts add complexity by disrupting health service delivery and increasing vulnerabilities among pregnant women and adolescents. The COVID-19 pandemic also caused setbacks by limiting access to maternal health services and straining the health system. Furthermore, the government's budget ceiling for health has restricted the launch of new programs, including the nationwide expansion of the Maternal and Perinatal Death Surveillance and Response (MPDSR) system, which is critical for identifying and addressing causes of maternal deaths.

Recommendations Grounded in the Means of Implementation Framework

To Government and policymakers

8.1.1 Financing

- Substantially increase and ring-fence national and local budgets for maternal health and SRHR, with a focus on adolescent/youth- friendly and marginalized populations.
- Ensure equitable allocation of resources across provinces, prioritizing underserved regions and disaster-prone areas.
- Establish transparent tracking and public reporting of health expenditures to reduce leakage and improve accountability.
- Develop innovative financing mechanisms such as social health insurance, voucher schemes for adolescents, and targeted subsidies for the poorest households.

8.1.2 Technology

- Expand digital health infrastructure, including telemedicine, e- health records, and mobile health platforms, especially in rural and hard-to-reach districts.
- Integrate real-time health information systems for maternal and SRHR data to support evidence-based planning and rapid response.
- Promote the use of digital tools for community awareness, service reminders, and feedback collection.

8.1.3 Capacity Building

- Institutionalize regular, mandatory training for all health workers on adolescent/youth-friendly SRHR, gender sensitivity, mental health, and respectful care.
- Strengthen the capacity of local governments for decentralized health planning, budgeting, and monitoring, with technical support from federal agencies.
- Invest in leadership development for women and youth in health governance at all levels.
- Enhance capacity for emergency preparedness and response, especially for climate- and disaster-related SRHR needs.

8.1.4 Trade

- Strengthen procurement and supply-chain systems to ensure uninterrupted availability of essential maternal health commodities and modern contraceptives, including last-mile delivery to remote areas.
- Reduce supply bottlenecks by improving import clearance, quality assurance, warehousing, and distribution for priority SRHR and maternal health commodities.

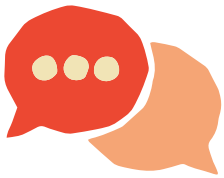
- Support local production/packaging where feasible, and create a reliable framework for contracting private-sector logistics providers for hard-to-reach areas.
- Promote fair and accountable partnerships with the private sector (pharmacies, distributors, transport providers) to improve access, affordability, and continuity of SRHR commodities especially for adolescents and marginalized groups.

To Health sector stakeholders

8.2.1 Financing

- Mobilize additional resources for outreach, quality improvement, and infrastructure upgrades through public-private partnerships, local fundraising, and donor engagement.
- Advocate for sustained funding for essential medicines, contraceptives, and emergency obstetric care supplies at all facility levels

8.2.2 Technology



- Accelerate adoption of electronic medical records and digital appointment systems in all secondary and tertiary facilities.
- Utilize telehealth and online counseling platforms to provide confidential SRHR information and services to adolescents and marginalized groups.
- Implement digital dashboards for real-time monitoring of service delivery, stockouts, and referrals.

8.2.3 Capacity Building

- Regularly update and disseminate clinical guidelines and protocols, ensuring all staff are trained in new technologies and service delivery models.
- Foster peer learning, mentorship, and recognition programs to improve staff retention and motivation.
- Build capacity for data-driven quality improvement, including routine use of service data for decision-making.
- Strengthen referral systems and emergency response capacity through simulation exercises and joint planning with local authorities.

8.2.4 Trade

- Improve forecasting, quantification, and inventory management for SRHR/maternal commodities to reduce stockouts and wastage.
- Establish/strengthen agreements with local suppliers and transporters to ensure timely restocking and emergency supply movement during disasters.
- Strengthen coordination with private pharmacies and community outlets to expand access points for contraceptives and essential SRHR commodities, while ensuring quality standards and privacy safeguards.

To Civil Society and Youth Organizations

8.3.1 Financing

- Diversify funding streams through grants, social enterprise partnerships with private sector, and local fundraising.
- Establish community solidarity funds or micro-insurance schemes to support marginalized youth in accessing essential SRHR services.

8.3.2 Technology

- Harness social media, interactive radio, and mobile apps for youth- led health education, myth busting, and service referrals.
- Develop and disseminate accessible digital content in local languages and formats for people with disabilities and low literacy.

8.3.3 Capacity Building

- Train youth leaders, peer educators, and community volunteers in SRHR, advocacy, digital literacy, and monitoring.
- Build organizational capacity for evidence-based advocacy, accountability, and program management.
- Facilitate exchange visits, learning forums, and mentorship programs for youth activists and community leaders.

8.3.4 Trade

- Work with local vendors/pharmacies to improve youth-friendly access to contraceptives and SRHR commodities, including referral linkages to health facilities.
- Advocate for affordability and non-discriminatory access to SRHR commodities, especially for adolescents, unmarried youth, and marginalized communities.
- Support community-level monitoring of commodity availability, pricing, and stockouts to strengthen accountability.

To Donors and development partners

8.4.1 Financing

- Provide catalytic, multi-year, and flexible funding to scale up proven interventions and pilot innovations in hard-to-reach and crisis-affected areas.
- Support pooled funding mechanisms for cross-sectoral SRHR initiatives, including climate resilience and emergency response.

8.4.2 Technology

- Invest in the development, evaluation, and scaling of digital health solutions that are interoperable with national systems and responsive to youth needs.
- Support research on the impact of technology-enabled interventions for adolescents, marginalized groups, and disaster- prone communities.

8.4.3 Capacity Building

- Fund technical assistance, south-south learning, and cross-sectoral training (health, education, disaster response) to build national and local capacity.
- Support the development of local expertise in digital health, SRHR program management, and data analytics.

8.4.4 Trade

- Support strengthened commodity security systems (forecasting, procurement, warehousing, last-mile logistics) for SRHR and maternal health supplies.
- Fund emergency logistics mechanisms for disaster periods (floods/landslides) to maintain continuity of maternal health and SRHR commodities.
- Encourage responsible private-sector engagement to expand access while protecting equity, privacy,and rights (especially for youth and key populations).

Limitations of the Study

While the inclusion of young people's perspectives provides valuable insights into lived experiences related to sexual and reproductive health and rights (SRHR), this component of the study has certain limitations that should be acknowledged. The focus group discussion involved a relatively small number of participants and was conducted in a single setting, which limits the representativeness of the findings. As a result, the perspectives captured may not fully reflect the diversity of experiences among all adolescents and young people across different geographic regions, socio-economic backgrounds, and cultural contexts in Nepal. Participants were selected through purposive sampling based on their interest and prior engagement in SRHR-related issues, which may have introduced selection bias. Young people who are more informed, outspoken, or connected to youth networks may be overrepresented, while the voices of the most marginalized, disengaged, or hard to reach adolescents may not be adequately captured. Additionally, the age range of FGD participants primarily reflected older youth, which may limit the applicability of findings to younger adolescents.

The sensitive nature of SRHR topics may also have influenced participants' willingness to openly share personal experiences, despite efforts to create a safe and confidential discussion environment. Social desirability bias and group dynamics within the FGD setting could have affected the depth or candor of some responses. Furthermore, the findings rely on self-reported perceptions and experiences, which may be influenced by recall bias or individual interpretation.

Despite these limitations, the youth perspectives presented in this report are intended to complement quantitative data and policy analysis rather than to provide statistically representative evidence. When triangulated with findings from the desk review and key informant interviews, these insights contribute to a richer understanding of the barriers, enabling factors, and opportunities for strengthening youth-responsive and rights-based SRHR programming in Nepal.

Conclusion

Nepal has made notable progress in advancing maternal health and sexual and reproductive health and rights (SRHR) over the past decade, aligning its national priorities with the global commitments set out in SDG 3.1 and 3.7. The reduction in maternal mortality, increased skilled birth attendance, and gradual improvements in family planning coverage reflect the country's dedication to improving health outcomes for women, adolescents, and young people. These achievements have been driven by progressive policies, community based interventions, and the expansion of health infrastructure and services. However, the journey towards achieving SDG targets by 2030 remains complex and unfinished. Persistent disparities by geography, socio-economic status, gender, age, and disability—continue to hinder equitable access to quality SRHR services. Adolescents, young people, Dalit and Indigenous communities, and those in remote or disaster-prone areas face compounded barriers, including stigma, traditional gender norms, economic hardship, and gaps in health literacy. The COVID-19 pandemic and recurrent climate-induced disasters have further exposed the fragility of service delivery and deepened vulnerabilities, particularly for the most marginalized.

This report's analysis, grounded in both qualitative and quantitative desk review of secondary data and the lived experiences of young people, health professionals, and policymakers, underscores that policy intent alone is insufficient. Effective implementation, adequate and equitable financing, robust health system capacity, and meaningful community and youth engagement are essential to translating commitments into real world impact. The findings highlight the need to address not only the supply-side challenges such as workforce shortages, infrastructure deficits, and supply chain gaps but also the demand-side barriers rooted in social norms, stigma, and limited agency among young people, especially adolescent girls. Opportunities for accelerated progress exist. Enabling factors such as community leadership, peer networks, digital health innovations, and multisectoral partnerships have demonstrated their potential to break down barriers and expand access. Scaling up these best practices, while tailoring interventions to local contexts and ensuring the voices of young people and marginalized groups are central to decision making, will be critical.

In summary, Nepal stands at a pivotal moment. Achieving SDG 3.1 and 3.7 by 2030 will require renewed political will, sustain investment, and coordinate action across government, health sector stakeholders, civil society, youth organizations, and development partners. By addressing systemic inequities, harnessing technology, building capacity at all levels, and fostering inclusive partnerships, Nepal can ensure that every woman, adolescent, and young person regardless of where they live or who they are has the opportunity to realize their right to health and well-being. The path forward demands urgency, innovation, and unwavering commitment to leaving no one behind.

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