A study analysis of the level of services available at the municipal and rural municipality level related to women's sexual and reproductive health

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Background and Introduction

Background:

Reproductive health is defined as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes." (1) Sexual health is a state of physical, mental and social well being in relation to sexuality throughout the life cycle. Sexual rights includes the right to not be subjected to sexual violence. (2)

Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. (2) (3)

In Nepal, most of the societies are still closed and traditional surrounded with myth and misconceptions about sexuality, reproductive health, contraceptives, STD's/HIV/AIDS and sexuality education. Consequently, they are bound to follow these myth and misconception that put them in high risk for reproductive health behavior. As a result, adolescent girls and women have to cope with various problems, which is a very serious issue. Young Nepali women are often forced to drop out of school, get married, and move to live with their new husband's family. They find themselves with limited social support; little to no knowledge about reproductive, maternal, and newborn health (RMNH); poor nutrition; few opportunities for financial gain; limited control of resources; and restricted mobility. Few programs address the unique health needs of young married girls and women in Nepal; fewer still engage young, married women's husbands and families, although it is widely recognized that they play an important role in decision making around reproductive health and seeking health care. (4)

Women's sexual and reproductive health is related to multiple human rights, including the right to life, the right to be free from torture, the right to health, the right to privacy, the right to education and the prohibition of discrimination. This means that States have obligations to respect, protect and fulfil rights related to women's sexual and reproductive health. Right to health maintains that women are entitled to reproductive health-care services, goods and facilities that are: (a) available in adequate numbers; (b) accessible physically and economically; (c) accessible without discrimination; and (d) of good quality. Despite these obligations, violations of women's sexual and reproductive health rights are frequent. These take many forms, such as denying access to services that only women require, providing poor-quality services, subjecting access to third-party authorization or performing procedures without the woman's consent, including forced sterilization, forced virginity examinations, and forced abortion. (5)

Violations of women's sexual and reproductive health rights are often deeply ingrained in societal values pertaining to women's sexuality. Patriarchal concepts of women's roles within the family mean that women are often valued according to their ability to reproduce. (6) The right to sexual and reproductive health means that people of any age and gender should freely be able to decide to have

their sexuality and fertility as they wish. (7) Whether it is a woman or a man or gender non-confirmative individual, the rights of either should not be violated in any way. Sexual and reproductive health rights are human rights. According to this right, people should be able to have a satisfactory and safe relationship in mutual understanding, without any kind of violence, coercion and fear of infection or pregnancy. (8) Existing gender dynamics and social norms has resulted in the neglect and barriers to SRH services for women. Women's reproductive health raises sensitive issues for many legal traditions because they are subject to sexuality and morality. (9)

All over the world, men exerted control over the bodies of women. It was only after the 1980s, the world began to look at women's issues from a feminist perspective. Similarly, the practice of feminist and rights-based development approach appeared on the world scene only after the 1990s. This shows the long history in which women and girls, despite their sexuality and reproductive capacity, have been subjected to various discriminatory behaviours, whether physical or mental, which is based on the unequal power relations that have persisted in the society. The universal risk factor for maternal mortality and morbidity is the fact of being female. (10) (11)

Worldwide, the sexuality and reproductive capacity of women have been considered to be under the control of men, due to existing patriarchal social structure that favours and puts men at the center, which is deeply rooted in the society. This results in sexual, physical, mental, social, economic and political violence in women. Therefore, there is an urgent need to address this issue. With this in mind, in order to achieve the goals within the country, efforts have been made by the government and donor agencies in this regard since 1990 to raise awareness and increase women's empowerment. In this context, this study is a cornerstone for overall understanding and imparting light on of the state of women and girls' sexual and reproductive health and rights. (12) Nepal's government has its own targets to meet the Sustainable Development Goals by 2030. Expansion of safe abortion services is one of the major ways to achieve SRHR-related goals, including reduction of maternal mortality from 239 per 100,000 live births in 2015 to below 70 per 100,000 live births by 2030. (13)

Nepal is currently facing an unprecedented health emergency with the continuing spike in COVID -19 cases and related deaths. Nepal ranks 9 among the top 10 countries in terms of daily increase in COVID-19 cases[2]. Despite having a relatively small population of 29.5 million, Nepal's current caseload stands at 472,354 active cases[3] with more than 45% of COVID-19 RT-PCR tests coming back positive. Infection rate in Nepal has increased by 233% in the last 30 days, the highest since the pandemic began.

The case burden has taxed Nepal's already fragile health care system. With limited numbers of hospital beds and medical supplies, the likelihood of people dying without being able to receive the necessary treatment has increased. The pandemic in Nepal has indirect consequences on women and girls' SRH as resources and capacity to provide SRH services are strained. Women are disproportionately affected by

any emergencies, particularly in relation to disruption in reproductive, maternal, newborn, child and adolescent health services. A recent study by UNICEF estimated that COVID-19 in Nepal has negatively impacted women and children with maternal mortality could increase by 16.7%, 16,531 additional unintended pregnancies and 31.7% increase in unsafe abortion[8]. Prior to the pandemic, Nepal already has a high unmet need for family planning at 24%[9]. Compromised access to SRH services will worsen during the prolonged COVID-19 pandemic.

Existing gender dynamics and social norms also has an impact. The right to sexual and reproductive health means that people of any age and gender should freely be able to decide to have their sexuality and fertility as they wish. Whether it is a woman or a man or gender non-confirmative individual, the rights of either should not be violated in any way. Right to health maintains that women are entitled to reproductive health-care services, goods and facilities that are: (a) available in adequate numbers; (b) accessible physically and economically; (c) accessible without discrimination; and (d) of good quality. Despite these obligations, violations of women's sexual and reproductive health rights are frequent. These take many forms, such as denying access to services that only women require, providing poor-quality services, subjecting access to third-party authorization or performing procedures without the woman's consent, including forced sterilization, forced virginity examinations and forced abortion.

Nepali women are disproportionately impacted by the COVID-19 pandemic due to increased unpaid care workload and household chores, causing stress, emotional and physical problems[16]. Many women are also dealing with loss of income, from imposed pay-cuts to lay-offs. Reduced household income leads to cash crisis and consequently burgeoning instances of domestic violence and abuse[17], further worsening existing barriers to SRH services.

While the local government has some capacity to address different dimensions of the pandemic, a robust technical assistance to local government is the pathway to achieving health security for all women, including women with disability and Dalits. The international best practices on SRH state that when local governments have improved supplies and capacity for health system preparedness and response, particularly addressing COVID-19 needs and unmet SRH needs of the most vulnerable women, then

negative impact on women's health could be reduced thereby ensuring national health security during emergencies.

National Policy Development on Sexual and Reproductive Health Rights of Women in Nepal

At the International Conference on Population and Development (ICPD) in Cairo in 1994, the Fourth World Conference for Women (FWCW) in Beijing in 1995, and the Social Summit in Copenhagen in 1995, attention was focused again on the social, cultural and gender-based determinants of health and development with special attention to women's sexual and reproductive health. (14) Nepal has shown commitment to different international human right conventions and conferencs thereby ratifying them and endorsing the key strategies and program plannings. The endorsement of ICPD was a groundbreaking process at state level with the aim to ensure women's sexual, reproductive and health rights which was followed by Beijing Conference. Nepal government showed commitment to ensure sexual and reproductive health rights of women asserting "Every women shall have the right to reproductive health and other reproductive matters with the draft of Interim Constitution if Nepal in 2007. (15) (16)

All these led to a series of policy reforms and programs were launched at national level which were implemented all the way to the local bodies and at community level through different hierarchy of health care service delivery points and institutions focusing on sexual and reproductive health. National Health Policy was formulated in 1991 with the aim to bring about improvement in the present health status of Nepalese people through basic primary health care services with focus on womens health. (17) The Second Long Term Plan (1997-2017) followed which was envisioned to address disparities in health status, assuring equitable access to quality health care services with full community participation and gender sensitivity. (18) The Nepal Safe Motherhood Long Term plan 2002-2017 was implemented with the goal of improving the maternal and neonatal health status. The overall mission statement was to facilitate the creation of an enabling environment where women's right to safe pregnancy, delivery and post-partum care is achieved. (19) In the year 2006, with the indicators drawn from MDG, National Safe Motherhood and Newborn Health- Long Term Plan (2006-2017) was implemented with the plan to improve sexual health reproductive health of both women and newborn child especially among poor and socially excluded communities. (20)

Abortion was strictly prohibited (without exception) under *Muluki Ain*, 1959 which characterized abortion as an offence against life even if pregnancy threatened a women's life. Persistent advocacy efforts by the government, non-governmental organizations, private sector, women health activists, the medical community and stakeholders to reform the restrictive abortion framework was finally addressed when the parliament approved the 11th amendment bill to Muluki Ain on the 14th of March 2002 and on the 27th of September 2002. For the first time in Nepal on this day abortion was conditionally liberalized. Safe abortion is necessary for two reasons: first, women have the right to reproductive health choices. Secondly, it is necessary because 20% of pregnancies globally end in induced abortion; unsafe abortion accounts for 13% of all maternal deaths and the hospitalization of a further five million women every year due to serious health complications. (21)

The National Health Policy (1991), Medium Term Strategic Plans, the National Reproductive Health Strategy (1995), the Adolescent Health and Development Strategy (2000), and the Nepal Health Sector Program II (NHSP II, 2010-2014) outline broad strategies for reproductive health in Nepal. The NHSP II called for establishing adolescent-friendly services through 1,000 health facilities by 2015. The National Adolescent Sexual and Reproductive Health Program addresses key issues related to adolescents and youth at the national level and seeks to integrate concerns regarding adolescents and youth into several other programs that provide specific services, including safe motherhood, family planning, HIV/AIDS, and STI programs. A new HIV/AIDS National Strategy (2011-2015) has recently been developed and approved by the government. Additional policies for research, information, education, and communication (IEC), safe motherhood and sexual and reproductive health have been developed, as have operational guidelines for reproductive health care at all levels. (22) The government of Nepal (GoN) under Family Welfare Division is conducting various national level programs to address all these issues under sexual, reproductive and maternal health which includes family planning services, safe motherhood program, adoleset and sexual reproductive health program, safe abortion services, female community health volunteer program and primary health care outreach program.

All the strategies and programs along with policies have provided certain sexual and reproductive health rights to women at national level which has been implemented all the way to the local level at municipal level. Nepal government has assured right to sexual and reproductive health care services to each and every woman and have right to choose the services they may seek to use. The right to informed decision on family planning is another important one which has enabled Nepalese women to decide on the number and space between children and also to limit the number of childbirth. The righ to safe abortion has provided right to reproductive health choices. Every woman has right to safe motherhood and health care services.

Problem Statement

The World Health Organization has estimated that each year 500,000 women die from pregnancy-related causes and that unsafe abortion causes some 25 to 50% of maternal deaths, simply because women don't have access to family planning services they want and need or have no access to safe procedures or to humane treatment for the complications of abortion. (23) In the United States alone, 700 women die each year during pregnancy, delivery, or soon after delivery which is a tragedy for the family, society and the whole world. (24) Girls in the age group 15-19 (29%) who are already in formal marriage lack access to critical information on SRHR and related services in Nepal. (25)

A recent study by UNICEF estimated that COVID-19 in Nepal has negatively impacted women and children with maternal mortality could increase by 16.7%, 16,531 additional unintended pregnancies and 31.7% increase in unsafe abortion. (Nepal already has a high unmet need for family planning at 24%[9].

Studies by Nepal Health Research Council and CREHPA noted that major barriers to accessing Sexual and Reproductive Health (SRH) services include: 1) fear of COVID-19 in accessing services, 2)

unavailability of family planning devices, 3) inadequate coordination for home services, 4) exemption of travel restriction with travel "passes", and 5) lack of access to transportation for women with disability. (26) (27)

A study demonstrated the potential impact on reduced of access to SRH services due to COVID-19: for a 10% proportional decline in a year may result in 131,700 additional women with unmet need for modern contraceptives, 19,000 additional pregnancies, 6,000 additional women experiencing major obstetric complications without care, 70 additional maternal deaths, 9,000 additional newborns experiencing major complications without care, 260 additional newborn deaths and 14,500 additional unsafe abortions. All over the world, men exerted control over the bodies of women.

Since time immemorial, the principal duty of women has been viewed as bearing children, bound to household and caring tasks. On this regard, women have to go through motley health complications influenced by early and excessive childbearing, premature death from prolonged labor, poor reproductive health services etc. Their complicated health in discharging this duty of bearing child went unrecognized and defamed as destiny rather than considering it the results from cultural, medical and socioeconomic factors that devalue the status and health of women.

Rationale

Nepali society is a rather conservative society with a strong patriarchal structure. Its social forms and community forms are also driven by a very patriarchal way of thinking, so the existing social relations are very narrow and discriminatory. The correlation between men and women is also plagued by this mentality. In such a background, women and girls cannot go out and put forward their view openly, especially on sexuality or reproduction. It is essential to create enabling environment for women and girls to make their own decisions on the issue of sexual and reproductive health. Therefore, it is very important to discuss broadly on this issue in a feminist light.

Even though policies and programs specially targeted for uplifting sexual and reproductive health rights if woman have been implemented since a long time and services are being made available free of cost, the implementation at municipal level have not found to be satisfactory and a huge gap remains. Not every woman, as the policies dictates, have been able to enjoy these rights as they should have and been. There are lots of limitations and restrictions that are preenting from utilizing these rights and services.

In this context, Tarangini Foundation under the Sahakarya Project aims at identifying the gaps in existing health care services and how it affects the women and adolescent girls and providing

recommendations on the issue of sexual and reproductive health of women and adolescents at the village and municipality level.

Objectives:

General Objective:

To identify gaps in access and quality of women's sexual and reproductive health services in the health care providers/institutes at local level municipalities and rural municipalities.

Specific Objectives:

1. To identify gaps in existing health care services and its impact on the women and adolescent girls SRH
2. To investigate the impact of COVID-19 in the level of SRH services
3. To provide recommendations on the issues of SRH of women and adolescents at the village and municipality level.

Study Design and Methodology

Study Method: Qualitative method

Study Area: five provinces of Nepal

Study Instrument: FGD guideline and case study

Data Collection Process:

A team of skilled researchers were mobilized for conducting qualitative study which includes focus group discussions and case studies collection.

Two municipalities from each province- one municipality and one rural municipality were taken as a sample. Altogether 10 FGDs were conducted with 70 FGD participants and 11 case studies were collected from these locations.

Focused Group Discusions (FGDS) and case studies were organized as follows:

Focus Group Discussions:

Province 1	Udaypur	Triyuga
Province 2	Siraha	Lahan
		Bhagwanpur
Province 5	Dang	Shantinagar
		Tulshipur
Province 6	Rukum West	Bafikot

		Tribeni
Province 7	Kailali	Gauriganga M
		Dhangadhi

Case Studies:

S.N	Name	Location
1	Sharada Pokhrel	Triyuga, Udaypur
2	Rita Dahal	Triyuga, Udaypur
3	Anita Devi Shah	Bhagwanpur, Siraha
4	Unnami Kami	Bafikot, Rukum West
5	Karishma BK	Tribeni, Rukum West
6	Bhagwati Shrestha	Ramechhap
7	Champa KC	Bafikot, Rukum West
8	Ganga BK	Tribeni, Rukum West
9	Sitani Kumari Chaudhary	Gauriganga , Kailali
10	Parbati BK	Shantinagar, Dang
11	Reshma BK	Dhangadi, Kailali

Outcomes:

The findings will help to analyze the level of services available at the municipal and rural municipality level related to SRH and hence produce a base of evidence for later reference and use for further planning and decision making. As a result of the study, the following outcome is expected.

- An all-encompassing document will be developed.
- Analysis of level of SRH services provided by health institutions
- Overview of control of women and adolescent girls over their own sexuality and sexual and reproductive health and rights, if not possible recommendations will be given in the matter
- Assistance in improving the level of sexual and reproductive as well as mental health services provided by health care providers
- Awareness program on sexual and reproductive and mental health services, which will aim at increasing the awareness of community level people about sexual and reproductive and mental health services

Ethical Consideration:

1. Written informed consent will be taken with each participant.
2. Confidentiality and privacy of respondents will be maintained

Limitations

Limited scope of opinion collected from the field: The FGDs and the case studies were conducted with very limited number of groups, individuals, relevant stakeholders, partners and beneficiairies. This became helpful on enriching the quality of the document but may not degrade or upgrade the authenticity of the document. This limits the universality of opinion expressed by other people and stakeholders. Thus generalization of opinion stated in this study should be understood as personal or institutional opinion rather than general.

Limited scope of the issue: This study is concentrated upon the SRHR of women. This document may only fulfill the academic and advocacy needs pertaining to youth SRHR and disability issues.

Chapter 2
Results and Findings

The study is based upon the FGDs organized among local adolescents girls and women and health workers working at the target location. Few case stories of the local women were also incorporated in this study.

2.1 Conceptual understanding on existing SRH services at their nearest respective health facility

Majority of the FGD participants have the basic knowledge of SRH. However their knowledge on the meaning of SRH is confined to reproductive process, physical wellness of the reproductive organs and the absence of reproductive health related diseases . The broad concept of sexual and reproductive health including sex education, mental well being and adequate and appropriate SRH eductaion is still lacking.

> *Sexual and reproductive health is the growth and the development of reproductive organs and the ability to give birth.*
>
> *- FGD Respondent from Tulsipur, Dang*

According to the FGD participants, their nearest located health facility has been providing basic sexual and reproductive health services namely- FP devices (Pills, DEPO, condom), menstruation hygiene management education, counselling services, ANC/ PNC check ups. Participants mentioned their convenience in accessing SRH and FP services because of the WOREC health center.

> *"Previously, I had to travel for atleast an hour just to receive pills for birth control.Now that the nearby health facility has been upgraded with basic essentials FP devices, I can easily have access to pills whenever necessary."*
>
> *- FGD Respondent, Triyuga, Udaypur*

According to the participants, they are unknown on any specific programs on mestruation hygiene by the government. Sanitary pads aren't available from the health institutions and whenever they went to the health institutions for the services on menstruation, they only received pain killers to solace any mesntruation related pain. Respondents from all FGD stated that the health facilities at their respective locations have no fertility care services.

Regarding the query about the safe motherhood and maternal and neonatal health services, the participants of all the provinces said that they are receiving regular immunization, counseling services and periodic checkups. Few of the respondents mentioned about the availability of birthing center at their location. In

> *The health facility located at my area provides free ambulance services during pregnancy. I really appreciate the services provided by my health institutions. They provide SRH counseling services to newly married couples and those in need. For lactating women, our health facility makes a visit at their house and gift a support package that includes impregnated nets, ghee and*
>
> *- FGD Participant, Kailali Gauriganga*

times of complications and higher health care services, respondents get referred to the other health care institutions. Hence the need of upgrading and properly equiping the health care institutions was mentioned during the discussion.

Information about SRHR and counselling services is limited. The community and family environment still understands that issues around sexuality, reproduction, family planning are private things and need not to be discussed openly. These restrictions to some extent limit the uptake of SRH servises especially among the adolescents. No ASRH programs and services are being provided at their respective health institutions. Participants indeed expressed that ASRH services are imperatives and need to be focused in their locations. ASRH services should be managed above counselling services. They are unknown about Adolescents friendly health services.

Inquiring upon the types of family planning services available in the government operated service sites, the participants have knowledge about free FP services and none of them were to be paid. Nevertheless, long term family planning services were hardly provided. The FGD respondents of all the interview areas mentioned that their repective health institutions lack of safe abortion services and provisions against voilence against women.

> *There is no female health service provider at the health facility. I feel reluctant to take sexual and reproductive health services from a male service provider. Hence I never visit health facility for SRH services even when having sexual and reproductive health issues.*
> *- FGD Respondent, Dang Tulsipur*

The participants had the opinion that, the service providers in every service sites should be capacitated in the sector of SRH and sexuality services. They also said that the quality of SRH services they have been receiving has to be improved. Irregular and in times no ambulance services is burgeoning issues in their sexual and reproductive health. Further people are unaware of the association between the mental health and the SRH. SRH issues like uterine prolapse etc among the community women is in fact kept covert. Consequently women with those issues went through various psychosocial impact including depression, anxiety and stress. These issues and the pyschosocial impact are overlooked and ignored worsening their mental health status for which they are never counselled.

> *The FP services are not adequately and timely available at my location. Once, I went for DEPO services but at that moment there was lack of DEPO. As a result, I couln't have the service which lead to unwanted pregnancy.*
>
> *- FGD Respondent, Siraha Lahan*

2.2 Conceptual understanding issues and barriers to access SRH services

Case studies collected from the local women from the above locations provided notable findings on the availability of SRH services and issues and challenges in accessing SRH services.

Through the case studies, we understand the barriers in accessing SRH services due to the COVID pandemic. Most women talked about the difficulties they faced in receiving even the basic health

services amidst pandemic. Most of the health institutions denied providing any health services beside referral and dispensary because of the COVID fear. ANC/PNC services were as well halted.

All participants responded that they had their first pregnancy as soon as they got married. Neither the girls themselves, nor the husbands or the mothers and fathers-in-law were in favour of postponing the first pregnancy. The health of the girl was not prioritised when she was expecting a baby:

"*I despite being pregnant have to work similar to any other days. Even if I complained of pain and difficulties, no one has helped me during those days. Being a labour worker, I had to lift heavy materials. After delivery, I found about my uterine prolapsed. I felt so awkward and shy regarding my condition and hence shared to no one. I quietly bear the pain alone unless WOREC health center provided the uterine ring to prevent from the uterine prolapse."*

- *65 years old women, Bafikot Rukum West*

However, many participants started using family planning methods because they suffered from complications during their first pregnancy and were not fully capable to care for the baby. Some of them complained about the side effects of family planning devices

Most participants had a negative perception towards health care facilities particularly during the COVID pandemic.Some had complaints on the quality of health care services provided by the respective health care institutions. However, some participants complained about the harsh language used by health care providers. They were denied for health services during the pandemic. Even during emergenicies, they were referred to other health institutions.Verbal abuse by health care personnel in the hospital setting influenced the preferred place of delivery and increased the probability of avoiding health services. Participants described that they were referred to various facilities. Mostly women went to the district hospitals to seek treatment when they were not satisfied with local health care and when resources at local facilities were inadequate.

Participants explained that early marriage brought economic instability which subsequently alterred choice of health care and facilities. They relied on family and relatives for health care. They rarely received any familial support instead were coerced to work.

> I got married at the age of 20 years old. I have to go through verbal and physical violence inflicted by the husband and mother-in-law. I never got chance of receiving health services even during my pregnancy. Due to pandemic, I couldn't reach to any health institutions or even FCHVs for iron tablets and vaccination and ANC services. Unfortunately, I had suffered miscarriage with my first pregnancy.
>
> -22 years old respondent, Triyuga Udaypur

Major factors acting as barriers to using health were prioritisation of domestic work, importance of first birth, mistrust towards contraceptive devices before first child, verbal abuse by health personnel, and shyness and discomfort. Lack of experience related to pregnancy and interpretation of labour pain

caused them to wait to seek care. Additionally, distance and lack of transport, caste and ethnicity, and economic factors influenced the choices of health care among the participants. COVID-19 had a major negative impact in their sexual and reproductive health.

Conclusion and Recommendations

This study is an attempt to understand the existing level of SRH services at the rural municipality and municipal level of Nepal. The purpose is to highlight the available SRH provisions and emphasize the barriers and gaps in this sector. This study was commissioned by Taringini Foundation.

Considering the results from this study, following recommendations have been made:

i) Psychosocial support and counselling: Upon discussion with various women groups including the health service providers, this study revealed the ongoing impact resulted because of the barriers to access of SRH services in the mental health. This study also presented that women's sexual and reproductive health has been worsened even before the pandemic too because of the social structure, male centered health services and female dominating societal perceptions. SRH services are compromised This stressed the need of psycosocial and mental health support and counselling services. Henceforth, psychosocial and counselling services should be provided.

ii) Laws and policies: Rural municipality and municipality are in the process of enacting health related acts and policies, some of them already table such acts/policies in the parliaments/councils or others are in the process of doing so. This is the right and high time to initiate women inclusive and accessible SRH and other level of health services.

i**ii) Inclusion and upgrade of essential SRHR and FP :** Local and provincial governments are in the process of enacting upgraded health policy. As of this research, the Inclusive Education Policy is silent on SRHR and FO education to all the school students therefore not for students with disability. It is important for Tarangini Foundation to start a dialogue with the authorities so that SRHR and FP understanding are inbuilt from the community level.

iv) ASRH corner: To ensure adolescent friendly and inclusive sexual and reproductive health services, health institutions of all level should have ASRH corner focusing on the needs and issues of

v) Abortion and fertility care services: Abortion and fertility care services should be organized at the local level. Health

vi) Awareness campaign:

Tarangini Foundation firmly believes that this study is one of the milestones in identifying not only the barriers in SRH sector but also the issues and challenges in overall health sector and influencing factor in the health sector. On this regards, awareness campaign to sensitize the importance of SRH services to all people regardless of any differences and eradicating This research revealed that the needs are rampant and the initiatives are

Vii) Capacity building programs to the health service providers

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