Kaleidoscope
Championing Reproductive Justice Centered Health Systems

Government of Nepal
Ministry of Health and Food Safety
Department of Health Services
Family Welfare Division

Access and Utilization of Safe Abortion Services in Madhesh, Lumbini, and Karnali Provinces of Nepal

A Baseline Study of the Kaleidoscope Initiatives

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-Family Welfare Division, Beyond Beijing Committee & Visible Impact Team

Abbreviations

ANM	Auxiliary Nurse Midwife
AHW	Auxiliary Health Worker
ARROW	Asian-Pacific Resource and Research Centre for Women
BBC	Beyond Beijing Committee
BHSC	Basic Health Service Center
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CMA	Community Medicine Assistant
CHU	Community Health Unit
D&C	Dilation and Curettage
DDA	Department of Drug Administration
D&E	Dilation and Evacuation
DFC	Direct Financial Contract
DHIS2	District Health Information System 2
DoHS	Department of Health Services
FCHV	Female Community Health Volunteer
FGD	Focus Group Discussion
FWD	Family Welfare Division
HA	Health Assistant
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HO	Health Office
HP	Health Post
HSC	Health Section Chief
IEC	Information, Education and Communication
KAP	Knowledge, Attitude and Practice
KI	Kaleidoscope Initiative
KII	Key Informant Interview
KP	Karnali Province
LP	Lumbini Province
MA	Medical Abortion

MCH	Maternal and Child Health
M&E	Monitoring & Evaluation
MDGP	Doctor of Medicine in General Practice
MI	Medication Induction
MMR	Maternal Mortality Ratio
MO	Medical Officer
MoHP	Ministry of Health and Population
MP	Madhesh Province
MVA	Manual Vacuum Aspiration
MWRA	Married Women of Reproductive Age
NDHS	Nepal Demographic and Health Survey
NHTC	National Health Training Center
NGO	Non-Governmental Organization
NHRC	Nepal Health Research Council
NPR	Nepalese Rupees
OPD	Outpatient Department
PAC	Post-Abortion Care
PHCC	Primary Health Care Center
PHD	Provincial Health Directorate
PHTC	Provincial Health Training Center
PLWD	People Living with Disability
PMTC	Prevention of Mother-to-Child Transmission
PPP	Public Private Partnership
RCT	Randomized Controlled Trial
RH	Reproductive Health
RHCC	Reproductive Health Coordination Committee
RM	Rural Municipality
RO	Research Officer
SAS	Safe Abortion Service
SMP	Sub Metropolitan
RSMRH	Right to Safe Motherhood and Reproductive Health
SRHR	Sexual and Reproductive Health & Rights
SRHRJ	Sexual and Reproductive Health, Rights and Justice
TWG	Technical Working Group
UHC	Urban Health Center

VCAT	Values Clarification and Attitude Transformation
VEMA	Very Early Medical Abortion
WGNRR	Women's Global Network for Reproductive Rights
WHO	World Health Organization

Executive Summary

1. Background

Nepal amended its Civil Code (*Muluki Ain*) in 2002 to allow abortion on certain grounds and to ensure Nepalese women's right to decide on their fertility choices. The Right to Safe Motherhood and Reproductive Health (RSMRH) Act 2018 was enacted as an umbrella legislation to govern sexual and reproductive health in the country reaffirming Nepal's commitment to women's rights. This act recognizes abortion as a women's fundamental reproductive right and broadens the scope and measures for safe abortion. Following the RSMRH Act 2018 and its preceding Regulation in 2020 was formulated to guarantee women's reproductive rights and earmarks budgets for Sexual and Reproductive Health (SRH) including a budget for ensuring free abortion care at all public health facilities. The Constitution of Nepal 2015 mandated a three-tier federal system, where the responsibilities of health services including SRH shifted from the federal to provincial and local level government.

Nepal's Maternal Mortality Ratio has declined significantly from 539 maternal deaths per 100,000 live births in 1996 to 239/100,000 in 2016 and 151/100,000 in 2021. Unsafe abortion alone contributed to 5% of all pregnancy-related maternal deaths in the country in 2021. This significant reduction is attributed to a combination of health care policy, health system strengthening and legalization of abortion law in 2002. Following legalization, the government scaled up safe abortion services to facilities across all seven provinces, introduced medical abortion and removed financial barriers by making abortion service free of charge for all women. Despite progressive legal framework and the notable trajectory of improvement, safe abortion is yet to be a universally accessible right for all, particularly among adolescents and women in remote communities. Deep rooted social stigma, geographic challenges, financial constraints, lack of awareness, shortage of trained personnel and failure in the coordination of government at different levels continue to impede timely access to service. The irony is stark as time is the single most factor in abortion care and delay in accessing service can push a woman beyond legally permissible gestational limits.

The main objective of the baseline study was to analyze the current status, gaps, and challenges in policy provision and access to safe abortion and SRHR services in the project municipalities. This report presents the results of the study conducted in 49 project municipalities of three provinces of Nepal – Madhesh (25), Lumbini (6) and Kanali (18) provinces, where the Visible Impact and the Beyond Beijing Committee (BBC) are currently implementing Kaleidoscope: Reclaiming Sexual and Reproductive Health and Rights and Justice for all (KI). The findings of the baseline are intended to guide effective implementation and strengthening of the Kaleidoscope Initiative for the next 4 years (2026-2029).

2. Study Design

A *mixed-methods cross-sectional design* was employed. The *quantitative study* encompassed health facility mapping to identify safe abortion services (SAS accreditation status for all the public health facilities located within the 49 project municipalities. Secondary data on total number of Safe Abortion Services (SAS) users and the estimated costs of SAS and post abortion services were obtained from the Family Welfare Division the, over the last five fiscal years (2020/21 to 2024/25). The *Qualitative component* included Key Informant Interviews (KIIs) and focus group discussions (FGDs). While the KII was carried out with the concerned focal person of each municipality and the facility in-charge/health provider of all 24 SAS facilities observed, FGDs were conducted with female community health volunteers (FCHVs), community women, men and adolescents. Fieldwork was carried out by 14 trained field researchers from mid-August to the end of September 2025.

Key Contextual Findings

1. Policy and Governance

As regards to the Policy Environment for SAS, the stakeholder stated that the SAS delivery is governed by the *Safe Abortion Program Implementation Guideline*, that outlines the processes of service provider and facility accreditation in detail and serves as the principal reference for SAS implementation.

Perspectives of the Provincial Stakeholders: While the existence of *SAS Implementation Guidelines for Madhesh Province* was mentioned by the concerned province level (PHD) stakeholder, the corresponding stakeholder of Lumbini Province felt that the federal SAS guideline was sufficient at the moment but they plan to develop one in the future.

Policies and Guidelines on SAS: Health section chief (HSC) across all three provinces stated that they follow SAS national policies and guidelines since none of their municipalities has developed local level policies/operational guidelines for the same. All HSCs identified several policy-level challenges that hinder effective implementation of SAS which include rigid guidelines that fail to reflect the realities of resource-constraint settings. For instance, the requirement for separate rooms for counseling, procedures, and waiting areas was considered impractical for health posts that have limited infrastructure/space. Similarly, ambiguity around abortion eligibility, such as unclear directives on termination of pregnancies that exceed the legal allowance by a few days, etc. They also felt that the gestational limits spelt out in the national policy disproportionately disadvantaged women in remote areas, where delayed abortion decisions occur due to lack of awareness about the legal gestational limits. The absence of legal provisions for abortion beyond 28 weeks, even in exceptional circumstances like rape or incest, was also cited as a gap that limits the policy's responsiveness to complex real-world situations.

Measures for addressing the gaps and challenges suggested by HSCs were: need for greater autonomy, proactive engagement, community awareness programs, and ownership by allocating a dedicated budget by all local governments. Additionally, HSCs emphasized that national guidelines and policies should be context-sensitive, acknowledging variations in geographical and socio-cultural conditions across provinces and in diverse local settings.

***Coordination Mechanism for SAS Provision*:** The majority of the HSCs acknowledged the importance of coordination among the three levels of governance. However, the level of coordination was weak and was mostly confined to foundational activities like service providers' training, facility accreditation and the supply of medicines and equipment. The HSCs of Karnali Province reported that their local governments have good coordination with the NGO sectors working within the province thereby enabling infrastructural, technical and financial support. Some local governments in Lumbini province also reported relatively stronger collaboration, including joint monitoring visits and coordination with NGOs for training, awareness, and referral support.

2. Safe Abortion Budget and Financing

Although provincial and federal budgets are allocated for SAS training, these funds remain insufficient to meet the high demand, with Karnali relying partly on partner support for MA training to providers. Only two batches of providers are trained each year by PHTCs, which was considered inadequate to ensure complete access to SAS across all local governments of all provinces.

According to the stakeholders of Lumbini and Madhesh Province, SAS are usually implemented in the province in collaboration with organizations such as UNFPA and Ipas due budget constraints. According to them, SAS programs do not receive much priority during the annual budget allocation.

Budget Allocation and Adequacy for SAS: Budget allocation for SAS varied considerably, reflecting differences in program prioritization and integration within the broader maternal and reproductive health

funding structure. Only 30 out of 49 municipalities reported having a separate budget allocated for free SAS. Budget allocation was often based on the number of SAS clients in the previous fiscal year, with some local governments applying an incremental increase (e.g., 5% or 10%) to maintain adequate drug supply. Only in a few cases, the health facilities procured MA drugs using their own funds and later sought reimbursement from the local government.

***MA drug procurement policy*:** HSCs have maintained that they generally follow the federal and public procurement guidelines including the *Public Procurement Act and Regulations* and the *Finance Act 2005 (Aarthik Ain 2062)* for the procurement of MA drugs. Two main mechanisms were reported in MA drug procurement – (i) Health facilities procure MA drugs directly and seek reimbursement or use the advance payment received from the local government based on service delivery volume (NPR. 800 per client), and (ii) Health facilities submit requisition forms to the local government, which then procures and supplies MA drugs to the health facilities as per their demand.

3. Safe Abortion Budget and Financing

***Perspectives of the Federal Stakeholder*:** The stakeholder at the federal government (FWD/MoHP) provided an updated information on the national total of SAS accredited health facilities. Of the total 1,686 accredited facilities, 727 are accredited to provide MA/MVA up to 10 weeks only; 351 for MVA up to 12 weeks and 63 facilities for second-trimester abortion (MI/D&E). However, the stakeholders pointed out that accreditation alone does not guarantee service availability. Presence of trained providers remains a critical determinant of service functionality.

SAS Accreditation Status: Only 91 (17.5%) out of the total 519 public health facilities are SAS accredited. Nine facilities (1.7%) were in the process of accreditation at the time of this baseline study. Province-wise, Madhesh province has 39 SAS accredited health facilities, Lumbini has 20 and Karnali province has 32. All the 10 hospitals of Madhesh, 4 out of 7 hospitals in Karnali and the only hospital of Lumbini, *Yasodha Aadharbhut hospital* is SAS accredited. Likewise, two primary health care centres (PHCCs) in Lumbini, one in Karnali and 5 PHCCs in Madhesh province are accredited. Health post-wise, 51.5% in Lumbini; 39% in Karnali and only 18% in Madhesh Province are accredited. Only one urban health center (out of 11 UHC) of Madhesh is SAS accredited, while none of the basic health service center (208 BHSC) has accreditation status.

***Reasons for non-accreditation*:** Absence of a trained service provider was cited as the main reason for SAS non-accreditation by service providers of Madhesh (215) and Karnali (154). Although the existing guidelines does not specify '*presence of a birthing center'* as a criteria for SAS accreditation, a significant number of service providers of 208 facilities cited this reason for non-accreditation. Lack of infrastructure was cited by service providers of 204 facilities, reflecting persistent challenges related to physical infrastructure, space or essential equipment needed for service provision. Service providers of 4 facilities perceived that there is no policy provision for listing a community health unit (CHU) and BHSC-level facility.

SAS Functional Status and Range of Service Offered: Only 55 out of 91 (60%) SAS accredited facilities offered SAS with free service in all except one. The majority of these SAS facilities offered medical abortion (MA) for gestations up to 10 weeks only. Manual vacuum aspiration (MVA) was available in only a few hospitals. Provision of second-trimester abortion care (medical induction MI/dilation and evacuation D&E) was restricted to only one provincial hospital, reflecting a significant service gap.

Capacity and Readiness for Consistent SAS Provision: A persistent shortage of trained service providers was reported by HSCs as a major barrier to the consistent provision of SAS. Only 7 HSC out of 49 felt that their health facilities have adequate numbers of trained providers for SAS service provision. Key barriers identified by them were low prioritization of SAS by elected representatives and paucity of human resource of requisite professional training (Staff nurse/ANMs, etc.). Despite multiple efforts, including formal requests to district and provincial health offices for staff deployment at vacant posts and for provision of necessary skill-based training, these concerns remained unsolved.

***Challenges in SAS provision*:** Health care providers (HCP) often reported lack of essential supplies, medicines, equipment, reporting forms and delayed/non-payment of providers' incentives, discouraging service provision. Some HCPs also cited persistent conflicting views with their local government authorities,

contradictory opinions pertaining to accreditation and providers' incompetence that contributed to service gaps.

While provincial health training centers (PHTC) are responsible for MA/MVA training of mid-level health providers, national health training centers (NHTC) provide training exclusively to medical officers/doctors including second-trimester abortion training for specialists (Sr. Obs&Gyne and MD/GPs). Training needs are generally assessed based on facility requests and gap in existing trained manpower, with additional methods such as site visits monitoring in Madhesh, digital data collection in Lumbini and coordination with district health offices in Karnali.

***Clients' Abortion Method Choice*:** MA remains the most preferred choice of method for reasons such as: lack of alternative choice to MA, convenience, simplicity, non-invasive, private and easier to manage as compared to MVA. The reason for unpopularity of MVA was due to fear and misconceptions about the procedure being harmful leading to uterus damage, also the procedure is seen as intimidating and embarrassing, particularly because it involves exposure of private parts, (Lumbini and Madhesh province).

4. Safe Abortion Information and Monitoring

***Data Management and Reporting*:** According to service providers, SAS data are reported on a monthly basis and submitted either to the respective local government (21 out of 25 SAS facilities) or to the provincial government (4 hospitals). All reporting is done electronically through district health information system 2 (DHIS2) in all three provinces. However, service providers from Lumbini Province and some from Madhesh province maintain dual reporting systems - hard copy formats and DHIS2 formats.

Monitoring and Supervision of SAS: The majority of the HSCs reported conducting monitoring visits on a quarterly or biannual basis. Monitoring visits typically involved reviewing service registers, stock records, and infrastructure conditions, as well as assessing the availability of medicines and equipment. Major challenges for HSCs in organizing monitoring visits were: inadequate budget allocation, shortage of human resources, terrain-related barriers during monsoon and limited technical capacity to conduct regular and focused supervisions.

All HSCs reported that SAS data are recorded in the health management information system (HMIS) and reported online through the DHIS2 platform within the first week of each month. In certain contexts (particularly in Karnali and Madhesh), health facilities submit their HMIS records to the local government, who then reports the data via DHIS2 platform. Challenges affecting quality and consistency in reporting SAS related data were: server instability, poor internet connectivity, frequent electricity outages, weak network coverage and shortage of trained personnel for data entry and reporting.

5. People Level

Challenges and Barriers to SAS Access: HSCs identified barriers and challenges to SAS access at the *individual level (*fear, ignorance, privacy concerns, lack of confidence, shyness, etc.); at the ***Family level***, (women's limited decision-making, lack of autonomy, illiteracy, and deeply-rooted cultural beliefs and religion, that paint an act of abortion as morally wrong, etc.); ***Community-level barriers*** (social stigma towards abortion, negative attitudes of community leaders and elected representatives regarding women's access to abortion, misconceptions about abortion, etc.). The ***Policy-level Barriers*** cited by HSCs were: lack of local level policy guidelines and limited awareness of national policies, weak monitoring and regulation of service sites, etc.

A considerable proportion of FCHVs from all three provinces perceived abortion as a sin. They further added that the procedure could harm the cervix and/or the act could be fatal. Regarding the reasons for abortion, majority of the FCHVs said that women are under immense pressure from their husband, in-laws and from the society to give birth to a son thus, coercing them to undergo an abortion whenever the sex identification tests reveal otherwise (a girl).

According to the majority of the FCHVs, they had minimum interaction with community women and girls on abortion related matters. Very few women and girls seek their advice on abortion directly and their query is often related to missing periods. Abortion-related topics are rarely discussed in their (FCHVs') monthly meetings. However, the majority of them acknowledged the importance of inducting abortion-related topics in their group discussions. They also expressed their interests in conducting door-to-door information sharing on SAS so as to create a supportive environment for women to access safe abortion services.

Community member's perceptions on the availability and safety of abortion services varied across provinces. Nearly half of the women in Karnali and a few in Lumbini identified public health facilities as safe places for abortion. While community participants from Madhesh Province believed that the health centers in their province did not offer safe abortion services. Few amongst them also suggested India for abortion care. The majority of the adolescent girls from the three provinces highlighted that it is difficult for an adolescent girl to utilize/receive abortion related services in their community.

A host of socio-cultural barriers to accessing safe abortion identified by married women and girls were; shyness/hesitation in accessing the service, fear of societal judgment or stigmatization, husband's objection, pressure to continue the pregnancy, and lack of financial support.

Recommendations

The five-year Kaleidoscope Initiative (2025-2029) is timely and highly warranted, considering the global impact of funding freeze (2025), termination of financial support for WHO, (2026); and the extended Global Gag Rule (since 2017) - a policy of the US Government that prohibits non-US-based non-governmental organizations (NGOs) from providing, referring for, or counseling on abortion as a method of family planning, or advocating for the liberalization of abortion laws, as a condition for receiving certain categories of US Global Health Assistance.

The following are the key recommendations arising from the Baseline Study:

1. Policy and Governance:

- Strengthen coordination among the three-tier government for accreditation of additional health facilities to ensure that each municipality has minimum one SAS facility offering MA and at least 1-2 PHCCs/hospital located within each project province offering MVA in addition to MA.
- Strengthen multi-level coordination by establishing a provincial platform involving PHD, PHTC, district offices, municipalities and partner organizations to share training data, provider placement status, resource needs and service delivery updates. This platform should be used to jointly plan training, follow-up and supportive supervision. Additionally, institutionalize a simple system within PHD/PHTC to track trained providers, staff transfers, and availability of SAS services across facilities. Joint supervision visits led by PHD/PHTC, with participation from partner organizations, should be conducted routinely to ensure service readiness, and identify and resolve gaps and challenges.
- Introduce 'Harm reduction initiatives (HRI)' targeting private pharmacy workers, informal medicines sellers and quacks. Under HRI, such persons are made aware of the abortion law, conditions for legal abortion, penalties for providers. The initiatives also inform the participants about the registered MA drugs and requirement of a physician's prescription for dispensing these MA drugs.

2. Safe Abortion Budget and Financing:

- Implement the provincial training strengthening package that includes: (i) updating the SAS curriculum to incorporate adequate practical/clinical sessions and fully integrate VCAT modules; (ii) establishing a routine refresher-training and mentoring system, by allocating adequate dedicated provincial and federal budgets for these trainings; (iii) ensuring consistent availability of IEC materials; and (v) expanding and capacitating the pool of trainers to increase the number of training batches each year.

3. Safe Abortion Service Availability:

- Prioritize in-service training on SAS for the health care providers (Sr ANM/ANM) who have replaced the previous SAS provider by strengthening coordination with the concerned provincial health training centers (PHTC). The training officials of the PHTC should be encouraged to conduct periodic appraisal/need assessment of all SAS accredited health facilities and conduct SAS orientation training as per demand. Strengthen municipal level monitoring and evaluation by directing municipality focal persons to perform routine M&E visits at all SAS accredited facilities to monitor the availability and stock of MA drugs, free SAS assurances, regular presence of SAS provider, and service visibility (updating public charter and display of signboard with SAS logo) of all listed SAS facilities.

4. People Level:

- Conduct public awareness and educational campaigns at community level in collaboration with the concerned local government representatives, NGOs/CBOs, health care providers and FCHVs. IEC/Advocacy materials and messages that amplify information pertaining to legal provision, conditions for legal abortion and 'as reproductive rights' should be written in simple local languages (Nepali, Maithali, Bhojpuri, Avadhi). These campaigns should target key community opinion leaders, elderly population, marginalized/disadvantaged communities, etc., to modify their beliefs, misperceptions and become supportive to abortion rights. The experiences of organizations involved in SRHR related behavior change communication programs in the past may be consulted for understanding the most effective mode of community-based education/awareness campaigns and the type of IEC/advocacy messages and audio-visual or printed materials relevant for the same.
- Organize orientation training on abortion law, rights for all FCHVs. Topics of the orientation training should also cover ways to overcome abortion stigma that abortion is sin and the misconceptions that all abortions lead to adverse health outcomes. They should also be encouraged to discuss openly about safe and legal abortions in their monthly meetings. In addition, FCHVs should be encouraged to share the information pertaining to service accessibility, safety of the procedure if carried by certified health care provider, privacy/confidentiality assurance at the SAS facility, free care, etc. while conducting mothers group meetings. Social barriers to service utilization should also be featured in their monthly meetings.
- FCHVs should be empowered as change agents through capacity building orientation training and engage them in community-level programs including in IEC campaigns that promote SRHR rights of women and overcome socio-cultural barriers faced by women to access safe abortion service. Health facilities should be encouraged to provide incentives or awards to FCHVs for carrying out *home-based urine pregnancy tests* and assisting the woman with an unintended pregnancy to decide with the pregnancy should be explored. FCHVs should also be encouraged to accompany women needing an abortion care to a conveniently located SAS facility.
- Raise community awareness on the abortion law that forbids sex determination tests for the purpose of sex selection and the negative impact of sex selective abortions and risk to health associated with late abortions. The awareness campaigns should particularly target male members of the community to discourage them from persuading their spouse for gender-biased sex selection, and encourage them to make right-based reproductive choices and decisions.

Content

Section 1: Introduction

1.1 Background

The right to safe abortion is a fundamental human right protected under numerous international and regional human rights treaties and national-level constitutions around the world.[1] The World Health Organization (WHO) states that safe-abortion services must be universally available and accessible to every woman, consistent with the legal framework of each country, and that an abortion is a simple health care intervention and is considered safe when it is carried out using a method recommended by WHO, appropriate to the gestational age, and by someone with the necessary skills. [2]

Nepal amended its Civil Code (*Muluki Ain*) in 2002 to allow abortion on certain grounds and to ensure Nepalese women's right to decide on their fertility choices.[3] This amendment allowed abortion under the following conditions, contingent on the woman's consent: up to 12 weeks' gestation on any ground; up to 18 weeks' gestation in cases of rape or incest; and at any gestation if the pregnancy posed a danger to the woman's life, physical health or mental health, or if there was a fetal abnormality. Abortion was highly restricted prior to this amendment, and women were imprisoned for acts of abortion. Deaths from unsafe and clandestine abortions had contributed significantly to the country's high maternal mortality ratio before the legalization of abortion.[4]

In 2018, Nepal passed a landmark legislation with the enactment of the Right to Safe Motherhood and Reproductive Health (RSMRH) Act 2018. This act recognizes abortion as a women's fundamental reproductive right and broadens the scope and measures for safe abortion. Under the Act, abortion is permitted on the following grounds by specific trained and listed service provider at the listed health facility:

i) with the consent of the pregnant woman up to 12 weeks' gestation ;

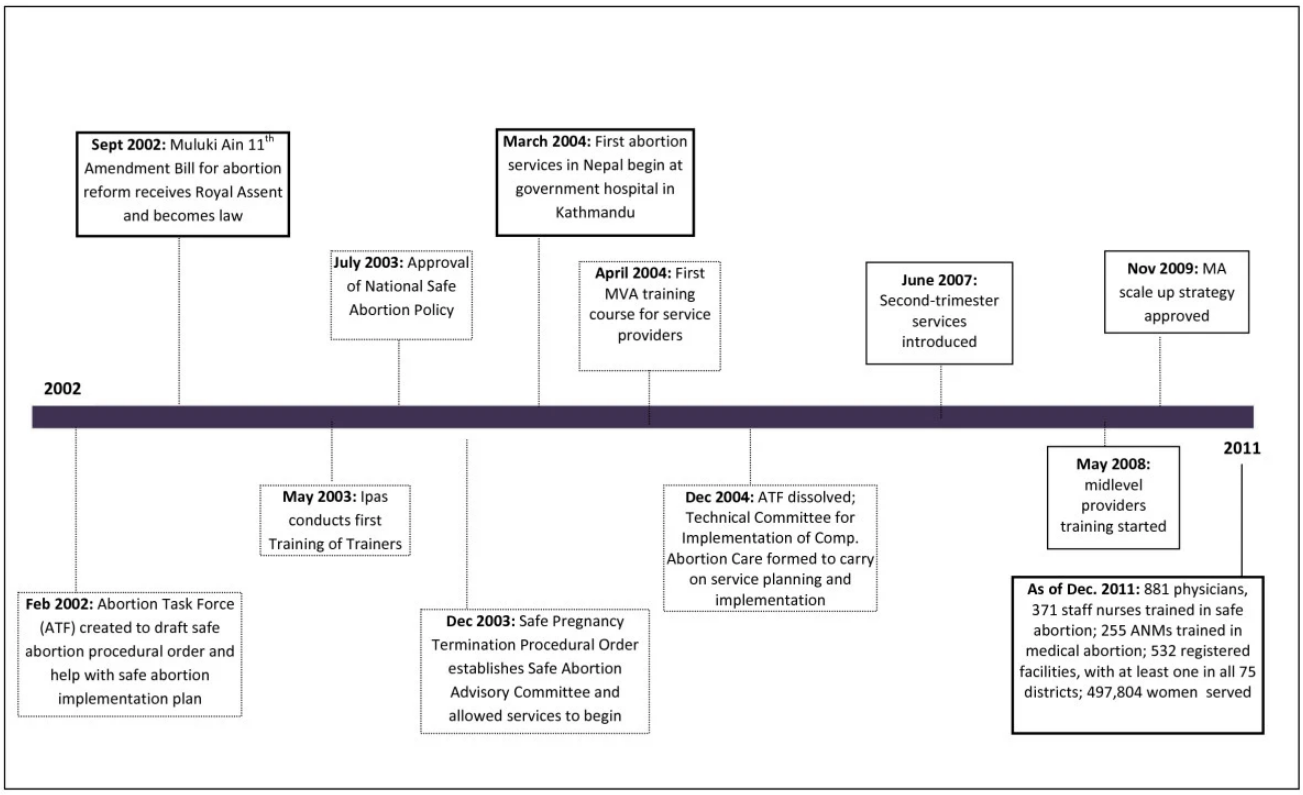
ii) Up to 28 weeks

- if the pregnancy poses a danger to the pregnant woman's life; if abortion not performed or it might affect her physical health or mental health; abortion can be performed for gestation licensed medical doctor, contingent to the woman's consent to abortion of such a pregnancy;
  if the pregnancy occurred due to rape or incest and the woman consented to abortion of such a pregnancy;
- if the pregnant woman is living with Human Immunodeficiency Virus (HIV) or some other incurable disease and has consented to an abortion of the pregnancy;
- with the consent of the woman, if there is a fetal anomaly and the fetus cannot survive upon birth, as diagnosed by the service provider.[5]

The Right to Safe Motherhood and Reproductive Health (RSMRH) Regulation (2020) sought to guarantee, safeguard, and enhance women's reproductive rights at all levels of the government - federal, provincial, and local through legislation and earmarking budgets for SRH including budget for ensuring free abortion care at all public health facilities. The RSMRH Regulation further specifies the various methods (either medical or surgical/vacuum aspiration), of safe abortion based on gestational age. Medical abortion (MA) is recommended for termination of pregnancies up to 10 weeks of gestation. This method involves intake of Mifepristone, followed by Misoprostol, and is recognized as a safe and effective abortion method.

Similarly, Manual Vacuum Aspiration (MVA) is permitted for pregnancies up to 12 weeks of gestation. For pregnancies between 13 and 28 weeks of gestation, termination is conducted using advanced methods such as Medical Induction (MI) and Dilatation and Evacuation (D&E). These procedures are performed by trained postgraduate medical practitioners, including those with a Doctor of Medicine in General Practice (MD/GP) or Obstetrics and Gynecology (Ob/Gyn), and are to be carried out at designated Comprehensive Emergency Obstetric and Neonatal Care (CEmONC) sites.[6]

Until 2015, the federal government led by the Family Welfare Division, Ministry of Health and Population (MoHP) was solely responsible for the accreditation of the health facilities to provide safe abortion services. of SAS facilities. The new Constitution of Nepal 2015 mandated a three-tier federal system, where the responsibilities of health services shifted from the central government to the provincial and local level government. The RSMRH Act and regulation decentralized the safe abortion site and service provider accreditation process to the provincial and local authorities.



MVA = Manual vacuum aspiration; MA = Medical abortion; ANM = Auxiliary Nurse Midwives

Ref: Implementation of legal abortion in Nepal: a model for rapid scale-up of high-quality care

Ref: IPAS Nepal, SAFOGNESOGCON 2026

Since the legalization of abortion in Nepal, the legal reform allowed Nepalese women to access legal and safe abortion services from government accredited safe abortion service (SAS) clinics.

The Government of Nepal has expanded the SAS in all the 77 districts of the country in a phased manner As per Nepal Health Facility Survey 2022, 19.2% facilities offering service, medical abortions are provided by 29% of facilities and 30% offered post-abortion care. There are few medical colleges and teaching hospitals outside the Kathmandu Valley that have received accreditation for the provision of second trimester abortions. As of 2021, over 4500 certified service providers offered SAS from accredited public and NGO/private clinics. Moreover, The Government of Nepal has been providing abortion service free in all the public health facilities since 2017, though anecdotal evidence suggests that the unit cost allocated for the free safe abortion services are not adequate particularly for the commodities and medicines.[19] Though there has been an ongoing advocacy to increase the budget for the service.

Although it has been more than two decades since abortion law reform, The 2021 study on the incidence of induced abortion in Nepal estimated a total of 333,343 cases, 48% were provided from legal sites and 52% outside the legal facilities[24] The level of awareness about the law is still low. The Nepal Demographic and Health Survey (NDHS) 2016 showed that only 41% of women of reproductive age were aware of the legal status of abortion, and only 23% of the women who knew abortion was legalized knew that abortion can be obtained up to 12 weeks of gestation on the woman's request and informed consent. [14] MA was featured as the most popular method of choice (72%) among Nepalese women in the NDHS 2016.

The expansion of MA greatly enhanced Nepalese women's access to legal and safe abortion care for early pregnancies as several outreach health care facilities of the government such as PHCC, Health post (HP), Basic Health Service Center (BHSC), as well as those facilities/clinics run by NGOs and private entrepreneurs began to expand their clinics. The criteria for accreditation of clinics run by the government and non-governmental organizations as well as the service providers were specified in the Safe Abortion Service Programme Implementation Directives 2011 (2068) followed by Safe Abortion Service Program Operational Guideline 2016 (2073).[10] The WHO published a guideline in 2015 that spelt out the range of health workers who can provide safe abortion care and manage non-life-threatening complications in the

first (up to 12 weeks) and second semester (13-28 weeks) in both low and high settings. The 2022 revised version of the guidelines recommends self-management for medical abortion up to 12 weeks along with telemedicine as an alternative to in person interaction with the health worker to deliver medical abortion in whole or in part.

Although the contribution of abortion to the total pregnancy-related maternal deaths has declined significantly over the past two decades, abortion related morbidity due to unsafe abortion practices continues to affect women's lives. As per the Nepal Maternal Mortality Study 2021, of the total Maternal Mortality Ratio (MMR) of 151 per 1,00,000 live births, unsafe abortion alone contributed to 5% of all pregnancy-related maternal deaths in the country with a wide inter-province variations in abortion-related maternal deaths ranging from a low 2% (Koshi province) and 3% (Bagmati province) to a high 7% (Lumbini province and Gandaki province) to 9% (Karnali province). [25] The practice of induced abortion remains high (9.6%) among the young Nepalese women aged 20-34 years as compared to older aged women. Province-wise, the practice among these young women is relatively the highest in Gandaki (16.9%), and Karnali (15.8%), followed by young women of Bagmati (11.6%), Sudurpashchim (11.4%) and Lumbini province (10.6%).[26] Fear of social stigma, lack of autonomy and other cultural barriers can prevent many women from seeking safe abortion services.[27] Additionally, the change in the system of governance in 2015 led to the transition of administrative authorities and a mass transfer of public servants including those serving in the health sector resulting in the disruption of safe abortion service in Nepal.

Trends of Reproductive Health Indicators in Nepal

S.N.	Reproductive Health Indicators	2011	2016	2022	Sources
1.	Total Fertility Rate	2.6	2.3	2.1	NDHS
2.	Adolescent Fertility Rate	81 Birth per 1000 women	88 Birth per 1000 women	71 Birth per 1000 women	NDHS
3.	Contraceptive Prevalence rate for Any Method			57.2%	NDHS
4.	Modern Contraceptive Prevalence Rate			42.7%	NDHS
5.	Traditional Contraceptive Prevalence Rate			14.6%	NDHS
6.	Unmet Need for Family Planning	28	24	21	NDHS
7.	Post-Partum family Planning Contraception	5.8 (2021/22)	8.2(2022/23)	10.9(2023/24)	Government Annual Reports

Trends of Reproductive Health Indicators in Nepal					
8.	Abortion Incidence			41 per 1,000 WRA	IPas Research Brief 2023
9.	Post Abortion Family Planning	74%(2021/22)	72% (2022/23)	72% (2023/24)	Government Annual Reports
10.	Maternal Mortality Ratio		151 per 100,000 live births		NATIONAL POPULATION AND HOUSING CENSUS 2021: A REPORT ON MATERNAL MORTALITY
11.	Pregnancy with abortive complications			7 %	Maternal and Perinatal Death Surveillance and Response [MPDSR] Factsheet No. 6 FY 2080/81 (Jul/Aug 2021 – Jun/Jul 2024)

1.2 About the Kaleidoscope Initiatives

Kaleidoscope is a collective of transnational feminist organizations in the Global South working for health systems change for SRHRJ particularly abortion rooted in Asia and Africa. The collective includes ARROW, MAMA Network, WGNRR, GFW and Country partners BBC and VISIM in Nepal, with evolving partnerships rooted in feminist and rights based access to SRHRJ, **particularly quality safe comprehensive abortion care.**

This is a five-year initiative from 2025-2029 with a focus to strengthen the existing health systems to enhance comprehensive Sexual and reproductive health and services including providing quality and safe abortion services. The baseline year 2025 of the Kaleidoscope Initiative is focused on understanding gaps, barriers and challenges on health systems for comprehensive abortion care and making a pavement towards working and engaging with government partners and safe abortion coalitions for impactful project planning and implementation. The data collected through this assessment will provide a comprehensive picture of existing conditions, enabling more precise setting of intermediate outcomes and targets. It will also inform the refinement of intervention strategies, ensuring that the subsequent implementation phase is grounded in accurate, context-specific evidence and aligned with the initiative's overall goals.

The Visible Impact and Beyond Beijing Committee, in collaboration with the Family Welfare Division in partnership with Crehpa Services Pvt. Ltd., conducted study in Kaleidoscope intervention municipalities and three provinces Madhesh, Lumbini, and Karnali Provinces. These three provinces were selected by the partners in consultation with provincial and the federal level stakeholders considering the maternal

mortality ratio (MMR) and the contribution of abortion to the total maternal mortality as well as availability and accessibility to safe abortion services and the geographical and socio cultural determinants.
As per the 2021 Maternal Mortality study, Nepal Population Census, the national maternal mortality ratio was 151 per 100,000 live births whereas Lumbini province has the highest MMR which was at (207 per /100,000 live births among the seven provinces followed by Karnali at (172), while Madhesh Province has MMR of 140/100,000 live births which is lower than the national average.

Karnali, Lumbini, and Madhesh Provinces were selected based on their relatively high contribution of abortion-related deaths to the total maternal mortality ratio (MMR). According to national data, abortion-related deaths accounted for 9% of maternal deaths in Karnali, 7% in Lumbini, and 5% in Madhesh, compared to the national average of 5%. In addition, Karnali faces significant geographical barriers and limited access to quality sexual and reproductive health services, while Lumbini and Madhesh are characterized by socio-cultural norms, religious beliefs, stigma, gender-related barriers, and disparities in access to safe abortion and post-abortion care services. These contextual challenges may increase the risk of unsafe abortion and abortion-related complications, making these provinces priority areas for targeted interventions.

The 49 program municipalities (18 municipalities in Karnali; 6 in Lumbini and 25 in Madhesh Province) were selected by implementing partners in consultation with the concerned provincial government bodies to represent municipalities that cover both the high need and the comparatively better served areas in terms of SRHR services.

1.3 Key Objectives of the Baseline Study

1.3.1 General Objective

The main objective of the baseline study was to assess the current status, gaps, and challenges in policy provision and health systems to access safe abortion and SRHR services in Madhesh, Lumbini, and Karnali provinces of Nepal.

1.3.2 Specific Objectives

- To analyze the current status, gaps, policy implementation challenges, and barriers to access related to safe abortion and broader SRHR services in Madhesh, Lumbini, and Karnali provinces.
- To establish baseline values for country-specific outcome indicators through the collection and analysis of quantitative and qualitative data, including addressing key data gaps identified.
- To generate and translate robust evidence into actionable insights for the design, implementation, adaptation, and policy advocacy of safe abortion services interventions under the Kaleidoscope initiative, ensuring context-responsive and evidence-informed programming across all target provinces.
- To contribute to the Kaleidoscope learning agenda through the generation of actionable evidence that supports adaptive programming, knowledge sharing, and cross-country learning at both country and consortium levels.

Section 2: Study Methodology

2.1 Study Design and Methods

The baseline study employed a mixed-methods cross-sectional design to collect data on key outcome indicators incorporated within the Theory of Change of the Kaleidoscope (Annex 1) for Nepal, particularly on SAS sites expansion; increased awareness regarding legal provision of abortion and place for SAS care, gaps in service provision and utilization of quality, accessible, gender sensitive, friendly and inclusive SAS services.

The *quantitative study* encompassed survey and observation to map and assess the health facility to provide the CAC and secondary data collection on the number of safe abortion services and costs related to SAS and CAC. The *qualitative component* encompassed Key Informant Interviews (KIIs) with the health-related focal person at the local government bodies (municipalities) as well as with the health facility in-charge/health provider of the health facilities observed. Focus Group Discussions (FGDs) were conducted with female community health volunteers (FCHVs), community women, men and adolescent girls and boys to gather insight of their awareness level and understand their perspectives on abortion law and SAS.

2.2 Geographical Coverage of the Study

A total of 49 municipalities from three provinces: Madhesh, Karnali and Lumbini, were identified for the implementation of the KI. Of these, 24 municipalities (approx. 50%) were intensively covered in the present baseline study.

Table 2.1 shows the district and municipality-wise distribution of the Implementation area in the three provinces. While the Initiative is confined to five districts and 18 municipalities in Karnali province, only two districts and six municipalities were identified for Lumbini province. On the other hand, 25 municipalities representing all the eight districts of Madhesh province are covered.

Table 2.1: Province-wise distribution of the districts and municipalities covered under Kaleidoscope Initiative

Province	District	Municipalities
Karnali Province (18 municipalities)	Dolpa	Tripurasundari Municipality and Thulibheri Municipality
	Mugu	Soru Rural Municipality and Khatyad Rural Municipality
	Humla	Adanchuli Rural Municipality and Sarkegad Rural Municipality
	Jumla	Sinja Rural Municipality, Kankasundari Rural Municipality and Patarasi Rural Municipality
	Kalikot	Raskot Municipality, Tilagufa Municipality, Khadachakra Municipality, Palata Rural Municipality, Pachaaljharana Rural Municipality, Sannitribeni Rural Municipality, Mahabai Rural Municipality, Subhakalika Rural Municipality and Narharinath Rural Municipality
Lumbini Province	Kapilvastu	Mayadevi Rural Municipality, Yoshadhara Rural Municipality and Suddodhan Rural Municipality

(6 municipalities)	Banke	Janaki Rural Municipality, Duduwa Rural Municipality and Baijanath Rural Municipality
Madhesh Province (25) municipalities)	Saptari	Rajbiraj Municipality and Saptakoshi Municipality
	Siraha	Arnama Rural Municipality and Siraha Municipality
	Dhanusha	Aurahi Rural Municipality, Dhanushadham Municipality, Janakpurdham Sub metropolitan City and Shahidnagar Municipality
	Mahottari	Gaushala Municipality, Jaleshwor Municipality, Matihani Municipality, Aurahi Municipality and Mahottari Rural Municipality
	Sarlahi	Barahathawa Municipality and Malangwa Municipality
	Rautahat	Baudhaimai Municipality, Brindaban Municipality, Durgabhagwati Rural Municipality, Madhav Narayan Municipality and Phatuwa Bijayapur Municipality
	Bara	Jitpur Simara Municipality and Nijgadh Municipality
	Parsa	Parsagadhi Municipality, Pokhariya Municipality and Thori Rural Municipality

2.3 Quantitative Components

2.3.1 Quantitative Survey:

The quantitative survey (health facility mapping) was conducted with the health facility in-charge or the administrative head/manager of all the public health facilities located within the 49 municipalities, using a structured survey questionnaire. This survey solicited information regarding the accreditation status of the health facility, the reasons for non-accreditation, current functionality of the SAS accredited facilities, range of SAS offered, availability of Information Education and Communication (IEC) materials, stock availability of MA drugs and extent of coordination with local government. Likewise, facility readiness for SAS was also assessed in those public health facilities.

2.3.2 Facility Observation:

For the facility observation, 24 municipalities were sampled, following a systematic random sampling technique.

Sampling procedure of municipalities: Initially, all the provinces were listed from east to west, and districts within each province were also listed from east to west. The municipalities within each district were then arranged alphabetically. The sampling interval was calculated by dividing the total number of municipalities by the required number of municipalities (24), yielding the sampling interval of 2. Then every second municipality in the list was subsequently selected until 24 municipalities were selected (Table 2.2).

Table 2.2: District-wise Municipality selection using systematic sampling technique

Province	District	Sampled Municipalities
Karnali Province (9 municipalities)	Dolpa	Tripurasundari Municipality
	Jumla	Patarasi Rural Municipality

	Mugu	Khatyad Rural Municipality
	Kalikot	Khadachakra Municipality Narharinath Rural Municipality Palata Rural Municipality Sannitribeni Rural Municipality Tilagufa Municipality
	Humla	Sarkegad Rural Municipality
Lumbini Province ***(3 municipalities)***	Kapilvastu	Mayadevi Rural Municipality Yoshadhara Rural Municipality
	Banke	Duduwa Rural Municipality
Madhesh Province ***(12 municipalities)***	Saptari	Saptakoshi Municipality
	Siraha	Siraha Municipality
	Dhanusha	Dhanushadham Municipality Shahidnagar Municipality
	Mahottari	Jaleshwor Municipality Mahottari Rural Municipality
	Sarlahi	Malangwa Municipality
	Rautahat	Brindaban Municipality Madhav Narayan Municipality
	Bara	Jitpur Simara Municipality
	Parsa	Parsagadhi Municipality Thori Rural Municipality

After the selection of 24 municipalities, a list of all SAS accredited public health facilities within these 24 sampled municipalities was prepared. Facility Observation was carried out using an observation checklist in all these SAS accredited public health facilities (Hospital/PHCC/HP). The service availability including presence of a SAS trained service provider, space for counseling cum examination, examination table, stock of MA (mifepristone & misoprostol combi-pack), display of SAS Logo, etc. were assessed in all the facilities.

2.3.3 Secondary Data Collection:

SAS related secondary data on the annual number of abortion clients served by health facilities in their respective municipalities was obtained for the last five fiscal years (2020-2021 to 2024-25) from the concerned municipality offices using a Data Collection Format developed for the purpose. All the health facility is expected to submit a monthly compiled data on all health-related statistics including immunization

data from the HMIS register using HMIS 9.3 format and upload the same onto the DHIS2 system to enable the concerned authorities at the municipality and higher levels to monitor the program performances.

Due to the Gen-Z protest that resulted in the destruction of municipality properties, secondary data could not be accessed at a few municipalities of Madhesh Province (Barhathwa of Sarlahi; Janakpurdham sub-metropolitan and Siraha municipality) for the present baseline study. In the case of Siraha municipality, the required data was directly collected from the concerned hospital (one) and health post (one). Baseline survey data validation was conducted at both provincial and district levels during the dissemination of baseline findings, with participation from health facilities, local governments, and district and provincial representatives. The data was further validated through stakeholder engagement at the national level during an advisory group sharing and validation meeting, ensuring comprehensive review and consensus across all levels of governance and implementation.

Additionally, secondary data on the utilization of Safe Abortion Services (SAS), including the total number of service users and the estimated costs of safe abortion and post-abortion care services, were obtained from the Family Welfare Division for the three fiscal years spanning FY 2022/23 to FY 2024/25.

2.4 Qualitative Components

2.4.1 Focus Group Discussions (FGDs):

Focus Group Discussion (FGD) was carried out to understand community members' knowledge, awareness, attitude, perception and practice related to abortion law, demand for abortion and reasons; SAS service access, stigma related to abortion as well as barriers faced in accessing SAS. Thirty FGDs was conducted targeting the five categories of community members viz., i) Married women of reproductive age (MWRA) 15-49 years of age; ii) Unmarried adolescent girls aged 15-19 years; iii) Married men (20-50 years of age); iv) Unmarried adolescent boys (15-19 years); and iii) Female Community Health Volunteers (FCHVs). (Table 2.3) Altogether 30 FGDs were conducted in 10 purposively selected municipalities. Criteria for purposive selection was governed by geographical location (urban/rural; hill/terai); socio-economic status (marginalized community; Dalits; Muslims etc.), and places where accredited SAS facility is absent. (Table 2.4) Although efforts were made to involve women of reproductive age and adolescent girls with physical and/or visual impairment in the FGDs, none of the FGDs could include them.

Table 2.3: Coverage of Different Categories of FGD Participants

SN	Category of FGD participants	Broad components to be covered in FGDs	Province	Coverage	Total FGDs
1	MWRA (15-49 years)	Knowledge, Attitude and Practice (KAP) on legal provision and places to access safe and legal abortion; societal attitudes on abortion and reasons; other barriers to accessing abortion care; etc.	Madhesh	1 per each of the 2 municipalities	6 FGDs
			Lumbini	1 per each of the 2 municipalities	
			Karnali	1 per each of the 2 municipalities	
2	Unmarried adolescent	KAP on legal provision and places to access safe and legal abortion; societal attitudes on abortion and	Madhesh	1 per each of the 2 municipalities	6 FGDs

	girls (15-19 years)	reasons; other barriers to accessing abortion care; etc.	Lumbini	1 per each of the 2 municipalities	
			Karnali	1 per each of the 2 municipalities	
3	Married men (20-50 years)	KAP on legal provision and places to access safe and legal abortion; societal attitudes on abortion and reasons; other barriers to accessing abortion care; etc.	Madhesh	1 per each of the 2 municipalities	4 FGDs
			Karnali	1 per each of the 2 municipalities	
4	Unmarried adolescent boys (15-19 years)	KAP on legal provision and places to access safe and legal abortion; societal attitudes on abortion and reasons; other barriers to accessing abortion care; etc.	Madhesh	1 per each of the 2 municipalities	4 FGDs
			Lumbini	-	
			Karnali	1 per each of the 2 municipalities	
5	FCHVs	KAP on legal provision and directives on abortion; Facilitating factors & barriers to SAS utilization; their perceived roles; demand for and pathways to safe and unsafe abortion care among women and ways to correct the practice; etc.	Madhesh	1 per each of the 4 municipalities	10 FGDs
			Lumbini	1 per each of the 2 municipalities	
			Karnali	1 per each of the 4 municipalities	

Criteria for Selection of FGD participants

FGD with MWRA (15-49 yrs) and Unmarried Adolescent Girls (15-19 yrs):
Criteria for Selection: i) Had visited the nearest health facility accredited for SAS for at least SRH related information and service in the past one year; and/or ii) knows a family member who had utilized SAS center either for contraceptive use, SAS, for treatment of abortion related matters, etc.

FGD with married men (20-50 years) and adolescent boys (15-19 years): Criteria for selection: i) Had visited a government health facility within the past one year for SRHR related services such as for conception or contraception, post-pregnancy services, or for information and services related to abortion; ii) Has a female friend who ever had visited a nearest health facility in the past 2 years; iii) knows a friend, family member or relatives who had utilized a health facility for contraceptive use, pregnancy or delivery care or for abortion related matters, etc.

FGD with FCHVs:
Criteria for FCHV selection: Actively supporting in SRH & Maternal and Child Health (MCH) matters, and residing within the municipal ward of the SAS center covered by the present baseline.

Table 2.4: District-wise Coverage of Different Categories of FGD Participants according to Ethnicity/Caste

SN	Category of FGD participants	District	Ethnicity/Caste
1	MWRA (15-49 years)	Parsa	Madhesi
		Mahottari	Mix group (Muslim, Terai Dalit and Madhesi)
		Banke	Muslim
		Kapilvastu	Mix group (Muslim and Madhesi)
		Kalikot	Brahmin/ Chhetri
		Mugu	Brahmin/ Chhetri
2	Unmarried adolescent girls (15-19 years)	Bara	Mix group (Muslim, Terai Dalit and Madhesi)
		Sarlahi	Mix group (Terai Dalit and Madhesi)
		Banke	Mix group (Madhesi, Muslim, Terai Dalit and Terai Brahmin/ Chhetri)
		Kapilvastu	Mix group (Terai Dalit and Madhesi)
		Kalikot	Mix group (Dalit and Brahmin/ Chhetri)
		Kalikot	Mix group (Brahmin/ Chhetri and Dalit)
3	Married men (20-50 years)	Saptari	Mix group (Terai Brahmin/ Chhetri and Terai Janajati)
		Dhanusha	Mix group (Terai Dalit, Muslim and Madhesi)
		Dolpa	Dalit
		Humla	Brahmin/ Chhetri
4	Unmarried adolescent boys (15-19 years)	Siraha	Madhesi
		Dhanusha	Mix group (Terai Dalit and Madhesi)
		Dolpa	Dalit
		Humla	Brahmin/ Chhetri
5	FCHVs	Mahottari	Mix group (Muslim, Terai Dalit and Madhesi)
		Sarlahi	Mix group (Madhesi and Muslim)
		Rautahat	Mix group (Madhesi and Terai Dalit)
		Bara	Mix group (Terai Janajati, Terai Brahmin/ Chhetri and Madhesi)
		Banke	Mix group (Madhesi, and Muslim)
		Kapilvastu	Mix group (Muslim and Terai Brahmin/ Chhetri)
		Jumla	Brahmin/ Chhetri

		Kalikot	Mix group (Brahmin/ Chhetri and Dalit)
		Mugu	Brahmin/ Chhetri
		Dolpa	Mix group (Brahmin/ Chhetri and Janajati)

2.4.2 Kei Informant Interviews (KIIs):

The key informants were interviewed to assess the availability, access and barriers pertaining to SAS services. Information such as the number and functionality of health facilities providing SAS services, number of trained providers, coordination mechanisms required to strengthen SAS services, policy as well as institutional gaps and challenges in increasing access and utilization of SAS services, etc. were solicited from the key informants. The baseline did not solicit service providers' perspectives about women's roles in fertility choices or abortion decision-making since these information were obtained directly from the community women and men participating in the FGDs.

Stakeholders for the KIIs comprised of: i) Provincial Health Director at three project provinces; ii) Director of Provincial Health Training Center (PHTC) at three project provinces iii) Health Section Chief (HSC) at the local government of the 49 municipalities; iv) SAS providers at the provincial hospitals of three project provinces; v) SAS providers at the outreach public health facilities located at the 24 sampled municipalities; and vi) Abortion Focal Person at Family Welfare Division (FWD), DoHS. (Table 2.5)

Table 2.5: Coverage of Different Categories of KII Participants

SN	Category of participants	Broad components to be covered	Province	Coverage	Total KIIs
1	FWD Abortion Focal Person	National strategy/guideline on SAS; expectation from KI	Federal government-	-	1 KII
2	Provincial Health Director	Development/need for and use of Province level SAS strategy/guideline; expectation from Kaleidoscope Initiative	Madhesh	1 in Province	3 KIIs
			Lumbini	1 in Province	
			Karnali	1 in Province	
3	PHTC Director	SAS and Value Clarification and Attitude Transformation (VCAT) training curriculum development and revision; annual trainings conducted; expectation from KI	Madhesh	1 in Province	3 KIIs
			Lumbini	1 in Province	
			Karnali	1 in Province	
4	HSC at the local government	Level of coordination between SAS facilities and the local govt; free service assurance; MA drug procurement policies & knowledge about Department of Drug Administration (DDA) approved MA drugs; staff shortage; training/refresher training policies of nurses	Madhesh	1 per municipality in 24 municipalities	48 KIIs
			Lumbini	1 per municipality in 6 municipalities	

		and physicians for SAS; SAS annual budget and adequacy; sources of alternative funds ; number of functional, non-functional SAS site, Palika interested in system strengthening, provision of budget allocated for Abortion, local level policies, annual trends in the number of clients receiving safe abortion service, number of People Living with Disability (PLWD) receiving safe abortions service, how gender-transformative is abortion curriculum	Karnali	1 per municipality in 18 municipalities	
5	SAS providers at the Provincial Hospitals	Range of SAS services (MI/D&E; MVA, MA) offered and client preferences with reasons; Number of trained MI/D&E, MVA/MA providers & adequacy perceptions. Type of clients denied for SAS and reasons for denial. Trends in SAS and Post Abortion Complication (PAC) cases over the past five years and reasons for upward/stagnant/downward trends; Constraints (including budgetary constraints) in SAS delivery; supply chain in drugs, equipment and infection prevention materials; Coordination with province/local govt on SAS delivery.	Madhesh	1 in Province	3 KII
			Lumbini	1 in Province	
			Karnali	1 in Province	
6	SAS providers at the outreach public health facilities	Range of SAS services (MVA, MA) offered and client preferences with reasons; Type of clients denied for SAS and reasons for denial. Number of trained MVA/MA providers & adequacy perceptions; Trends in SAS and PAC cases over the past five years and reasons for upward, stagnant, or downward trend; Constraints (including budgetary constraints) in SAS delivery; supply chain in drugs, equipment and infection prevention materials; Coordination with local govt on SAS delivery.	Madhesh	In 12 municipalities	35 KIIs
			Lumbini	In 3 municipalities	
			Karnali	In 9 municipalities	

2.5 Data Collection Tools and Techniques

A total of 14 field researchers (10 females and 4 males) were recruited and trained for both quantitative and qualitative data collection. They were trained to collect quantitative data electronically using tablets using two sets of questionnaires in Nepali (Health facility assessment tool and Health facility observation checklist). Informed consent was obtained from all the study participants prior to data collection. All quantitative data collected from the field were transferred to the main server at Crehpa Services each day.

For the qualitative component, the same field researchers were trained to collect information at the local level using different sets of participatory tools such as FGD guidelines and KII guidelines. The KII at Federal and Provincial levels were carried out by the core team members. (Table 2.6) A written informed consent was obtained from the parents/guardians of adolescents aged less than 18 years prior to conducting the focus group discussions. A written informed consent was obtained for those participants aged 18 years and

above. All the interviews and discussions were carried out in-person, and audio recorders were used to record the interviews and discussion with prior consent.

Both quantitative and qualitative data collection was carried out from September 4 to October 1, 2025.

Table 2.6: Data Collection Tools Employed and Participants Coverage

SN	Tool/Methods	Participants	Coverage
Quantitative			
1	Mapping of all SAS accredited health facilities *(Quantitative survey questionnaire)*	Health Facility In-charge/ Manager/ Service Provider	All public SAS accredited health facilities within the 48 municipalities
2	Facility Observation *(Facility observation checklist)*	Health Facility In-charge/ Manager/ Service Provider knowledgeable about the services and physical facilities/equipment/drugs within the health facility	All public SAS accredited health facilities within the 24 sampled municipalities
3	Secondary Data *(SAS status assessment sheet)*	Health Section Chief at Local level and/or personnel responsible for overlooking data recording and reporting at the local level	All 48 project municipalities
Qualitative			
1	KII at Federal Level *(KII guideline)*	Abortion Focal Person at FWD	1 KII at Federal level
2	KII at Provincial Level *(KII guideline)*	Provincial Health Director	1 KII per province in all 3 provinces
		Provincial Health Training Center Director	1 KII per province in all 3 provinces
		SAS service provider at Provincial Hospital	1 KII per province in all 3 provinces
3	KII at Local Level *(KII guideline)*	HSC at Local Government	1 KII per municipality in all 49 municipalities
		SAS service provider at SAS accredited public health facilities (Municipal hospital/ PHCC/HP) within the	All public SAS accredited health facilities within 24 municipalities
4	FGD at Local Level	For FGDs, 10 out of 24 municipalities was sampled	

	*((*FGD *guideline)*	FGD with Married Women (15-49 years)	*Madhesh:* 1 per municipality in 2 municipalities *Lumbini:* 1 per municipality in 2 municipalities *Karnali:* 1 per municipality in 2 municipalities
		FGD with Married Men (20-50 years)	*Madhesh:* 1 per municipality in 2 municipalities *Karnali:* 1 per municipality in 2 municipalities
		FGD with Unmarried adolescent girls (15-19 years)	*Madhesh:* 1 per municipality in 2 municipalities *Lumbini:* 1 per municipality in 2 municipalities *Karnali:* 1 per municipality in 2 municipalities
		FGD with Unmarried adolescent boys (15-19 years)	*Madhesh:* 1 per municipality in 2 municipalities *Karnali:* 1 per municipality in 2 municipalities
		FGD with FCHVs	*Madhesh:* 1 per municipality in 4 municipalities *Lumbini:* 1 per municipality in 2 municipalities *Karnali:* 1 per municipality in 4 municipalities

2.6 Data Management and Analysis

The quantitative data (survey and observation) collected from the field were transferred to the main server at Crehpa Services each day. Two research officers (ROs) and data manager were responsible for keeping track of uploading the completed questionnaire in the server. All quantitative data were cleaned, labelled and tabulated in MS Excel. Likewise, all the KIIs and FGDs were manually coded. Data obtained through facility mapping, service providers' interviews and municipality health focal persons' interviews were analyzed and presented thematic-wise, across the three provinces to allow province-wise comparisons, while municipality level analysis of key themes are presented in the form of annexures.

Analysis of the qualitative information obtained through KIIs and FGDs with different stakeholders and community representatives including FCHVs were primary on awareness about the abortion law and rights, knowledge about legal and safe place for obtaining an abortion, socio-cultural barriers to abortion seeking and ways to overcome abortion stigma in the community. The perceptions of the various government stakeholders (federal, provincial and local) were obtained to assess the policy and logistic barriers to SAS

accreditation, SAS training, service discontinuation, drug supply situation, provision of free SAS to clients and ways to overcome these challenges.

The secondary data related to the total number of clients who had received abortion care at SAS facilities under each municipality are presented on an annual basis (fiscal year) to indicate a five-year trend. As mentioned in sub-section 2.4.2 above, data obtained through interviewing SAS providers of accredited health facilities pertains to the 24 sampled municipalities only and is presented province-wise in the main report and while the municipality-wise data is shown as Annexure.

2.7 Ethical Approvals

This baseline study received ethical approval from the Nepal Health Research Council (*Ref. No.289; 04 Sept.2025*). The participants were informed about the purpose of the study, the procedures adopted and how their responses would contribute in meeting the objective of this study. The participation was strictly voluntary. Audio recording was used to capture participants' responses and consent for recording was obtained before the session. A written informed consent was obtained from participants aged 18 and above and a written parental consent was obtained for adolescents aged less than 18.

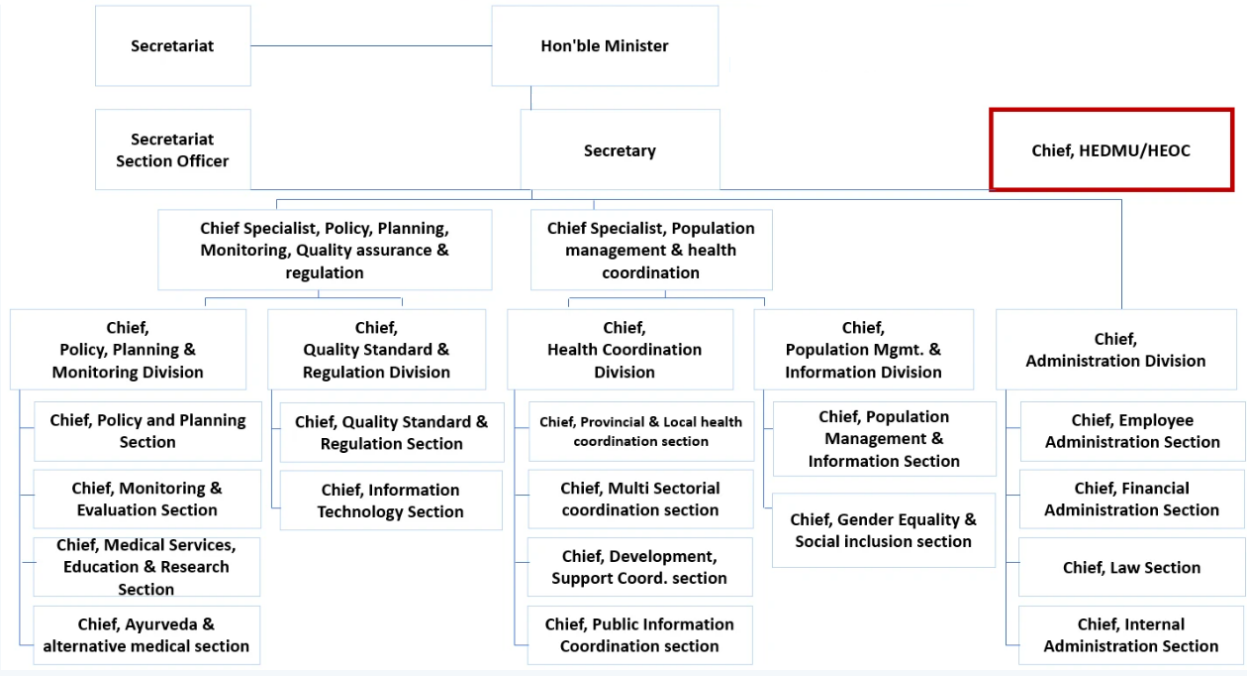
Section 3: Findings

3.1 Health Systems Pillars

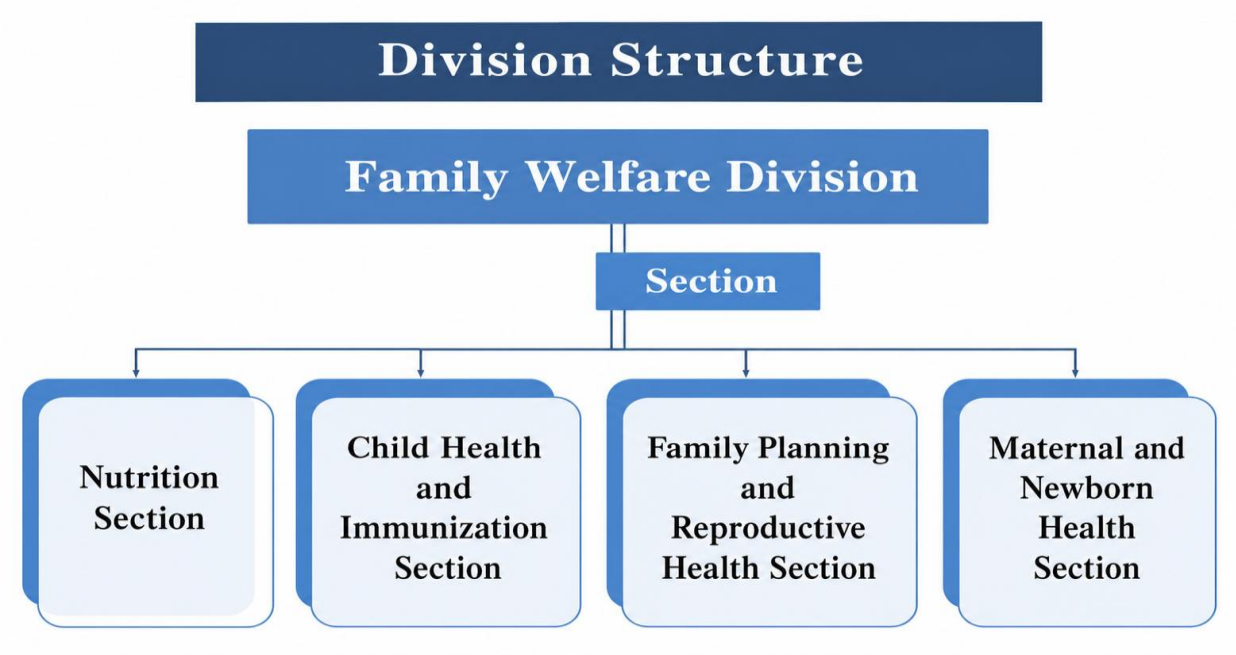
This section includes the findings related to different health systems pillar status to assess access to safe abortion services. This section includes the findings on i) Policy and Governance ii) Safe abortion Budget and Financing iii) Safe Abortion Service & Availability iv) Safe Abortion Information & Monitoring v) People Level finding.

3.1.1 Policy and Governance

This section includes findings related to Policies and Guidelines, focusing on the existing legal and regulatory framework, national and provincial directives, and guiding documents that shape the provision, implementation, and oversight of safe abortion services.



Organogram of Ministry of Health and Water Safety



Organogram of Family Welfare Division

a. Policy Environment for SAS

A. Amendments of RSMRH Act 2018

In mid-2024, the MoHP prepared a Draft Amendment of the RSMRH Act 2018 to remove the gestation limit for abortion from 28 weeks to "any gestation stage' during pregnancy on conditions such as i) if the pregnancy poses a danger to the pregnant woman's life if abortion not performed or it might affect her physical health or mental health or if there is a fetal anomaly ii)in case of rape or incest if the pregnancy poses a danger to the pregnant woman's life if abortion not performed or it might affect her physical health or mental health; or iii) if the pregnant woman is suffering from HIV or any kind of immune deficiency diseases. [28] Decriminalization of abortion *(no woman should be criminalized for abortion in any circumstances)* also features in the draft amendment. MoHP solicited opinions and suggestions on these proposed amendments from the general public. [29] The Draft Amendment is yet to be tabled in the parliament.

The legal and policy reform process experienced significant setbacks following the Gen Z protests in September 2025, during which several paper-based agreement documents were lost, including those related to proposed amendments to the RSMRH (Right to Safe Motherhood and Reproductive Health) Act concerning abortion provisions. In addition, the formation of a new government has shifted policy priorities, resulting in delays in advancing revisions to key legal frameworks, including the National Criminal Code and the Reproductive Health Act. Consequently, while advocacy efforts continue to focus on the decriminalisation of abortion and the amendment of restrictive legal provisions, the current political context is likely to slow progress toward these reforms in the short term.

I. Policies and Guidelines Pertaining to SAS Provisions

SAS delivery is governed by the *Safe Abortion Program Implementation Guideline*, which needs to be applied uniformly across all seven provinces. According to the federal level focal person, no province has yet developed its own contextualized or provincial-level implementation guideline on SAS. The federal guideline outlines the processes of service provider and facility accreditation in detail and serves as the

principal reference for SAS implementation. However, the Provincial Health Director of Madhesh province highlighted that the province's Ministry of Health and Population has already developed its Safe Abortion Service Implementation Guideline two years ago (approved on 29-08-2023)

"Our province has developed a province level Safe Abortion Guideline with the support from CREHPA. This guideline was approved on August 29, 2023. Based on this guideline, we have already accredited 15–20 health facilities, and we have also been accrediting the service providers."

- KII, PHD, Madhesh province

The provincial health directorate of Lumbini province shared that they have not developed their province-level SAS guideline because the federal guideline is seen as sufficient for now, although there are plans to develop one gradually in the future. In Madhesh province, the provincial guideline exists but it has not been given strong priority. Even when policymakers allocate budget, nutrition programs often receive more attention. In both provinces, non-governmental organizations have played a significant role in the prioritization and progress of SAS. Organizations such as UNFPA (in both provinces) and Ipas (in Lumbini) currently support SAS-related activities.

"*Policy exists, but it is not given a high priority. We raise the issue when allocating the budget, Unfortunately, the bulk of the budget goes to nutrition programs. Some work is being done gradually with support from other organizations. UNFPA, and the RH committee has been supporting."*

- KII, PHD, Madhesh province

"*Our province has not developed any such policy or guideline. We follow the existing policies and guidelines at the federal level. Currently, we have plans to develop guidelines for ANC and PNC first, and then for safe abortion, which will be implemented in a phased manner. The guidelines developed at the federal level seem sufficient for now, and there is currently no perceived urgent need for provincial-level guidelines."*

- KII, PHD, Lumbini province

The Health Section Chiefs (HSCs) across all three provinces consistently mentioned that the implementation of SAS was primarily guided by the national policies and guidelines. None of the municipalities has developed additional local level policies/operational guidelines to govern SAS implementation.

"Our local government does not have its own separate guidelines on safe abortion services. Instead, we follow the guidelines provided by the federal and provincial governments."

- KII 26, Local Government, Rautahat, Madhesh

"*SAS has not yet started in this municipality, so there is no guideline developed by our municipality. Also,the municipality has not shown interest in the national policy or guidelines in this matter."*

- KII 2, Local Government, Dolpa, Karnali

II. Policy-level Gaps and Challenges

The key informant at the federal level highlighted several policy-level gaps. *First,* the 28-week gestational limit for conditional abortion specified in the RSMRH Act 2018 restricts abortion even in cases of severe fetal anomalies or maternal health risks beyond this period, which poses challenges in exceptional cases. *Second,* the definition of "abortion" does not clearly differentiate miscarriage from induced abortion, creating regulatory confusion in situations where miscarriage should not be subject to regulation. *Third,* provisions allowing women with chronic illnesses such as HIV/AIDS to seek abortion up to 28 weeks were described

as unreasonable, given the advances in Prevention of Mother-to-Child Transmission (PMTCT) interventions and reduced transmission risks. These gaps indicate the need for policy revision to align regulation with current medical evidence and client needs.

"*The guideline sets a gestational age limit of 28 weeks for legal abortion. Even in cases of birth defect, or in cases where the mother's health is at risk due to pregnancy, the woman is not allowed to perform abortion after the 28 weeks gestational age limit. Also, the definition of abortion needs to be amended, such that miscarriage gets omitted from induced abortion. We cannot regulate miscarriages. So, this should be treated separately from abortion."*

- KII, Federal level

All HSCs identified several policy-level challenges that hinder effective implementation of SAS. They emphasized that existing guidelines are rigid and do not adequately reflect the realities of resource-constraint settings. For instance, the requirement for separate rooms for counseling, procedures, and waiting areas was considered impractical for health posts that have limited infrastructure/space. Similarly, ambiguity around service eligibility, such as unclear directives on termination of pregnancies slightly exceeding the legal allowance by just a few days, created confusion and restricted service provision. HSCs also highlighted that the gestational limits set by national policy disproportionately disadvantaged women in remote areas, where delayed abortion decision making, lack of awareness about the legal gestational limits for SAS due to poor access to information and services are common features.

Furthermore, the key-informants perceived the policy as being designed around urban or better-resourced contexts like Kathmandu, with limited consideration for the geographical and socio-economic constraints of resource-limited settings of Karnali province. The absence of legal provisions for abortion beyond 28 weeks, even in exceptional circumstances like rape or incest, was also cited as a gap that limits the policy's responsiveness to complex real-world situations.

"*The guideline mentions that there should be a separate waiting room, counseling room and procedure room for SAS to ensure privacy, but it is difficult to ensure separate rooms at health post level, so, it would be better if the guideline mentions one room for SAS."*

- KII 6, Local Government, Saptari, Madhesh

"*Abortion service can be obtained till 12 weeks of gestation. But it is not clear what to do in the case of gestational age of 12 weeks and 2 days."*

- KII 13, Local Government, Kapilbastu, Lumbini

"*The policy does not allow abortion after 12 weeks of gestation. In remote places, where abortion service is not available nearby, or where people do not have adequate information about abortion, it is challenging for people to receive abortion service if their gestational age exceeds 12 weeks."*

- KII 17, Local Government, Banke, Lumbini

"*The policy is favorable applicable for developed places such as Kathmandu, but not for underdeveloped districts or provinces such as ours (Karnali) which is backwards in many aspects - geographically, in education, in awareness and so on. The context of Karnali is very different from the context of Bagmati. The national policy does not consider this difference in settings."*

- KII 21, Local Government, Kalikot, Karnali

"*In case of rape or incest, the guideline allows abortion for gestation up to 28 weeks. There is no legal provision for abortion of 28 weeks' gestation."*

- KII 36, Local Government, Kalikot, Karnali

When asked about the measures that can be taken to address these gaps and challenges, HSCs emphasized the need for greater autonomy and proactive engagement of local governments in the implementation of SAS. They suggested that municipalities should take ownership by allocating dedicated budgets, enforcing existing laws, and conducting community awareness programs to strengthen service delivery at the local level. Some HSCs further advocated for policy amendments based on research evidence, particularly to address gaps related to gestational limits that currently restrict service access by only a few days. Additionally, HSCs insisted that national guidelines and policies should be context-sensitive, acknowledging variations in geographical and socio-cultural conditions across provinces and in diverse local settings.

"The local government should develop its own implementation guideline."

- KII 11, Local Government, Saptari, Madhesh

"*Local governments should be self-dependent. We should implement the laws, allocate separate budgets at the local level, and also conduct awareness programs on abortion."*

- KII 13, Local Government, Kapilbastu, Lumbini

"*Considering the potential future effects this policy gap may have, the health service act should be amended through evidence- based research, to ensure service can be received even after exceeding gestational age of 12 weeks by a few additional days."*

- KII 17, Local Government, Banke, Lumbini

"The guideline and policy should consider different geographical and socio-cultural contexts."

- KII 21, Local Government, Kalikot, Karnali

The HSCs of Karnali province viewed the absence of local guidelines and limited awareness of national policies as an important barrier hindering SAS. The response from Madhesh province echoed similar concern, although national guidelines existed, municipalities lacked localized frameworks to operationalize them. While the HSCs of Lumbini province identified weak monitoring and regulation of service sites as the key policy-level barriers. In both Karnali and Lumbini provinces, the HSCs believed that legal restrictions that permit abortion only up to certain gestational age as the main policy-level barrier hindering access to SAS.

"Local-level policy/guideline is not available, and we do not have complete awareness about the Federal level policy/guideline."

- KII 2, Local Government, Dolpa, Karnali

"According to our guideline, abortion is allowed only until 28 weeks of gestation. Women are not allowed to seek abortion legally after 28 weeks, even if pregnancy imposes a threat to the mother's body and life."

- KII 39, Local Government, Mugu, Karnali

"Although the Nepal Government has provided national guidelines, the municipality itself has not prepared any local guidelines. This lack of locally contextualized policy limits proactive planning and coordination to expand services."

- KII 27, Local Government, Parsa, Madhesh

"There is a lack of proper regulation of facilities providing SAS, such that non-accredited health facilities are providing abortion service, or sex selective abortion is being performed."

- KII 15, Local Government, Banke, Lumbini

"We have a strict guideline regarding abortion, such that abortion cannot be performed at the gestational age of 12 weeks and just an additional few day."

- KII 17, Local Government, Banke, Lumbini

b. Coordination Mechanism for SAS Provision

National-level coordination is facilitated through the Reproductive Health Coordination Committee (RHCC) and its Technical Working Group (TWG), which integrates SAS into broader Reproductive, Maternal, Newborn and Child Health (RMNCH) discussions. For SAS-specific dialogue, the Abortion Partners Meeting brings together government, NGOs, and private-sector actors.

Coordination with the provincial government is mostly informal and conducted over the phone. The focal person reported a critical gap in the flow of information. These include delays in updates on facility functionality and provider accreditation, limiting federal supervision and responsiveness. This weak coordination is also reflected in the fact that the federal government is not aware of the policy developments at the provincial level.

"*There are certain gaps in coordination. Sometimes, we do not get timely information about the functionality of SAS at the health facilities. The information about the accreditation of the service providers is also lacking."*

- KII, Federal level

At the provincial level, the RH committee conducts quarterly meetings to carry out discussions on reproductive health related matters, including safe abortion. Additionally, non-governmental organizations like UNFPA, MSI, Ipas and CREHPA have been providing awareness and training support.

"*The RH committee meets every quarter, where RH-related issues are discussed. Organizations like UNFPA, MSI, and Ipas have been providing support. They have also been assisting with awareness and training activities*."

- KII, PHD, Lumbini province

In both Madhesh and Lumbini provinces, Reproductive Health (RH) committees play a key role in supporting SAS access. In Lumbini, the committee coordinates with partners like MSI to address access gaps and human resource challenges. Overall, RH committees serve as important platforms for coordination, technical guidance, and improving service availability.

"*In our province, the RH committee is very active. CREHPA has played a major role in this. When we were developing the safe abortion service implementation guideline, they supported us by constantly guiding and*

reminding (prompting) us, almost like doing half the work. Activities such as organizing press conferences and providing feedback during review meetings have helped increase access to safe abortion."

- KII, PHD, Madhesh province

When asked about the role of Technical Working Groups (TWGs), the key informants in Madhesh and Lumbini provinces stated that TWGs play a supportive role in strengthening SAS implementation. In Madhesh, the TWG is highly active and directly involved in accrediting service providers and health facilities, helping accelerate SAS expansion despite limited prioritization at the municipal level. In Lumbini, the TWG functions more as a discussion and review forum, engaging in identifying gaps in accreditation and access and then seeking solutions.

"Our committee is very active. Based on the guideline, this committee has been carrying out the accreditation work. Within just the last 4-5 months, about 40-50 service providers and 15-20 health facilities have already been accredited. Municipalities are allowed to accredit health facilities below 15 beds, but they have not paid any attention to this yet. If there is someone in the municipality who understands what safe abortion is, then they will show interest, but in most municipalities, HAs and AHWs are the ones working as health section chiefs. Because of that, it seems like they have not placed safe abortion as a priority."

- KII, PHD, Madhesh province

"*Various discussions on issues related to abortion services such as on service gaps, matters related to access and matters related to physical infrastructure, etc. These topics are discussed within this TWG. Based on this, we prepare the criteria for accreditation. We also discuss issues such as whether facilities can be accredited, whether there are gaps, and whether there is access to services. This has helped us in reviewing the status. If there are any issues, this TWG helps in solving them."*

- KII, PHD, Lumbini province

Across the three provinces, regular sharing of training related information, curriculum revisions or service delivery challenges remain weak and uneven in the absence of a dedicated platform for sharing such information. In Madhesh and Lumbini province, few review meetings are conducted at the Provincial Health Directorate. Additionally, in Lumbini province, limited discussions on SAS issues are carried out within the RH Committee.

"*We conduct an annual review meeting at the Provincial Health Directorate. Discussions also take place in the RH committee."*

- KII, PHTC, Lumbini province

When asked about the involvement of PHTC in joint supervision or technical support visits related to SAS at service sites, the key informant at Madhesh province cited that PHTC participates in monitoring SAS sites with partner organizations. On the contrary, in Lumbini and Karnali province, PHTC was not engaged in joint supervision or technical support visits. However, in Karnali province, the partner organizations have requested PHTC to include post-training follow-up in their MoU.

"*It has not been done yet. However, now the partner organizations have requested that an MoU with us should include post-training follow-up. It has been agreed that monitoring should be conducted within three months after training, but it has not yet been implemented."*

- KII, PHTC, Karnali province

As per the Provincial Health Training Centers/Human Resource Development Centers, all three provinces expect additional support for training and logistics from federal and provincial governments and NGO partners. The key informant from Madhesh province highlighted the need for coordination and monitoring from the District Drug Administration (DDA) to monitor illegal or unregistered drugs. In Lumbini, the key informant emphasized support across multiple levels. They cited training and logistics support from the federal government, additional accreditation support from provincial government and infrastructure and IEC materials support from thenon-governmental sector. In Karnali province, support in IEC materials, equipment and overall coordination was emphasized by the key informants.

"They should provide support for training and logistics. They need to enhance regulation and bring activities happening outside the system into the system. In addition, monitoring and coordination from the DDA also seems necessary."

- KII, PHTC, Madhesh province

"*We expect training and logistics support from the federal level. The provincial level should initiate accreditation of training sites, because site accreditation cannot be done solely because we or the health facilities want it. NGOs should provide support for setting up sites, including IEC materials and rooms."*

- KII, PHTC, Lumbini province

The majority of the HSCs across all three provinces acknowledged the importance of coordination among the three levels of governance - local, provincial, and federal levels - for effective SAS implementation. However, some of them lamented over the weak coordination, particularly in relation to service providers' training, facility accreditation and the supply of medicines and equipment. In Karnali province, in particular, the HSCs pointed out that training activities were held by national level NGOs (One Heart Worldwide and KIRDARC) within local government jurisdiction without informing them, as an example to underscore the gaps in information flow and accountability. However, the local governments within the Karnali province reported a positive relationship with the NGO sectors working within the province for infrastructural, technical and financial support. Some local governments in Lumbini province also reported relatively stronger collaboration, including joint monitoring visits and coordination with NGOs such as Marie Stopes and Green Tara Nepal for training, awareness, and referral support.

"There is a lack of coordination. The provincial government generally informs the district (DHO) about any training opportunities on SAS. The district provides training to service providers directly without informing us. We did not even know that one provider per health post located within this municipality had received SAS training."

- KII 4, Local Government, Humla, Karnali

"We have constant coordination with DHO. DHO readily fulfills the demands/requisition of health posts. We coordinate mostly through the phone as it is easier nowadays. We also conduct monitoring visits to health posts, and have meetings with facilities in-charge."

- KII 20, Local Government, Jumala, Karnali

"*Coordination with provinces is mostly for training of service providers and for accreditation of health facilities. There is also coordination with accredited health facilities regarding the service provision."*

- KII 3, Local Government, Dolpa, Karnali

"*We have good coordination with DHO for training and logistics supply. We also coordinate with health facilities and provide them with necessary logistics for SAS, conduct monitoring of facilities and provide feedback to them. We coordinate with non-governmental organizations for infrastructural, technical and financial support."*

- KII 39, Local Government, Mugu, Karnali

"Coordination done for financial and technical support. Coordination done with NGOs so as to ensure there is no duplication of programs, and also to seek support in planning for training of providers and equipment procurement."

- KII 17, Local Government, Banke, Lumbini

"We coordinate with the provincial health office for training of service providers, and provision of budget to community level health facilities. Coordination with Marie stops for referral mechanism."

- KII 18, Local Government, Kapilbastu, Lumbini

c. SAS Training Curriculum

The key informants noted that while national SAS guidelines and protocols are available at PHTCs across all three provinces, the provinces themselves have not developed their own contextualized SAS training guidelines, protocols or standard operating procedures. Across all three provinces, the existing national curriculum has neither been reviewed nor updated to reflect provincial needs, and no formal assessment has been done to evaluate whether it incorporates gender-transformative or rights-based approaches and VCAT components. In Karnali, attempts to update the curriculum were unsuccessful. The key informant at Lumbini province reported inadequacy of learning resource packages and IEC materials. Similarly, the trainees provided feedback that the curriculum is more theoretical, with limited practical content and insufficient duration. VCAT components are minimally integrated but remain inadequate. In Lumbini, training on VCAT components is delivered through a game on the last day of SAS training, while in Karnali, although two-days of training is dedicated to providing VCAT training, only some of the components of VCAT are delivered within this limited time duration.

"*The guideline is available to us. However, there is a lack of learning resource packages, such as IEC materials. We have not evaluated the current curriculum till now. The participants provided feedback that the training is more theoretical, with very little practical components, and the duration of the training is also not sufficient. On the fourth day of the training, we play a game, where the participants are provided with VCAT training through that game. This has been effective."*

- KII, PHTC, Lumbini province

"*I heard that once they tried to review and update the curriculum, but this effort was not successful. There has been some informal discussions regarding updating the curriculum. We have not evaluated the curriculum to assess if it covers VCAT components. However, we provide 2-days VCAT training to the providers, where we cover only some of the components of VCAT."*

- KII, PHTC, Karnali province

3.1.2 Safe Abortion Budget and Financing

This section includes findings related to Safe abortion Budget and Financing, focusing on budget allocation, utilization, sufficiency, and the flow of financial resources for safe abortion services, including how funds are planned, disbursed, and spent across different levels of the health system.

a. Estimation of the Cost of SAS

Abortion Related Budget MNH Section (NPR in 000)					Total
F.Y.	Federal	Training		Province	
	Capital	MA/MVA	VCAT	MA/MVA	
2022.23	500	2300	800	5600	9200
2023.24	1000	1400	0	4900	7300
2024.25	1000	2390	0	10830	14220

Source: Family Welfare Division

b. Budget Allocation and Adequacy for SAS

When asked by the federal Government about their perceptions on budget allocation for SAS activities, they mentioned that SAS activities are funded through a combination of the Government of Nepal's budget and WHO's Direct Financial Contract (DFC) mechanism. The federal government allocates the budget for SAS to provinces, which is then distributed to local governments based on HMIS-reported service data. The abortion focal person at the federal level noted that although there has been an overall decline in the Safe Motherhood Program budget in recent years, budget allocation for SAS has remained relatively stable. Accordingly, budgets for training have not increased, thereby limiting the number of providers trained annually.

A significant challenge identified was the absence of a separate SAS budget line, as SAS is currently funded under the Safe Motherhood Program. This arrangement was attributed to continuing policy-level stigma, with some decision-makers perceiving abortion as a "luxury", rather than a "necessity". The key informant noted that budget planning is constrained by pre-defined ceilings, rather than by programmatic needs.

"*At the federal level, we allocate the budget from the Government of Nepal's own resources. Under WHO support, the Direct Financial Contract (DFC) comes directly through the red book. Then we allocate the budget to the provinces and local levels. An equal budget is allocated to all 7 provinces for SAS provision. There is no separate budget heading for SAS, but rather the budget for Safe Motherhood Program is provided to provinces, which is used to implement various programs under safe motherhood, including SAS. This is because the policy makers also do not understand the importance of SAS, and there is still stigma associated with SAS even among the policy makers. Some policy makers think that abortion is a luxury, not a necessity*."

- KII, Federal level

At the provincial level, budget allocation for SAS remains limited and primarily focused on training service providers. In Madhesh, the provincial health director informed that no dedicated provincial budget exists,

but rather only a small amount is sent to the training center for a few batches of training, which they felt was insufficient. In Lumbini, while a separate budget has been allocated, it is still inadequate to meet the growing demand, and both provincial and federal contributions are not enough. In the context of a budget for free SAS, the federal government sends that budget directly to the municipalities, and the facilities receive it from there.

"*The province has not allocated a separate budget. I have only heard that this year some budget was sent to the training center to train 4-5 batches of service providers. But the budget sent is not sufficient*."

- KII, PHD, Madhesh province

"*The province has allocated a separate budget, but it is not enough. The demand is high and the allocated budget cannot meet that demand. We have been working in a phase-wise manner. The federal government has also allocated some budget, but that too is not sufficient."*

- KII, PHD, Lumbini province

Across the local governments, the process of budget allocation for SAS varied considerably, reflecting differences in program prioritization and integration within the broader maternal and reproductive health funding structure. Among the 49 municipalities, 30 reported having a separate budget allocation for free SAS. In most cases, the federal government provides conditional grants under the Safe Motherhood or Maternal, Newborn and Child Health (MNCH) programs, from which municipalities allocate or reimburse expenses related to SAS. Budget allocation was often based on the number of SAS clients in the previous fiscal year, with some local governments applying an incremental increase (e.g., 5%–10%) to maintain adequate drug supply. However, a local government of Karnali province noted that due to limited budget allocation, clients were at times required to pay for SAS services, indicating shortfalls in maintaining "free SAS" consistently. There were a few cases where the health facilities procured MA drugs using their own funds and later sought reimbursement from the local government.

According to the HSCs, despite the presence of separate budgets in most municipalities, seven municipalities reported that the allocated amount was insufficient to meet service demand. Reported reasons for this inadequacy included increased client load and competing priorities within the Safe Motherhood program. In contrast, a few municipalities indicated stock carryover as the reason for reduced or no budget allocation in the current fiscal year.

"*The budget allocation is based on the number of SAS clients, procurement of medicines, number of cases of complications, and the equipment required. The federal government provides a lumpsum budget to the local government for maternal and neonatal health programs, and a certain amount from this budget is allocated for SAS. However, the allocated budget is not adequate."*

- KII 13, Local Government, Kapilbastu, Lumbini

"*We get a lumpsum budget for the safe motherhood program. We first allocate a budget for safe motherhood and Nyano jhola programs, and then, allocate the remaining budget for SAS. Last year 50,000 rupees was allocated for SAS. This amount is not adequate to provide SAS."*

- KII 42, Local Government, Mahottari, Madhesh

"In the previous years (2021/22/23), there was no budget and clients had to pay for the service, but this year (2024/25), the budget is available under the safe motherhood program."

- KII 22, Local Government, Kalikot, Karnali

"*The federal government provides a lumpsum budget for the MNCH program. The budget for SAS is used from that budget. The budget allocation is not done initially, but rather reimbursed to the health facility based on their request. Last year the total expense for SAS was NPR. 1.5 lakh."*

- KII 17, Local Government, Banke, Lumbini

"*The MA drugs from the previous year are still in stock, so there will be no further procurement of MA drugs this year. None of the health facilities has claimed for SAS reimbursement and we are still unsure how to allocate budget for SAS from the total budget.*"

- KII 3, Local Government, Dolpa, Karnali

"*There isn't any kind of specific budget for SAS. The budget for SAS is allocated from the Safe Motherhood Program and looking at the increase in the demand for SAS, our local government is struggling with the budget. In the context of trained SAS providers, there are a limited number of trained providers which has been caused due to limitation in the training opportunities.*"

- KII 30, Local Government, Bara, Madhesh

These findings indicate that while most local governments have initiated budget allocation for SAS, financial support remains inconsistent and often inadequate. The absence of separate budgets in some local governments and limited allocations in others reflect uneven prioritization of SAS within local health financing mechanisms. In a few municipalities, clients were required to pay for SAS services out-of-pocket due to budget shortages. Strengthening budget allocation for SAS, aligning allocations with service utilization, and ensuring timely and adequate financial disbursement would be crucial for sustaining and expanding equitable access to safe abortion services across the local governments within the three provinces.

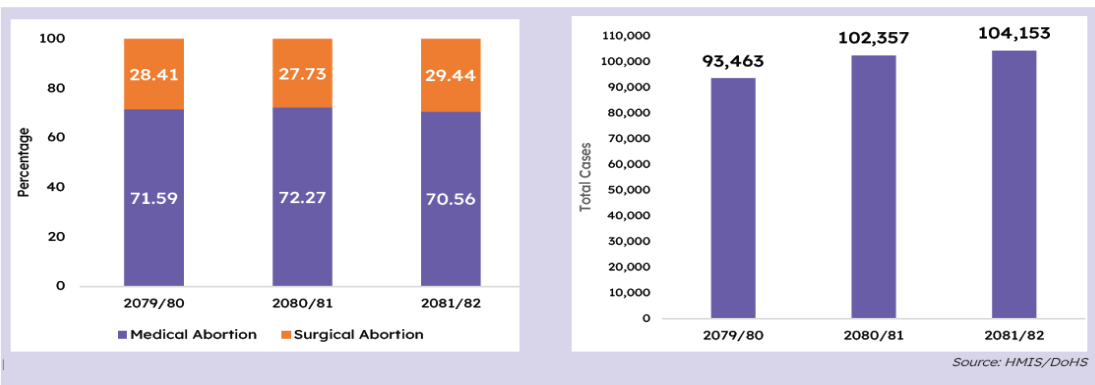
3.1.3 Safe Abortion Service Availability

This section includes findings related to Safe Abortion Service Availability, highlighting the availability and accessibility of safe abortion services across health facilities, including the status of trained service providers, the availability of medical abortion drugs, essential commodities and equipment, and the procurement and supply chain systems that support uninterrupted service delivery.

a. Service Availability

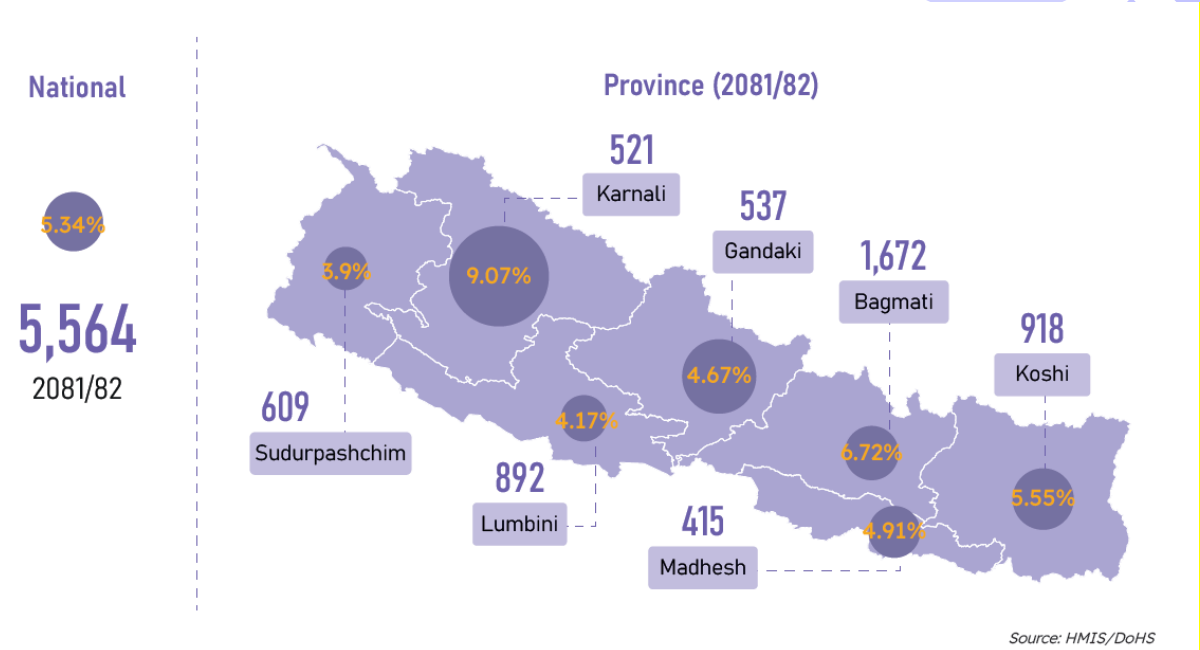
A. Utilization of Safe Abortion Service at National Level:

In FY 2081/82, a total of 104,153 cases used safe abortion services, of which the majority used medical abortion (70.56%), showing a slight decline compared to previous years. In contrast, surgical abortions showed an increasing trend. Regarding provincial distribution, Lumbini province had 21,401 cases, Madhesh had 8445 cases, and Karnali province had 5,744 cases of utilizing safe abortion services.



Types of safe abortion services among total cases in FY 2022/23 – 2024/25

In FY 2081/82, among total SAS users, 5.34% (5,564 women) were under 20 years of age, with notable provincial variation. The highest proportion of under-20 users was reported in Karnali province (9.07%). In Madhesh (415), and Lumbini (892), and Karnali (521), the absolute number of SAS users was comparatively lower. The data reflects only registered cases, suggesting the situation may represent the "tip of the iceberg.



National and provincial distribution of women under 20 years utilizing safe abortion services in FY 2024/25

The table presents national and provincial data on abortion complications, post-abortion care (PAC), and safe abortion services (SAS) for FY 2081/82. The data shows that PAC services were utilized for 8.64 percent of induced abortions and 6.06 percent of spontaneous abortions at the national level. A total of 104,153 safe abortion services were reported nationally, with variations across provinces, including Madhesh, Lumbini, and Karnali. Nationally, 1.2 percent of safe abortion cases experienced complications, while 7 percent of MNH obstetric/abortion complication cases were referred out.

National/ Provincial	Total Safe abortion Service	% PAC services (Induced)	% PAC services (Spontaneous)	% of safe abortion complications among total safe abortion cases	% MNH-Obstetric Complication-Abortion complication-Referred Out
National	**104,153**	**8.64**	**6.06**	**1.2**	**7**
Koshi	16,553	9.42	6.28	1.6	5
Madhesh	8,445	9.34	8.57	2.6	1
Bagmati	24,884	4.71	4.41	0.6	6
Gandaki	11,510	8.18	3.87	0.6	21
Lumbini	21,401	12.06	7.20	0.8	10
Karnali	5,744	16.50	10.52	3.2	7
Sudurpashchim	15,616	6.49	5.53	1.4	8

Source: HMIS/DoHS

Number of SAS, percentage of PAC and safe abortion complications among total safe abortion cases in FY 25/26

B. Five Year Trend Analysis of Clients Served at SAS Facility

Table 3 represents the five-year trend of the number of SAS clients served annually from SAS-accredited facilities across Madhesh, Lumbini, and Karnali provinces (2077/78–2081/82). These data were obtained from the records maintained by the health section of the respective municipality and also from FWD. The data indicates a consolidated number of clients served in the year under reference, irrespective of the number or category of health facility submitting the SAS performance records. For instance, in Lumbini Province, a value of "4" under the category *1–10 clients* for the year 2079/80 indicates that four municipalities reported annual client volumes between 1 and 10. A striking feature of the dataset is the substantial proportion of "data not available" across provinces, particularly in the earlier years:

In Madhesh Province, data were unavailable for 20 out of 21 municipalities in 2077/78, and remained high in subsequent years (18 in 2078/79, 12 in 2079/80), only gradually declining to 9 municipalities by 2080/81 and 2081/82. In Lumbini Province, although coverage improved over time, data were still missing in 4 municipalities in 2077/78 and 2078/79, reducing to 1-2 municipalities in later years. In Karnali Province, 10 municipalities lacked data in 2077/78 and 2078/79, which dropped to 3 municipalities from 2079/80 onwards. This indicates that trend interpretation for earlier years should be approached with caution, as the data are heavily influenced by incomplete reporting. Among municipalities with available data, the findings show that: Across all three provinces, the majority of municipalities consistently fall within the lowest client-load category (1-10 clients per year). Lumbini Province shows persistently low utilization, with no municipality reporting more than 10 clients annually throughout the five-year period.

In contrast, Madhesh and Karnali provinces demonstrate greater variability, with: Some municipalities reporting moderate client loads (21-70), a few municipalities, particularly in Karnali, reporting high client volumes (above 100 and even 200+). Madhesh Province shows a gradual increase in reporting completeness and some movement toward higher client-load categories over time. Karnali Province presents a mixed pattern, where a small number of municipalities report high client volumes, while many continue to show low utilization. As the Table shows, across all the three provinces, the number of SAS clients per municipality hovered around 10 annually during the past five years in majority of the cases, while few municipalities particularly in Madhesh and Karnali province received SAS performance data that exceeded 100 clients annually. None of the municipalities in Lumbini province received more than 11 clients per year. Karnali Province shows mixed performance, with a small number of municipalities serving higher numbers (200 above) of clients, while several municipalities of this province continue to report low utilization of SAS.

Annex Table 3A depicts the Five Years' trend in the Total Number of Clients Served at SAS facilities (2077/78 to 2081/82)within the Project Municipalities

Table 3: Five Years' trend in the Total Number of Clients Served at SAS facilities (2077/78 to 2081/82)

# of clients served	MADHESH PROVINCE					LUMBINI PROVINCE					KARNALI PROVINCE				
	No. of Municipalities (21 out of 24*)					No. of Municipalities (6 out of 6)					No. of Municipalities (15 out of 18*)				
	77/78	78/79	79/80	80/81	81/82	77/78	78/79	79/80	80/81	81/82	77/78	78/79	79/80	80/81	81/82
Data not available	20	18	12	9	9	4	4	2	1	2	10	10	3	3	3

NiL												1	1		
1-10	1	1	3	4	2	2	2	4	5	4	2	1	2	3	3
11-20		1			2						1	1		2	1
21-40			2	1	3							1	2	1	2
41-70		1		2	1						1		1	2	1
71-100			1										3	1	2
101-130			1	2	1								1	1	1
131-180			2	2	3									1	2
181-200				1							1		1	1	
200+												1	1		
Total	**21**	**21**	**21**	**21**	**21**	**6**	**6**	**6**	**6**	**6**	**15**	**15**	**15**	**15**	**15**

C. Status of Safe Abortion Services at Public Sector Health Facilities

As guaranteed by the Right to Safe Motherhood and Reproductive Health (RSMRH) Act 2018, access to legal, safe and free abortion is a fundamental right for all women. The Government of Nepal has the obligation to provide information and expand access to safe and effective methods of comprehensive abortion care to every woman who needs the service and as per choice. Unfortunately, provision of abortion service as an essential reproductive health service and continuity of its provision at an accredited health facility remain a challenge in the country. This Section analyses the extent of provision of SAS and their current status at all public health facilities by category/facility type covered by the 'facility mapping' in each of the 49 municipalities of the three provinces covered by the KI project. The information for the 519 public health facilities that were listed are presented in this section. Of the 519 health facilities, 18 are provincial/municipal hospitals; 10 PHCC; 231 HP; 12 Urban Health Centers (UHC); 208 BHSC, and 40 Community Health Units (CHU).

D. Availability of Safe Abortion Service Site at Public Health Facilities

The number of public sector hospitals lying within the project municipalities of the three project provinces are: Madhesh province =10 (5 provincial hospitals and 5 municipal hospitals); Karnali province has seven (one district hospital and 6 municipal hospitals); and Lumbini province has just one hospital (*Yasodhara Aadharbhut Hospital).* Of the total *10 PHCCs,* Madhesh province has 7 PHCCs within the project municipalities, Lumbini province has 2 PHCCs, while there is just one PHCC located within the project municipalities of Karnali province.

As presented in Table 3.1, of the total 231 HPs listed through mapping, 129 HPs are located in the project municipalities of Madhesh province. The project municipalities of Karnali province have 69 HPs while the corresponding number for Lumbini Province is 33 HPs. There was a large number of BHSCs (208). More than a half of these (115) are confined in Madhesh province, while Karnali province has 87 and Lumbini has 6. Likewise, 11 out of the total 12 UHC are located in Madhesh province and the remaining one is located in Karnali. Karnali has the highest number of CHUs (32 out of 41 CHU). *Annex Table 3.1A* depicts the distribution of different categories of public health facilities within the Project Municipalities

Table 3.1: Distribution of different categories of public health facilities within the Project municipalities in the three provinces

Category of Health Facility Assessed	Province			Total (n)
	Madhesh (n)	Lumbini (n)	Karnali (n)	
Hospital	10	1	7	18
PHCC	7	2	1	10
HP	129	33	69	231
BHSC	115	6	87	208
UHC	11	0	1	12
CHU	5	3	32	40
Total	**277**	**45**	**197**	**519**

E. Provision of Free SAS

Almost all the facilities across the three provinces (54 out of 55 facilities) reported provision of free SAS in adherence to the national guidelines. However, one provincial hospital located at Siraha district of Madhesh Province had stopped procuring MA pills under the free SAS provision and persuaded clients to purchase MA pills from private pharmacies despite claiming the service provider's incentives per client served (Table 3.8). On inquiry, the concerned SAS provider reported that the hospital authority had decided to stop keeping stocks of MA pills with effect from the current fiscal year on the ground of insufficient space in their store room. The retail price for one government registered MA combi-pack (Mifepristone 200mg+ Misoprostol 200mcgx4) in a private pharmacy was NPR 600 (brand name 'Mefiprist by Lomus Co.).

Table 3.8: Extent of Availability of Free SAS by category of health facility across the three provinces

	Province										Total
	Madhesh				Lumbini			Karnali			n
	Hosp.	PHCC	HP	UHC	Hosp.	PHCC	HP	Hosp.	PHCC	HP	
Free service	**n**	**n**	**n**	**n**	**n**	**n**	**n**	**n**	**n**	**n**	
Yes (both service and MA pills are free)	9	4	9	1	1	2	13	2	1	12	**54**
MA pills need to be procured by the client.	1										**1**
Total	**10**	**4**	**9**	**1**	**1**	**2**	**13**	**2**	**1**	**12**	**55**

F. SAS Accreditation Status

Of the total 519 public health facilities located within the project municipalities of three provinces, only 91 facilities (17.5%) were SAS accredited, 9 facilities (1.7%) were in the process of accreditation while the remaining 419 (80.7%) were not accredited. It should be noted that 248 health centers which consist of BHSCs and CHUs (48%) are currently accredited for SAS. However, only one BHSC of Karnali province is being considered for accreditation. Province-wise, Madhesh province has 39 SAS (14.07%) accredited health facilities among 277 health facilities, Lumbini province has 20 (44.44 %) among 45 and Karnali province has 32 (16.24 %) among 197 health facilities that are accredited. In addition, 9 health facilities (2 health posts of Madhesh province, 3 health posts of Lumbini province and 3 health posts (including 1 BHSC

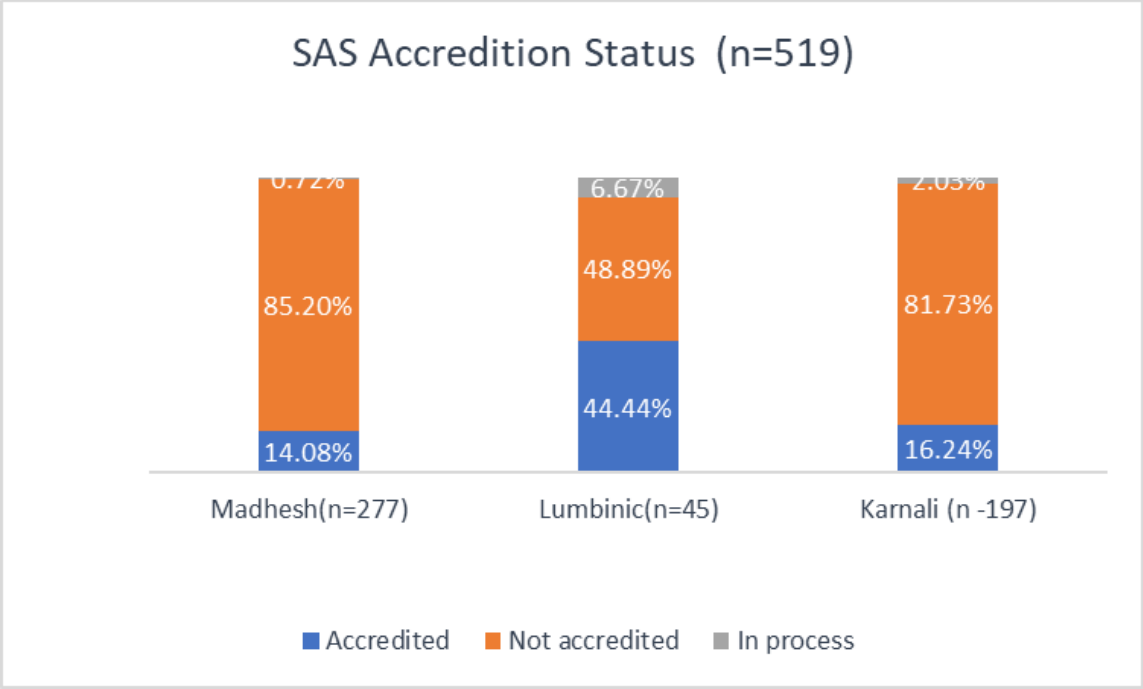
of Karnali province) are in the process of accreditation. Table 3.2 below shows the province-wise distribution of different categories of health facilities according to their accreditation status.

All the 10 hospitals of Madhesh province and four out of seven hospitals in Karnali are listed for SAS. The only hospital of Lumbini province within the project municipalities is also listed for SAS. In Madhesh province, only 5 out of the total 7 PHCCs located within the project municipalities are SAS accredited. In Lumbini, both the PHCCs are accredited. Likewise, the single PHCC located within the project municipalities of Karnali province is also accredited.

In terms of SAS status of HPs, about half in Lumbini province (17 out of 33 or 51.5%); nearly a fifth in Karnali (27 out of 69 or 39%) and only one-sixth in Madhesh province (23 out of 129 or 18%) are accredited. The only UHC out of the total 11 located in Madhesh province has been accredited for SAS (Table 3.2). Annex 3.2A presents the municipality-wise SAS accreditation status of health facilities for the three project provinces.

Table 3.2: Number of public health facilities by SAS Accreditation Status across the 48 project municipalities of three Provinces (n-519)

SAS accreditation status	Madhesh						Lumbini					Karnali						**Total n**
	Hosp.	**PHCC**	**HP**	**BHSC**	**UHC**	**Others**	**Hosp.**	**PHCC**	**HP**	**BHSC**	**Others**	**Hosp.**	**PHCC**	**HP**	**BHSC**	**UHC**	**Others**	
	n	**n**	**n**	**n**	**n**	**n**	**n**	**n**	**n**	**n**	**n**	**n**	**n**	**n**	**n**	**n**	**n**	
Accredited	10	5	23		1		1	2	17			4	1	27				**91**
Not accredited		2	104	115	10	5			13	6	3	3		39	86	1	32	**419**
In process			2						3					3	1			**9**
Total	**10**	**7**	**129**	**115**	**11**	**5**	**1**	**2**	**33**	**6**	**3**	**7**	**1**	**69**	**87**	**1**	**32**	**519**



G. Range of SAS Offered at Accredited Public Health Facilities

While MA is permitted at all levels of SAS certified health facilities, MVA and MI/D&E services are confined to higher level health facilities (mostly at hospitals) where service providers with requisite qualifications and training are stationed and emergency backup care is present.

Among the 55 functional SAS accredited facilities across the three provinces, the majority were providing medical abortion (MA) services up to 10 weeks of gestation. MA was available across all levels of accredited facilities, including hospitals, PHCCs and health posts, making it the most widely accessible service. MVA was available in only a few hospitals and in none of the PHCCs. Provision of second-trimester abortion care (MI/D&E) was restricted to only one provincial hospital, reflecting a significant service gap (Table 3.6). These findings suggest that while early medical abortion services are well integrated, access to MVA and second-trimester abortion care remains extremely limited, even within higher-level accredited facilities (Table 3.6). Annex Table 3.6A indicates municipality-wise range of SAS offered by category of health facility.

***Table 3.6: Range of SAS offered by facility* across all categories of public health facilities accredited for SAS**

Range of SAS offered	Province										Total
	Madhesh				Lumbini			Karnali			
	Hosp.	PHCC	HP	UHC	Hosp.	PHCC	HP	Hosp.	PHCC	HP	
	N	n	n	n	n	n	n	n	n	n	n
MA (10 weeks)	10	4	9	1	1	2	13	1	1	12	**54**
MA/MVA (10 weeks)	4							1			**5**
MVA (12 weeks)	3							1			**4**

MI/D&E	1										1
Total	**10**	**4**	**9**	**1**	**1**	**2**	**13**	**2**	**1**	**12**	**55**

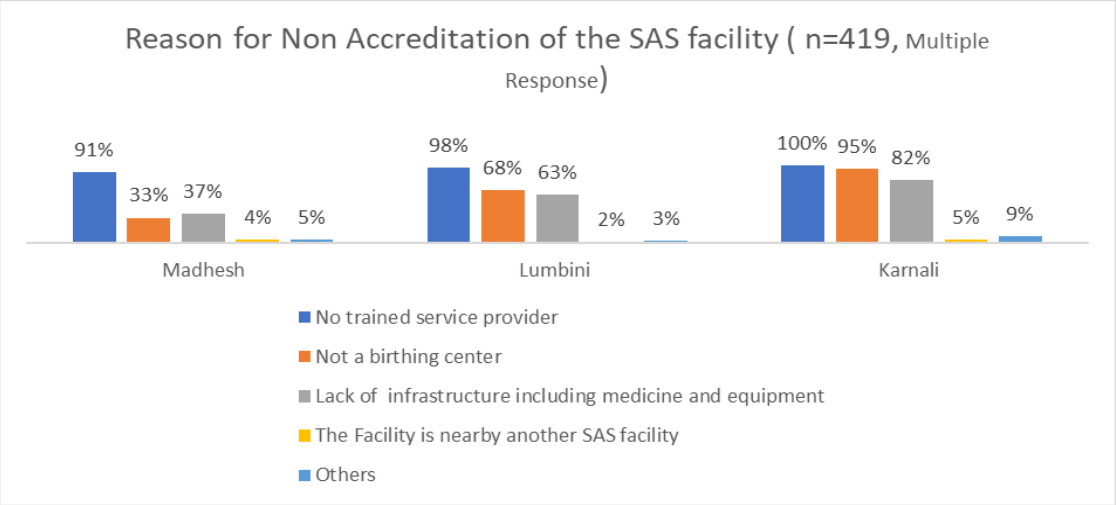
Along with Quantitative and Qualitative data collection, Health facility assessment of a total 41 SAS accredited public health facilities located within the three project provinces were assessed using a structured observation checklist. The observation checklist covered different aspects such as physical structure/building, equipment, space for different services including Outpatient Department (OPD), client waiting, privacy (during check-up and counselling to clients), along with the display of service-related information, including availability and display of concerned IEC materials.

H. Reason for Non-Accreditation for SAS

A total of 419 public health facilities across Madhesh, Lumbini, and Karnali provinces are not accredited for SAS. The reasons for non-accreditation of the 419 public health facilities were solicited from the respective health facility in-charge during the health facility mapping and assessment. Reasons varied, but several common factors emerged across provinces. The most frequently cited reason was the absence of trained service providers, reported in (75.9%) 394 facilities, indicating a major human resource gap in SAS readiness. This issue was especially evident in Madhesh (215 facilities) and Karnali (154 facilities), where a large number of health posts and basic health service centers lacked staff with SAS training. Although the current guideline does not specify the requirement of health facility to have a birthing center for SAS accreditation, a significant number of facilities (208 facilities) reported not having a birthing center as the reason for non-accreditation, indicating a persistent information gap at the health facility level regarding SAS accreditation criteria. This was particularly common among health posts in Madhesh and Karnali.

The other most common reason was lack of infrastructure including medicines and equipment , cited in 207 facilities, reflecting persistent challenges related to physical infrastructure, space or essential equipment needed for service provision .Less frequent but still important reasons for non-accreditation were grouped under a single “Others” category. These included proximity to another SAS facility (14 facilities), Responsible organization has not carried out the listing (9 facilities), newly established facilities (4 facilities), lack of provision for listing CHU/BHU-level facilities (4 facilities), Municipality yet to inaugurate the SAS program (3 facilities), and lack of medicines or equipment (3 facilities). (Table 3.3). Annex 3.3A presents the municipality-wise reasons cited for non-accreditation of health facilities according to the type of health facility.

Figure 3.3: Reasons for non-accreditation of public health facilities (n=419)



Interestingly, a previously accredited PHCC of Parsagadi Municipality in Madhesh province stopped providing MA service in the past 6 years as its accreditation was not recognized by the present local government authorities. Instead, this PHCC was persuaded to apply for new accreditation. However, this PHCC continues to display its old SAS board (depicting SAS logo, listing of SAS (up to 12 weeks) as one of the SRH services offered) in their waiting hall. Upon further investigation with the local municipality and FCHVs, it was found that this health facility is currently not accredited and they do not provide abortion services. The SAS trained senior auxiliary nurse midwife (ANM) stationed at this PHCC for the past six years expressed her frustration for not being able to offer SAS (MA) service.

"My position is Senior ANM. I have been posted here for over six years and am in-charge of the Birthing Center of this PHCC. I am interested in providing MA service since I have received SAS training and this PHCC provided MA services in the past. The ANM in charge used to provide this service before she got transferred elsewhere but I have been told repeatedly that this PHCC needs to get accredited first as there is no official record of its accreditation even though we have an old sign board depicting the availability of safe MA service in this PHCC. But the concerned authorities are adamant. Recently, they accredited a nearby HP instead…I am quite frustrated about what is happening"

- Sr. ANM, PHCC, Parsa, Madhesh Pradesh

Overall, the findings suggest that human resource shortages and inadequate infrastructure are the major constraints in SAS accreditation, particularly at health post level. In addition, the frequent reporting of non-birthing center status, despite not being an accreditation requirement, particularly by health posts, points to gaps in awareness and understanding of SAS accreditation criteria at the facility level. Addressing these gaps through training, infrastructure strengthening, and policy-level support for service expansion could significantly improve SAS coverage across provinces.

I. Functionality Status of SAS Accredited Public Health Facilities

Only 55 SAS facilities (60%) out of the total 91 SAS accredited health facilities observed were found to be functional at the time of the present baseline assessment at 48 municipalities. The remaining 36 facilities (40%) had stopped providing SAS for various reasons (Table 3.4). In Madhesh province, all the 10 hospitals and 4 out of 5 PHCCs are functional, whereas a considerable number of health posts (14 out of 23) had stopped providing SAS. Similarly, in Lumbini province, only one hospital and two PHCCs were found offering SAS, while the remaining four SAS facilities (HPs) ceased to offer SAS. In Karnali province, only about half of the SAS accredited hospitals (2 out of 4) and less than this proportion of HPs (12 out of 27) had stopped offering SAS. Municipality-wise functional status of the SAS accredited public health facilities are presented in Annex 3.4A.

The concerned SAS accredited service provider of a HP under Dolpa Municipality of Karnali province, gave the reasons why her facility could not start SAS provision since its accreditation one year ago. She said:

"*Our Municipal Ward Chairperson is reluctant to start SAS because he believes that abortion is a sin and provision of abortion service will lead to deterioration of our society. That's why our HP has been in limbo since its accreditation one year ago..."*

- *ANM of a HP, Dolpa*

Table 3.4: SAS Functionality Status by type of health facility across the three project provinces (n=91)

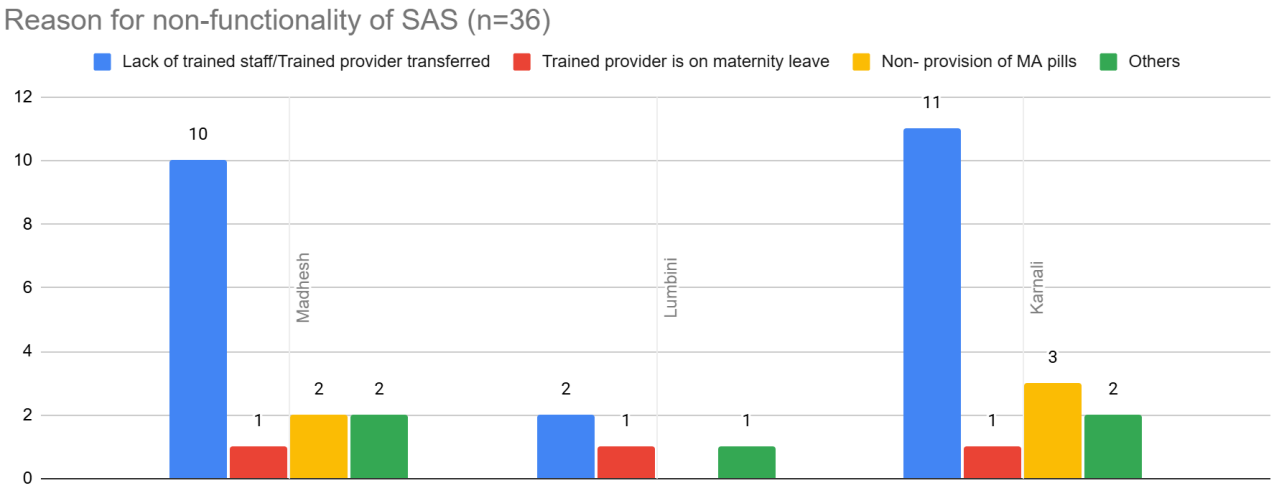
Status of Functionality	*Province*						*Total*
	Madhesh		***Lumbini***		***Karnali***		
	Frequency	Percentage	Frequency	Percentage	Frequency	Percentage	
Functional	24	61.53%	16	80%	15	55.56%	55
Not Functional	15	38.46%	4	20%	17	62.96%	36
Total	39		2420		27		91

J. Reason for Non-Functionality of SAS

The main reasons cited by the Service providers were: i) transfer of SAS provider and non-replacement by SAS trained provider (23 out of 36 facilities i.e. 64%); ii) lack of MA pills supply (5 facilities), iii) SAS provider on maternal leave (3 facilities) and iv) non-provision of SAS incentives by the concerned local government (1 facility). SAS services had been discontinued for periods ranging from one month to several years because the trained providers were not replaced by other trained personnel in that facility. The reasons like : Trained staff's inability to submit SAS training certificate, Non-provision of SAS incentives, Ward chair against abortion, thereby had not inaugurated the listed facility, Concern municipal authority declined to provide a certificate of accreditation to the health facility despite documents despite verbal assurance, listing processes on progress (might get listed in one week) have all been grouped into one category. There were also other reasons like: missing official signatures on certificates and mishandling of these certificates or pending facility registration, etc., contributed to the non-resumption of SAS service.

Province-wise analysis showed non-replacement of trained SAS provider as the main reason for the disruption in SAS services with the highest impact in Karnali province (1 Hospital and 10 HP out of 17 affected); followed by Madhesh Province (1 PHCC and 9 HP out of 15 affected). Lumbini province had only 2 HP (out of 4 affected) that cited the above reason (Table 3.5). Annex Table 3.5A indicates municipality-wise reasons for non-functionality of SAS by category of health facility.

Figure 3.5: Reason for non-functionality of SAS across the three Provinces by category of health facility



The findings indicate that human resource-related issues, especially the unavailability or transfer of trained SAS providers continue to remain as the primary cause of service disruption, compounded by supply shortages and weak administrative support and insufficient coordination among the different stakeholders.

Key Informant Interviews (KIIs) were conducted with health care providers to gather information on the range of services offered in the health facility, client preferences, provider training and capacity, service denial, trends in SAS and PAC cases, constraints in SAS delivery, supply chain of medicines and equipment and coordination with the local government.

A total of 41 SAS accredited health facilities are present in the 24 municipalities covered. Of these 41 accredited facilities, only 24 were providing SAS at the time of the present baseline, while the remaining 17 accredited health facilities had stopped providing the service due to various reasons. The service providers of 17 SAS accredited health facilities revealed multiple and overlapping reasons for discontinuing SAS service provision. A prominent factor was the absence of trained personnel due to transfers, contract expirations, or delay in appointing replacements. Consequently, services in several facilities were discontinued for periods ranging from one month to several years. Facilities with trained providers faced organizational constraints, such as missing official signatures on certificates and mishandling of these certificates or pending facility registration that prevented them from initiating services.

Other significant constraints were systemic and operational. Facilities often reported lack of essential supplies, including medicines, equipment, and reporting forms, which limited the service provision. In some instances, local government authorities and service providers had conflicting perceptions regarding supply availability or client demand, contributing to service gaps, which also highlights poor communication mechanisms between the facility and local government. For instance, the health section chief of one of the local governments of Lumbini province stated that a health facility is not registered, while the helper staff of that facility reported that they had rendered services before federalization (around 2017-2018) but the chief was not aware of this information. In another instance, according to the service provider, it had been two years since they received SAS training, but the local government had neither informed them about the facility's accreditation nor provided them with necessary supplies for the service. However, the local government contradicted by saying that the service provider did not offer the service because they lacked confidence.

Additionally, social and administrative factors, such as un-inaugurated facilities or local leadership opposition due to personal beliefs, further hindered service initiation. Cases of delayed incentives or non-payment for previously handled cases, despite the promise of reimbursement by the local government, also discouraged continued service provision.

"The health facility had previously provided services about a year ago, and the local government had also promised to pay NPR 800 per case. However, despite providing services to five cases, no incentive was provided, which led to the discontinuation of the service."

- KII16, Service provider, Sarlahi, Madhesh

"This facility has not been providing services for the past 3 years because the service provider was transferred to another health facility, and after that no new trained provider has been appointed in this facility."

- KII37, Service provider, Kalikot, Karnali

"Although the health facility has been registered, services have not yet started because it has not been formally inaugurated. The ward chairperson holds the belief that abortion is a sin, which has prevented the initiation of the service."

- KII32, Service provider, Dolpa, Karnali

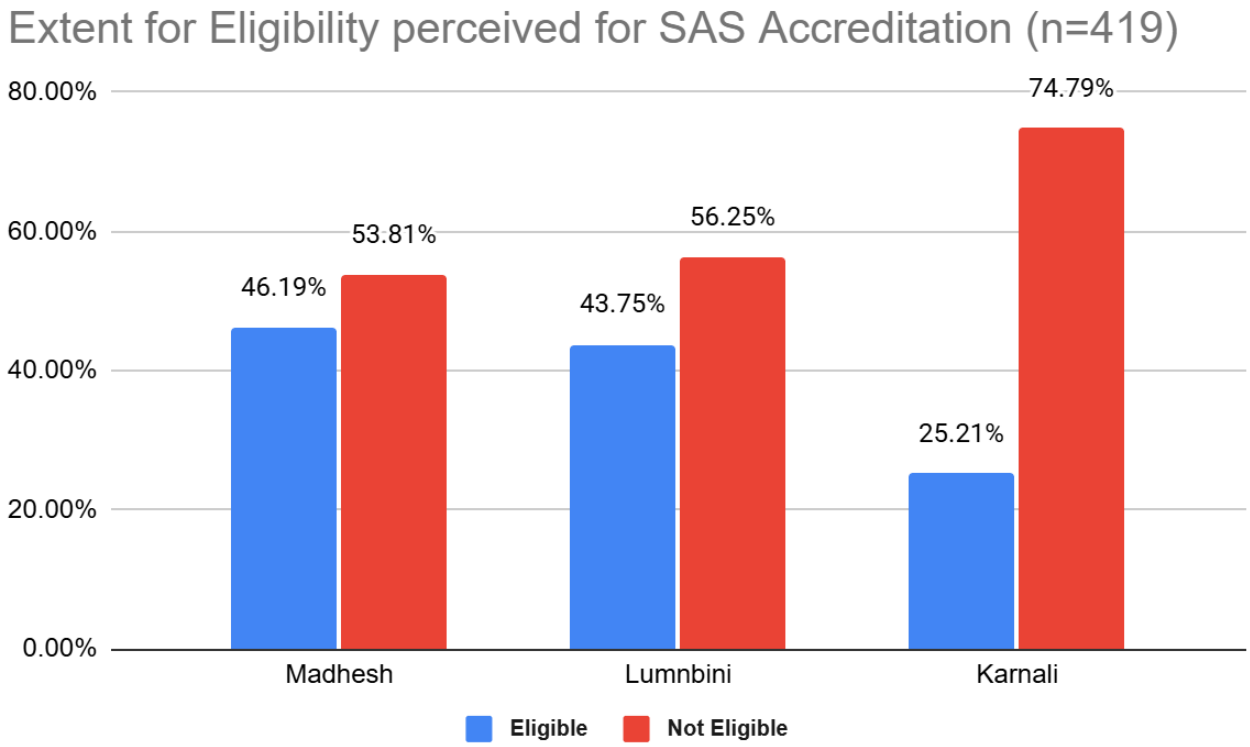
Overall, these findings suggest that a combination of human resource challenges, administrative and regulatory barriers, supply chain issues, and socio-cultural barriers contributed to the non-functionality of SAS services in these facilities.

K. Extent of Eligibility for SAS Accreditation Perceived by Health Workers (HW) of Non-Accredited Public Health Facilities

Out of the 419 non-accredited public health facilities assessed across Madhesh, Lumbini and Karnali provinces, a total of 167 facilities (40%) have claimed to be eligible for SAS accreditation. The remaining 252 facilities (60%) stated that they are not eligible for accreditation. In Madhesh province, the concerned health care providers of 109 out of 236 facilities (46%), mostly health posts and BHSCs, cited that their facilities are eligible for SAS accreditation. In Lumbini province, only 2 facilities (one health post and one HFSC) expressed their readiness (eligibility) for accreditation while 56 facilities in Karnali claimed to be eligible and ready to extend their services (Table 3.9). Annex 3.9A shows municipality-wise eligibility perception for SAS accreditation.

Table 3.9: Extent for Eligibility perceived for SAS Accreditation

Perceived eligibility for SAS accreditation	Province													Total
	Madhesh					Lumbini			Karnali					n
	PHCC	HP	BHSC	UHC	Others	HP	BHSC	Others	Hosp.	HP	BHSC	UHC	Others	
	n	n	n	n	n	n	n	n	n	n	n	n	n	
Eligible	2	60	39	6	2	1	1		1	25	27		3	**167**
Not eligible		44	76	4	3	12	5	3	2	14	59	1	29	**252**
Total	**2**	**104**	**115**	**10**	**5**	**13**	**6**	**3**	**3**	**39**	**86**	**1**	**32**	**419**



In a qualitative interview with the SAS Focal person from the Federal level regarding the expansion of SAS-accredited sites, they mentioned that currently there are 1,686 SAS-accredited health facilities in the country. Of these, 727 sites are accredited to provide MA/MVA up to 10 weeks, 351 sites provide MVA up to 12 weeks and 63 sites provide second-trimester abortion (MI/D&E). While these numbers suggest a substantial network of accredited facilities across the country, the concerned focal person cautioned about the fact that not all accredited facilities may be functional, mostly due to transfer of trained providers or delay in appointment of new trained service providers. This indicates that accreditation alone does not guarantee service availability and presence of trained providers remains a critical determinant of service functionality.

"*All of the accredited sites might not be functional, because in some places the trained service providers may have been transferred and are no longer providing services*."

- KII, Federal level

L. Perceived Reason for Non-Qualifying for SAS Accreditation

While a substantial number of facilities demonstrate potential for SAS accreditation, more than half remain ineligible. The primary reason for perceiving non-eligibility for SAS accreditation was lack of trained providers (in 242 out of 252 ineligible facilities), followed by insufficient infrastructure (147 facilities). Other contributing factors included 'facility is not a birthing center' (33 facilities) and 'lack of necessary equipment' (26 facilities).

These findings highlight that human resource and infrastructure gaps are the major barriers to achieving SAS accreditation, with other factors being relatively minor (Table 3.10). Strengthening these areas through targeted capacity-building training of providers and enhancing the physical infrastructures of the health facilities could expand SAS accredited facilities, improving access and service coverage across provinces.

Annex Table 3.10A indicates municipality-wise non-eligibility perceptions by service providers for SAS accreditation by category of health facility.

Table 3.10: Reasons for non-eligibility perceptions by service providers for SAS accreditation of their health facilities

	Province												Total
	Madhesh				Lumbini			Karnali					n
Reasons for non-eligibility for SAS accreditation	**HP**	**BHSC**	**UHC**	**Others**	**HP**	**BHCC**	**Others**	**Hosp.**	**HP**	**BHSC**	**UHC**	**Others**	
	n	**n**	**n**	**n**	**n**	**n**	**n**	**n**	**n**	**n**	**n**	**n**	
Lack of trained provider	42	72	4	3	12	5	3	1	14	56	1	29	**242**
Lack of infrastructure	21	45	1	1	12	3	2	1	7	36	1	17	**147**
Not a birthing center	6	9	2		8	1	1			5		1	**33**
Lack of equipment	2	5		1					3	8		7	**26**
Newly established facility		1								1			**2**
Not eligible as per the policy		1						1*					**2**
Local govt. has not given interest	1												**1**
Lack of budget										1			**1**
Total	**44**	**76**	**4**	**3**	**12**	**5**	**3**	**1**	**14**	**59**	**1**	**29**	**252**

- Multiple responses possible
**Ayurvedic hospital not considered eligible for SAS*

M. Client Preference for SAS

The service providers were asked about the choice of method (MA or MVA) preferred by the majority of clients for terminating pregnancy. All the service providers reported that clients prefer MA mainly because it is the only abortion service available in their area. In facilities where both options exist, MA was still described as being more popular due to perceived convenience, simplicity and privacy. Several service providers explained that clients consider MA less invasive and easier to manage compared to MVA. In Lumbini and Madhesh province, fear and misconceptions about MVA were frequently mentioned. Clients were scared that MVA would result in uterine damage and they found the procedure intimidating and embarrassing, particularly because it involves exposure of private parts. In contrast, MA allows women to maintain greater privacy, which was seen as important in the community context. In some context, specifically with Lumbini province, the service providers noted that clients' habit of directly purchasing abortion medicines from pharmacies also contributes to MA being more familiar and widely accepted. Overall, the preference for MA reflects a combination of availability, convenience, perceived safety, privacy concerns and fear of MVA.

"Due to fear of uterine infection from MVA, MA is preferred. Also, the women have a common practice of buying medicine directly from medical shops, so they prefer MA."

- KII2, Service Provider, Banke, Lumbini

"Due to the easy availability of MA in our area, the clients prefer it. Also, they consider MVA to have more complications than MA."

- KII12, Service Provider, Bara, Madhesh

"They feel MA is simple, and also it helps maintain their privacy as they feel shy to expose private parts in case of MVA. They fear performing MVA due to the use of equipment in it."

- KII19, Service Provider, Dhanusha, Madhesh

"They feel MA is simple, and maintains their privacy, as their private parts do not have to be exposed. Also they feel that they can easily take MA at home, so they prefer MA."

- KII35, Service Provider, Jumla, Karnali

"Most prefer MA because many women are afraid of undergoing a surgical procedure. Since MA is easier, just like simply taking medicine so, they tend to choose MA."

- KII39, Service Provider, Provincial Hospital, Dhanusha, Madhesh

Regarding the perspective of Local Government regarding Client's preference for SAS, HSCs of all the 49 municipalities (including the newly added municipality of Madhesh province) across three provinces – Madhesh (25), Lumbini (6), and Karnali (18), were interviewed to explore about the policy formulation and guidelines for implementation of SAS, service readiness, availability and placement of trained human resources, coordination mechanisms and community women's access to and utilization of SAS service. Information such as barriers to SAS service provision, efforts to improve SAS access for adolescents, marginalized communities, and people living with disabilities, and ways to improve SAS access were also covered in the KII. The data triangulates with the data obtained in qualitative data.

b. Training on SAS

The assessment found that a total of 68 trained Safe Abortion Services (SAS) providers are currently available across the project provinces, including 30 in Karnali, 14 in Lumbini, and 21 in Madhesh Province. Similarly, the number of listed SAS providers was reported to be 84, with the highest number in Madhesh Province (41), followed by Karnali (30) and Lumbini (16).

When we conducted a qualitative interview with representatives from the Federal Level, they mentioned that Training for safe abortion is coordinated by the National Health Training Center (NHTC) and respective Provincial Health Training Centers (PHTCs). PHTCs, with budget support from NHTC, are responsible for MA/MVA training of staff nurses and ANMs. NHTC provides training exclusively to medical officers/doctors including for second-trimester abortion training for specialists (Sr. Obs&Gyne and MD/GPs), which currently takes place only at Paropakar Maternity and Women's Hospital, Kathmandu and Kathmandu Model Hospital, Kathmandu. PHTCs offer MA/MVA training to ANMs in their respective provinces. Only two batches of service providers per province are trained each year, a number described as insufficient but constrained by limited budget. Training is provided to both permanent and contract-based staff, reflecting an intentional strategy to expand availability without waiting for permanent staff placement.

Despite receiving training, many providers do not apply for accreditation, and there is no mechanism to track post-training accreditation status. The abortion focal person explained that providers often hesitate to seek accreditation due to low level of confidence, particularly when trained at the provincial level. Some also express moral or value-based objections to abortion. This demonstrates that provider training does not always translate into service delivery, and emphasizes on the need for VCAT training and confidence-building support to ensure that trained providers actually begin offering services.

"*There is no mechanism to track whether the trained providers have submitted the application for accreditation or not. In some cases, the providers are interested in receiving training but do not wish to be accredited for service provision. Many of them tend not to provide the services. This is mainly because*

some of them lack the confidence to provide SAS even after receiving training; some providers have a very low level of confidence for SAS provision. Not all training is conducted here at the federal level, so it may also be that they are not confident because of the training they received from provincial level. The other reason is that some of the service providers still have stigma towards abortion. They have conscientious objections when it comes to abortion. Hence, although they receive the training, they do not wish to be accredited for service provision. Such trained providers need additional VCAT training."

- KII, Federal level

At the provincial level, KIIs were conducted with the directors of PHTCs to gather information about SAS and VCAT training curriculum development and revision, annual training conducted, training implementation and gaps.

All three provinces noted that they follow the SAS training curriculum developed by the NHTC. In Madhesh province, additional lecture sessions are included within the training to orient the service providers about the context specific to Madhesh. In Karnali province, the PHTC conducts planning and coordination meetings with the Provincial Heath Directorate to determine the number and type of training based on the available budget and support from supporting organizations. Training decisions, such as the number of sessions, identification of target districts and target groups largely depends on the budget. The process also relies on annual expenditure review, with current plans shaped by previous years' spending patterns.

"*We follow the curriculum developed by the NHTC. For Madhesh specific context, we include some lecture sessions during the training, where we explain the context of Madhesh province."*

- KII, PHTC, Madhesh province

"*There are regular meetings at the health directorate. They inform us about how many sites there are and what their needs are. Based on that, decisions are made on how many trainings to conduct in each district, how to coordinate with the government and with other organizations. Coordination is done with the Directorate to decide which site will receive the training. The training sites are decided and coordination is done with them accordingly. When we plan for the training, we plan the number of training to be conducted based on the budget received from the federal level. We also look at how much was spent on training in the previous year, and using that as a reference, we plan what can be done within the current year's budget."*

- KII, PHTC, Karnali province

Talking about SAS Training implementation and gap, The PHTCs provide SAS training to nursing staff and doctors. In Madhesh province, training focuses on MA, MVA and D&E, while Lumbini and Karnali provinces focus on MA and MVA only. Training needs are generally assessed based on requests from the facility and gap in existing trained manpower, with additional methods such as site monitoring visit in Madhesh, digital data collection in Lumbini and coordination with district health offices in Karnali.

"*The training request is made by the health facility itself, through request letters. Recent data are also reviewed to assess how many providers have already received training from each district and municipality, which helps determine the need. We have created a QR code on our website for training. After scanning the code, some questions appear and based on the responses, we shortlist participants. These questions help us understand whether the training is genuinely needed or simply requested. We also send letters directly to health facilities."*

- KII, PHTC, Lumbini province

"*We receive request letters from the health facilities. We also review the data on trained manpower. Sometimes, we also get information about the trained manpower in the specific health facilities during monitoring visits."*

- KII, PHTC, Madhesh province

Key gaps and challenges in training include unmet demand for training due to limited resources, inadequate IEC materials (specifically in Lumbini and Karnali) and low training frequency in Karnali, where only one batch of training is conducted annually in the absence of trainers and resources. Coordination with the PHD and local governments is weak across all three provinces. In Madhesh and Lumbini, some of the trained providers are not actively involved in providing the services. There is also a lack of a system to track trained providers and frequent staff transfers or long duration of leaves, that further disrupt service continuity.

"*The demand for training is high, but we have not been able to meet that demand. There is a shortage of resources for training because clinical costs are high, and complaints often arise that 2,000 - 2,500 NPR per client is insufficient. Similarly, participants request IEC materials, which we do not have. Similarly, the coordination with the Provincial Health Directorate and local governments is limited. Some trained providers are not delivering services despite having completed training. We ourselves tracked where the trained providers are and whether they are providing services or not. Our follow-up showed that 75% of trained providers are actively delivering services, while 25% are not due to reasons such as the provider was trained but the facility is not accredited, the provider is on leave, maternity leave, provider is transferred to another department or to a non-accredited health facility. We report these findings to the Directorate and Ministry. There is no system in place to track trained providers systematically. Coordination with local governments is also limited.*"

- KII, PHTC, Lumbini province

"*It is difficult for two trainers to conduct training for two full days. When we conduct training, the participants request for guidelines, flip charts and IEC materials, but we are unable to provide these, which remains a problem. We also are not able to print and distribute the guidelines. During the training, participants see the counseling flip charts, but later they say they do not have them in their own facilities. Similarly, only a limited number of training batches can be conducted each year, usually just one batch per year. These batches mainly include participants from district-level hospitals, making it difficult to reach the municipal level. For MA training, usually only 1–2 participants from each district receive training. Due to limited resources, only a small number of participants can be included, so it is not possible to cover everyone.*"

- KII, PHTC, Karnali province

These findings highlight systemic limitations in training capacity, resource allocation and follow-up mechanisms. While all three provinces use multiple approaches to assess training needs, resource constraints restrict both the scale and quality of training, particularly in Karnali. The absence of robust tracking and coordination mechanisms undermines the adequate placement of trained staff. These gaps suggest a need for stronger planning, monitoring and resource allocation to ensure effective placement of trained providers and SAS service delivery is consistent across all three provinces.

Regarding the resources and quality assurance, when done qualitative data collection, it was observed that Across all three provinces, resource and quality assurance gaps significantly limit the SAS service delivery. Although provincial and federal budgets are allocated for SAS training, these funds remain insufficient to meet the high demand, with Karnali relying partly on partner support for MA training to providers. Only a few batches of providers are trained each year, which is not adequate to ensure complete access to SAS across all local governments of all provinces.

"*The budget has been allocated for SAS training. Funds come from both the provincial and federal levels. The province has allocated a budget for three batches and the federal level for one batch of training, but it is still insufficient because the demand here is high, and we are not able to meet that demand.*"

- KII, PHTC, Madhesh province

"*The budget for SAS training comes from the federal level. Partner organizations also provide support for MA training. The current budget cannot meet the actual demand. MVA requires comparatively less budget and can be covered with a small increase in budget, but MA requires a significantly larger budget.*"

- KII, PHTC, Karnali province

Training coverage is inadequate in all three provinces. Lumbini province faces major coverage gaps in Kapilvastu, Banke and Rupandehi mostly due to frequent transer of trained providers. The key informant at Karnali province mentioned that there is good coverage only in Surkhet, while other districts lag behind because of fewer service sites. Post-training follow-up is also inconsistent across the three provinces. Madhesh province conducts some post-training follow-up to monitor the quality and outcomes of the trainings delivered, while in Lumbini province, the PHTC relies on PHD for follow-up, with occasional phone follow-ups by PHTC. On the other hand, Karnali province has no mechanism for post-training follow-up.

"*At the district level, coverage is low in Kapilvastu, Banke and Rupandehi. These are large districts and frequent staff transfer is the main reason for the shortage of trained providers."*

- KII, PHTC, Lumbini province

"Follow-up is the responsibility of the Health Directorate, and it does not fall under our target or budget. However, we still do phone follow-ups. For quality, we consider post-training follow-up as our main basis."

- KII, PHTC, Lumbini province

"*We don't have exact figures by district. But based on the previous review meeting, there are SAS sites in areas close to Surkhet, and coverage seems fairly adequate there. Many providers there also appear to be trained. In other districts however, very few sites are accredited and training is also limited. Recently, Ipas has been supporting 4 - 5 districts, but not the entire districts, but rather only selected municipalities within them."*

- KII, PHTC, Karnali province

Refresher training, mentoring and continuous professional development opportunities are absent across the provinces, except for limited refresher training support from Ipas in selected areas of Lumbini and Karnali province. Additionally, none of the provinces have any mechanism for mapping trained providers or SAS service sites. These gaps constrain service readiness, undermine quality assurance, and limit equitable expansion of SAS services.

"*There is no such system. There is no curriculum for providing refresher training and the need has not really been recognized. But Ipas had conducted a three-day refresher training, which was very good. We can also use that curriculum to conduct refresher training, and we are considering doing so next year."*

- KII, PHTC, Lumbini province

Service providers reported receiving some additional training and orientation relevant to SAS provision, including VCAT, client-friendly counseling, and HMIS recording and reporting training. These training and orientation were delivered by different authorities, including the Provincial Health Directorate (PHD), Health Office (HO), National Health Training Centre (NHTC), local government and NGOs. Specifically, among the 38 SAS service providers, six providers (1 from Lumbini, 1 from Karnali, and 4 from Madhesh) reported receiving VCAT training from their respective PHDs. Eleven providers (4 from Lumbini, 4 from Karnali, and 3 from Madhesh) reported receiving HMIS recording and reporting training from a range of sources, including PHD, HO, NHTC or local government. Regarding client-friendly counseling training, seven providers (1 from Lumbini, 4 from Karnali, and 2 from Madhesh) reported receiving training either from the PHD or the non-governmental sector. However, the service providers of all three provincial hospitals reported that they did not receive any in-service training for HMIS recording, reporting and client friendly counseling. The service providers of Madhesh and Lumbini province mentioned that they had received training on some components of VCAT during SAS training.

The findings suggest that the majority of the SAS service providers have not received training on VCAT, and the uneven distribution of such training across provinces and different types of training may limit

capacity-building of the providers, and also potentially affect both the quality of services and equitable access to SAS across different provinces.

During the qualitative interview, the service providers were asked about the choice of method (MA or MVA) preferred by the majority of clients for terminating pregnancy. All the service providers reported that clients prefer MA mainly because it is the only abortion service available in their area. In facilities where both options exist, MA was still described as being more popular due to perceived convenience, simplicity and privacy. Several service providers explained that clients consider MA less invasive and easier to manage compared to MVA. In Lumbini and Madhesh province, fear and misconceptions about MVA were frequently mentioned. Clients were scared that MVA would result in uterine damage and they found the procedure intimidating and embarrassing, particularly because it involves exposure of private parts. In contrast, MA allows women to maintain greater privacy, which was seen as important in the community context. In some context, specifically with Lumbini province, the service providers noted that clients' habit of directly purchasing abortion medicines from pharmacies also contributes to MA being more familiar and widely accepted. Overall, the preference for MA reflects a combination of availability, convenience, perceived safety, privacy concerns and fear of MVA.

"Due to fear of uterine infection from MVA, MA is preferred. Also, the women have a common practice of buying medicine directly from medical shops, so they prefer MA."

- KII 2, Service Provider, Banke, Lumbini

"Due to the easy availability of MA in our area, the clients prefer it. Also, they consider MVA to have more complications than MA."

- KII12, Service Provider, Bara, Madhesh

"They feel MA is simple, and also it helps maintain their privacy as they feel shy to expose private parts in case of MVA. They fear performing MVA due to the use of equipment in it."

- KII19, Service Provider, Dhanusha, Madhesh

"They feel MA is simple, and maintains their privacy, as their private parts do not have to be exposed. Also they feel that they can easily take MA at home, so they prefer MA."

- KII 35, Service Provider, Jumla, Karnali

"Most prefer MA because many women are afraid of undergoing a surgical procedure. Since MA is easier, just like simply taking medicine so, they tend to choose MA."

- KII 39, Service Provider, Provincial Hospital, Dhanusha, Madhesh

We also asked about the adequacy of trained SAS Providers. When asked about the adequacy and availability of SAS trained providers, the health directorates of both Madhesh and Lumbini provinces mentioned that they do not have an accurate or updated picture of whether all SAS accredited public health facilities have trained SAS providers in place. The provincial health director of Madhesh province said that owing to a limited number of SAS training coverage, it is difficult to ensure and confirm SAS trained providers' presence at a health facility in the absence of any systematic assessment or verification visit to the health facilities, which was long overdue. Similarly, in Lumbini, the provincial health director reported that they only had informal information and didn't have any evidence backed data about the presence of SAS trained providers in the health facilities. It was assumed that gaps are likely to exist potentially due to staff transfers, temporary positions, or contract terminations. Both these provinces lack systematic, routine mapping of trained SAS providers, resulting in uncertainty about service readiness and possible gaps in service provision.

"*We cannot say exactly how many SAS accredited facilities do not have trained providers. We have not been able to provide training in sufficient numbers, so we cannot say with certainty what the situation is in*

each place. We do have a plan to visit health facilities to find out where services are currently being provided and which facilities are not accredited yet."

- KII, PHD, Madhesh province

"*We have been doing indirect mapping, but there has been no formal process where everyone sits together to confirm exactly which facilities have trained SAS providers and which do not. At present, instead of mapping based on demand, we are processing accreditation for those who request it. I do not have exact information on where trained providers are lacking, but the data can be checked. We cannot say precisely right now. In some places, there may not be a single provider because of transfers, or if they were temporary staff (hired on contract basis), due to termination of their contract terms.*"

- KII, PHD, Lumbini province

Both Madhesh and Lumbini province experience challenges in ensuring the consistent availability of trained providers and essential medicines. Inadequate federal training budgets limit the number of service providers who can be trained. In Madhesh, the absence of regular follow-up and monitoring makes it difficult to track provider placement, and logistical availability is affected when municipal representatives are not supportive. In Lumbini, staff transfers and contract terminations often leave accredited facilities without trained providers. These issues contribute to uneven service readiness and periodic service gaps.

c. Medical Abortion Drug, Commodities, and Equipment Availability and Procurement

A. Status of Basic Facilities and Commodities at SAS Accredited Health Facilities

In Madhesh province, all the hospitals and PHCCs had separate and spacious waiting areas, counseling and examination rooms, while all the health posts did not have similar facilities. Some health posts did not have a separate waiting area for clients and in some, the waiting area was small and cramped. One of the HPs located in Malangwa Municipality was in a dilapidated condition and ill maintained. Similarly, the construction work in Ankar HP of Mahottari had been left incomplete for the past ten years. Furthermore, their examination tables and other furniture were not maintained well and the health facility lacked water supply.

While most SAS facilities reported having emergency and referral mechanisms, several lacked disability-friendly infrastructure, separate toilets, or ambulance services. Only a few facilities displayed their accreditation certificates and some lacked SAS trained providers or Health Management Information System (HMIS) 3.7 registers for recording abortion services. Visibility of service information in the citizen charter was also limited. The extent of privacy maintenance during counseling, examination, and procedures varied across the SAS facilities with hospitals and PHCCs generally ensuring both audio and visual privacy, but this was less consistent in health posts. Basic amenities such as running water and waste management systems were available in hospitals and PHCCs. Stock for MA drugs (combi packs) were not available in half of the facilities due to delays or non-timely reimbursements. The most commonly used MA drug in Madhesh province was Synopill (combi pack).

In Lumbini province, the SAS accredited hospitals and PHCCs were better organized in terms of physical infrastructure. They had dedicated spaces for counseling, examination, and procedures, along with functional MVA equipment. Privacy during service delivery was generally maintained and most facilities had reliable water supply and proper waste disposal systems. The availability of family planning commodities such as Intrauterine Contraceptive Devices (IUCD), implants, Depo-Provera, pills and condoms was relatively better than in other provinces. Yet, similar to Madhesh province, the display of SAS information in citizen charters and visible signage was obscure. Stock for MA drugs (combi packs) was sufficient in most of the health facilities except for two. Most commonly used MA drugs in Lumbini province were *Mistol* (not combi pack) and *Pregno* (not combi pack).

In Karnali province, most of the hospitals and PHCCs met the minimum standards for service readiness, but health posts showed considerable gaps. Many lacked designated counseling or procedure rooms. Issues with audio and visual privacy were common, particularly in health posts where service rooms were shared or partitioned. Many health facilities reported using the counseling room of ANC and family planning to provide SAS counseling and client examination, often violating the client's privacy. Basic infrastructure, such as running water, sanitation, and waste management systems, was available in some facilities. While hospitals generally provided 24-hour emergency services and referral systems, several peripheral facilities had limited transport access or no ambulance services. Display of SAS accreditation certificates, citizen charters, and information on service fees or timings was inconsistent, and visibility of safe abortion-related IEC materials was minimal. Stock for MA drugs (combi packs) was not sufficient in many of the health facilities.

While basic infrastructure such as waiting areas, examination rooms, and contraceptive availability appears relatively adequate in many facilities, key components required for providing safe surgical abortion (MVA & PAC) services are alarmingly low across Madhesh, Lumbini, and Karnali. Procedure rooms (dedicated space for MVA & PAC) are almost non-existent. Only a *few hospitals in Madhesh (2) and Karnali (1)* reported having such space, while none of the facilities in Lumbini had a designated procedure room. This indicates that most facilities are not structurally prepared to conduct safe procedures.Recovery rooms for post-procedure care are virtually absent, with only *2 hospitals in Madhesh and 1 in Karnali* reporting availability, and no facilities in Lumbini. This raises serious concerns about post-procedure monitoring and client safety. Availability of a functioning MVA set is extremely limited, reported in only 3 facilities overall (2 in Karnali and 1 elsewhere), showing that even where services could be provided, essential equipment is missing. Space for instrument processing (infection prevention for MVA & D&E) is also nearly absent, with only *2 facilities in Madhesh and 1 in Karnali* reporting availability, highlighting major gaps in infection prevention and quality of care. The use of light boxes to check Products of Conception (POC), a critical step to ensure completeness of abortion is reported in only a handful of facilities (2 in Madhesh and 2 in Karnali), and completely absent in Lumbini, suggesting compromised clinical quality assurance practices. The most commonly used MA drug in Karnali Province was Pregnokit (combi pack) (Table 4.1).

Table 4.1: Status of Service facilities and Commodities Available for SAS provision across the three provinces

Presence of Infrastructures and Commodities *('Yes' only*)	**Madhesh**			**Lumbini**			**Karnali**		
	Hosp. (n=4)	**PHCC (n=2)**	**HP (n=10)**	**Hosp. (n=1)**	**PHCC (n=1)**	**HP (n=5)**	**Hosp. (n=5)**	**PHCC (n=1)**	**HP (n=12)**
Waiting Hall for clients that is spacious and sufficient sitting arrangements	4	2	4	1	1	5	4	1	7
Separate room for counselling on SAS to clients	4	1	4	1		4	1	1	3
Client Assessment/Examination room	4	2	6	1	1	5	1	1	5
Examination table ~~for physical exam~~	4	2	6	1	1	3	1	1	8
Procedure Room (separate space for performing MVA & PAC)	2	1					1		
Recovery room (for MVA & PAC)	2						1		
Functioning MVA set							2		1
Canula (No. 4-12)	2						4		3
Space for instrument processing (for MVA and D & E)	2	1					1		

Sufficient stock of MA drug to last at least for 1 month (combi pack)	2	2	5	1	1	3	2	1	4
(For MVA and PAC) Use of light box to check Product of Conception (POC)	2					2	1		2
IUCD	4	2	5		1	3	3		5
Implant	4	2	10	1	1	5	4	1	10
Depo-Provera	3	1	9	1	1	5	5	1	8
Pills	4	2	10	1	1	5	5	1	11
Condom	4	1	10	1	1	5	5	1	11
Audio privacy at counseling room	4	2	6	1	1	4	4	1	7
Visual privacy at counseling room	4	2	7	1	1	4	5	1	8
Audio privacy at client assessment and examination room	4	2	6		1	4	4	1	8
Visual privacy at client assessment and examination room	4	2	6		1	4	5	1	9
Audio privacy at procedure room	4	1	4	1	1	4	3	1	8
Visual privacy at procedure room	4	2	4	1	1	4	5	1	8
Reliable source of running water	4	2	7	1	1	4	3	1	11
Waste Management system (Specify - Pit/Incinerator)	4	2	5	1	1	5	5	1	12
Emergency services available 24 hours	4	1	6	1	1	5	5	1	7
Referral mechanism	3	2	10	1	1	5	5	1	12
Disable-friendly entrance	4	2	3	1	1	4	2		1
Separate toilets for Male & female clients	4	2	3	1	1	4	5		8
Ambulance service	4	2	2	1	1	5	4		3
SAS providers	4	2	6	1	1	5	3	1	6
Certificate of accreditation (Facility and Provider)	4	2	7	1	1	5	4	1	11
HMIS 3.7 logbook (SAS service register)	3	2	6	1	1	4	4	1	8
Flip chart for SAS counseling	4		3			2	1		
Information regarding safe abortion services (time and fees) is written in the citizen charter in a way that is visible to everyone	3	1	4	1		2	1		

During the qualitative data collection a large majority of the HSCs in all the three provinces reported an inadequate number of accredited SAS facilities, shortage of trained providers and insufficient supplies (medicines/equipment) as the major barriers to SAS. In Karnali province, scarcity of trained providers, shortages of medicines and equipment, and long travel distances due to rugged terrains were identified as major challenges. In Madhesh province, limited number of service sites, inadequate privacy arrangements at the health facility and irregular drug supplies were emphasized. In Lumbini province, distance to health facilities, unavailability of trained staff, and unfriendly provider attitudes were key barriers. Comparatively, geographic inaccessibility was more pronounced in Karnali, distance factor in Lumbini province, while facility-level constraints were a more prominent feature of Madhesh province.

"There is a lack of adequate number of trained providers, and also adequate availability of medicine/equipment. Furthermore, the SAS sites are very far away, due to which the accessibility is low among the women in the community."

- KII 20, Local Government, Jumla, Karnali

"We do not have enough trained providers, and an adequate supply of medicines and drugs. Also, many health facilities do not have a separate room/space for SAS provision. So, people may not come to receive services due to privacy concerns."

- KII 35, Local Government, Kalikot, Karnali

"There is a lack of adequate and timely supply of drugs/medicine for continued service provision."

- KII 48, Local Government, Sarlahi, Madhesh

B. Availability of Drugs, Commodities and Equipment

Across the municipalities of all three provinces, inadequate and irregular supply of essential drugs, equipment, and commodities was consistently reported as a major challenge affecting the provision of SAS. The majority of the HSCs frequently emphasized on the delay and inadequate supply of MA drugs, as barriers to SAS provision. Even in accredited facilities, essential medicines and equipment were not consistently available, leading to service interruptions. In some cases, medicines and equipment were supplied but remained unused or expired in the absence of a trained provider to deliver the service. This not only resulted in wastage of commodities but also discouraged future resource allocation from the provincial government. The participants also mentioned administrative and logistical hindrances, including delayed procurement, absence of key personnel (such as section heads or accountants), and inadequate communication between municipal and provincial supply chains.

"MA drugs are not supplied in a timely manner and in adequate quantity as per the demand by the health facility."

- KII 14, Local Government, Banke, Lumbini

"*Medicines are often not supplied on time, which affects service readiness."*

- KII 26, Local Government, Rautahat, Madhesh

"*Although the facility is accredited, a trained provider is not available, so medicine and equipment are being wasted."*

- KII 21, Local Government, Kalikot, Karnali

"*It is difficult to ensure timely availability of drugs and equipment to health facilities if the section heads and accountants are absent for a longer period."*

- KII 39, Local Government, Mugu, Karnali

These findings suggest that service readiness for SAS is undermined not only by lack of trained human resources but also by systemic weaknesses in supply-chain management. Timely and adequate provision of commodities is largely dependent on higher tiers of government, with local governments playing a limited role. The lack of coordination in the appointment of service provider and commodity distribution reflects a fragmented approach to SAS accessibility. Addressing these issues requires institutionalizing local-level inventory management systems, establishing buffer stocks for essential medicines, and improving inter-governmental coordination to ensure continuous availability of drugs, equipment, and supplies in all accredited facilities.

C. MA Drug Procurement

In regard to the MA drug procurement policy, the procurement process generally follows the federal and public procurement guidelines established by the Government of Nepal, including the *Public Procurement Act and Regulations* and, in some cases, provisions of the *Finance Act 2005 (Aarthik Ain 2062).* Across the municipalities of all three provinces where SAS are functional, two main mechanisms were reported: (i) Health facilities procure MA drugs directly by themselves and later receive reimbursement or advance payment from the local government based on service delivery volume (NPR. 800 per client), and (ii) Health facilities submit requisition forms to the local government, which then procures and supplies MA drugs to the health facilities as per their demand.

"MA drugs are procured by the municipality and distributed to health facilities as per their need/request."

- KII 3, Local Government, Dolpa, Karnali

"The health facility fills the requisition form, and sends it to us. We purchase MA drugs directly from Nepalgunj, and register its stock here at the health section. Then, we supply the requested amount of MA drugs to the health facility. The health facility is provided with the stock adequate for 1 year (usually 40 combi packs).

- KII 25, Local Government, Jumla, Karnali

"*The health facility purchases the drugs directly from the market and seeks reimbursement from us. We reimbursed the facility based on NPR. 800 per client."*

- KII 37, Local Government, Kalikot, Karnali

"The health facility is entitled NPR. 800 per MA client. The health facility submits the lists of clients served every 4 months. We reimburse the health facility as per the data (lists) submitted accordingly. It is up to the health facility to decide how to allocate that money on different things. They decide on what to procure?, how much to spend on MA drugs?, how much the service provider gets?, and how much the health facility should retain."

- KII 14, Local Government, Banke, Lumbini

"The health facility procures the MA drugs, and we reimburse that amount to the facility. It is done so because it is difficult for us to make an accurate estimate of the required drugs to be purchased, and there is also a risk of date expiry of the drugs if supply estimates exceed the annual demand. Under the Procurement act, procurement up to NPR. 1 Lakh, the facility will be reimbursed the money as per the bill they present. The facility receives NPR. 800 per client, and from that money, 20% will be given to the service providers as service delivery incentive."

- KII 17, Local Government, Banke, Lumbini

"*Local government has given direct authority to health facilities for the purchase of drugs and to seek reimbursement*."

- KII 30, Local Government, Bara, Madhesh

"*In some cases, the health facility fills the requisition form, and the local government provides MA drugs to the facility based on that request. In some other cases, the health facility purchases the MA drugs, and then, the local government reimburses the facility."*

- KII 41, Local Government, Mahottari, Madhesh

"*The health facility fills the requisition form, and the local government provides MA drugs to the facility based on that request."*

- KII 48, Local Government, Sarlahi, Madhesh

The process of MA drug procurement is closely linked with the broader budget allocation and reimbursement mechanisms for SAS. In many local governments, health facilities initially procure MA drugs using their own funds and are subsequently reimbursed by the local government, while in others, supplies are provided directly through the municipal health section upon requisition. In the absence of dedicated budget lines for SAS, MA drugs are often purchased under the broader Safe Motherhood and Reproductive Health program budget, which affects both the timeliness and consistency of drug supply. These patterns indicate that limitations in budget allocation and coordination across government levels directly influence the availability of essential commodities and the continuity of SAS delivery at the facility level. Strengthening procurement planning and ensuring timely disbursement of funds could therefore play a critical role in maintaining uninterrupted access to SAS.

The MA drugs are procured through two main mechanisms - directly from the market by health facilities or supplied by the local government. Among the 24 health facilities that are currently providing MA services, 13 of them (4 from Lumbini, 3 from Karnali and 6 from Madhesh) reported purchasing the MA drugs directly from the market by themselves and subsequently submitting reports to the local government for reimbursement. The reimbursement process varied widely, ranging from 2-4 days to 6 months, with some providers noting that reimbursement only occurs annually. On the other hand, service providers of 11 accredited (and currently functional) health facilities (2 from Lumbini, 4 from Karnali and 5 from Madhesh) reported receiving MA drugs supply directly from the local government. These findings highlight variability in procurement mechanisms and reimbursement timelines across provinces, which may affect timely availability of MA drugs at the facility level.

"Once there was some delay in MA procurement. At that time, the client flow increased unexpectedly, and we could supply the adequate drugs when needed."

- KII4, Service Provider, Banke, Lumbini

"There has been a shortage of MA drugs for the past 5 months. Even after requesting it from the store, it was not available. During this time, the women have to buy medicines by themselves."

- KII22, Service Provider, Siraha, Madhesh

"Last year, there was a three-month shortage of medicine because the municipality did not supply it on time. If the health facility is provided with the responsibility to buy the MA pills themselves, then, there might not be a shortage."

- KII26, Service Provider, Kalikot, Karnali

3.1.4 Safe Abortion Information and Monitoring

This section presents information on the availability, accessibility, and dissemination of safe abortion information within the project areas. It also examines the existing monitoring and reporting mechanisms

used to track the provision, quality, and utilization of safe abortion services. The section highlights how information is shared with communities, the systems in place for data collection and review, and the effectiveness of monitoring processes in ensuring accountability, service quality, and evidence-based decision-making.

a. Data Management and Reporting System

Across all three provinces, data management and reporting for SAS service delivery are conducted on a monthly basis and submitted either to the respective local government (21 out of 25 SAS facilities) or to the provincial government (4 SAS facilities). In Lumbini province, the reporting is carried out in both electronic and hard copy formats, using the District Health Information System 2 (DHIS2) platform and the HMIS 9.3/9.4 recording forms, respectively. In Karnali province, reporting is predominantly conducted through electronic submission through DHIS2, whereas in Madhesh province, practices vary by facility. Some facilities in Madhesh submit reports solely through DHIS2, while others maintain dual reporting systems by submitting both electronic and hard copy reports.

Five SAS facilities submit hard copies of the SAS data. These are Bankatti HP Banke, Dumarbana HP, Bara, Malangwa provincial hospital, Sarlahi; Jaleswor Provincial Hospital, Mahottari and Siraha provincial hospital). Ten health facilities (6 in Karnali and 4 in Madhesh province) submit their monthly SAS data digitally (DHIS-2). The remaining 10 facilities (5 from Lumbini; 3 from Madhesh and 2 from Karnali province) submit both hard copies and digital data. In terms of place of submission, all health posts (12) and 5 PHCC, 3 basic hospitals and 1 urban health center (21 facilities in all) submit SAS data to the respective health section of their municipality. The remaining four health facilities (3 provincial hospitals and 1 district hospital) submit their monthly SAS data to the concerned health directorate office of their respective provincial government. When asked about the suggestions received from the reporting department, responses varied across provinces. In Lumbini province, most of the respondents reported that no specific suggestions were provided. A few mentioned that they received feedback on timely reporting and were asked to address data gaps and unclear information in their submitted reports. A similar pattern was observed in Madhesh province where they were advised to correct reporting errors and ensure timely submission of the report. In Karnali province, most of the service providers mentioned that they did not receive any suggestions from the reporting department. However, a few mentioned having received directions related to the correction of data errors.

When asked about the recommendations to strengthen the HMIS and DHIS2 systems, the service providers provided some suggestions. In Lumbini province, most of the service providers emphasized the need for additional or refresher training on data reporting and recording, along with broader capacity-building support for system use while some mentioned that the existing system was functioning well and required no major changes. In Madhesh province, the service providers highlighted technical and infrastructural issues such as frequent system errors, glitches and slow or unreliable internet connectivity, which disrupted timely data entry. In Karnali province, the main concerns were network problems, irregular system function and server issues, system outage or failure to display data entry fields. The service providers recommended regular system updates, resolving website errors and providing training for service providers on DHIS2 use. Overall, suggestions across all provinces focused on improving technical reliability, connectivity and user capacity to ensure efficient and accurate reporting.

“Additional training should be provided for the service providers on reporting and recording.”

- *KII4, Service Provider, Banke, Lumbini*

“The main change needed in HMIS data reporting is to fix the system errors and glitches. These technical issues make reporting difficult, and should be corrected.”

- *KII11, Service Provider,Parsa, Madhesh*

"The issue of the DHIS2 errors needs to be resolved, the DHIS2 system needs to be updated, and training should be provided to service providers."

- *KII26, Service Provider, Kalikot, Karnali*

b. Reporting System of SAS

As per the key informants at federal as well as provincial level, SAS reporting is conducted through DHIS2. The abortion focal person noted that health facilities also maintain HMIS 3.7 registers. When asked about the major challenges in quality data reporting, the abortion focal person identified internet connectivity issues as a major barrier to timely reporting, particularly in remote areas. Additionally, the focal person also mentioned that the person in charge of reporting lacked training and skills in digital reporting even after having undergone integrated HMIS/DHIS2 orientation training. At the provincial level, the Provincial Health Directors cited lack of adequate training for dedicated staff, and lack of sincerity in data reporting, as a major challenge in accurate reporting. These gaps contribute to delays and inconsistency in SAS data, which may directly affect budget allocation and monitoring.

"If the person who provides the service is also given training, only then can data quality be maintained. When one person provides the service and another person enters the data, the one doing data entry often does not fully understand it, so the data sometimes appears to be over reported and sometimes underreported."

- *KII, PHD, Madhesh province*

All the local governments within the three provinces stated that SAS data were recorded in the Health Management Information System (HMIS) and reported online through the District Health Information System (DHIS2) platform within the first week of each month. In certain contexts, particularly within Karnali and Madhesh provinces, health facilities submit their HMIS records to the local government, who then reports the data via online DHIS2 platform.

"The SAS data is reported on a monthly basis through HMIS and DHIS2. The online reporting in DHIS-2 is done within the first 7 days of each month."

- *KII 18, Local Government, Kapilbastu, Lumbini*

"The health facilities send one copy of the report to the municipality within the 7th day of each month, and also directly report in DHIS2 through their respective health facility."

- *KII 3, Local Government, Dolpa, Karnali*

"Reporting of data related to SAS is done every month between the 2nd and 5th day, through the DHIS2 online system."

- *KII 27, Local Government, Parsa, Madhesh*

"The health facility provides the paper-based report (HMIS report) and then I enter them in the software (DHIS2 platform)."

- *KII 24, Local Government, Kalikot, Karnali*

"The health facilities send the paper-based report to the municipality within the 4th day of each month, and the municipality uploads the data to the online platform."

- *KII 41, Local Government, Mahottari, Madhesh*

Across all three provinces, the participants identified several challenges affecting quality and consistency in reporting SAS related data. In Madhesh and Lumbini provinces, the most frequently cited issue was server instability, with participants reporting repeated system breakdowns and delays in uploading data to

DHIS2. In contrast, Karnali province faced multiple structural barriers, such as poor internet connectivity, frequent electricity outages, weak network coverage and shortage of trained personnel for data entry and reporting, which collectively disrupted regular data reporting and accuracy of the data.

"There are certain issues from time to time, such as electricity outages and internet issues. The quality might be compromised to some extent, as the service providers have not been adequately trained in data reporting."

- *KII 3, Local Government, Dolpa, Karnali*

"We face certain barriers such as issues with the internet, network and electricity. We do not have laptops, so reporting needs to be done through mobile phones, but there are issues with the mobile network. There is no electricity in most of the wards within the local government, which poses further challenges."

- *KII 35, Local Government, Kalikot, Karnali*

"Since the past 4-5 months, we have been facing issues with the DHIS2 platform. Sometimes, the column where we fill the data goes missing or hidden. There is an issue with the software."

- *KII 17, Local Government, Banke, Lumbini*

"The DHIS2 server does not work properly sometimes."

- *KII 9, Local Government, Siraha, Madhesh*

While data reporting systems in Madhesh and Lumbini provinces remain operational with intermittent technical issues, the challenges faced by Karnali province are more fundamental and persistent, reflecting both infrastructural and human resource constraints. These findings suggest that strengthening digital infrastructure, ensuring reliable power and connectivity, and enhancing data management capacity are critical for improving the quality, timeliness and completeness of reporting SAS related data across the provinces.

c. Monitoring Mechanism

The information regarding frequency of monitoring visits and the suggestions received during the monitoring visits varied across provinces. In Lumbini province, monitoring was carried out by HSC either on a monthly or quarterly basis with visits ranging from two to twelve times in a year. Most of the service providers reported that they did not receive any specific suggestions, though a few noted that they received feedback related to medicine distribution and quality service delivery. In Madhesh province, monitoring typically occurred two to four times annually, done by PHD or FWD (in case of provincial hospitals or some PHCCs) and the HSC at local level. While most of the service providers said that they didn't receive any feedback, some mentioned that they received suggestions on waste management, ensuring effective service delivery and conducting more community awareness activities. A few also said that they received advice on the administration of MA drugs within the health facilities, while some reported saying that they had requested for the provision of second-trimester abortion training. In Karnali province, monitoring was conducted on a more regular basis (two to five times a year), done by PHD (in case of provincial hospitals or some PHCCs), and HSC at local level. The feedback was comparatively more specific, focusing on cleanliness, timely staff attendance, expired medicine management, data recording and reporting accuracy. Although the monitoring visits were carried out periodically across provinces, feedback remained limited and largely confined to administrative issues rather than technical.

"The monitoring is done by the Heath Section Chief of the local government, around 4 times a year. During the last monitoring visit, we received feedback on medicine distribution and quality service provision."

- *KII6, Service Provider, Kapilbastu, Lumbini*

"The health section chief from the local government comes for monitoring two times a year. When they came for the monitoring, they recommended proper management, especially expired medicine management."

- *KII24, Service Provider, Kalikot, Karnali*

Across the study sites, most of the local governments reported carrying out quarterly or biannual monitoring visits, while a very few municipalities conducted frequent monitoring visits - monthly or even twice a month, depending upon staff availability and resource allocation. However, these visits primarily focused on an integrated monitoring approach covering all health service programs such as maternal and child health, nutrition, immunization, and reproductive health, with limited focus specifically on SAS. A common practice observed was the use of standard monitoring tools or checklists, such as the Minimum Service Standards (MSS) checklist. Monitoring visits typically involved reviewing service registers, stock records, and infrastructure conditions, as well as assessing the availability of medicines and equipment. Some municipalities also reported the participation of elected representatives such as mayors, deputy mayors, and health facility management committees in the monitoring visits, indicating a degree of local accountability and administrative engagement.

"Monitoring visits conducted 3-4 times a year, where the information such as number of clients served, and the stock of drug/ equipment is gathered."

- *KII 47, Local Government, Sarlahi, Madhesh*

"The monitoring visit is done on a quarterly basis, with the involvement of HSC, mayor/deputy mayor, chief administrative officer, chairperson of the management committee, etc. The monitoring is done for all health service provision, and not just specifically for SAS."

- *KII 12, Local Government, Siraha, Madhesh*

"Monitoring visits conducted every month, where we review the record registers, logistics management and waste management."

- *KII 48, Local Government, Sarlahi, Madhesh*

"The health section of the local government conducts integrated quarterly or bi-annual monitoring visits to monitor various programs, using the checklist provided by the federal level. Minimum Service Standard (MSS) tool is also employed."

- *KII 24, Local Government, Kalikot, Karnali*

"The health section of palika conducts monthly monitoring visits to assess the status of the health facilities, where we review the register records, and ask about any problems or complications with the facility in-charge or trained provider."

- *KII 20, Local Government, Jumla, Karnali*

"The monitoring visit is done on a monthly basis (or sometimes even twice a month), based on the necessity. The monitoring is done for all health service provision (including RH, MNCH, Nutrition, and Immunization programs), and not just specifically for SAS."

- *KII 14, Local Government, Banke, Lumbini*

"The monitoring visit is done on a quarterly basis or based on the necessity. The monitoring is done for all health service provision (including safe motherhood, RH and SAS programs), and not just specifically for SAS. During the monitoring visit, we review the register (for data record) and cross-check the expense against the money supplied by the local government."

- *KII 15, Local Government, Banke, Lumbini*

"We have an integrated supervision and monitoring system, and not only for SAS. We conduct supervision and monitoring of health facilities 4-5 times a year, where we review HMIS register, medicine stock and assess the physical infrastructure."

- *KII 18, Local Government, Kapilbastu, Lumbini*

Despite these efforts, monitoring systems remain constrained by several persistent challenges. The most frequently cited issues included inadequate budget allocation, shortage of human resources, and limited technical capacity to conduct regular and focused supervision. In many municipalities, monitoring was conducted only once or twice a year due to budgetary constraints, and often covered all health programs jointly, rather than focusing on SAS-specific performance and quality. Several municipalities, particularly in Karnali province, also cited geographical barriers and seasonal difficulties, such as travel restrictions during the rainy season, that limit field visits.

"Lack of adequate number of human resources creates challenges to conduct timely monitoring visits."

- *KII 5, Local Government, Dhanusha, Madhesh*

"There is a lack of adequate budget for monitoring, and we also face difficulty in managing time for monitoring visits."

- *KII 9, Local Government, Siraha, Madhesh*

"There is a lack of adequate manpower and budget, at the local government for monitoring health services."

- *KII 39, Local Government, Mugu, Karnali*

"It is challenging for us to conduct monitoring visits in the rainy season due to our geographical context."

- *KII 35, Local Government, Kalikot, Karnali*

"We do not have complete information and training about abortion. For example, there are different tools and annexes for abortion, and we do not know much about them. So, we can monitor SAS only if we receive training about these things."

- *KII 23, Local Government, Kalikot, Karnali*

The lack of structured monitoring and supervision specifically for SAS, along with limited resources and logistical challenges, indicates that regular program monitoring is still weak. Strengthening supervision through dedicated budgets, clear accountability mechanisms, and trained supervisory teams is essential to improve the quality, continuity, and responsiveness of SAS at the local level.

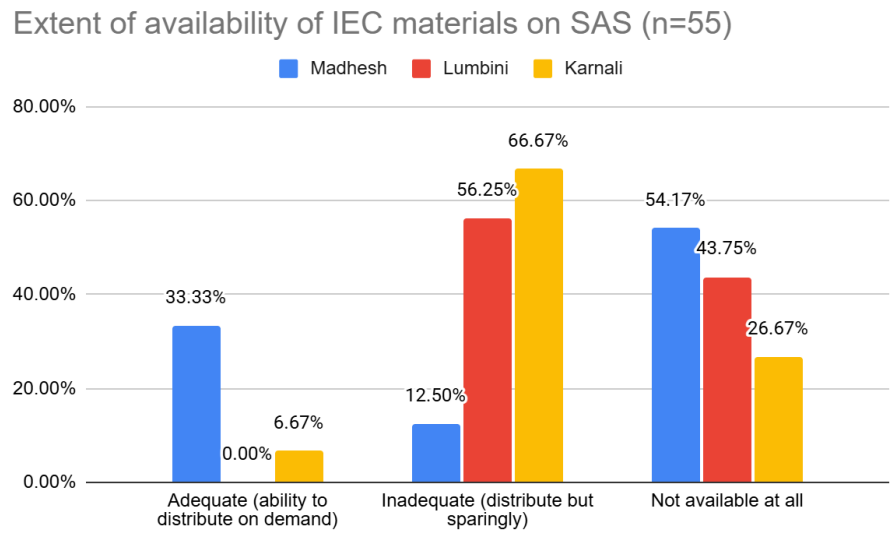
d. Extent of Availability of IEC Materials on SAS

Information on the availability and adequacy of IEC materials related to SAS was collected from in-charges of all 55 functional SAS-accredited facilities across 49 municipalities. The findings reveal a significant and concerning gap in IEC material availability. Out of 55 facilities, only 9 facilities (just 16%) had adequate IEC materials, with most of these concentrated in Madhesh Province and only one health post in Karnali. In contrast, 46 out of 55 facilities (84%) were not adequately equipped to support awareness on SAS.

Among these: 22 facilities had limited IEC materials, but distribution was constrained due to insufficient stock; this was particularly evident in Lumbini and Karnali provinces, especially at PHCCs and health posts. 24 facilities, nearly half of all assessed, had no IEC materials at all, spanning all three provinces. This clearly demonstrates that IEC material availability is not only low but also highly uneven across provinces and facility types. With such a large proportion of facilities lacking adequate or any materials, the system is currently under-equipped to effectively inform and engage clients and communities on SAS services. Overall, the findings highlight a critical programmatic gap: only a very small fraction of facilities are adequately prepared to support awareness and informed decision-making on SAS. Strengthening the consistent supply, distribution, and visibility of IEC materials is therefore essential to improve access and

utilization of services. The type of IEC materials being displayed, message contents and visibility are discussed in Section 4.2. Strengthening the regular and adequate supply of IEC materials is essential to ensure enhanced access to SAS services through awareness and information dissemination (Table 3.7).

Table 3.7: Extent of availability of IEC materials on SAS



e. Visibility and Display of SAS-Related Information and IEC Materials, During the Health Facility Assessment

Observation across the SAS accredited facilities revealed limited and inconsistent visibility of information related to SAS across provinces and categories of health facilities. In Madhesh province, only a few hospitals displayed the SAS logo, range of services offered, or indication that services were free, while most PHCCs and nearly all health posts lacked such visual identifiers. Where displays were present, they were mostly in the form of posters, wall writings, or citizen charters. Majority of the health facilities lacked the display of indication of “Free” SAS. Display of clinic hours was visible at some hospitals but rarely in other categories of health facilities. The visibility of SAS information in Madhesh province remained inadequate, which may hinder client awareness and access to accurate service information.

In Lumbini province, hospitals and PHCCs generally performed better in displaying service information and IEC materials. However, similar to Madhesh province, health posts lagged behind, with many lacking visible SAS logos or displays about the range of services. IEC materials such as posters, wall charts, and flip charts were present in most facilities. In Karnali province, visibility and display of SAS related information were the weakest among the three provinces. Only a few hospitals displayed the SAS logo or service range and most PHCCs and health posts had no visible indication of SAS. Displays about free services or clinic hours were scarce and IEC materials related to abortion or family planning were either missing or available but not displayed.

The findings indicate that visibility of Safe Abortion Services (SAS) information is highly inadequate across all provinces, with most facilities failing to clearly display essential information for clients. The SAS logo (displayed and visible) is present in only a very small number of facilities, while the majority, especially HPs (8 in Madhesh and 10 in Karnali) reported it as not available. This suggests that clients may not even

recognize that SAS services are offered at these facilities. Similarly, information on the range of SAS services offered is largely not displayed, with most facilities across provinces reporting non-availability. This lack of visibility limits informed decision-making and awareness among service seekers. The indication of "Free" SAS services, a crucial element to improve access, is also poorly displayed, with a significant number of facilities (again particularly HPs) reporting it as not available. This could directly discourage clients from seeking services due to perceived cost barriers. The absence of clear and visible information on service availability, fees and timing was notable, especially in peripheral health posts, which could affect client awareness and access to SAS. (Table 4.2).

Table 4.2: Province-wise Visibility and Display of SAS Information and IEC Materials Across SAS Accredited Facilities

SAS Information and IEC Materials		Madhesh			Lumbini			Karnali		
		Hosp. (n=4)	PHCC (n=2)	HP (n=10)	Hosp. (n=1)	PHCC (n=1)	HP (n=5)	Hosp. (n=5)	PHCC (n=1)	HP (n=12)
Logo of SAS	Displayed & Visible	1		2	1	1	2	1		2
	Not available	3	2	8			3	4	1	10
Forms of display	Poster	1			1	1		1		
	Wall painting			2			2			
	Sign board									2
Range of SAS services offered	Displayed & Visible	1		3	1		2	1	1	2
	Not available	3	2	7		1	3	4		10
Forms of display	Written on wall			1			2	1		
	Board			1					2	
	Flex print	1		1						
	Poster				1					
Indication of "Free" SAS	Displayed & Visible	2		4	1	1	2	1		2
	Not available	2	2	6			3	4	1	10
Forms of display	Written on wall			3		1	1	1		
	Citizen's Charter	2					1			
	Board									2
	Flex print			1						
	Poster				1					
Display of clinic hours for SAS	Displayed & Visible	3		2	1		2	1		3
	Not available	1	2	8		1	3	4	1	9
Forms of display	Citizen's Charter	2		1	1		2			
	Board	1								3
	Written on wall			1				1		
Display of PAC services	Displayed & Visible							1		
	Not available	4	2	10	1	1	5	4	1	12
Forms of display	Written on wall							1		
Display of Post Abortion	Displayed & Visible	2			1		4	1	1	3
	Not available	2	2	10		1	1	4		9

Contraceptive services										
Forms of display	Poster	2						1	1	3
	Citizen's Charter				1		2			
	Brochure						2			
Display of IEC Materials about Abortion and Family Planning	Displayed & Visible	2		6			3	4	1	10
	Not available	1	2	4	1			1		2
	Available but not displayed	1				1	2			
Forms of display	Poster	1		1			1	4	1	6
	Flip Chart	1		3				1		2
	Brochure			1			2			
	Wall Chart			2						1
	Pamplet	1		1						1
	Condom Box									1
	Sign Board	1								

3.1.5 People Level

Over one-fifth of the women in Karnali province cited having a large number of children and poor economic conditions as reasons for seeking an abortion. Similarly, more than a quarter of women in Madhesh and fewer than one in five women in Lumbini mentioned these factors. Additionally, less than one in five women in Lumbini reported that women seek abortion due to the risks posed to their health during pregnancy. Majority in Karnali, and very few in Madhesh, identified son preference as a reason for seeking abortion. A few participants across all three provinces also mentioned that unwanted pregnancy was the reason for seeking abortion.

a. Community and Individual Perceptions of Abortion

The findings from the interviews conducted with 49 local government representatives (HSC) reveal that the community has mixed views on abortion. While certain communities viewed abortion as socially and morally wrong, others tend to have progressive perceptions on abortion because of increased awareness and understanding about the legality and safety of abortion. Province-wise, the key informants particularly from Madhesh and Karnali province, believed about the persisting strong negative views on abortion among the community due to deeply rooted religious and cultural influence. These communities consider abortion as “sin” and “against community norms”. On the other hand, some of the key informants from Karnali perceived that due to a rise in awareness about the law and reproductive rights guaranteed by the national policy, the community have become a bit supportive of the abortion act on certain socio-economic and health grounds.

“Some people have negative perceptions towards abortion, due to religious and cultural reasons. They have a belief that babies are blessings of God, and it is a sin to kill a child given by God. This belief is reflected specifically among traditional healers (Dhami/Jhakri) and religious leaders (Pujari). On the other hand, some believe that safe abortion services are necessary, and it is good to abort unwanted pregnancy. The people with many children, those who are poor and financially weak, and those mothers who are sick should be allowed to get an abortion.”

- KII 2, Local Government, Dolpa, Karnali

"The community has a negative perception towards abortion. If a married woman seeks abortion, or if a woman with many children seeks abortion, then it is fine. But if an unmarried girl seeks abortion, then it is considered wrong. According to our Hindu religion, it is bad to perform such activities (sexual relation and also abortion) before marriage. So, people have a belief that it is bad."

- KII 19, Local Government, Jumla, Karnali

"The community believes that safe abortion services are necessary, and it is good to abort unwanted pregnancy. The people with many children, those who are poor and financially weak, and those mothers who are sick should be allowed to get an abortion."

- KII 2, Local Government, Dolpa, Karnali

In Madhesh and Lumbini province, participants explicitly mentioned that members of the Muslim community viewed abortion as a sin. Some participants also referred to older or more traditional community members as particularly resistant to abortion, contrasting them with younger or more educated groups who were perceived to be more open to discussion about sexual and reproductive health matters, including abortion.

"The Muslim community perceives abortion as a sin. The other communities also have negative perceptions towards it. They look at the women seeking abortion with suspicion, saying whether the pregnancy was from her husband or from someone else, and why she wants to abort her pregnancy. On the other hand, the Madhesi community has mixed views on abortion- the literate community has positive perception, while the illiterate community perceives it as a sin."

- KII 15, Local Government, Banke, Lumbini

"The educated people have a positive perception towards abortion. They say that if the pregnancy is unwanted, then, it is good to abort rather than continuing the pregnancy. However, the people with the traditional mindset say that those who perform abortion are sinners, or a bad person."

- KII 46, Local Government, Rautahat, Madhesh

"There is mixed opinion. In the Northern belt, where the hill communities/ethnic groups reside, they have a good level of awareness, and have a positive perception towards abortion. But in the Southern belt, where the Terai Madhesi communities/ethnic groups reside, they have low level of awareness, and thus negative perception."

- KII 5, Local Government, Dhanusha, Madhesh

Negative attitudes were particularly strong toward unmarried girls seeking abortion. Participants across all three provinces noted that seeking abortion services are viewed as a matter of personal shame and moral failure, with communities often questioning the character of the woman or the girl. This stigma discouraged young women from seeking timely care, pushing them toward secrecy or unsafe options. In Madhesh province, such moral judgments were mentioned most frequently, whereas in Karnali and Lumbini, participants suggested that although similar attitudes exist, discussions tend to remain private rather than open.

"I think the community has a negative perception towards unmarried girls seeking abortion services, because people believe that being pregnant before marriage brings shame/disgrace to the family."

- KII 1, Local Government, Humla, Karnali

"The community has positive perception towards married women seeking abortion, but if an unmarried girl seeks abortion care, then she is looked at and judged in a negative way. So, they seek MA secretly at private pharmacies."

- KII 25, Local Government, Jumla, Karnali

"The community has positive perception towards married couples having abortion through shared decision making. But when an unmarried woman has an abortion, the community thinks negatively of her. They say she is trying to hide her wrongdoing. People believe that allowing abortion encourages those who commit immoral acts and try to conceal them."

- KII 43, Local Government, Rautahat, Madhesh

The KIIs indicate that while awareness regarding abortion is slowly and gradually increasing, abortion still remains a socially and morally sensitive issue across all provinces. Deeply rooted social norms and religious beliefs continue to shape how communities perceive both abortion and those who seek it, often reinforcing stigma and silence around the topic. Strengthening community-level awareness initiatives that engage local leaders, women's groups, and youth networks could help normalize open discussion and promote more informed, supportive attitudes toward safe and legal abortion care.

Similarly The majority of the FCHVs in Karnali province and some of the FCHVs in Lumbini province felt that it is wrong to undergo an abortion as it can harm the cervix and also risk women's or girl's life. However, more than a quarter of the FCHVs in Karnali province but very few FCHVs in Madhesh and Lumbini provinces opined that if a woman ought to undergo an abortion, she should do it from a safe place. FCHVs from all the three provinces believed that women tend to be under immense pressure from their husband, in-laws and also from the society to produce a son and hence are coerced to undergo an abortion if the pregnancy tests show otherwise (girl). One FCHV in the FGD voiced her dissent on sex selective abortion saying, *"Demand for sons is wrong. Women should use family planning services*." Another FCHV viewed that undergoing abortion is okay if it is a woman's choice and if her economic condition is weak.

"Abortion is a sin. If something happens to the uterus due to abortion, it can cause cancer in the uterus, so one should not have an abortion."

- FCHV, Kalikot

"*Abortion is not good, but the husband and society talk negatively if there is no son, it has been necessary to have abortions after having many daughters."*

- FCHV, Jumla

In Karnali province, the participants referred to disapproving attitudes of community leaders and elected representatives, which constrained women's access to services. In Madhesh province, widespread stigma, rumors, and misconceptions that abortion is illegal discouraged open discussion and service-seeking, particularly among unmarried women. In Lumbini province, strong religious beliefs labeling abortion as a sinful and immoral act that is unacceptable by the society, were reported. These findings indicate that stigma, whether rooted in religious, moral, or leadership attitudes, remains a significant barrier across all provinces.

"There is a negative perception of elected representatives and community leaders towards abortion. This hinders access to SAS."

- KII 3, Local Government, Dolpa, Karnali

"There are rumors, stigma, and social norms surrounding abortion, that discourage open discussion or acceptance in the community."

- KII 31, Local Government, Bara, Madhesh

"*There is a strong belief that abortion is illegal. The community does not accept unmarried women utilizing SAS. There is a stigma associated with it."*

- KII 26, Local Government, Rautahat, Madhesh

"There is a religious belief that abortion is a sin. This belief is most common among people with a traditional mindset. The community has a negative perception towards abortion."

- KII 17, Local Government, Banke, Lumbini

b. Knowledge and Awareness of Abortion Law and Services

A. Knowledge on Abortion Law

At the individual level, awareness of the legal status of abortion was generally low, especially in rural areas. Personal barriers, such as feeling shy, hesitant, or scared of societal judgment, were mentioned by married women and girls. Many women were unaware of the circumstances under which abortion is legally permitted, and knowledge about the risks of unsafe abortion was also limited. Economic constraints, lack of access to information and SAS services, stigma associated with abortion and personal fears regarding societal judgment were cited as significant barriers to seeking safe abortion services.

Most of the participants had heard about the abortion law, but the level of awareness varied substantially across provinces. Knowledge on abortion law was higher among women in Karnali province) as compared to women in Madhesh province) whereas it was the lowest in Lumbini province), where very few women were aware of the legal status of abortion. Majority of the girls participating in the FGDs were not aware of any law related to abortion. Similarly, half of the women participants in Karnali province stated that Nepal does not have an abortion law. This misconception was also common among adolescent boys, indicating limited awareness of the legal framework across different age groups. On the other hand, many married men were aware of the abortion law. However, none of the respondents had complete or accurate knowledge about the legal circumstances of lawful abortion. In Karnali and Madhesh provinces, most of the respondents who were aware of the law had incorrect information, such as, 'abortion is allowed when couples have many children'. There were very few FGD participants with some level of misconception or mixed understanding.

"If a teenager wishes, she can have an abortion according to the law. She must be physically and mentally fit; only then can she have an abortion."

- Adolescent girls, Kapilvastu

"Abortion is allowed within three months, but it seems not allowed after three months. It cannot be done without the consent of both parties."

- Adolescent boys, Humla

"I have heard that it is allowed for up to 12 weeks. With the woman's consent, she can voluntarily have an abortion up to 12 weeks, but it is not allowed beyond that."

- Married Man, Dhanusha

Lack of accurate knowledge on the legality of abortion was widely observed across all the study sites. None of the respondents from any of the three provinces had complete and correct information regarding the legal circumstances under which abortion is allowed. The very few participants who claimed to be aware held incorrect interpretations. Many women reported that abortion was allowed for reasons such as, "having too many children," "fetal disability", or "pregnancy in underage girls".

B. Source of Information on Abortion Law

Information on abortion law was mostly received via informal sources and it was inconsistent across provinces. Among married women and girls in Karnali province, social media (e.g., YouTube, Facebook)

was the primary source of information, followed by community members and health providers. In Lumbini province, only one woman mentioned that she learned about abortion law from a health provider. In Madhesh province, community members were the main source of information and few participants also mentioned books, school, radio and social media platform like Facebook and YouTube as their sources. Overall, formal and health-system–based communication about the legal provisions appeared minimal. Unlike women and girls, half of the married men received information about abortion law from health facilities or workers, while there were few who heard about it through radio, school, or books.

"Such information can also be heard on radio and TV programs about reproductive health."

- Married man Humla

C. Safe Place for Abortion

Participants' perceptions on the availability and safety of abortion services varied across provinces. Nearly half of the women in Karnali and a few in Lumbini reported the presence of safe abortion services in government health facilities, with very few mentioning private pharmacies. In contrast, it was mentioned that Madhesh province does not have any health centers offering safe abortion services. More than half of the girls in Madhesh and slightly more than a quarter of the respondents in Lumbini had mentioned on the presence of government health facilities like hospitals and health posts. Few participants from Karnali and Lumbini even suggested travelling to India for abortion as an alternative option. Half of the men in Madhesh province and a few in Karnali believed that their communities lacked health centers offering safe abortion services. However, some men in Madhesh reported the availability of both government and private health centers for these services.

"Abortion services for pregnancies of two to two-and-a-half months are available at health posts, but accessing services becomes difficult for pregnancies beyond this period. In such cases, women often have to travel to Bheri or seek care at private facilities."

- Married Women of Reproductive Age (MWRA), Banke

"Even at the place where we live (Yadukuwa Primary Health Center), abortion services are available. It is not excellent, but it is satisfactory. I have also heard that it is available at Parharwa Health Post."

- Married Man, Dhanusha

"To do that, one has to go to a hospital and consult a doctor; it cannot be done on one's own will. I have also experienced this issue - my wife has gone through this situation twice. There was a lot of bleeding."

- Married man, Humla

c. Gender Dynamics and Decision-Making in Abortion Care

According to the HSCs from all the three provinces, women's limited decision-making autonomy in the family emerged as the major barrier to SAS access. While the HSCs of Karnali province attributed this to illiteracy, lack of awareness, and deeply-rooted cultural beliefs that paint an act of abortion as morally wrong, those from Madhesh province identified husbands' and in-laws' as the primary decision-makers who, often restricted women's autonomy in seeking abortion care. Similarly, dependency on husbands for reproductive decisions was reported by the HSCs of Karnali province. From the KIIs, it was evident that while the pattern of low autonomy was consistent across provinces, the influence of extended family members appeared more pronounced in Madhesh province. On the other hand, moral and religious reasoning was more dominant in Karnali.

"Many people are still unaware about its importance due to illiteracy and lack of awareness. In addition to that, women and girls lack the decision-making power when it comes to abortion or any other matter."

- KII 3, Local Government, Dolpa, Karnali

"There is a lack of decision-making power of women. She faces obstruction from husband or family to seek abortion. This is due to the traditional mindset among the family that abortion is bad - it is a sin."

- KII 37, Local Government, Kalikot, Karnali

"Decisions are made by husbands or sometimes influenced by mothers-in-law and fathers-in-law. Women often cannot decide on their own."

- KII 26, Local Government, Rautahat, Madhesh

"There is a low level of education and lack of awareness. Women are forced to continue unwanted pregnancy, as they have low autonomy and decision-making power."

- KII 28, Local Government, Rautahat, Madhesh

"There is a lack of decision-making power of women in the family. They are dependent on their husband for any decision."

- KII 16, Local Government, Kapilbastu, Lumbini

A. Men's Role in Supporting and Decision-Making in Abortion Care

The opinion of SAS service providers on the role of men in supporting and decision-making in abortion care was solicited through KIIs. Men emerged as the key actor in influencing women's access and decisions regarding abortion care in all the three provinces. Their role was described through two interrelated dimensions - the extent of men's support in helping women seek safe abortion services and their influence in decision-making about whether to seek these services or not. Together, these findings underscore that men's involvement can either enable or constrain women's reproductive autonomy depending on their attitudes, behaviors and level of engagement.

B. Men's Role in Supporting Women to Seek Abortion Services

Men's involvement in supporting women to seek abortion services was largely facilitative but varied across provinces in terms of the extent and form of support. Most service providers highlighted that men commonly accompany women to health facilities, cover transportation expenses and help in making or reinforcing abortion-related decisions. In Lumbini province, men's support primarily included accompanying women to health facilities and taking decisions regarding the treatment. In Madhesh province, men's engagement was seen in accompanying women to the health facility and understanding the process through the service provider and explaining to the process to help women to make a decision. Whereas, in Karnali province, men's support was described in more comprehensive and empathetic terms, with references to emotional, social and financial contributions, as well as providing support in household activities during post-abortion recovery stage.

"They should provide emotional support, accompany women to the health facility and be there for her throughout the process and provide her with care after abortion."

- KII10, Service provider, Bara, Madhesh

"Men support women by accompanying the woman to the health facility, maintaining their privacy and helping to make a decision."

- KII4, Service provider, Banke, Lumbini

"The husband needs to discuss this matter with their wives. He should create an environment where she feels cared for and supported. After the abortion, he should provide her with both physical and emotional (mental) support to help her recover."

- KII33, Service provider, Dolpa, Karnali

"Since the Nepalese society is predominantly patriarchal, men play an important role in almost every matter. When women come for abortion services accompanied by a man, counseling becomes easier and potential complications later on can be minimized."

- KII40, Service provider, Provincial hospital, Rupendehi, Lumbini

C. Men's Role in Decision-Making Regarding Abortion Services

The data also reveal that men play a decisive role in women's abortion-related decision-making, often determining whether women are able to seek services at all. The service providers across all three provinces consistently reported that a woman's decision is based on the man's thinking, with male approval or disapproval directly influencing women's confidence and access. When men held positive attitudes toward abortion, women were able to access services more easily and receive emotional and logistical support. However, negative or unsupportive attitude frequently led to hesitation, fear, and in some cases, forced continuation of unintended pregnancies or unsafe abortions.

In Lumbini and Madhesh provinces, this dependency appeared more evident, with repeated emphasis on the husband's dominant role and the mental stress experienced by women facing male disapproval. In Karnali province, the service providers similarly described strong male influence but also provided richer accounts of the consequences of restrictive attitudes, indicating heightened awareness of how such control affects women's well-being. Across all provinces, while men's decision-making power remains dominant, there are emerging recognitions, particularly in Madhesh and Karnali province, that positive male engagement can enhance women's emotional security and access to safe abortion care.

"If men have a positive mindset, women receive good mental and physical support. But if men's attitude is not good, women cannot speak openly (specifically about abortion), and it affects them both mentally and physically. If men's attitude is not good then women's health is affected."

- KII29, Service provider, Kalikot, Karnali

"A woman's decision is based on the man's thinking. Once, there was a woman who already had a child who was malnourished and weak. Later, she became pregnant again, but her husband refused to allow an abortion, so she carried the pregnancy to term, with a nine-month gap between the two children."

- KII25, Service provider, Kalikot, Karnali

"A man's positive attitude enables women to access services easily, while a negative attitude prevents them from doing so and may force them to undergo unsafe abortions."

- KII7, Service provider, Kapilbastu, Lumbini

"*Male perspectives affect women a lot in their access to abortion services. In many communities, men are the main decision-makers, and often they pressurize women to continue with an unwanted pregnancy."*

- KII9, Service provider, Bara, Madhesh

"In our community, men make decisions about everything, so they also play a role in whether women seek abortion service. In our Madhesi community, whatever men say, women usually accept it. The women who come to seek abortion services here also tend to come with their husbands."

- KII39, Service provider, Provincial hospital, Dhanusha, Madhesh

"In a male-dominated country like ours, women's thoughts and decisions carry little weight, so it is the man's opinion that ultimately determines the decision. If the man does not want it, women give birth even when they do not want the pregnancy, and when the man does not want the pregnancy, women are often found

to undergo abortion as well. Although they say outwardly that they have come for an abortion with mutual consent, in reality the decision is mostly in the hands of the man."

- KII41, Service provider, Provincial hospital, Surkhet, Karnali

d. Stigma, Socio-Cultural Factors and Community Norms

A. Socio-Cultural Factors Impeding Abortion Access

The findings from the interviews conducted with 49 local government representatives (HSC) reveal that the community has mixed views on abortion. While certain communities viewed abortion as socially and morally wrong, others tend to have progressive perceptions on abortion because of increased awareness and understanding about the legality and safety of abortion. Province-wise, the key informants particularly from Madhesh and Karnali province, believed about the persisting strong negative views on abortion among the community due to deeply rooted religious and cultural influence. These communities consider abortion as "sin" and "against community norms". On the other hand, some of the key informants from Karnali perceived that due to a rise in awareness about the law and reproductive rights guaranteed by the national policy, the community have become a bit supportive of the abortion act on certain socio-economic and health grounds.

"Some people have negative perceptions towards abortion, due to religious and cultural reasons. They have a belief that babies are blessings of God, and it is a sin to kill a child given by God. This belief is reflected specifically among traditional healers (Dhami/Jhakri) and religious leaders (Pujari). On the other hand, some believe that safe abortion services are necessary, and it is good to abort unwanted pregnancy. The people with many children, those who are poor and financially weak, and those mothers who are sick should be allowed to get an abortion."

- KII 2, Local Government, Dolpa, Karnali

"The community has a negative perception towards abortion. If a married woman seeks abortion, or if a woman with many children seeks abortion, then it is fine. But if an unmarried girl seeks abortion, then it is considered wrong. According to our Hindu religion, it is bad to perform such activities (sexual relation and also abortion) before marriage. So, people have a belief that it is bad."

- KII 19, Local Government, Jumla, Karnali

"The community believes that safe abortion services are necessary, and it is good to abort unwanted pregnancy. The people with many children, those who are poor and financially weak, and those mothers who are sick should be allowed to get an abortion."

- KII 2, Local Government, Dolpa, Karnali

In Madhesh and Lumbini province, participants explicitly mentioned that members of the Muslim community viewed abortion as a sin. Some participants also referred to older or more traditional community members as particularly resistant to abortion, contrasting them with younger or more educated groups who were perceived to be more open to discussion about sexual and reproductive health matters, including abortion.

"The Muslim community perceiveabortion as a sin. The other communities also have negative perceptions towards it. They look at the women seeking abortion with suspicion, saying whether the pregnancy was from her husband or from someone else, and why she wants to abort her pregnancy. On the other hand, the Madhesi community has mixed views on abortion- the literate community has positive perception, while the illiterate community perceives it as a sin."

- KII 15, Local Government, Banke, Lumbini

"The educated people have a positive perception towards abortion. They say that if the pregnancy is unwanted, then, it is good to abort rather than continuing the pregnancy. However, the people with the traditional mindset say that those who perform abortion are sinners, or a bad person."

- KII 46, Local Government, Rautahat, Madhesh

"There is mixed opinion. In the Northern belt, where the hill communities/ethnic groups reside, they have a good level of awareness, and have a positive perception towards abortion. But in the Southern belt, where the Terai Madhesi communities/ethnic groups reside, they have low level of awareness, and thus negative perception."

- KII 5, Local Government, Dhanusha, Madhesh

Negative attitudes were particularly strong toward unmarried girls seeking abortion. Participants across all three provinces noted that seeking abortion services are viewed as a matter of personal shame and moral failure, with communities often questioning the character of the woman or the girl. This stigma discouraged young women from seeking timely care, pushing them toward secrecy or unsafe options. In Madhesh province, such moral judgments were mentioned most frequently, whereas in Karnali and Lumbini, participants suggested that although similar attitudes exist, discussions tend to remain private rather than open.

"I think the community has a negative perception towards unmarried girls seeking abortion services, because people believe that being pregnant before marriage brings shame/disgrace to the family."

- KII 1, Local Government, Humla, Karnali

"The community has positive perception towards married women seeking abortion, but if an unmarried girl seeks abortion care, then she is looked at and judged in a negative way. So, they seek MA secretly at private pharmacies."

- KII 25, Local Government, Jumla, Karnali

"The community has positive perception towards married couples having abortion through shared decision making. But when an unmarried woman has an abortion, the community thinks negatively of her. They say she is trying to hide her wrongdoing. People believe that allowing abortion encourages those who commit immoral acts and try to conceal them."

- KII 43, Local Government, Rautahat, Madhesh

The KIIs indicate that while awareness regarding abortion is slowly and gradually increasing, abortion still remains a socially and morally sensitive issue across all provinces. Deeply rooted social norms and religious beliefs continue to shape how communities perceive both abortion and those who seek it, often reinforcing stigma and silence around the topic. Strengthening community-level awareness initiatives that engage local leaders, women's groups, and youth networks could help normalize open discussion and promote more informed, supportive attitudes toward safe and legal abortion care.

B. Community-Level Barriers Hindering Access to SAS

Community-level stigma and negative perceptions towards abortion were prevalent across provinces. In Karnali province, the participants referred to disapproving attitudes of community leaders and elected representatives, which constrained women's access to services. In Madhesh province, widespread stigma, rumors, and misconceptions that abortion is illegal discouraged open discussion and service-seeking, particularly among unmarried women. In Lumbini province, strong religious beliefs labeling abortion as a sinful and immoral act that is unacceptable by the society, were reported. These findings indicate that stigma, whether rooted in religious, moral, or leadership attitudes, remains a significant barrier across all provinces.

"There is a negative perception of elected representatives and community leaders towards abortion. This hinders access to SAS."

- KII 3, Local Government, Dolpa, Karnali

"There are rumors, stigma, and social norms surrounding abortion, that discourage open discussion or acceptance in the community."

- KII 31, Local Government, Bara, Madhesh

"*There is a strong belief that abortion is illegal. The community does not accept unmarried women utilizing SAS. There is a stigma associated with it."*

- KII 26, Local Government, Rautahat, Madhesh

"There is a religious belief that abortion is a sin. This belief is most common among people with a traditional mindset. The community has a negative perception towards abortion."

- KII 17, Local Government, Banke, Lumbini

C. Opposition to Abortion and Reasons for Anti-Abortion Views

Nearly a quarter of the FCHVs in Karnali province and a very few in Lumbini and Madhesh province believed that educated people, people who are aware of SAS and people who work in this sector like health workers, teachers and FCHVs support abortion and consider it a part of women's reproductive health rights. In addition, few FGD participants in Karnali province cited 'Marie stopes' as an organization that supports women's right to abortion. On the contrary, more than a quarter of the FCHVs in Lumbini and some of them in Karnali and Madhesh province believed that illiterate people, people who are ignorant about SAS as women's reproductive rights and certain religious leaders have strong objection to abortion and call it an act of sin and against God's will or religion.

"In our community, abortion is not regarded as a reproductive health right, and no one supports it. People believe that terminating a pregnancy is a sin against the gift of life given by God."

- *FCHV, Kapilvastu*

"There aren't many people who completely oppose abortion, but many feel that having too many abortions is sinful."

- *FCHV Jumla*

D. Discussion on Abortion in the Community

Most of the FCHVs participating in FGDs held in Karnali province and very few of them in Madhesh and Lumbini province responded that most of the women and adolescent girls seek advice from them. When asked if women and girls in their community seek their advice on abortion related matters, very few of the participants in all three provinces responded positively saying that some women and young girls in their community ask them what to do and where to go for abortion services. Their advice is also often sought by women and girls whenever they miss their periods.

"People come to me for advice on abortion services, and I inform them that they can go to a health post, consult with a healthcare provider, and receive abortion services"

- FCHV, Banke

"Only married women come to me. Adolescent girls never come; maybe they are scared or too shy. When married women come, they don't say directly that they want abortion. They say, "I have missed my period". After talking for a while, they tell the truth. Then I advise them to go to Keshariya Hospital. I just guide them,

and I don't go with them, because I'm not given any incentive for referral. But still, I send them because that is the only safe place nearby."

- FCHV, Rautahat

"No one comes to ask for advice on abortion services; they go on their own, bring the medicine themselves, take it themselves, and throw it (the fetus) away themselves (laughing)."

- FCHV, Dolpa

e. Access to Safe Abortion Services and Barriers to Care

A. Access to Safe Abortion Services

Some married women in Lumbini province reported that it is easy for women to access abortion-related services in their community. In contrast, very few women in Karnali and all the participants in Madhesh stated difficulties in accessing abortion services. Majority of the girls in Lumbini and Karnali , and more than half of the participants in Madhesh responded that it is difficult for an adolescent girl to utilize/receive abortion related services in their community.

B. Barriers to Receiving Safe Abortion Services

Personal barriers, such as feeling shy, hesitant, or scared of societal judgment, were mentioned by married women and girls. Some women identified obstacles from husbands, including refusal to grant permission, pressure to continue the pregnancy, and financial denial for abortion care. Family and community pressures were also cited by a few women in all provinces, with societal stigma—including religious and moral judgments - being a common concern. Additionally, a single respondent in Lumbini pointed out that service providers sometimes create barriers to accessing abortion services.

"Husbands also prevent women from accessing abortion services. They say that even if she gives birth to a child, it is fine, and they do not understand the pain the woman experiences. Additionally, mothers-in-law and fathers-in-law often remark that previous women gave birth to many children, so now she cannot even have one or two. There is also little support from the family at home, and financial burdens make the situation even more difficult."

- MWRA, Mugu

"I had a friend who had an unwanted pregnancy. When she discussed with her husband whether to have an abortion, he said it should not be done because it is a sin and they must accept what Allah has given. As a result, she carried the pregnancy and gave birth to the child."

- MWRA, Banke

"It is difficult to go outside the house." "If you reach the hospital, they first ask you to bring your guardian and then ask why you want to do this."

- Adolescent girls, Kapilvastu

C. Challenges and Barriers of Access to SAS

Regarding Efforts Made to Improve Easy Access of Prioritized Groups to SAS, HSCs were asked about the efforts and initiatives undertaken at the local level to improve SAS access among certain prioritized groups, namely, adolescent girls, marginalized communities and people living with disabilities (PLWDs). The findings indicated that efforts to improve access to SAS for these prioritized groups remain uneven and limited in scope across all three provinces.

In the case of adolescent girls, some initiatives were mentioned such as school-based programs that integrate reproductive health education, peer education and the role of school nurses in information dissemination. A few schools have included awareness activities on safe abortion within broader sexual

and reproductive health programs, and referral mechanisms and confidentiality measures were also highlighted in such awareness programs. However, these initiatives appear to be irregular and primarily focused on general reproductive health matters and less on SAS.

"Some schools have conducted awareness programs on safe abortion, along with reproductive health (RH) rights."

- KII 15, Local Government, Banke, Lumbini

"School-going adolescent girls are provided with training about SRH matters including abortion, and they are used as peer educators to provide information to their peer groups (in 2 AFIC schools). There are also School Health Nurses in some schools for education and information dissemination. The health facilities also ensure maintenance of privacy and confidentiality during service provision to adolescent girls, and there is a referral system available for referral of cases which cannot be managed locally. Additionally, there is availability of OCMC."

- KII 21, Local Government, Kalikot, Karnali

"There are initiatives. These include school teachers raising awareness among students about SRHR including abortion, and there are even separate sessions and workshops specifically for adolescent girls on this topic."

- KII 29, Local Government, Rautahat, Madhesh

HSCs opined that minimal efforts exist to improve SAS access to marginalized communities and PLWDs. Whereas limited awareness-raising activities have been conducted through mother groups and women's groups meetings held in marginalized communities, persistent stigma and lack of engagement from local representatives continue to hinder SAS access for marginalized communities. On the other hand, the HSCs noted that existing health facilities are not disability-friendly, and little to no targeted interventions have been implemented to address their specific needs for PLWD.

"Among the marginalized communities, the access to SRH services is good, but it is very difficult to ensure access to SAS. We are trying to raise awareness about SAS. It is very difficult to change the perception of elected representatives."

- KII 3, Local Government, Dolpa, Karnali

"The marginalized communities are provided with information about SAS by FCHVs, mothers group and women's group, through discussions."

- KII 14, Local Government, Banke, Lumbini

"The marginalized communities generally have access to SRHR and SAS related information and services through mothers' group meetings and FCHV support."

- KII 33, Local Government, Parsa, Madhesh

"They face difficulties in accessing SAS because the health facilities are not disability-friendly."

- KII 26, Local Government, Rautahat, Madhesh

"Some efforts are being made to ensure hospitals have disability-friendly environments."

- KII 27, Local Government, Parsa, Madhesh

Although some progress has been made for adolescents through school-based approaches, there remains a clear gap in systematic and inclusive strategies to ensure equitable access to SAS for all these priority populations.

"Women lack privacy, confidence, and accurate information about SAS. Many still believe in myths."

- KII 31, Local Government, Bara, Madhesh

"There is a lack of awareness among adolescent girls. They are scared about confidentiality issues surrounding sensitive topics."

- KII 29, Local Government, Rautahat, Madhesh

"Women lack awareness about abortion and also they do not have information about places to seek abortion service."

- KII 17, Local Government, Banke, Lumbini

"There is some level of fear, shyness and privacy concerns among unmarried girls to seek abortion services."

- KII 15, Local Government, Banke, Lumbini

f. Service Delivery, Outreach, and Community Support Mechanisms

A. Perceived Ways to Enhance Safe Abortion Services Access

Very few FCHV participants in FGDs held in all the three provinces were able to voice their opinions on ways to enhance safe abortion service access. According to them, women should be informed about safe abortion services, and their husbands should be urged to support them financially whenever they make this choice. They also cited the need for providing abortion training to service providers since there were very few facilities offering SAS with trained providers within their reach. The importance of mobilizing volunteers for door-to-door information about SAS, inclusion of SAS topics in mothers group meetings, introducing awareness programs for community people, family members and also separate sessions for male family members on abortion, were emphasized as the ways to create a supportive environment for women and girls to access SAS.

"If a facilitator from the hospital could go door-to-door to give advice, it would be easier for everyone, especially since health facilities are far away. Having the service nearby would make it much more convenient."

- *FCHV, Kalikot*

"There should be meetings in the community to raise awareness. Abortion services should be available at the local health posts in the village."

- *FCHV, Sarlahi*

B. Extent of Discussion on Abortion Related Issues in FCHVs' Monthly Meetings

When asked about the inclusion of abortion related discussions in their (FCHVs') monthly meetings, the majority of the FCHVs in Karnali province reported that their meeting focuses more on ways to avoid the demand for abortion among women in their community with more emphasis on the importance of family planning services. Only few FCHVs in all the FGDs held in three provinces said that they share information on safe abortion and places for safe abortion care during their monthly meetings. Two-fifths of the FCHV

participants in Madhesh province, more than a quarter in Lumbini province and very few in Karnali province declared that they have not discussed safe abortion related topics during their monthly meetings.

"*Discussions are held in certain months, and only women attend; adolescents do not participate. During these meetings, we explain that abortions within the first three months should be done in a safe place".*

- FCHV, Sarlahi

"We advise using temporary methods and avoiding abortion if possible. If abortion is necessary, we inform them to go to a hospital."

- *FCVH, Jumla*

"We mostly discuss vaccination, child nutrition, and family planning. Abortion topics are rarely discussed. Maybe once or twice someone mentioned it, but not in detail."

- *FCHV, Rautahat*

C. Community Efforts to Reduce Abortion-Related Stigma

When asked about existing community initiatives to address abortion stigma and promote safe abortion information, most key informants across all three provinces reported little to no dedicated activity. This absence was mostly reported in Madhesh province, where the majority of the participants said there was no efforts targeting abortion specifically. Only 14 out of 49 local governments cited to have made efforts or taken initiatives to reduce stigma related to abortion. In Madhesh province, a few local governments stated that information about abortion was provided through the Female Community Health Volunteers (FCHVs) during mother's group meetings. In Karnali province as well, a few participants described general reproductive health or family planning sessions delivered by Female Community Health Volunteers (FCHVs) during the mothers' group meetings, or by health workers, which occasionally included abortion-related messages, though not as a main focus. Lumbini province had slightly more mentions of awareness or advocacy efforts, such as information dissemination during mothers group meetings, community meetings or school-level education sessions discussing reproductive rights.

"Information about abortion is provided by FCHVs during mother's group meetings. Also, last year the palika celebrated National safe abortion day."

- KII 42, Local Government, Mahottari, Madhesh

"Information was disseminated about abortion during discussions about safe motherhood in the mothers group meeting. The Adolescent Girls Network raises the issue about abortion during different programs on reproductive health. The health facilities within this local government also provide information and awareness to adolescents through school-based education sessions."

- KII 16, Local Government, Kapilbastu, Lumbini

"The FCHVs provide information and awareness about abortion in monthly meetings of mothers' groups. The health workers also provide information and awareness to people during outreach clinics."

- KII 14, Local Government, Banke, Lumbini

"Program, meeting or training are conducted by the local government on safe motherhood (including SAS) each month, with health facilities including FCHVs."

- KII 38, Local Government, Mugu, Karnali

"Abortion-related information is disseminated by FCHVs during mothers' group meetings."

- KII 21, Local Government, Kalikot, Karnali

While structured community interventions to reduce stigma towards abortion are scarce, these indirect enablers highlight existing community structures, such as FCHVs (and high level of trust of the community towards FCHVs) and School Health Education Programs, which could be strengthened to promote accurate information, foster open discussion, and reduce stigma surrounding abortion.

g. Strategies for Creating Enabling Environment for SAS Access

FCHVs participating in the FGDs were asked to provide suggestions on the type of initiatives needed in the community to create an enabling environment to increase women's and girls' access to free and safe abortion service without fear and stigma. Unfortunately, very few FCHVs gave their opinion on this matter. Among those who did, they highlighted the need for increased awareness about the law and availability of safe abortion services on a broader scale as well as laid emphasis on the need to encourage women seeking abortion to visit safe health facilities that offered free abortion care. There were few who emphasized on providing abortion related training to women and girls. They further added the need to communicate and encourage discussion on this topic in mother's group meetings. Some of them suggested awareness programs targeted towards the older generation who often tend to have negative perception towards abortion. One of the FCHVs also emphasized on the importance of maintaining privacy and confidentiality for all clients so that they could obtain abortion service without fear and social stigma.

"FCHVs can hold separate group meetings just to talk about abortion. In other meetings, we talk about many things at once, like about vaccination, family planning, and so on. So, abortion topic gets left out. If we conduct a special session just about abortion, women can ask questions openly."

- FCHV, Rautahat

"Awareness programs on abortion services should be implemented. Women and adolescent girls in the village should be informed that the services they need are easily accessible. Male members of the households should also be included so they can receive information on this topic."

- FCHV Banke

h. Consequences of Unsafe Abortion

Few married women in Madhesh province identified excessive bleeding as the primary consequence of unsafe abortion, followed by infertility and various mental and physical health issues. Similarly, one in five women in Karnali mentioned infertility, risks to the mother's life, and a range of health problems as potential outcomes of unsafe abortion. In Lumbini, a single woman noted excessive bleeding as a consequence of unsafe abortion.Similar findings were also observed among adolescent girls. Few of the girls in Lumbini reported that infertility, excessive bleeding, irregular periods, risk of life and various health problems like mental stress, weakness and cervical cancer as the major consequences of unsafe abortion. Whereas very few girls in Madhesh province reported that unsafe abortion could pose risk to life and may lead to various health problems like mental stress, weakness and cervical cancer. Likewise, some girls in Karnali Province reported similar consequences of unsafe abortion.

"I have had five abortions. After the first one, I thought I would stop having abortions and use family planning methods instead, but I got pregnant again and had another abortion using medication. Since my husband lives away, whenever he visited, I would become pregnant, and then I would take medication to terminate the pregnancy. Later, even if my period was only five days late, I would go to the pharmacy, get the medicine, and take it. This has happened a total of five times so far. I bought medicine from a pharmacy at the Nepal-India border. The duplicate medicine costs 200, while the original costs 400. In my experience the duplicate medicine does not work well."

- MWRA, Kapilvastu

"I have barely survived once after taking abortion medicine. I took abortion medicine three times. Because the abortion didn't happen. When the bleeding started, I just continued bleeding. All the blood in my body was drained, and only three pints were left. The bleeding wouldn't stop, so the family members took me to Soharatgad (India border) and admitted me in the hospital and gave me a whole litre of blood and I survived."

- MWRA, Kapilvastu

"A woman, a victim of domestic violence, underwent an unsafe abortion. Her husband used to scold, threaten, and even beat her. Suffering from her husband's violence, she had an unsafe abortion by taking medicine at home. After heavy bleeding, her physical and mental condition worsened, and she died on the way without even reaching the health post."

- Adolescent girls, Kapilvastu

Married men in Karnali identified physical health issues, such as cervical problems, anemia, lower abdominal pain, and mental stress, as consequences of unsafe abortion. Additionally, a few male participants mentioned risks like death, infertility, and excessive bleeding. In Madhesh province, more than a quarter of married men cited infertility as a consequence of unsafe abortion, while a few others noted risks to women's lives, health problems (such as cervical issues, anemia, and abdominal pain), mental stress, excessive bleeding, and weakness. One married man shared his wife's experience:

"My wife had heavy bleeding for the first time and had to be taken by helicopter to Surkhet Provincial Hospital. She was admitted there for five days, received treatment, and was then sent home in better condition. The cost of the helicopter transfer and treatment was covered by the Aama Surakchya Program. My wife went through a lot of suffering, but thankfully, she survived."

- Married man, Humla

3.1.6 Recommendations from Stakeholders for Improving SAS Access

At the national level, the major recommendations focus on strengthening provider capacity, expanding SAS service sites and improving community awareness.

Key strategies include VCAT training for providers, ensuring adequate numbers of trained and accredited providers, broadening SAS site coverage and enhancing client awareness about safe abortion services to improve informed access.

The key informants at the federal as well as provincial level stated that they require providers' training for quality data reporting, logistics support, and support in demand generation through awareness from government and non-governmental sectors to increase access to SAS. Additionally, the focal person at the federal level cited expectations in expansion and strengthening of SAS sites, and efforts to address government health system gaps. This indicates that non-governmental sectors are viewed as essential partners in both capacity-building and service expansion. Additionally, the abortion focal person at the federal level mentioned that provincial and local governments are expected to play an active role in training needs assessment, regular supervision and monitoring, ensuring quality reporting and data use, and efficient utilization of available resources and services.

"*We expect them to provide support in training and support in expansion and strengthening of SAS sites. They should work in a way that addresses the gaps of the government."*

- KII, Federal level

"*We expect training and logistics support from the federal government. Although such support is already being provided by the federal government, additional support is anticipated. NGOs and INGOs should generate demand through awareness to improve access and service utilization. They can play a role in linking the local and provincial levels. Programs should not be carried out directly at the local level without*

informing the province. Activities need to be implemented in coordination with the province to reach the local level effectively."

- KII, PHD, Lumbini province

HSCs from the study municipalities of the three provinces were asked to suggest recommendations to improve access to safe abortion services in their local governments. Across all three provinces, HSCs emphasized on the following four priorities:
(1) expanding community awareness to reduce stigma,
(2) ensuring adequacy of listed sites and regular availability of trained providers,
(3) ensuring regular availability of commodities (medicines and equipment), and
(4) strengthening coordination between the three tiers of the government

"The major focus should be on community level awareness programs through street dramas, or dissemination of SAS related information through radio programs and jingles. It is also essential to focus on initiating SAS in the listed health facilities through training of permanent government staff and management of trained staff. Ensuring adequacy of physical infrastructures of local level health facilities to provide SAS should also be kept under consideration."

- KII 1, Local Government, Humla, Karnali

"I would suggest reactivating those health facilities that have been inactive for years. We already have the infrastructure, it just needs to be functional again. We also need to make sure all the required equipment and medicines are available, otherwise even listed centers cannot run services properly. Another important thing is manpower. Trained staff should be posted where needed, and those who were trained a long time ago should get refresher training so they can confidently provide services."

- KII 28, Local Government, Rautahat, Madhesh

"We need to focus on ensuring availability of medicine and equipment for SAS provision. After that it is important that we raise awareness in the community about abortion, also informing women about their reproductive health rights and available services."

- KII 13, Local Government, Kapilbastu, Lumbini

At the provincial level, provincial health director of Madhesh province emphasizes infrastructure and workforce development, recommending a dedicated SAS section in provincial hospitals, trained manpower, functional referral mechanisms, integration with family planning services, post-training assessment, skill and learning exchanges, and regular monitoring of service delivery to ensure quality service provision.

On the other hand, the provincial health director of Lumbini province highlighted geographic coverage and cost effectiveness, recommending mapping and assessment of existing sites, establishing services in hard-to-reach areas, and ensuring cost-effective service expansion to cover the entire population. These recommendations highlight that improving SAS access requires strengthening both the supply side (providers, facilities, accreditation) and the demand side (information, awareness, access).

"*At the district level, we have coverage in most areas. However, it seems we have not reached some remote areas at the local level. Simply accrediting facilities is not enough. It also needs to be cost-effective. Services should be established in places where it is difficult for people to come to the district headquarters. For this, we first need to conduct mapping. Only by knowing how many sites we have, how much population each site covers, and whether all populations are covered, can we determine where services are needed. At present, we cannot yet say where services are required and where they are not*."

- KII, PHD, Lumbini province

Summary, Conclusions, and Recommendations

Although praised as one of the most permissive abortion laws in South Asia, Nepal's existing abortion law remains partially criminalized for acts performed beyond the legally stated gestational limits, performed without the consent of the pregnant woman or by an unauthorized person. With an objective to expand the gestational limits for legal abortion and for complete decriminalization of the act, the MoHP has been taking the lead in the amendment of the existing RSMRH Act 2018. The current status of the amendment process is yet to be updated.

Legal and policy reforms on abortion have contributed to a significant decline in pregnancy-related maternal mortality. Over two decades ago, the country's maternal mortality ratio (MMR) was 539 per 100,000 live births (1998) and unsafe abortion as cause of maternal death accounted for 13%. Two decades on, the MMR reduced to 151/100,000 (2021). Unsafe abortion as cause of death declined to 5%.

Despite the success in reducing MMR, various factors including non-prioritization of SAS by the government particularly in budget allocation continue to impede uninterrupted provision of safe abortion service in the country. These barriers prevail with varying degrees across all levels from the societal level to the health system and at individual level.

As evident from the present baseline, limited provincial budgets are allocated for SAS, particularly on capacity building training of service providers, with Karnali relying partly on partner support for MA training to providers. Only two batches of providers are trained each year by PHTCs, leading to a huge gap of skilled personnel across all local governments of all provinces.

The five-year Kaleidoscope Initiative (2025-2029) from Global South, which is intended to work closely with all three tiers of the government is timely and highly warranted, considering the global impact of funding freeze (2025) termination of financial support to the World Health Organization (2026); continued imposition of the Global Gag Rule since 2017 - a policy of the US Government that prohibits non-US-based non-governmental organizations (NGOs) from providing, referring for, or counseling on abortion as a method of family planning, or advocating for the liberalization of abortion laws, as a condition for receiving certain categories of US Global Health Assistance.[30]

This Baseline Assessment has analyzed the current status, gaps, and challenges in the law and policy provisions, SAS accreditation of public health facilities, coordination across the three-tier federal system, capacity building of service providers, service delivery gaps including reasons for non-accreditation and cessation of service provision by accredited SAS sites and challenges to health management information system. The assessment also explored the extent of clients' access to and challenges encountered in service utilization in the three Project Provinces covered by the *Kaleidoscope Initiatives*.

The following are the recommendations based on the key issues and programmatic challenges identified in the present assessment:

1. Policy and Governance

Challenge 1: Coordination across the three tiers of the federal system is weak.

Coordination across federal, provincial and local levels remains weak, irregular and fragmented. Many local governments reported coordination occurring primarily for training, accreditation and commodity supply, with little engagement on broader SAS planning or monitoring. In some cases, some municipalities were unaware of training conducted within their jurisdiction, highlighting serious gaps in communication and accountability. Provincial platforms for sharing training data, curriculum updates or service delivery challenges are either absent or inconsistently used. At the federal level, delays in receiving updates on certified providers and facility functionality restrict effective oversight. Furthermore, coordination with NGOs and private facilities varies widely. Overall, the lack of a systematic, institutionalized coordination mechanism undermines management of SAS implementation across tiers of government.

Recommendation: Strengthen multi-level coordination by establishing a provincial platform involving PHD, PHTC, district offices, municipalities and partner organizations to share training data, provider placement status, resource needs and service delivery updates. This platform should be used jointly to plan training, follow-up and for supportive supervision. Additionally, institutionalize a simple system within PHD/PHTC to track trained providers, staff transfers, and availability of SAS services across facilities. Joint supervision visits led by PHD/PHTC, with participation from partner organizations, should be conducted routinely to ensure service readiness, and identify and resolve gaps and challenges.

Challenge 2: Private pharmacy outlets are relied upon by community women and girls for confidential abortion care, thereby risking their health and lives.

The type of abortion inducing medication (registered/unregistered MA pills and unknown abortifacient drugs), doses and regimen recommended by private pharmacy outlets and mobile (informal) medicine sellers remain unknown. Life-threatening incidents requiring ICU admission, hemorrhage, blood transfusion, etc., are reported in the present study.

Recommendations: Introduce 'Harm reduction initiatives (HRI)' targeting private pharmacy workers, informal medicines sellers and quacks. Under HRI, they should be made aware of the abortion law, conditions for legal abortion and penalties for providers. The initiatives should also inform the participants about the registered MA drugs and requirement of a physician's prescription for dispensing these MA drugs.

2. Safe Abortion Budget and Financing

Challenge 3: Limited budget allocation for SAS

Limited budget allocation for SAS has constrained service expansion, sufficient SAS provider training, and the institutionalisation of VCAT programmes. In addition, the absence of formal endorsement and prioritisation of these activities across federal, provincial, and local governments has affected their scale-up and accessibility.

Recommendations: Allocate dedicated funding and formally endorse SAS expansion, provider training, and VCAT programmes within annual health plans and budgets at federal, provincial, and local levels to ensure sustainable and equitable access to quality safe abortion services.

3. Safe Abortion Service Availability

***Challenge 4*: The number of SAS accredited public health facilities in the three project provinces are low. Moreover, very few health facilities offer abortion care beyond 10 weeks gestation.**

Less than a half of key public health facilities (Provincial hospital, PHCC and HP) are currently listed for SAS. The top three reasons for non-accreditation of health facilities are: not being a birthing center; lack of a trained service provider; and lack of desired space and equipment.

As many as 36 SAS listed PH/PHCC/HPs have stopped providing SAS service – two Hospitals; one PHCC, and 33 HPs. The main reasons being: i) transfer of trained providers, and ii) non-provision of MA pills by the concerned LG. Six municipalities- three each in Madhesh and Karnali province- do not have a single SAS accredited facility.

In the project municipalities of the three provinces, there are very few options for women to seek abortion beyond 10 weeks gestation as most of the accredited SAS facilities offer MA only that too for gestation up to 10 weeks. Only 4 PHCCs (out of 10) offer MVA for 12 weeks gestation; while MI/D&E is offered at one hospital only (out of 18).

Recommendations: Strengthen coordination among the three-tier government for accreditation of additional health facilities to ensure that each municipality has minimum one SAS facility offering MA and at least 1-2 PHCCs/hospital located within each project province offering MVA in addition to MA.

***Challenge 5*: Not all accredited SAS facilities are functional.**

Close to two-fifths of SAS accredited facilities (36 out of 91) have stopped providing SAS service. The main reason for SAS service closing down was non-replacement of the vacant position due to transfer of the listed SAS provider. Poor coordination between the concerned authority at the local government and the health facility regarding MA pills procurement policies, certification issues of service providers, etc., have been the other reasons.

Recommendations: Prioritize in-service training on SAS for the health care providers (Sr ANM/ANM) who have replaced the previous SAS provider by strengthening coordination with the concerned provincial health training centers (PHTC). The training officials of the PHTC should be encouraged to conduct periodic appraisal/need assessment of all SAS accredited health facilities and conduct SAS orientation training as per demand.

Concerned municipality focal persons should perform routine M&E visits at all SAS accredited facilities to monitor the availability and stock of MA drugs, free SAS assurances, regular presence of SAS provider, and service visibility (updating public charter and display of signboard with SAS logo) of all listed SAS facilities.

***Challenge 6:* Training System Gaps impacted SAS Providers' adequacy & requirements**

Provider training coverage across provinces remains insufficient due to limited budget and fewer training batches. Additionally, the current SAS curriculum has not been updated and localised to reflect province-specific needs and is predominantly theoretical. Moreover, the essential IEC materials, such as flipcharts and guidelines, are often unavailable during and after training. Furthermore, none of the provinces have an established system for refresher training, mentoring or continuous professional development. The VCAT

content, which is critical for addressing provider bias and ensuring rights-based and stigma-free care, is either minimal, confined to a single session or activity, or not systematically integrated into the curriculum.

Recommendation: Implement the provincial training strengthening package that includes: (i) updating the SAS curriculum to incorporate adequate practical/clinical sessions and fully integrate VCAT modules; (ii) establishing a routine refresher-training and mentoring system, by allocating adequate dedicated provincial and federal budgets for these trainings; (iii) ensuring consistent availability of IEC materials; and (v) expanding and capacitating the pool of trainers to increase the number of training batches each year.

4. People Level

***Challenge 7*:** **Community Awareness about the Abortion law and Conditions for legal abortion are very low**:

A large majority of the community members (married women, married men, adolescent girls and boys) in all the three provinces are unaware of abortion law reform. Very few of them were able to cite the first condition for legal abortion - that permits abortion up to 12 weeks for any reason. Negative perceptions and opposition to abortion continue to prevail especially among those individuals who are illiterate, elderly population and those who belong to certain religious groups.

***Recommendations*:** Conduct public awareness and educational campaigns at community level in collaboration with the concerned local government representatives, NGOs/CBOs, health care providers and FCHVs. IEC/Advocacy materials and messages that amplify information pertaining to legal provision, conditions for legal abortion and 'as reproductive rights' should be written in simple local languages (Nepali, Maithali, Bhojpuri, Avadhi). These campaigns should target key community opinion leaders, elderly population, marginalized/disadvantaged communities, etc., to modify their beliefs, misperceptions towards abortion rights. The experiences of organizations involved in SRHR related behavior change communication programs may be consulted for understanding the most effective mode of community-based education/awareness campaigns and the type of IEC/advocacy messages and audio-visual or printed materials relevant for the same.

Challenge 8: **FCHVs lack adequate knowledge about the legal conditions for abortion. Abortion topics rarely get featured in the monthly meetings of FCHVs.**

Knowledge about the legal conditions for abortion is low among most FCHVs. Some FCHVs consider abortion as a "wrong" reproductive decision that could lead to damage of the uterus. FCHVs mostly discuss SMNCH related matters in their regular monthly meetings and also in the monthly meeting of mothers' groups held in their community. Abortion issues get attention only when someone asks questions about it during the monthly meetings.

Recommendations: Organize orientation training on abortion law and comprehensive abortion care for all FCHVs. Topics of the orientation training should also cover ways to overcome abortion stigma and misconceptions surrounding abortion. They should also be encouraged to discuss openly about safe and legal abortions in their monthly meetings. In addition, FCHVs should be encouraged to share information pertaining to service accessibility, safety of the procedure, privacy/confidentiality assurance at the SAS facility, free care, etc. while conducting mothers group meetings. Social barriers to service utilization should also be discussed in their monthly meetings.

Challenge 9: **FCHVs are rarely contacted by community women and adolescent girls on abortion related matters.**

Very few women and adolescent girls approach FCHVs in their community to seek advice on abortion because they are shy and uncomfortable owing to the sensitive nature of the topic. FCHVs hardly accompany women needing an abortion care to a SAS facility due to non-provision of incentives for taking abortion clients there.

Recommendations: FCHVs should be empowered as change agents through capacity building orientation training and engage them in community-level programs including in IEC campaigns that promote SRHR rights of women and overcome socio-cultural barriers faced by women to access safe abortion service. Health facilities should be encouraged to provide incentives or awards to FCHVs for carrying out *home-based urine pregnancy tests* and assisting the woman with an unintended pregnancy to make safe abortion decisions. FCHVs should also be encouraged to accompany women needing an abortion care to a conveniently located SAS facility.

Challenge 10: **Abortion is often associated to sex selection; to get rid of the fetus of an undesired sex.**

Communities in all the three provinces associate abortion to sex selection which has become a growing concern in the country. Although community members are generally aware that sex selective abortion is illegal in the country, couples, particularly husbands, often urge their spouse to undergo sex determination tests and terminate the pregnancy if the test reveals a female fetus. Cross border abortions (in clinics located in border towns of India) are often linked to clandestine sex selective abortion since abortion in India is permitted for gestation up to 20 weeks.

Recommendations*:* Raise community awareness on the abortion law that forbids sex determination tests for the purpose of sex selection and the negative impact of sex selective abortions and risk to health associated with late abortions. The awareness campaigns should particularly target male members of the community to discourage them from persuading their spouse for gender-biased sex selection, and encourage them to make right-based reproductive choices and decisions.

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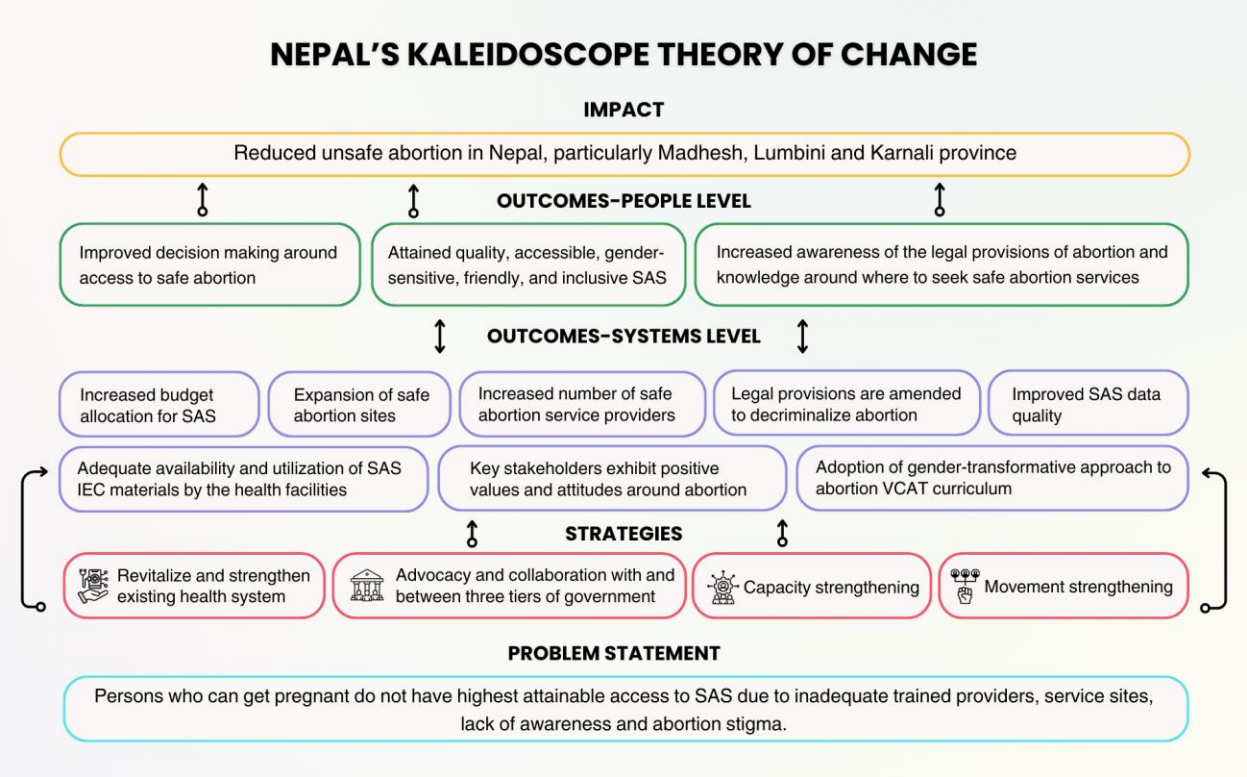
Annex

Kaleidoscope Nepal Theory of Change (TOC)



Annex Table 2.3A: Five Years' trend in the Total Number of Clients Served at SAS facilities (2077/78 to 2081/82) by Municipality

Madhesh Province								
District	**Municipality**		**77/78**	**78/79**	**79/80**	**80/81**	**81/82**	Remarks
			MA	MA	MA	MA	MA	
Bara	Jeetpur Simara	Hosp.			50	84	34	
		PHCC			49	71	75	
		UHC					12	
	Nijgadh Municipality							No SAS
Saptari	Rajbiraj Municipality							
	Saptakoshi							No SAS
Rautahat	Baudhimai							
	Madhav Narayan	HP		11	9	5	14	

	Durga Bhagwati							
	Phatuwa Bijayapur							
	Brindaban							
Mahottari	Matihani Municipality							
	Jaleshwar Municipality	HP				110*	23	The number is total number of the SAS clients of Jaleshwar Provincial Hospital and health post. The data is not separated.
	Gaushala	Hosp.			34	58	29	
	Mahottari							No SAS
Sarlahi	Malangawa	HP			1	2	1	
	Barhathawa Municipality							
Parsa	Parsagadhi	HP			2	30	30	
	Pokhariya	Hosp.		59	130	198	168	
	Thori							
Dhanusha	Janakpurdham Sub Metro							Data is not available due to GenZ movement
	Aurahi Rural	PHCC	3	4	37	42	9	
	Shahidnagar Municipality	PHCC			147	58	0	
		HP			12	49	70	
	Dhanushadham Municipality	PHCC				7	17	
Siraha	Arnama Rural Municipality	Hosp.				10	87	
		HP					49	
	Siraha Municipality	Hosp.			123	76	93	This data is collected from the hospital as the data couldnt be available from municipality due to GenZ movement so the data of MA/MVA clients is not separated
		HP			38	53	58	

Lumbini Province								
District	**Municipality**		**77/78**	**78/79**	**79/80**	**80/81**	**81/82**	Remarks
			MA	MA	MA	MA	MA	
Kapilvastu	Mayadevi	PHCC	1	1	1	1	1	
		HP	1	1	2	2	2	
	Yashodhara	Hosp.				1	1	
	Suddhodana							Not functional
Banke	Baijanath	PHCC	1	1	1	1	1	
		HP	3	3	3	3	3	
	Janaki Rural Municipality	HP			4	2		
	Duduwa	HP			1	1	2	

Karnali Province											
District	**Municipality**		**77/78**	**78/79**	**79/80**		**80/81**		**81/82**		**Remarks**
			MA	MA	MA	MVA	MA	MVA	MA	MVA	
Kalikot	Tilgufa	Hosp.			9		26		17		
		HP	51	30	50		29		63		
	Shubhakalika	HP			90		68		66		
	Sani Triveni	HP	17	0	0		16		9		
	Palata	Hosp.		8	14						
		HP	9	3	16		3		5		
	Raskot	HP			100		137		123		
	Mahabai	HP			25		22		25		
	Khadachakra	Hosp.			97	31	92	6	132	13	
	Pachal Jharna	HP	5	5	4		13		11		
	Narharinath	Hosp.			73		81		64		
		HP			28		20		30		
Mugu	Khatyad	PHCC	46	58	26		32		30		
		HP	152	208	189		154		117		
	Soru	HP			87		8				
Dolpa	Tripurasundari										1 HP is not functional and there are no clients yet in another HP
	Thulivery										No SAS
Humla	Sarkegad										No SAS
	Adanchuli										No SAS
Jumla	Patarasi										
	Sinja	HP							21		

	Kankasundari	HP			3		1		9		

Annex Table 3.1A Province-wise presence of different levels of public health facilities within the Project Municipalities of Kaleidoscope Initiative

Madhesh Province								
District	**Municipality**	**Hosp.**	**PHCC**	**HP**	**BHCC**	**UHC**	**CHU**	**Total**
		n	n	n	n	n	n	n
Saptari	Rajbiraj Municipality	1		8	3	1		13
	Saptakoshi Municipality			3	7	1		11
Siraha	Arnama Rural Municipality	1		3	1			5
	Siraha Municipality	1		12	9			22
Dhanusa	Aurahi Rural Municipality		1	3	2			6
	Dhanushadham Municipality		1	3	3	1		8
	Janakpurdham Sub-Metropolitan city	1		10	13	3		27
	Shahidnagar Municipality		1	8				9
Mahottari	Gaushala Municipality	1		7	5			13
	Jaleshwor Municipality	1		5	3	2	1	12
	Matihani Municipality			4	5			9
	Mahottari Rural Municipality			3	3			6
Sarlahi	Barahathawa Municipality	1		6	14			21
	Malangwa Municipality	1		4	6			11
Rautahat	Baudhaimai Municipality			5	3		1	9
	Brindaban Municipality			5	4			9
	Durgabhagwati Rural Municipality		1	4	1			6
	Madhav Narayan Municipality			8	1		1	10
	Phatuwa Bijayapur Municipality			6	3			9
Bara	Jitpur Simara Municipality	1	1	8	13	2		25
	Nijgadh Municipality		1	2	6	1		10
Parsa	Parsagadhi Municipality		1	4	4			9
	Pokhariya Municipality	1		5	4			10
	Thori Rural Municipality			3	2		2	7

Lumbini Province							
District	**Municipality**	**Hospital**	**PHCC**	**HP**	**BHCC**	**CHU**	**Total**
		n	n	n	n	n	n
Banke	Baijanath RM		1	3	4		8
	Duduwa RM			5	2	1	8
	Janaki RM			6			6
Kapilbastu	Mayadevi RM		1	6		1	8
	Susodhan RM			6		1	7
	Yoshadhara RM	1		7			8
Total		**1**	**2**	**33**	**6**	**3**	**45**

Karnali Province								
District	**Municipality**	**Hospital**	**PHCC**	**HP**	**BHCC**	**UHC**	**CHU**	**Total**
		n	**n**	**n**	**n**	**n**	**n**	**n**
Dolpa	Thulivery M			3	5		3	11
	Tripurasundari M			5	6		2	13
Jumla	Kankasundari RM			5	3		2	10
	Patarasi RM			4	3		1	8
	Sijana RM			3	3			6
Mugu	Khatyad RM	1	1	6	5		5	18
	Soru RM			8	3		3	14
Kalikot	Khadachakra M	1		2	9			12
	Mahabau RM			2	5		1	8
	Narharinath RM	1		4	4			9
	Pachal Jharana RM			3	6			9
	Palata RM	1		3	7			11
	Raskot M	1		3	6	1	1	12
	Sani Tribeni RM	1		3	6		3	13
	Subhakalika RM			3	5		2	10
	Tilagufa M	1		4	6			11
Humla	Adanchuli RM			2	3		4	9
	Sarkegad RM			6	2		5	13
Total		**7**	**1**	**69**	**87**	**1**	**32**	**197**

Annex Table 3.2A Number of public health facilities by SAS Accreditation Status across the 48 project municipalities

Madhesh Province				
District	**Municipality**	**Accredited**	**Not accredited**	**In process**
Saptari	Rajbiraj M	4(1Hosp.,3 PHCC)	9 (5 HP,3 BHSC,1 UHC)	
	Saptakoshi M		11(3 HP,7 BHSC,1 UHC)	
Siraha	Arnama RM	2(1 Hosp.,1HP)	3 (2 HP,1 BHSC)	
	Siraha M	2(1Hosp.,1 HP)	20(11 HP,9 BHSC)	
Dhanusa	Aurahi RM	1(PHCC)	5(3 HP,2 BHSC)	

	Dhanushadham M	1(1 PHCC)	7(3 HP,3 BHSC,1 UHC)	
	Janakpurdham SMP	4(1 Hosp.,3 HP)	23(7 HP,13 BHSC,3 UHC)	
	Shahidnagar M	2(1 PHCC,1 HP)	6(6 HP)	1 (1 HP)
Mahottari	Gaushala M	1(1 Hosp.)	12(7 HP,5 BHSC)	
	Jaleshwor M	2(1 Hosp.,1 HP)	10(4 HP,3 BHSC,2 UHC,1 Other)	
	Matihani M	1(HP)	8(3 HP,5 BHSC)	
	Mahottari RM		6(3 HP,3 BHSC)	
Sarlahi	Barahathawa M	4(1 Hosp.,3 HP)	17(3 HP,14 BHSC)	
	Malangwa M	3(1Hosp.,2HP)	8(2HP,6 BHSC)	
Rautahat	Baudhaimai M	1(1HP)	8(4 HP,3 BHSC,1 Other)	
	Brindaban M	1(1 HP)	8(4 HP,4BHSC)	
	Durgabhagwati RM	1(PHCC)	5(4 HP,1 BHSC)	
	Madhav Narayan M	2(2HP)	8(6 HP,1 BHSC,1 Other)	
	Phatuwa Bijayapur M	1(1HP)	8(5 HP,3 BHSC)	
Bara	Jitpur Simara M	3(1Hosp.,1PHCC,1 UHC)	22(8 HP,13 BHSC,1 UHC)	
	Nijgadh M		10(1PHCC,2HP,6BHSC,1UHC)	
Parsa	Parsagadhi M	1(1HP)	8(1 PHCC,3HP,4BHSC)	
	Pokhariya M	1(1Hosp.)	9 (5 HP,4 BHSC)	
	Thori RM	1(1HP)	5 (1 HP,2 BHSC,2 Other)	1 (1 HP)
		39(10Hosp.,8 PHCC,20 HP,1 UHC)	**236(2 PHCC, 104HP, 116 BHSC, 9 UHC, 5 Other)**	**2(2HP)**
Lumbini Province				
District	**Municipality**	**Accredited**	**Not accredited**	**In process**
Banke	Baijanath RM	4(1 PHCC,3 HP)	4 (4 HP)	
	Duduwa RM	4 (4 HP)	4(1 HP,2 BHSC,1 Other)	
	Janaki RM	6(6 HP)		
Kapilbastu	Mayadevi RM	3(1 PHCC,2 HP)	4(3 HP,1 Other)	1(1 HP)
	Susodhan RM	2(2 HP)	4(3 HP,1 Other)	1(1 HP)
	Yoshadhara RM	1(1Hosp)	6(6 HP)	1 (1 HP)
		20 (1Hosp.,2 PHCC,17 HP)	**22(17 HP,2 BHSC,3 Other)**	**3(3HP)**
Karnali Province				
District	**Municipality**	**Accredited**	**Not accredited**	**In process**
Dolpa	Thulivery M		11(3 HP,5 BHSC,3 Other)	
	Tripurasundari M	2(2 HP)	11(3 HP,6 BHSC,2 Other)	
Jumla	Kankasundari RM	2(2 HP)	7(3 HP, 2 BHSC,2 Other)	1(1 BHSC)
	Patarasi RM	1 (1 HP)	7 (3 HP,3 BHSC,1 Other)	
	Sijana RM	2 (2 HP)	4 (1HP, 3 BHSC)	
Mugu	Khatyad RM	4(1 PHCC,3 HP)	14(1 Hosp.,3 HP,5 BHSC,5 Other)	
	Soru RM	3 (3 HP)	11 (5 HP,3 BHSC, 3 Other)	
Kalikot	Khadachakra M	2(1Hosp.,1 HP)	10(1HP, 9 BHSC)	
	Mahabau RM	1 (1 HP)	7 (1 HP,5 BHSC,1 Other)	

	Narharinath RM	2(1Hosp.,1 HP)	5(1 HP,4 BHSC)	2(HP)
	Pachal Jharana RM	2 (2 HP)	6(6 BHSC)	1 (HP)
	Palata RM	3(1Hosp.,2 HP)	8(1 HP,7 BHSC)	
	Raskot M	3(3 HP)	9(1 Hosp.,6 BHSC,1 UHC,1 Other)	
	Sani Tribeni RM	2(2 HP)	11(1 Hosp.,1 HP,6 BHSC,3 Other)	
	Subhakalika RM	1 (1 HP)	9 (2 HP,5 BHSC, 2 Other)	
	Tilagufa M	2(1Hosp., 1 HP)	9(3 HP,6 BHSC)	
Humla	Adanchuli RM		9(2 HP,3 BHSC,4 Other)	
	Sarkegad RM		13(6 HP,2 BHSC,5 Other)	
		32(4 Hosp., 1 PHCC, 27 HP)	**161(3 Hosp.,39 HP, 86 BHSC, 1 UHC,32 Other)**	**4 (3 HP,1 BHSC)**

Annex Table 3.3A: Reasons for non-accreditation of specific public health facilities : Municipality-wise distribution

Madhesh Province										
		Reasons for non-accreditation								
		Not a birthing center	**No trained service provider**	**Lack of infrastr-ucture**	**Another accredited facility nearby**	**Not Yet Initiated SAS**	**Newly established Health Facility**	**Lack of medicine / equipment**	**Responsible Authority not keen to accredit**	**No provision of listing CHU/ BHSC**
District Saptari	Municipality Rajbiraj M		7(3 HP, 3 BHSC, 1 UHC)	5(3HP, 1 BHSC, 1UHC)					2(HP)	
	Saptakoshi M	4 (1 HP, 2BHSC, 1 UHC)	10(2 HP, 7 BHSC, 1 UHC)	8(2 HP, 5 BHSC, 1 UHC)	1 (1 BHSC)					
Siraha	Arnama RM	3(2 HP, 1 BHSC)	3(2 HP, 1 BHSC)	1(HP)						
	Siraha M	11(8 HP, 3 BHSC)	20(11 HP, 9 BHSC)	11(4 HP, 7 BHSC)						
Dhanusa	Aurahi RM	1(1 HP)	5(3 HP, 2 BHSC)	2 (2BHSC)	1(1 HP)		1 (1 BHSC)			
	Dhanushadham M		7(3HP, 3BHSC, 1 UHC)	3(2 HP, 1 BHSC)					1 (1 HP)	
	Janakpurdham SMP	3(1 HP, 1 BHSC, 1 UHC)	18(5 HP, 10 BHSC, 3 UHC)	9 (1HP, 7 BHSC, 1 UHC)	4 (1 HP, 3 BHSC)			1 (1 HP)	2 (2 HP)	
	Shahidnagar M	3 (3 HP)	6 (6 HP)	6 (6 HP)					1 (1 HP)	

Mahottari	Gaushala M	7(3 HP, 4 BHSC)	12 (7 HP, 5 BHSC)	3(3 BHSC)						
	Jaleshwor M	5(1HP, 2 BHSC, 2 UHC)	9(4 HP, 3 BHSC, 2 UHC)	5(3BHSC, 1UHC, 1Other)						
	Matihani M	4 (1 HP, 3 BHSC)	8(3 HP, 5 BHSC)	4 (1 HP, 3 BHSC)						
	Mahottari RM	3 (1 HP, 2 BHSC)	6 (3 HP, 3 BHSC)	3 (2 HP, 1 BHSC)						
Sarlahi	Barahathawa M	7 (2 HP, 5 BHSC)	15 (3 HP, 12 BHSC)	6 (6 BHSC)	2 (2 BHSC)		1 (1 BHSC)	1 (1 HP)		
	Malangwa M	1 (1 BHSC)	7 (2 HP, 5 BHSC)	5 (5 BHSC)			1 (1 BHSC)			
Rautahat	Baudhaimai M	6 (2 HP, 3 BHSC, 1 other)	7 (3 HP, 3 BHSC, 1 Other)	3 (2 BHSC, 1 Other)	1 (1 HP)					
	Brindaban M	4 (1 HP, 3 BHSC)	8 (4 HP, 4 BHSC)	2 (2 BHSC)						
	Durgabhagwati RM	3 (2 HP, 1 BHSC)	4 (4 HP)							
	Madhav Narayan M	2 (1 BHSC, 1 Other)	7 (5 HP, 1 BHSC, 1 Other)	1 (1 HP)						
	Phatuwa Bijayapur M	2 (2 HP)	8 (5 HP,3 BHSC)	2 (1 HP, 1 BHSC)						
Bara	Jitpur Simara M	3 (1 HP, 2 BHSC)	18 (8 HP, 9 BHSC, 1 UHC)	2 (1 HP, 1 BHSC)						2 (2 BHSC)
	Nijgadh M	2 (1 HP, 1 BHSC)	9 (1 PHCC, 2 HP, 5 BHSC, 1 UHC)			1 (1 BHSC)				
Parsa	Parsagadhi M	2 (1 HP, 1 BHSC)	8 (1 PHCC, 3 HP,	3 (1 HP, 2 BHSC)						

			4 BHSC)							
	Pokhariya M	8 (5 HP, 3 BHSC)		1 (1 HP)					1 (BHSC)	
	Thori RM	1 (1 Other)	5 (1HP, 2 BHSC, 2 Other)	1 (1 Other)						
TOTAL		**85 (39 HP, 39 BHSC, 4 UHC, 3Other)**	**207(2 PHCC, 92 HP, 99 BHSC, 10 UHC, 4 Other)**	**86(27 HP, 52 BHSC, 4 UHC, 3 Other)**	**9(3 HP 6 BHSC)**	**1 (1BHSC)**	**3 (3 BHSC)**	**2(2 HP)**	**7(6 HP, 1 BHSC)**	**2 (2 BHSC)**

Lumbini Province

		Reasons for non-accreditation				
		Not a birthing center	No trained service provider	Lack of infrastructure	Another accredited facility nearby	No provision of listing CHU/BSHC
Banke	Baijanath RM	3 (3 BHSC)	4 (4 BHSC)	2 (2 BHSC)		1 (1 BHSC)
Kapilbastu	Duduwa RM	4 (1 HP, 2 BHSC, 1 Other)	4 (1 HP,2 BHSC, 1 Other)	4 (1 HP,2 BHSC, 1 Other)		
	Mayadevi RM	4 (3 HP, 1 Other)	4 (3 HP, 1 Other)	3 (2 HP,1 Other)		
	Susodhan RM	4 (3 HP, 1 Other)	4 (3 HP, 1 Other)	4 (3 HP, 1 Other)	1 (1 Other)	1 (1 Other)
	Yoshadhara RM	6 (6 HP)	6 (6 HP)	5 (5 HP)		
TOTAL		**21(13 HP, 4 BHSC, 3 Other)**	**22(13 HP, 6 BHSC, 3 Other)**	**18 (11 HP, 4 BHSC, 3 Other)**	**1(1 Other)**	**2(1 BHSC, 1 Other)**

Karnali Province

		Reasons for non-accreditation							
		Not a birthing center	No trained service provider	Lack of infrastructure	Another accredited facility nearby	Not Yet Initiated SAS	Newly established Health Facility	Lack of medicine/ equipment	Responsib-le Authority not keen to accredit
Dolpa	Thulivery M	8 (5 BHSC, 3 Other)	10 (3 HP, 4 BHSC, 3 Other)	9 (1 HP, 5,BHSC, 3 Other)	1 (1 HP)	1 (1 BHSC)			
	Tripurasundari M	10 (2 HP, 6 BHSC, 2 Other)	11 (3 HP, 6 BHSC, 2 Other)	8 (3 HP, 3 BHSC, 2 Other)	1 (1 BHSC)				
Jumla	Kankasundari RM	4 (2 BHSC, 2 Other)	7 (3 HP, 2 BHSC, 2 Other)	2 (1 BHSC, 1 Other)					

	Patarasi RM	4 (3 BHSC, 1 Other)	7 (3 HP, 3 BHSC, 1 Other)	2 (2 BHSC)					
	Sijana RM	4 (1 HP, 3 BHSC)							
Mugu	Khatyad RM	10 (1Hosp. 5 BHSC, 4 Other)	14 (1 Hosp, 3 HP, 5 BHSC, 5 Other)	10(1 Hosp, 4 BHSC, 5 Other)			1 (1 Other)		
	Soru RM	7 (2 HP, 3 BHSC, 2 Other)	11 (5 HP, 3 BHSC, 3 Other)	9 (3 HP, 3 BHSC, 3 Other)					
Kalikot	Khadachakra M	6 (6 BHSC)	10 (1 HP, 9 BHSC)	3 (3 BHSC)				1 (1 BHSC)	
	Mahabau RM	5 (4 BHSC, 1 Other)	7 (1 HP, 5 BHSC, 1 Other)	2 (1 BHSC, 1 Other)					
	Narharinath RM	3 (3 BHSC)	5 (1 HP, 4 BHSC)	4 (4 BHSC)					1 (1 HP)
	Pachal Jharana RM	6 (6 BHSC)	6 (6 BHSC)	1 (1 BHSC)					
	Palata RM	5 (5 BHSC)	7 (1 HP, 6 BHSC)	2 (1 HP, 1 BHCC)	1 (1 BHSC)				
	Raskot M	7 (5 BHSC, 1 UHC, 1 Other)	9 (1Hosp., 6 BHSC, 1 UHC, 1 Other)	8 (6 BHSC, 1 UHC, 1 Other)					
	Sani Tribeni RM	9(1Hosp., 6 BHSC, 2 Other)	11(1Hosp, 1 HP, 6 BHSC, 3 Other)	10 (1 Hosp., 6 BHSC, 3 Other)			1 (1 BHSC)		
	Subhakalika RM	8 (1 HP, 5 BHSC, 2 Other)	9 (2 HP, 5 BHSC, 2 Other)	8 (1 HP, 5 BHSC, 2 Other)					
	Tilagufa M	6 (1 HP, 5 BHSC)	9 (3 HP, 6 BHSC)	6 (1 HP, 5 BHSC)					
Humla	Adanchuli RM	5 (1 BHSC, 4 Other)	8 (1 HP, 3 BHSC, 4 Other)	8 (1 HP,3 BHSC,4 Other)		1(1 HP)			
	Sarkegad RM	7 (2 HP, 1 BHSC, 4 Other)	12 (5 HP, 2 BHSC,	8 (3 HP, 1 BHSC, 4 Other)					1 (1 HP)

			5 Other)						
TOTAL		**114 (2 Hosp., 9 HP, 74 BHSC, 1 UHC, 28 Other)**	**153 (3 Hosp., 36 HP, 81 BHSC, 1 UHC, 32 Other)**	**100 (2 Hosp, 14 HP, 54 BHSC, 1 UHC, 29 Other)**	**3(1 HP, 2 BHSC)**	**2(1 HP, 1 BHSC)**	**2(1 BHSC, 1 Other)**	**1 (1 BHSC)**	**2 (2 HP)**

Annex Table 3.4A: Municipality-wise distribution of functional and nonfunctional SAS facilities by level of health facility

Madhesh Province			
District	**Municipality**	**Functional**	**Not Functional**
Saptari	Rajbiraj M	1(1 Hosp)	3(3 HP)
Siraha	Arnama RM	2 (1 Hosp, 1 HP)	
	Siraha M	2 (1 Hosp, 1 HP)	
Dhanusa	Aurahi RM	1 (PHCC)	
	Dhanushadham M	1(1 PHCC)	
	Janakpurdham SMP	4(1Hosp.,3 HP)	
	Shahidnagar M	1 (1 PHCC)	1(1 HP)
Mahottari	Gaushala M	1(1 Hosp)	
	Jaleshwor M	1(1 Hosp)	1(1HP)
	Matihani M		1(1 HP)
Sarlahi	Barahathawa M	3(1Hosp.,2 HP)	1(1HP)
	Malangwa M	1(1 Hosp.)	2(2 HP)
Rautahat	Baudhaimai M		1(1 HP)
	Brindaban M		1(1 HP)
	Durgabhagwati RM		1(1 PHCC)
	Madhav Narayan M	1(1 HP)	1(1 HP)
	Phatuwa Bijayapur M		1(1 HP)
Bara	Jitpur Simara M	3(1Hosp.,1 PHCC,1 UHC)	
Parsa	Parsagadhi M	1(1 HP)	
	Pokhariya M	1(1 Hosp.)	
	Thori RM		1(1 HP)
	Total	**24(10 Hosp. 4PHCC, 9HP, 1UHC)**	**15(1PHCC, 14HP)**
Lumbini Province			
District	**Municipality**	**Functional**	**Not Functional**
Banke	Baijanath RM	4 (1 PHCC,3 HP)	
	Duduwa RM	3(3HP)	1(1 HP)
	Janaki RM	6(6 HP)	

Kapilbastu	Mayadevi RM	2 (1 PHCC,1 HP)	1(1 HP)
	Susodhan RM		2(2 HP)
	Yoshadhara RM	1(1Hosp.)	
	Total	**16 (1Hosp., 2PHCC, 13HP)**	**4(4 HP)**
Karnali Province			
District	**Municipality**	**Functional**	**Not Functional**
Dolpa	Tripurasundari M		2(2 HP)
Jumla	Kankasundari RM	1(1 HP)	1(1 HP)
	Patarasi RM		1(1 HP)
	Sinja RM	1(1 HP)	1(1 HP)
Mugu	Khatyad RM	2(1PHCC,1HP)	2(2HP)
	Soru RM	1(1HP)	2 (2 HP)
Kalikot	Khadachakra M	1(1Hosp.)	1(1HP)
	Mahabau RM	1(1 HP)	
	Narharinath RM	2(1 Hosp.1 HP)	
	Pachal Jharana RM	2(2 HP)	
	Palata RM		3 (1Hosp.,2 HP)
	Raskot M	2(2 HP)	1(1HP)
	Sani Tribeni RM	1(1 HP)	1(1 HP)
	Subhakalika RM		1(1 HP)
	Tilagufa M	1(1 HP)	1(1 Hosp)
	Total	**15 (2 Hosp., 1 PHCC, 12HP)**	**17(2Hosp., 15HP)**

Annex Table 3.5A: Reason for non-functionality of SAS by category of health facility across the municipalities

Madhesh Province						
District	**Municipality**	**Lack of trained staff/ Trained provider transferred**	**Lack of medicine for MA service**	**trained provider is on maternity leave**	**No SAS service reimbursement received.**	**Accreditation in process**
Saptari	Rajbiraj M	1 (HP)	2 (HP)			
Dhanusa	Shahidnagar M	1 (HP)				
Mahottari	Jaleshwor M	1 (HP)				
	Matihani M			1 (1 HP)		
Sarlahi	Barahathawa M	1 (HP)				
	Malangwa M				1 (1HP)	1 (1HP)
Rautahat	Baudhaimai M	1 (HP)				
	Brindaban M	1 (HP)				
	Durgabhagwati RM	1 (PHCC)				
	Madhav Narayan M	1 (HP)				
	Phatuwa Bijayapur M	1 (HP)				
Parsa	Thori RM	1 (HP)				

		10(1 PHCC, 9 HP)	2(2 HP)	1(1 HP)	1(1HP)	1 (1HP)

Lumbini Province				
District	**Municipality**	**Lack of trained staff/Trained provider transferred**	**trained provider is on maternity leave**	**Accredited certificate and required materials not provided by municipality**
Banke	Duduwa RM			1 (1 HP)
Kapilbastu	Mayadevi RM	1 (1 HP)		
	Susodhan RM	1 (1 HP)	1 (1 HP)	

Karnali Province						
District	**Municipality**	**Lack of trained staff/Trained provider transferred**	**Lack of medicine for MA service**	**Trained provider is on maternity leave**	**Elected representative does not have a positive view on abortion**	**Provincial office misplacement of service provider's certificate**
Dolpa	Tripurasundari M		1 (1 HP)		1 (1 HP)	
Jumla	Kankasundari RM	1 (1 HP)				
	Patarasi RM					1 (1 HP)
	Sijana RM	1 (1 HP)				
Mugu	Khatyad RM	2 (2 HP)				
	Soru RM	2 (2 HP)				
Kalikot	Khadachakra M	1 (1 HP)				
	Palata RM	3 (1Hosp.2 HP)				
	Raskot M	1 (1HP)				
	Sani Tribeni RM		1 (1HP)			
	Subhakalika RM			1 (1HP)		
	Tilagufa M		1 (1Hosp.)			
TOTAL		**11 (1 Hosp., 10 HP)**	**3 (1 Hosp., 2 HP)**	**1(1HP)**	**1(1HP)**	**1(1HP)**

Annex Table 3.6 A: Range of SAS offered by facility* across all categories of public health facilities accredited for SAS *by municipality

Madhesh Province					
District	**Municipality**	**Type of Service Offered**			
		MA (10 weeks)	**MA/MVA (10 weeks)**	**MVA (12 weeks)**	**MI/D&E**
Saptari	Rajbiraj M,	1 (1 Hosp.)	1 (1 Hosp.)	1 (1 Hosp.)	
Siraha	Arnama RM,	2 (1 Hosp., 1 HP)			
	Siraha M,	2 (1 Hosp., 1 HP)	1 (1 Hosp.)	1 (1 Hosp.)	
Dhanusha	Aurahi RM	1 (1 PHCC)			
	Dhanushadham M	1 (1 PHCC)			
	Janakpurdham SMP	4 (1 Hosp., 3 HP)	1 (1 Hosp.)	1 (1 Hosp.)	
	Shahidnagar M	1(HP)			
Mahottari	Gaushala M	1 (Hosp.)			
	Jaleshwor M	1 (Hosp.)			

Sarlahi	Barahathawa M	3(1 Hosp., 2 HP)			
	Malangwa M	1 (Hosp.)	1 (Hosp.)	1 (Hosp.)	1 (Hosp.)
Rautahat	Madhav Narayan M	1(HP)			
Bara	Jitpur Simara M	3(1 Hosp, 1 PHCC,1 UHC)			
Parsa	Parsagadhi M,	1(HP)			
	Pokhariya M,	1(Hosp.)	1(Hosp)		
Total		**24**	**5**	**4**	**1**

Lumbini Province

District	**Municipality**	**Type of Service Offered**
		MA (10 weeks)
Banke	Baijanath RM	4 (1PHCC, 3 HP)
	Duduwa RM	3 (1 HP)
	Janaki RM	6 (6 HP)
Kapilvastu	Mayadevi RM	2 (1 PHCC, 1 HP)
	Yoshadhara RM	1 (1 Hosp.)
Total		**16 (1 Hosp., 2 PHCC, 13 HP)**

Karnali Province

District	**Municipality**	**Type of Service Offered**		
		MA (10 weeks)	**MA/MVA (10 weeks)**	**MVA (12 weeks)**
Jumla	Kankasundari RM	1 (1 HP)		
	Sinja RM	1 (1 HP)		
Mugu	Khatyad RM	2 (1 PHCC, 1 HP)		
	Soru RM	1 (1 HP)		
Kalikot	Khadachakra M	1 (1 Hosp.)	1(Hosp.)	1(Hosp.)
	Mahabau RM	1 (1 HP)		
	Narharinath RM	2 (1 Hosp., 1 HP)		
	Pachal Jharana RM	2 (2 HP)		
	Raskot M	2 (2 HP)		
	Sani Tribeni RM	1(1 HP)		
	Tilagufa M	1(1 HP)		
Total		**15 (2 Hosp., 1 PHCC, 12 HP)**	**1 (1 Hosp.)**	**1 (1 Hosp.)**

Annex Table 3.9 A: Extent for Eligibility perceived for SAS Accreditation by Municipality

Madhesh Province

District	**Municipality**	**Yes**	**No**
Saptari	Rajbiraj M	6(4 HP,1 BHSC,1 UHC)	3(1 HP,2 BHSC)
	Saptakoshi M	5(3 HP,1 BHSC)	6 (6 BHSC)
Siraha	Arnama RM	2(1HP,1 BHSC)	1 (1 HP)
	Siraha M	10(8 HP,2 BHSC)	10(3 HP, 7 BHSC)
Dhanusa	Aurahi RM	1(HP)	4 (2 HP, 2 BHSC)
	Dhanushadham M	3(1HP,1BHSC,1 CHU)	4(2 HP, 2 BHSC)
	Janakpurdham SMP	13(5 HP,6 BHSC,2UHC)	10(2 HP, 7 BHSC, 1 UHC)
	Shahidnagar M	2(HP)	4(HP)

Mahottari	Gaushala M	4(3HP,1BHSC)	8(4HP,4BHSC)
	Jaleshwor M	3(2 HP,1 Other)	7(2 HP,3BHSC,2 UHC)
	Matihani M	4(2HP,2BHSC)	4(1HP,3BHSC)
	Mahottari RM	1(HP)	5(2HP,3BHSC)
Sarlahi	Barahathawa M	5(3 HP,2 BHSC)	12(12BHSC)
	Malangwa M	2(1 HP, 1 BHSC)	6(1HP,5 BHSC)
Rautahat	Baudhaimai M	3(2 HP,1 BHSC)	5(2 HP,2BHSC,1 Other)
	Brindaban M	2(1HP,1BHSC)	6(3 HP,3BHSC)
	Durgabhagwati RM	2(2 HP)	3(2 HP,1 BHSC)
	Madhav Narayan M	6(4HP,1 BHSC,1 Other)	2(2 HP)
	Phatuwa Bijayapur M	4(3 HP, 1 BHSC)	4(2HP,2 BHSC)
Bara	Jitpur Simara M	15(6 HP,8 BHSC,1 UHC)	7(2HP,5BHSC)
	Nijgadh M	4(1 PHCC,3 BHSC)	6(2HP,3BHSC,1UHC)
Parsa	Parsagadhi M	5(1 PHCC,2 HP,2 BHSC)	3(1HP,2BHSC)
	Pokhariya M	4(2 HP,2 BHSC)	5(3 HP,2 BHSC)
	Thori RM	3(1 HP,2 BHSC)	2(2 Other)
	TOTAL	**109(2 PHCC, 62 HP,**	

Lumbini Province

District	**Municipality**	**Yes**	**No**
Banke	Baijanath RM	1(1 BHSC)	3(3 BHSC)
	Duduwa RM		4(1 HP,2 BHSC,1 Other)
Kapilbastu	Mayadevi RM	1(1 HP)	3(2 HP,1 Other)
	Susodhan RM		4(3 HP,1 Other)
	Yoshadhara RM		6(6 HP)
	Total	**2(1 HP,1 BHSC)**	**20(12 HP,5 BHSC,3 Other)**

Karnali Province

District	**Municipality**	**Yes**	**No**
Dolpa	Thulivery M	1(1HP)	10(2 HP, 5 BHSC, 3 Other)
	Tripurasundari M		11(3 HP, 6 BHSC, 2 Other)
Jumla	Kankasundari RM	6(3 HP, 2 BHSC, 1 Other)	1 (1 Other)
	Patarasi RM	3 (3 HP)	4 (3BHSC,1 Other)
	Sijana RM	3 (1 HP,2 BHSC)	1 (1 BHSC)
Mugu	Khatyad RM	3 (3 HP)	11(1 Hosp.5 BHSC,5 Other)
	Soru RM	1(1 HP)	10(4 HP,3 BHSC,3 Other)
Kalikot	Khadachakra M	7(1 HP,6 BHSC)	3 (3 BHSC)
	Mahabau RM	3(1 HP,2 BHSC)	4(3 BHSC,1 Other)
	Narharinath RM	1(1 HP)	4(4 BHSC)
	Pachal Jharana RM	5(5BHSC)	1(1 BHSC)
	Palata RM	6(1 HP,5 BHSC)	2(2 BHSC)
	Raskot M	2(1Hosp.1 BHSC)	7 (5 BHSC,1 UHC,1 Other)
	Sani Tribeni RM	4(1 HP,1 BHSC,2 Other)	7 (1 Hosp.,5 BHSC,1 Other)
	Subhakalika RM	2(1 HP,1 BHSC)	7 (1 HP,4 BHSC,2 Other)
	Tilagufa M	4(3 HP,1 BHSC)	5 (5 BHSC)

Humla	Adanchuli RM	1(1HP)	8 (1 HP,3 BHSC,4 Other)
	Sarkegad RM	4(3 HP,1 BHSC)	9(3 HP,1 BHSC,5 Other)
	Total	**56(1 Hosp.25HP,27 BHSC, 3 Other)**	**105 (2 Hosp.,14 HP,59 BHSC, 1 UHC, 29 Other)**

Annex Table 3.10 A: Reason for non-eligibility perceptions by service providers for SAS accreditation of their health facilities by Municipality

Madhesh Province								
District	**Municipality**	**Lack of trained provider**	**Lack of infrastructure**	**Not a birthing center**	**Lack of equipment**	**Newly established facility**	**Not eligible as per the policy**	**Local govt. has not given interest**
Saptari	Rajbiraj M	3(1 HP, 2 BHSC)	3 (1 HP, 2 BHSC)					
	Saptakoshi M	5(5 BHSC)	5 (5 BHSC)					
Siraha	Arnama RM	1(1 HP)	1(1 HP)	1(1 HP)				
	Siraha M	9(3 HP, 6 BHSC)	8(3 HP, 5 BHSC)			1(1BHSC)		
Dhanusa	Aurahi RM	4(2 NH, 2 BHSC)	3(1 HP, 2 BHSC)					
	Dhanushadham M	4(2 HP, 2 BHSC)	4(2 HP, 2 BHSC)					
	Janakpurdham SMP	9(1 HP, 7 BHSC, 1 UHC)	8(1 HP, 6 BHSC, 1 UHC)					1(1HP)
	Shahidnagar M	4(4 HP)	3(3 HP)					
Mahottari	Gaushala M	9(4 HP, 5 BHSC)	2(1 HP, 1 BHSC)	4(1 HP, 3 BHSC)				
	Jaleshwor M	7(2 HP, 3BHSC, 2 UHC)	2(2 BHSC)	4(1HP, 1BHSC, 2UHC)				
	Matihani M	4(1HP, 3 BHSC)	4(1 HP, 3 BHSC)	1 (1 BHSC)				
	Mahottari RM	4(1HP, 3 BHSC)	5(2 HP, 3 BHSC)	2(1HP, 1 BHSC)				
Sarlahi	Barahathawa M	11 (11 BHSC)	8 (8 BHSC)	1 (1BHSC)	3 (3 BHSC)			
	Malangwa M	5(1HP, 4 BHSC)	3(1 HP, 2 BHSC)	1 (1 BHSC)				
Rautahat	Baudhaimai M	5(2 HP, 2 BHSC, 1 Other)	3(2 BHSC, 1 Other)	1(1HP)				
	Brindaban M	6(3HP, 3 BHSC)	3(2 HP, 1 BHSC)	2(1 HP, 1 BHSC)	2(2 BHSC)			
	Durgabhagwati RM	3(2HP, 1BHSC)	1(1 HP)					
	Madhav Narayan M	2(2HP)						
	Phatuwa Bijayapur M	3(2HP, 1BHSC)	1(1HP)		1(1HP)		1 (1 BHSC)	
Bara	Jitpur Simara M	7(2 HP, 5 BHSC)						

	Nijgadh M	6(2 HP, 3BHSC, 1 UHC)						
Parsa	Parsagadhi M	3(1 HP, 2 BHSC)						
	Pokhariya M	5(3 HP, 2 BHSC)	1(1 BHSC)	1(1 HP)				
	Thori RM	2(2 Other)	1(1 Other)					

Lumbini Province

District	Municipality	Lack of trained provider	Lack of infrastructure	Not a birthing center
Banke	Baijanath RM	3(3BHSC)	2(2BHSC)	
	Duduwa RM	4(1 HP,2 BHSC, 1 Other)	2(1 HP, 1 BHSC)	1(1BHSC)
Kapilbastu	Mayadevi RM	3(2HP,1 Other)	3(2HP,1 Other)	2(1 HP,1 Other)
	Susodhan RM	4(3 HP,1 Other)	4(3 HP,1 Other)	2(2HP)
	Yoshadhara RM	6(6 HP)	6(6 HP)	5(5 HP)

Karnali Province

District	Municipality	Lack of trained provider	Lack of infrastructure	Not a birthing center	Lack of equipment	Newly established facility	Not eligible as per the policy	Lack of budget
Dolpa	Thulivery M	10(2HP, 5 BHSC, 3 Other)	7(5 BHSC, 2 Other)		5(1 HP, 3 BHSC, 1 Other)			
	Tripurasundari M	11(3 HP, 6 BHSC, 2 Other)	7(2 HP, 3 BHSC, 2 Other)	2(2BHSC)	5(1 HP, 3 BHSC, 1 Other)			
Jumla	Kankasundari RM	1(1Other)						
	Patarasi RM	4(3BHSC, 1 Other)	1(1BHSC)					
	Sijana RM	1(1BHSC)						
Mugu	Khatyad RM	10(5BHSC, 5 Other)	5(2 BHSC, 3 Other)	3(2 BHSC, 1 Other)	3(1 BHSC, 2 Other)		1(1 Hosp.) * Aurveh	
	Soru RM	10(4HP, 3 BHSC, 3 Other)	5(2 HP, 1 BHSC, 2 Other)					
Kalikot	Khadachakra M	3(3 BHSC)	3(3 BHSC)					
	Mahabau RM	4(3 BHSC, 1 Other)	1(1 BHSC)					
	Narharinath RM	3(3 BHSC)	4(4 BHSC)					
	Pachal Jharana RM	1(1 BHSC)	1(1 BHSC)					
	Palata RM	2(2 BHSC)		1(1 BHSC)				

	Raskot M	7(5 BHSC, 1 UHC, 1 Other)	3(2 BHSC, 1 Other)					
	Sani Tribeni RM	6(1Hosp., 4 BHSC, 1 Other)	6(1Hosp., 4 BHSC, 1 Other)			1(1BHSC)		
	Subhakalika RM	7(1 HP, 4 BHSC, 2 Other)	4(1 HP, 3 BHSC)					
	Tilagufa M	5(5 BHSC)	3(3 BHSC)					
Humla	Adanchuli RM	7(1HP, 2 BHSC, 4 Other)	6(1 HP, 2 BHSC, 3 Other)		2(1BHSC, 1 Other)			1(1BHSC)
	Sarkegad RM	9(3HP, 1BHSC, 5Other)	6(1 HP, 1 BHSC, 4 Other)		3(1 HP, 2 Other)			

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