Access to family planning services by migrant couples in Nepal – barriers and evidence gaps

A review of the literature

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# Contents

1 Introduction ............................................................................................................. 1  
1.1 About this study ................................................................................................ 1  
1.2 Context and rationale ....................................................................................... 1  
1.3 The programmatic and policy context .............................................................. 2  
2 Methods ................................................................................................................. 3  
2.1 Objectives ......................................................................................................... 3  
2.2 Search strategy ................................................................................................ 4  
2.3 Outcome of the literature search ..................................................................... 5  
2.4 Stakeholder consultation ................................................................................. 5  
3 Findings ................................................................................................................... 5  
3.1 The evidence on spousal separation and reproductive health ....................... 5  
3.2 Evidence on knowledge and use of family planning ....................................... 7  
3.2.1 Knowledge about family planning methods .............................................. 7  
3.2.2 Use of family planning methods .............................................................. 8  
3.3 Barriers to family planning access and use by migrants and their spouses .... 10  
3.3.1 Barriers to accessing family planning ..................................................... 10  
3.3.2 Lack of preparedness on husband’s return .............................................. 11  
3.3.3 Socio-cultural factors ............................................................................. 11  
4 Interventions ......................................................................................................... 12  
5 Discussion and way forward .............................................................................. 14  
5.1 The evidence and the evidence gaps ............................................................... 14  
5.2 Programme and policy implications ................................................................. 15  
5.2.1 The need for systemic focus on migrant couples ................................... 15  
5.2.2 The needs of male migrant workers ....................................................... 16  
5.2.3 The needs of the wives of migrants ....................................................... 17  
5.3 Key points from the stakeholder consultation .............................................. 18  
6 References .............................................................................................................. 20  

Annex 1: Organisations approached for this study ............................................... 23  
Annex 2: Consultation workshop participants ...................................................... 24  
Annex 3: Acronyms and abbreviations ................................................................... 26
Introduction

1.1 About this study

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

For each group the studies are expected to:

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

This study focuses on migrant couples (intended as couples where one spouse has migrated for foreign employment) within Nepal. It does not look at the specific needs of migrants in the destination countries, although we acknowledge this is an important concern.

1.2 Context and rationale

Over the past decade, Nepal has experienced a surge in out-migration for foreign employment to various countries. Although this is not a new phenomenon, the high volume of individuals opting to migrate is unprecedented (MoLE 2014).

More recently, the Ministry of Labour and Employment (MoLE 2014) calculated that between 2008/09 and 20013/14, about 8% of Nepal’s total population were issued permits to work.

1 Until 2016 the Minstry of Health was referred to as the Ministry of Health and Population. We have maintained the latter name and its acronym MoHP for the references only.
abroad. Based on labour permits issued, about 95% of migrants were men, although there has also been an increase in women seeking to migrate. The top five destinations were Malaysia, Saudi Arabia, Qatar, UAE and Kuwait. However, the magnitude of unregistered foreign labour migrants is unknown – including those travelling to India, because of the open border policy, and women migrating to the Middle East for domestic work through irregular channels\(^2\) (MoLE 2014). It has been estimated that nearly half of all households in Nepal either have at least one migrant in a foreign country or someone who has returned from a stint abroad (Sharma et al 2014).

In recent years, a number of studies have highlighted the need of family planning programmes to consider the implications of spousal separation on reproductive health need and provision. According to Nepal Demographic and Health Survey (NDHS) 2011 data, Nepalese women with non-resident husbands increased from 26% to 32% between 2006 and 2011. NDHS analysis suggested that the increase in unmet need for family planning between 2006 and 2011 was driven by women whose husbands had been away for less than one year, suggesting a close correlation to migration (Khanal et al 2013). Another survey found that women tended to discontinue family planning methods when their husbands were away and often did not plan for contraceptive needs before the husband’s return, meaning that couples reverted to less effective contraceptive methods (CREHPA 2012).

Migration in Nepal is also associated with exposure to sexually transmitted infections (STIs) and HIV through the returning labour migrants (in the case of HIV, particularly those returning from some high risk districts in India) who currently account for about 16% of HIV infections among 15-49 years in Nepal (NCASC 2014). Roos et al reported in 2012 that wives of migrants represented approximately 23% of all detected HIV infections in Nepal.

This paper reviews what is known about these issues, how they are addressed, what the gaps are, and makes recommendations for the future.

1.3 The programmatic and policy context

The Nepal Government has developed a series of policies and legal frameworks to govern labour migration and to promote foreign employment as a safe, dignified and decent prospect for would-be migrants (outlined in MoLE 2014). In this context, the main health concerns are those related to the health of migrants in destination countries. Pre-departure orientation programmes are mandatory and include information on HIV/AIDS, communicable diseases and sexual health. However it has been argued that they are insufficient as mechanisms to provide the scope and breadth of general information that migrants need, and should be supplemented

\(^2\) There is a ban (lifted in 2010, and reinstated in 2012) to prevent women younger than 30 from travelling to the Middle East for domestic work. Although the intent is to protect women from many risks, young women continue to migrate through irregular channels, without any form of protection that the formal system can offer (MoLE 2014).
with information provided by other stakeholders and media, and information initiative in local communities, which some local NGOs are already implementing\(^3\) (Asis and Agunias, 2012). Family Planning is one of the priority programmes of the Ministry of Health (MoH). Reproductive health (including family planning) is a component of the package of essential health services as outlined in the Nepal Health Sector Program II 2010-2015 (NHSP II) The programme aims to foster equitable access and utilisation of quality family planning services throughout the country. However, it does not seem to have explicit strategies targeting the specific needs of the growing numbers of couples with migrant spouses.

The Government is also addressing the reproductive health of migrant workers (and their wives) in the context of the HIV response. There is a specific National Targeted Intervention Operational Guideline for Migrants developed by the National Centre for AIDS and STI Control (NCASC 2010). The guideline includes strategies and activities for reducing vulnerabilities to HIV, but does not address the specific family planning needs of migrants and their wives – including wives affected by HIV.

2 Methods

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

2.1 Objectives

The specific objectives of this review are: to review the national and international literature in order to identify and assess the barriers faced by the migrant population and their spouses in accessing and utilising family planning services, and to synthesise the existing evidence on the determinants of access to family planning services. The review is primarily targeted at policy makers, health planners and programme managers.

Specifically, the review aims to answer the following questions:

- What are the barriers that migrants and their spouses face to access and use of family planning services in Nepal?
- What interventions have been implemented to increase access to family planning among migrant workers and their spouses in Nepal, or in countries that bear similarities with Nepal?
- Are there relevant lessons to be learned from other low and middle income countries?

\(^3\) For example by Women’s Rehabilitation Centre (WOREC) and Youth Action Nepal.

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What are the existing gaps in evidence that require further research in the context of Nepal?

2.2 Search strategy

For the literature review we used the following search strategies:

- Structured searches of PubMed, Research gate and Google Scholar to identify peer-reviewed academic articles;
- Structured and unstructured Google searches to identify non-academic literature (‘grey literature’);
- Reference checking of retrieved articles;
- Searching specific websites including: WHO, USAID Clearinghouse, DFID Research for Development (R4D), the World Bank;
- We searched for literature both in English and Nepali.

The search terms used for literature review included a combination of terms related to family planning, reproductive health and to migration including:

- **Family Planning terms**: family planning, sexual and reproductive health, fertility/fertility control, contraceptive/contraception, birth control, contraception, contraceptives.
- **Migration terms**: migration/migrant, labour migrant, migrant workers, spousal separation, migrant couples, mobility, wives/spouses of migrants, wives left behind, returning women migrants.
- **Reproductive health, STIs, HIV** (in order to cover the broader reproductive health angle).

The searches included both male and female migrants as well as spouses of migrants. For the purpose of this review, we defined migrants as individuals temporarily residing within the country or in other destination countries only for economic purposes. We did not include refugees and other people displaced for other reasons. We refer to spousal separation as cases of married (not divorced or legally separated) couples in which one spouse is reported to be away.

All the searches were conducted in English and Nepali and only studies published between 2000 and 2015 were included.

As part of document gathering we approached a number of individuals and organisations from Nepal with experience of work in family planning or with migrant workers (listed in Annex 1) for suggestions on additional documents to be included in our review.
2.3 Outcome of the literature search

There is a very small body of literature on the implications of migration for family planning. The literature from Nepal mainly consists of (well-known) analyses from NDHS and other surveys, and their focus is principally on the effects of migration on fertility or the extent to which family planning is used, but rarely (or at least not in depth) on the reasons for specific behaviours related to family planning. There is only one qualitative study (CREPHA 2012) looking specifically at the family planning needs of migrant couples in Nepal. The literature invariably covers women whose husbands have emigrated, but does not include the family planning needs of returning women migrants.

The literature on returning women migrants tends to focus on the broader vulnerabilities they face, such as economic challenges, addressing the consequences of exploitation and reintegration into Nepali society.

In general, the international literature on migrants (men and women) tends to be concerned with their health issues and needs in destination countries. There is less attention to those ‘left behind’, except in the context of socioeconomic status and impact of remittances. One recent essay on the effects of migration on ‘left behind’ Nepali wives similarly focuses on socioeconomic status and does not mention reproductive health concerns (Shrestha 2015).

The existing international literature touching on issues related to this paper is largely from contexts very different from Nepal, and therefore not useful. Commenting on the scarcity of literature from neighbouring Asian countries, Ban et al (2012) argued that the extent of out-migration is much lower in those countries, making Nepal’s situation a ‘unique’ case.

There is also a separate body of literature on HIV and migration in Nepal, including a body of grey literature from a number of projects implemented in the country.

2.4 Stakeholder consultation

The findings of the literature review were presented and discussed at a stakeholder consultation workshop on 30 May 2016, attended by 42 participants from government and non-government organisations (listed in Annex 2), and chaired by the FHD Director. Key points from the consultation are presented in Section 5.3 of this paper.

3 Findings

3.1 The evidence on spousal separation and reproductive health

As discussed in the previous section, the literature allows us to cover mainly wives of male migrants; they will therefore be the main focus of our review.
What we know about the family planning and broader reproductive health needs of couples separated by migration is not new, and limited to a series of studies and analyses conducted (or published) in the period between 2008 and 2013. Any new available literature is largely self-referential, i.e. repeats data and findings published earlier.

The potential effects of family separation and out-migration on lowering fertility were already noted in an analysis of the 2006 NDHS (Karki and Krishna 2008) and confirmed by a survey by the Nepal Family Health Program II (NFHP II) in 2008/2009 and the NDHS 2011. The NFHP survey (NFHP and New ERA 2010) reported that the husbands of nearly one-third (32%) of the rural women surveyed were living away from them at the time of the survey, and less than one-quarter (23%) of the separated couples used contraceptives, compared to 62% among couples living together, and that the use of contraception decreased as the duration of separation increased. This issue was further examined in an analysis of 2006 and 2011 NDHS which also looked closely at what the data revealed about contraceptive prevalence and unmet need (Khanal et al 2013).

Khanal et al (2013) found that when disaggregated by type of marital arrangement, unmet need was extraordinarily high among women whose husbands were living elsewhere for at least one year, and also high among women whose husbands had been living elsewhere for less than a year (Fig 1).

![Fig 1: Unmet need by marital arrangement, 2006 and 2011](Reproduced from Khanal et al 2013)
A qualitative study conducted for the USAID-funded NFHP II looked for the first time specifically at the family planning needs of migrant couples in Nepal (CREHPA 2012) and raised the issue of the different family planning and reproductive health needs of migrant couples (intended as couples where the husband had migrated). The study revealed that a majority of wives of migrants did not make any prior arrangements on the use of contraceptive methods before their husbands returned home, and that very few couples used contraception during the first night of sexual intercourse (CREHPA 2012).

Data reported by Ban et al. (2012) suggested very little risk of unintended pregnancy during periods of spousal separation: in the NHFP survey, only 0.1% of female respondents whose husband had been away for at least three months reported sexual activity (similar to the figure reported in the 2006 NDHS – 0.2%). Although self-reported data is subject to bias, it seems safe to assume that most sexual activity by wives of migrants takes place within marriage. Ban et al. observed that in adjusting for the needs of couples separated by migration, the emphasis of family planning programmes might be on using emergency contraception and barrier methods.

Ban et al. also commented on the scarcity of literature on family planning programme performance in settings with high levels of migration-related spousal separation, noting however the uniqueness of the Nepal situation. Their analysis of DHS data from the region between 2005 and 2007 found that labour-related spousal separation was significantly more common in Nepal than anywhere else: the proportion of married women of reproductive age whose husbands lived away was 4–5% in Vietnam and Cambodia and 9–12% in India, Bangladesh and Pakistan, compared with Nepal’s 26% (Ban et al. 2012). Our review confirms that the body of literature (from Nepal, or other low income settings) does not appear to have grown since then.

The association between mobility and HIV infection in Nepal has been known longer (see for example 1.2), and the vulnerability to HIV and STIs among women from migrant communities in Nepal described by Smith-Estelle & Gruskin (2003). There is a separate body of literature on this topic, rarely meeting with the literature on family planning. One exception is the documentation from the USAID funded Saath-Saath project which has integrated family planning services into existing HIV services for key populations, including migrants and their wives, and had a specific goal to increase the use of family planning services among most at risk populations.

3.2 Evidence on knowledge and use of family planning

3.2.1 Knowledge about family planning methods

Knowledge of at least one contraceptive method is nearly universal in Nepal, among both women and men (NDHS 2011). Modern methods are more widely known than traditional methods; almost all women know of a modern method, while 67% know of a traditional method.
Female sterilization, injectables, male sterilization, the pill and condoms are the most commonly known modern methods among women, with a slightly smaller percentage mentioning IUCDs. Emergency contraception is known by a relatively smaller percentage of women (29%) (NDHS 2011).

However we know little on whether migrants, and especially their wives, know enough about what might be the most appropriate method in their circumstances, whether they want more children or not.

A baseline survey conducted in four districts as part of the Saath Saath project had findings not dissimilar from the NDHS: all (but two) wives of migrants were aware of at least one family planning method: the most popular method known was sterilization (99%) followed by male condom (92%) and male sterilization (89%), but knowledge of emergency contraception and IUCDs was lower (19% and 69% respectively) (FHI 2012b). All male migrants had heard of at least one method; the condom was the best known (100%); 97% had heard of female sterilization, 91% of male sterilization and injectables, 83% of the oral pill. They reported lower knowledge of IUCDs (52%), implants (59%) and emergency contraceptives (26%). In the discussion of findings, survey authors noted that wives of migrants and their husbands lacked comprehensive information on different methods, their duration, and availability (FHI 2012a; FHI 2012b).

Similarly the CREPHA qualitative study (2012) reported that migrant couples were aware of the different contraceptive methods, however effective knowledge was low, and they were not aware of the duration of protection given by each long-acting method; very few had heard about emergency contraception, and did not know how to use it.

Another study assessing the vulnerability of wives of migrants to India to unsafe sex and HIV found that the majority of the wives (88.9%) of migrant workers had heard of condoms, but only 5.4% of them had used one during the most recent sexual contact with their husbands (Aryal 2013). This study was only concerned with protection from HIV infection and not with family planning.

3.2.2 Use of family planning methods

What we know about use of family planning is mainly from the studies mentioned earlier. The CREPHA study (2012) reports common consensus among the different respondents that family planning was essential, for limiting, spacing and for protection from HIV (the latter mainly mentioned by men). It found that use of a method of family planning depended on the frequency of the husband’s visit: the wives of those husbands who came home more frequently used methods such as injectables and pills, while the wives of those who visited less frequently resorted to withdrawal or condoms. Switching of methods during the migrant husband’s stay was common. Although husbands informed their wives a month in advance about their arrival, planning and preparedness on family planning was not common. It was very rare for the wives of
migrant men to procure or use any contraceptive method prior to their husband’s arrival, and men mostly relied on withdrawal if they were unable to procure condoms on arrival. Only a few of the couples interviewed desired more children, and some wanted to wait, yet among those couples some were not using any family planning method. Experience of abortion due to unwanted pregnancy was also common, and some women had resorted to unsafe abortion (CREPHA 2012).

There is little evidence on the use of family planning among people living with HIV in Nepal (Mishra 2014).

The Saath Saath project baseline survey findings (FHI 2012a; FHI 2010b) are less useful in relation to wives of migrants as the survey only finds, predictably, that use of family planning was much lower among wives whose husbands were absent. However, condom use with their husband during the previous two visits was also very low (reported by only 3% of wives). The habits of male migrants were more telling: although they mostly understood the dual protection offered by condoms, they were not using them with their wives, but consistently with sex workers or girlfriends (Fig. 2).

Figure 2: Condom use among male labour migrants by type of partners in past year while in Nepal

![Figure 2: Condom use among male labour migrants by type of partners in past year while in Nepal](image)

*Reproduced from FHI 2012a (Survey among male labour migrants).*

Use of condoms by migrants while outside Nepal has also been reported to be very low despite the common practice of visiting sex workers. In a qualitative study in India, one married respondent said that while he occasionally used a condom with female sex workers, he never used condoms with his wife “first because I don’t think it’s necessary, as I am not carrying any disease; and second, if I use condoms, my wife will suspect me of infidelity”, and mostly those who were married were afraid that carrying condoms would communicate something negative to relatives who happened to see them (Bam et al 2013).
FHI (2012a) also reports that the majority (83%) of male migrant labourers perceived condoms as dual protection from both unwanted pregnancy and HIV transmission. Dual protection can also be achieved with a combination of methods – using both condoms plus another method of contraception, such as an intrauterine device (IUCD), implants, the birth control pill or injectables (UNAIDS/WHO 2012).\(^4\) This is important because women need safe contraceptive and HIV prevention options that they can own and manage – which is not always achievable with the male condom.

A recent study by Mishra (2014) looks specifically at the family planning knowledge and practice among people living with HIV in Nepal, but does not have a specific focus on migrants, and it is not clear whether the study area (Pokhara sub-metropolitan city area) contains large number of migrants. In this study two thirds of respondents were using at least one family planning method: the majority (65.8%) used condoms, only 2.5% used the oral contraceptive pill, and only 0.8% used condoms in addition to another contraceptive. The author argues that this figure (0.8%) is low in comparison to other countries such as India (23%), and that the lower rate of dual contraception could be explained by two main reasons: low emphasis on dual methods during family planning counselling sessions (which 67% had received); and misconceptions about non condom family planning methods, reported to be common among people living with HIV in Nepal (Mishra 2014).

3.3 Barriers to family planning access and use by migrants and their spouses

Just as we know little about use of family planning in the context of spousal separation, we know very little about the specific barriers to access and use. The most useful study in this respect is the qualitative study by CREHPA (2012), although its analysis of the issue appears somewhat limited. The study asked about barriers to using family planning on the first night of the husband’s return, and about barriers to accessing family planning during the husband’s migration.

3.3.1 Barriers to accessing family planning

When asked about specific barriers, respondents (men and women, but also FCHVs and health providers) cited the ‘common’ demand and supply barriers that have been extensively described elsewhere (including in our reviews of other groups – the urban poor, Muslims and young people): fear of side effects, shyness in discussing family planning with providers, distance to health facilities, unavailability of the desired method at the health facilities, attitude of health

\(^4\) WHO has recently issued guidance on the use of hormonal contraception by women at high risk of acquiring HIV. Some methods can be used without restriction: combined oral contraceptive pills, combined injectable contraceptives, combined contraceptive patches and rings, progestogen-only pills, progestogen-only injectables (with some caveats), and levonorgestrel and etonogestrel implants, LNG-releasing IUCDs (WHO 2015).
providers, lack of service providers at the health facility and religious restrictions (CREHPA 2012). Interaction with FCHVs\(^5\) was common among the wives of migrants (CREHPA 2012). It appears that the study did not probe as to whether there were any different, or specific barriers during the period of spousal separation which may explain the limited information obtained.

3.3.2 Lack of preparedness on husband’s return
CREHPA (2012) report that planning and preparedness on family planning was not common, especially when husbands’ informed their wives about their return less than a month in advance. ‘Lack of preparedness’ is not a barrier in itself, but the reasons behind it might be. A women’s focus group in the CREHPA study reported that they expected their husbands to bring condoms; while the men’s focus group tended to see family planning as a responsibility of their wives.

Many women stated that they couldn’t make decisions about family planning without their husbands; however, communication between spouses on whether to have children did take place, both while the husband was away and on his return. Another frequently cited reason for not seeking family planning advice in advance was the fear of being accused of infidelity by the community as well as the husband (CREHPA 2012).

3.3.3 Socio-cultural factors
Other sociocultural factors, such as unequal power and gender dynamics, lack of education and cultural values are likely to play a role in family planning among wives of migrants, as they do in the general population. However, how these factors exactly ‘play out’ in the context of male migration and family planning has not been described in the literature from Nepal.

Various studies have indicated that remittances have some empowering effects on women, but that these effects are not automatic and in some cases only temporary (UNESCAP 2012). When husbands migrate, women tend to have more responsibilities and an increased workload, but sometimes can also benefit from greater autonomy in decision making, which in turn can affect family planning decisions. For example, a study on gender and labour migration in Asia reports that in Sri Lanka the decision making power of the female spouse increased sharply as she stepped into the role of ‘manager’ of the family; in India (especially from studies in Kerala), remittances from the husbands often led to an improvement of women’s economic and social status, which in turn, often had a permanent empowering effect; in Bangladesh the spouses left behind frequently became the de facto head of household and as a result experienced an increase in their decision-making power, for some (but not all) women this was temporary, i.e. only while the husband was away (IOM 2009). There is some evidence that this may also be the case in Nepal (see for example, ICIMOD, 2010; Kaspar, 2006, Maharjan et al 2012, Shrestha

\(^5\) As shown by Wang 2013, community-level contact with family planning providers is significantly associated with modern contraceptive use in Nepal.
2015), however the evidence is highly contextual, depending on household structure, composition, locality, specific socioeconomic conditions and the types of decision that women are allowed to make autonomously.

4 Interventions

Several interventions targeting migrant workers and their wives have been carried out in Nepal, although mainly as part of the HIV response.

The USAID-funded Saath Saath Project (2011-2016) is particularly relevant because it had a specific goal to increase the use of family planning services to most-at-risk populations. A key approach was the integration of family planning services into existing HIV services through strengthening both existing NGO and government outreach and service delivery sites. Although we have some data, publicly available documentation says little about how effective the approach was, specific lessons, and whether or how the initiative is going to be sustained by the government (as originally envisaged).

Saath Saath provided family planning counselling and five methods (condom, oral contraceptive pills, injectable and implants) and referral services from 57 integrated health services (EIHS) sites until August 2014, and after that counselling and four methods (condom, oral contraceptives, injectable and implants) and referral services from 21 EIHS sites from seven districts. IUCD services were provided from only one site in Kapilbastu district. Migrants were specifically targeted in four districts – Bara, Kapilbastu, Nawalparasi and Palpa. By August 2014 17,939 migrants and 25,339 spouses of migrants had been reached with HIV and STI prevention information and family planning promotion through the following activities:

- One-on-one and group contacts by outreach educators and community mobilisers, including along the Indo-Nepal border exit and entry points;
- ‘Edutainment’ activities in drop-in centres;
- Information and education during pre-and post-migration periods;
- Special festival campaigns (e.g. during Dashain, Tihar, Chhath and Eid);
- A mass media like radio programme and facilitated radio listeners’ group;
- Female Community Health Volunteers (FCHVs) and mother’s group meetings;
- Distribution of strategic behavioural change communication materials.

Other projects in the context of the HIV response tell us about specific strategies to reach migrants and their wives.

A large component of DFID support to the Nepal national HIV/AIDS programme\(^7\) in 2005–2011 was a comprehensive package of services targeted at labour migrants (or potential migrants) and their wives, especially to increase their knowledge about HIV and empower them to negotiate safe sex with their husbands. The activities were implemented in 11 districts by 11 NGO partners and included:

- Outreach education and peer education on HIV and STIs and psycho-social counselling, and community outreach: implementing NGOs built up a system of outreach, service delivery and referral by forming peer groups. In many cases, coverage was extended by working with FCHVs, health posts and sub health posts and mothers’ groups to scale up awareness in communities.
- Drop-in centres and HIV/STI clinics (including mobile clinics).
- A behaviour change communication intervention.

One of the areas of support with the largest impact was the diagnosis and treatment of the wives of labour migrants for STIs. The evaluation’s discussions with the wives of migrants found them well satisfied in terms of being empowered to negotiate condom use with their husbands after having been tested and treated for STIs (Roos et al 2012). The evaluation report also comments on the lack of institutional framework or platform for migrants and their families to address issues related to HIV and AIDS in a sustained manner (i.e. no migrants’ civil society organisations, at least at the time of the report) and that the best option for enhancing sustainability might be to work with peer groups of migrant families for their empowerment (Roos et al 2012).

A good example of this is the EMPHASIS project\(^8\) (2009-2014) which addressed both HIV vulnerability and safe mobility issues of cross border migrant populations, moving between Nepal and Bangladesh to India and return. EMPHASIS involved a complex set of interventions in both origin and destination countries, and placed a particular focus on migrant’s wives as agents of change, using women’s groups as a specific approach.\(^8\)

The independent evaluation (Drinkwater et al, 2014) found that women’s groups played a significant role both in women’s empowerment and in increasing the numbers of male migrants seeking VCT services and accepting safe sex practices – through the intercession of their wives. These groups were reported to have increased women’s awareness of their vulnerability and helped them gain confidence in communicating more openly and frankly with partners, including

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\(^7\) Through UNDP.

\(^8\) The project helped women to form 21 groups in Nepal, 9 in Bangladesh and 12 in India.
about safe sex practices. Women reported being confident to talk to their husbands over the phone about such practices, and being able to ask them to go for VCT services on their return, and to use contraceptives. There was also an effect on managing remittances, with women playing a role in the decision making on expenditures, and an increase in women with bank accounts. Women’s groups also tackled broader social issues, such as the practice of ‘Chaupadi’ (forcing menstruating women to sleep in animal sheds) in Nepal, or sexual harassment against spouses left at home in Bangladesh (Drinkwater et al, 2014).

In addition to these examples, the Health Communication Capacity Collaborative (HC3) is supporting the National Health Education Information Communication Centre of the Ministry of Health to design, implement and evaluate Social and Behavior Change and Communication programmes for family planning. Migrants are among the target groups of this initiative; however we found no details of specific interventions to include in this review.

5 Discussion and way forward

5.1 The evidence and the evidence gaps

The surge in out-migration from Nepal for foreign employment has triggered a number of studies highlighting the need of family planning programmes to consider the implications of spousal separation on reproductive health need and provision. The literature from Nepal mainly consists of (well-known) analyses from NDHS and other surveys, and their focus is principally on the effects of migration on fertility or the extent to which family planning is used. However, literature on the implications of migration for family planning is scarce. Little is known (or at least not in depth) on the reasons for specific behaviours related to family planning or on the specific barriers faced by migrant couples to access health and family planning services. The existing international literature touching on issues related to this paper is largely from contexts very different from Nepal, and therefore not useful.

Even if we do not know the specific barriers, there is considerable evidence pointing to high unmet need for, and lower use of, family planning among migrant workers (most of whom are men) and their wives who stay at home. Specific findings include:

- Use of condoms by migrants while outside Nepal has been reported to be low or inconsistent despite the common practice of visiting sex workers.
- Unprotected sex exposes wives of migrants to HIV and STIs. In one study only 3% of wives reported the use of condoms by their husbands during the last two visits (FHI 2012a); another found that although the majority of wives (88.9%) of migrants had heard of condoms, only 5.4% had used one during the most recent sexual contact with their husbands (Aryal 2013). Another study reported little planning and preparedness on
contraception by women before their husband’s return, and that very few couples used contraception during the first sexual intercourse after the husband’s return (CREHPA 2012).

- Unprotected sex when the husband returns home exposes wives to unwanted pregnancies. The CREHPA 2012 study found that only a few of the couples interviewed desired more children, and some wanted to wait, yet among those couples some were not using any family planning method. Experience of abortion due to unwanted pregnancy was also common, and some women had resorted to unsafe abortion (CREHPA 2012).

- Analysis of 2011 NDHS data showed that the unmet need for family planning was extraordinarily high among women whose husbands were living elsewhere for at least one year, and also high among women whose husbands had been living elsewhere for less than a year (Khanal et al. 2013).

5.2 Programme and policy implications

While not a new phenomenon, migration in Nepal has reached unprecedented levels. Ban et al (2012) estimated that labour-related spousal separation was significantly more common in Nepal than anywhere else: the proportion of married women of reproductive age whose husbands lived away was 4–5% in Vietnam and Cambodia and 9–12% in India, Bangladesh and Pakistan, compared with Nepal’s 26%.

Given the scale of migration and that it will remain at similar levels in the foreseeable future, the case for providing dual protection to women against HIV and STIs as well as against unwanted pregnancies seems fully justified and urgent. Is such protection being provided to migrant couples? What lessons emerge from programme and policy initiatives undertaken in the Nepal context? What more is needed and what is missing?

5.2.1 The need for systemic focus on migrant couples

The National Family Planning Programme in Nepal needs to go beyond its natural realm and specifically address the needs of migrant couples. Interventions are required at the policy level (to emphasise the importance of migration), at the programme level (to integrate the circumstances linked to migration into the National Family Planning Programme), at service delivery and at the community levels.

For example, at the programme level, every woman of reproductive age approaching or being approached by a government, private health or family planning provider should be asked early on whether her husband is a migrant – triggering a series of measures. The most important one should be to check if she wants more children, if she is using contraceptives and if she would like advice on contraceptive options and on protection from STIs. Likewise, men approaching government health services should be asked whether they are migrants, in which case proper
counselling should be provided for the prevention (barrier methods), diagnosis and treatment of STIs and HIV and the adoption of an appropriate family planning method, both by the male migrant and his wife. In other words, migration should become a flag for government health workers and volunteers (FCHVs) and for private healthcare providers, requiring them to apply specific protocols that respond to the needs of migrant couples. Such protocols and service delivery strategies should be designed or, if they already exist, revised and updated.

It is also important to integrate the reality and implications of migration into other national programmes or initiatives. For example, programmes targeted at young people should include the issue of migration, as many young people are either the migrants of tomorrow or migrants themselves. Socio economic programmes with a poverty reduction focus should incorporate migration as an element that makes this population group more vulnerable to certain changes.

At the service delivery level there is much that can be done both by public and private health care and family planning service providers to increase the availability of all the required contraceptive commodities and the quality of care provided. As part of strengthening quality of care, efforts should be targeted at better training of health care providers and removal of certain misconceptions and attitudes among some of them which may further stigmatise wives of migrants while their husbands are away. Counselling skills among service providers and community volunteers are crucial, yet seldom available among many health workers.

At the community level, interventions are required to increase awareness about how migration affects family planning and to change certain community attitudes about access to family planning by wives of migrants that can result in prejudice and stigma. FCHVs should be part of such effort by identifying households affected by migration and by targeting specific information and advice to those households.

Several interventions described in this review have provided a focus on migrant couples, but most of these remain small, pilot, research-type interventions that are yet to be adapted and brought to scale for the whole of Nepal. Likewise, there are several interventions, such as pre-departure briefing of migrant workers and other possible measures discussed later, that may require close collaboration of the MoHP with other ministries.

All these and other measures aimed specifically at migrants should become a clear, identifiable component of the National Family Planning Programme. However, interventions should be properly tailored to the country and local contexts (terai, hill, mountain areas, etc); therefore piloting would be advisable.

5.2.2 The needs of male migrant workers

A comprehensive response to the family planning needs of migrant workers is difficult as migrants have different needs depending on whether they are in their destination countries or
back visiting Nepal. This literature review did not explore in depth the literature on migrants at destination (given our primary focus on Nepal) but some of the reported interventions with migrant workers shed light on to this matter.

In destination countries migrants are vulnerable because of their social status, sub-standard living conditions, stringent working patterns and engagement in risky sexual activity, mostly with sex workers. Migrants need proper health care, which may not be available, or affordable, or which is simply discarded for whatever reason. Certain precautions such as the use of condoms and personal hygiene could reduce the incidence of STIs, and while many workers may be aware of it, or made aware of it during pre-departure briefings, many of them still engage in unprotected sex. There are various measures that could be taken, or at least tested, to mitigate the health risks to migrants. For example:

- Strengthening pre-departure briefings provided to migrants could be a way to increase awareness. We did not find literature discussing in depth the quality of such briefings or on their health-related contents, so this would seem worth researching.

- Reaching out to returning migrants when they travel to Nepal for festivals and social occasions. At this time the emphasis should be on the importance of ruling out infections and protecting their wives from STIs, while encouraging these men to adopt jointly with their wives family planning methods adapted to their reproductive preferences. Treatment of STIs among returning migrants together with the empowerment of their wives to negotiate condom use have been shown to have a high impact (Roos et al 2012).

- Multi-country focused strategies in coordination with destination countries such as India and the Gulf countries might, in principle, help to address some issues by building upon the success of planning interventions at source, transit and destination to target migrants at all possible locations (Sultana et al). However, the evidence base on these approaches remains rather limited.

5.2.3 The needs of the wives of migrants

Wives of migrants are particularly vulnerable when their husbands return home, but also when their husbands are away, their workload increases and they may face multiple stresses. It is important for them to be in good health and to be able to make reproductive decisions at a time when the entire family relies heavily on women. We found limited evidence on specific needs and barriers (both demand and supply) among wives of migrants. One study suggested a higher incidence of abortion (including unsafe abortion) but the findings were based on a relatively small sample.

Regardless of the knowledge gaps, several authors emphasise the importance of increasing awareness of risk – the dual risk of HIV or STI infection and of unwanted pregnancies – among
wives of migrants. They also advocate for enhancing the use and increasing the supply of all methods of dual protection. Dual protection can be achieved with a combination of methods – using both condoms plus another method of contraception, such as an intrauterine device (IUCD), implants, the birth control pill or injectables (UNAIDS/WHO 2012). The importance of safe contraceptive and HIV prevention options that women can own and manage has long and widely been recognised in the context of the global HIV response; this is not always achievable with the male condom alone. The low rate of dual contraception among migrant couples has been attributed to low emphasis on dual methods during family planning counselling sessions and to misconceptions about non condom family planning methods, reported to be common among people living with HIV in Nepal (Mishra 2014). Authors also point to the need for contraceptive options to be adapted to the reproductive preferences of migrant couples:

…This trend [i.e. the misleading CPR as recorded] is not unique to Nepal and invites program managers to ask ourselves, “What is the appropriate method that caters to the unpredictable schedule of male migrants?” While we know that short return visits by these migrant workers to their homes do sometimes result in unintended pregnancies, many of these pregnancies are deliberate, and short visits provide a rare window for couples to expand their families. As a result, family programs must support migrants in their decision-making process and provide contraceptive options that support these unpredictable leave schedules. Additionally, initiatives that cater to spousal communication, both before and during a male migrant’s return to his home, may provide an additional opportunity for couples to prepare for their time together. (Safi, 2015).

In conclusion, we found several good examples of initiatives worth testing or replicating that approach migration in a comprehensive way. These initiatives point to the need of approaching migration at the policy and programme level, and across a variety of programmes and initiatives that can achieve a virtuous circle of protection of migrant couples – focusing on both wives and husbands – as well potential migrants such as young people.

5.3 Key points from the stakeholder consultation

The findings of this literature review were discussed at a stakeholder consultation in May 2016. Key discussion points included:

1. Acknowledging the increasing trend of female migrants seeking employment opportunities abroad, and their family planning needs.

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9 See for example the Saath Saath and EMPHASIS projects, and the evaluations by Roos et al (2012 – while evaluating the Nepal HIV/AIDS programme) and Drinkwater et al (2014, who evaluated the EMPHASIS project).

10 E.g. integration of HIV and family planning, strategic behaviour change communication, and strengthening the availability of services.
2. The important role of health workers in providing appropriate family planning counselling to spouses of migrants, and in addressing existing ‘myths and misconceptions’ on the use of family planning by migrants’ wives (booklets for health workers on this topic already exist). However health workers should take into account user preferences when recommending specific methods, especially in contexts where women are stigmatised for using family planning.

3. Considering the nature of mobility patterns and duration when designing interventions – for example, the fact that many migrants return home only for short periods of time.

4. Assessing awareness, accessibility and utilisation of family planning among migrants in destination countries: this could help to understand migrants’ attitudes and behaviours regarding family planning when they are back in Nepal.
6 References


Asis, Maruja MB and Agunias DR (2012). Strengthening Pre-Departure Orientation Programmes in Indonesia, Nepal and the Philippines IOM-MPI Issue in Brief No. 5.


Annex 1: Organisations approached for this study

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<th>Organisation</th>
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<td>July 15, 2015</td>
<td>Mr Jagat Basnet</td>
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<td>Centre for Research on Environment, Health and Population Activities (CREHPA)</td>
<td>July 17, 2015</td>
<td>Dr Mahesh Puri</td>
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<td>Green Tara Nepal</td>
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<td>July 22, 2015</td>
<td>Mr Bishwa Rai</td>
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<td>July 23, 2015</td>
<td>Dr Shilu Adhikari</td>
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<td>Family Planning Association of Nepal (FPAN)</td>
<td>July 23, 2015</td>
<td>Ms Jamuna Sitaula</td>
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<td>August 19, 2015</td>
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<td>Marie Stopes International</td>
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<td>September 6, 2015</td>
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### Annex 2: Consultation workshop participants

<table>
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<tr>
<th>Name</th>
<th>Organisation</th>
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<tr>
<td>1  Dr. RP Bichha</td>
<td>FHD</td>
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<td>2  Ghanshyam Pokhrel</td>
<td>FHD</td>
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<tr>
<td>3  Chandra Rai</td>
<td>Jhpiego</td>
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<tr>
<td>4  Shanti Thapa</td>
<td>CARE NEPAL</td>
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<tr>
<td>5  Jagadishwor Ghimire</td>
<td>PSI/N</td>
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<tr>
<td>6  Netra Bhatta</td>
<td>USAID</td>
</tr>
<tr>
<td>7  Khim Bdr. Khadka</td>
<td>Save the Children</td>
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<tr>
<td>8  Kanak Raj Shrestha</td>
<td>FHD</td>
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<tr>
<td>9  Dr. Jhalak Gautam</td>
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<tr>
<td>10 Bhakta Raj Pokhrel</td>
<td>FHD</td>
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<tr>
<td>11 Yuba Raj Pokhrel</td>
<td>NHSSP</td>
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<tr>
<td>12 Deepak Thapa</td>
<td>NTAG</td>
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<tr>
<td>13 Pranab Rajbhandari</td>
<td>HC3</td>
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<tr>
<td>14 Minu Adhikari Khanal</td>
<td>FHD</td>
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<tr>
<td>15 Mohan Lal Shrestha</td>
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<tr>
<td>16 Vidya DC</td>
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<tr>
<td>17 Manju Thapa</td>
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<tr>
<td>18 Kalpana Thapa</td>
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<td>19 Yogendra Prasai</td>
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<td>20 Ashesh Regmi</td>
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<td>21 Parshu Ram Shrestha</td>
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<td>22 Dr. Ishwor Pd. Upadhyya</td>
<td>NHTC</td>
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<tr>
<td>23 Dr. Sandesh Pantha</td>
<td>SIFPO-2</td>
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<td>24 Subash Shrestha</td>
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<tr>
<td>25 Prakash Adhikari</td>
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<tr>
<td>26 Chandra Mani Dhungana</td>
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<tr>
<td>27 Om Khanal</td>
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Access to family planning services by migrant couples in Nepal – barriers and evidence gaps
A review of the literature

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<td>Pankaj K. Tiwari</td>
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<td>Sangita Khatri</td>
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<td>Bimala Paudel</td>
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(This list does not include participants from HERD)
## Annex 3: Acronyms and abbreviations

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<td>Acquired Immune Deficiency Syndrome</td>
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<td>Contraceptive Prevalence Rate</td>
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<td>Department for International Development</td>
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<td>Epoch Integrated Health Services</td>
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<td>FCHV</td>
<td>Female Community Health Volunteer</td>
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<td>HIV</td>
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<td>IUCD</td>
<td>Intrauterine contraceptive device</td>
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