ACTION FOR CHANGE

An initiative for the promotion of inclusive SRH and FP services for persons with disabilities in Nepal

Blind Youth Association Nepal

Supported by :

CBM Global Disability Inclusion

CONTENTS

Abbreviations and Acronyms

A4C	Action for Change
AIDS	Acquired Immunodeficiency Syndrome
APFSD	Asia-Pacific Forum on Sustainable Development
APPC	Asia-Pacific Population Conference
BYAN	Blind Youth Association Nepal
CBM	CBM Global Disability Inclusion
CDC	Curriculum Development Center
CDS	Center for Karnali Rural Promote and Society Development
CEHRD	Center for Education and Human Resource Development
CMC	Centre for Mental Health and Counselling-Nepal
COP	Community of Practitioners
CRPD	Convention on the Rights of Persons with Disabilities
CRS	Contraceptive Retail Sales (Nepal CRS Company)
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organization
DRR	Disaster Risk Reduction
FP	Family Planning
FP2020	Family Planning 2020
FPAN	Family Planning Association of Nepal
FWD	Family Welfare Division
GDS	Global Disability Summit
GEDSI	Gender Equality, Disability, and Social Inclusion
HIV	Human Immunodeficiency Virus
ICFP	International Conference on Family Planning
IEC	Information, Education, and Communication
INGO	International Non-Governmental Organization
KII	Key Informant Interview
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, Plus
M&E	Monitoring and Evaluation
MEAL	Monitoring, Evaluation, Accountability, and Learning

MHM	Menstrual Hygiene Management
MoU	Memorandum of Understanding
MSI	Marie Stopes International
NDFN	National Deaf Federation Nepal
NERF	Nepal Earthquake Recovery Fund
NGO	Non-Governmental Organization
NHEICC	National Health Education, Information and Communication Center
NHTC	National Health Training Center
NONDO	Northern Nomadic Disabled Persons' Organization
OPD	Organization of Persons with Disabilities
PEC	Picture Exchange Communication
PFPID	Parents Federation of Persons with Intellectual Disabilities
PWDs	Persons with Disabilities
RECU	Reach, Enter, Circulate, Use
RHRN	Right Here Right Now
SDG	Sustainable Development Goals
SOP	Standard Operating Procedure
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
ToT	Training of Trainers
UHPC	Urban Health Promotion Center
UN	United Nations
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities

ACKNOWLEDGMENT

Over its 13 years of inception, BYAN has emerged from a targeted initiative into a leading national advocate for the rights and empowerment of young people with disabilities. The organization has established itself as a key leader in promoting inclusion and advancing the right of persons with disabilities to a dignified and adequate standard of living. We have worked on multiple cross-cutting issues and achieved meaningful results at the individual, community, and institutional levels.

In this right-based journey, BYAN, from 2023-2025, implemented project titled "Action for Change: An initiative for the promotion of inclusive SRH and FP services for persons with disabilities", in support of the CBM Global Disability Inclusion Nepal, by placing young people with diverse disabilities at the center of a national movement for inclusive SRHR. As the project activities have now concluded, we feel it essential to document the project achievements, lessons learned, best practices, and inspiring impact stories through this booklet.

We extend our sincere appreciation to our valued partner CBM Global Disability Inclusion Nepal and global team for their continued collaboration, guidance, and technical, administrative and financial support throughout this joint venture. We also gratefully acknowledge our central and chapter members, young peer educators and community of practitioners from the cross-disability section, government and non-government stakeholders, and each individual and institutions who shared their meaningful experiences and actively contributed to document these meaningful changes.

Our special thanks go to the Samanyayik Legal Service and Research Center Pvt. Ltd. for their technical expertise and committed support in documenting and shaping BYAN's achievements, best practices, experiences and learnings into this publication.

Finally, we express our deep gratitude to everyone who has contributed to this journey and supported BYAN's mission to advance an inclusive, rights-based, and equitable society for persons with disabilities.

With gratitude,

Ram Chandra Gaihre
President
Blind Youth Association Nepal (BYAN)

EXECUTIVE SUMMARY

Blind Youth Association Nepal (BYAN) is working to ensure the youths with disabilities enjoy right to a dignified living within an inclusive society. Along with broader working mandates, the organization is undertaking health equity initiatives, specifically addressing Sexual and Reproductive Health and Rights (SRHR) for the young people with diverse disabilities in Nepal. In this context, BYAN implemented "Action for Change: An initiative for the promotion of inclusive SRH and FP services for persons with disabilities", in partnership with CBM Global Disability Inclusion from February 2023 to December 2025. This rights-based intervention was implemented in Kathmandu, Bara, and Surkhet, with the aim of rectifying a systemic exclusion of young people with disabilities from the enjoyment of their SRH and FP rights, empowering and engaging them to access SRH services and meaningfully understand and enjoy their sexuality. The initiative was built upon a "Power Shift" model, where the implementing partner BYAN was involved in designing the project activities according to the need-based approach and incorporating the recommendations of various OPDs and disability rights activists, rather than embracing the pre-designed mandates.

At the individual level, the project enhanced SRHR knowledge by developing disability-friendly, multi format and accessible health education, information, and communication materials. A core component of this project involved developing 75 peer Educators on SRHR and FP issues among young people with diverse disabilities, including those with from the underrepresented groups. The peer led sessions encouraged open dialogue, and providing individualized counseling to help normalize SRHR issues among persons with diverse disabilities. PWDs showed notable improvements in knowledge across key thematic areas, including menstrual hygiene management, sexual behavior such as the ability to differentiate between good touch and bad touch, use of urine bags and menstrual pads, condom use, personal hygiene and temporary family planning methods. Health service providers also reported a significant rise over the past two years in demand for both temporary and permanent family planning methods, maternal health services, STI screening, and reproductive health education. Young people are increasingly rejecting harmful myths, such as the desexualization of persons with disabilities and the practice of menstrual exile.

At the systemic level, BYAN advocated for policy reforms and structural changes to ensure inclusive SRHR policies and services for all. A key intervention involved collaboration with local governments to establish model health facilities: the Urban Health Promotion Center Dumarwana in Bara, the Birendranagar Municipal Hospital in Surkhet, and the Budhanilkantha Hospital in Kathmandu. These facilities were modified using the 'RECU' principle to ensure physical and communication related accessibility. Tangible modifications included the installation of wheelchair-friendly ramps, tactile paths, widened doorways, and accessible washrooms with non-slippery floors and grab bars. Furthermore, the installation of Braille signages, orientation maps, and audio-visual Citizen Charter displays ensured that information regarding services was available to those with diverse impairments. Parallel to infrastructural changes, service providers, government officials and CSO representatives were also trained in disability etiquette and rights-based care. Consequently, these trainings and sensitization efforts have yielded concrete and measurable outcomes; including the local levels allocating dedicated budget for the disability inclusive SRHR and FP issues and empowerment and leadership provisions. In national levels, the state and non-state actors have resorted to policy changes, accessibility incorporation and inclusive budgeting and partnership.

At the institutional level, the project worked to enhance the organizational capacity and visibility, contributing to movement-building efforts. Through the Power Shift model, BYAN enhanced its internal governance by updating its statute, expanding membership, and the formation of the Community of Practitioners for a cross-disability advocacy mechanism that unified the voices of all ten disability clusters recognized in Nepal. BYAN has gained recognition as a subject-matter expert in disability-inclusive SRHR and has been invited to multiple official government and CSO forums to provide expert insights and policy recommendations. On the international stage, BYAN represented Nepali youth at the Global Disability Summit in Germany, the International Conference on Family Planning in Colombia, and the Asia-Pacific Forum on Sustainable Development in Bangkok. These platforms allowed the organization to influence global declarations, such as the GDS 'Youth Call to Action,' and showcase innovative Nepali models for inclusion to a global audience.

While generating the tangible and measurable achievements, the project also faced multifaceted challenges stemming from inadequate infrastructure, bureaucratic barriers, and the inherent complexities of implementing a rights-based approach. High staff turnover, political unrest, budgetary Delays, local level leadership confrontations and frequent gap between verbal support and formal written contracts necessitated a constant restart of advocacy efforts and postponing of the accessibility installations. Entrenched cultural taboos and conservatism initially hindered discussions on topics of sexuality, SRHR and FP in the project areas. Technical barriers were also identified, such as the digital divide in rural areas and the lack of inclusive pedagogical skills among some external trainers, demanding the need for specialized local capacity. The plan to pilot accessible pregnancy test kits was abandoned as SRH tests in Nepal are largely provider-administered and importing accessible kits was deemed costly and unsustainable without a local supply chain.

Nonetheless, for the continuity and sustainability of the project achievements, it is essential to formally embed disability inclusive and accessible SRHR materials into the national education curriculum, health training manuals, government plans, programs, policies and actions. The government must scale the model of accessible health infrastructure across all municipalities and prioritize formalizing partnerships with Organizations of Persons with Disabilities through written Memorandums of Understanding. Furthermore, the peer-led model should be institutionalized at the ward level to provide a permanent community presence, and geographical reach must be extended to remote areas. Digital tools like the 'Hami for SRHR' app should technically be overhauled to ensure wider reach of the IEC materials in the hands of every individual. The multi stakeholder and multisectoral partnership can contribute to carrying forward public awareness initiatives in combating cultural hesitations.

Overall, the project A4C generated valuable institutional learning for BYAN and the broader disability rights movement in Nepal by demonstrating that effective advocacy must be grounded in tangible models, adaptive management, and sustained engagement. Establishing model accessible health facilities provided concrete proof that inclusion is practical and replicable. The project also underscored the need for continuous, institutionalized government engagement, flexible coordination mechanisms across disability groups and government actors, and demand-responsive peer education approaches that prioritize tailored, accessible training and confidential counseling for sensitive SRHR issues.

CHAPTER ONE

INTRODUCTION

1.1 Introduction of the Organization

Blind Youth Association Nepal (hereinafter referred to as BYAN) is an organization established by the blind and partially sighted youths of Nepal. The organization operates as a rights-based institution, guided by a vision wherein youth with disabilities enjoy right to a dignified living within an inclusive society. Its primary mandate is to advocate for and advance the rights of youth with disabilities in general, while specifically prioritizing the needs of the blind and partially sighted population throughout the nation.

The organization's membership base consists exclusively of visually impaired individuals within the demographic cohort of 16 to 40 years of age, comprising more than 900 members nationwide. Structurally, BYAN maintains a decentralized presence across all provinces through ten strategic chapters. These are located in Jhapa and Morang (Koshi Province), Bara (Madhesh Province), Kathmandu and Chitwan (Bagmati Province), Kaski (Gandaki Province), Rupandehi and Banke (Lumbini Province), Surkhet (Karnali Province), and Kailali (Sudur Pashchim Province).

Currently, BYAN's operational portfolio encompasses a diverse range of thematic interventions, including policy advocacy, the promotion of inclusive education, and economic empowerment through employment and self-employment schemes. Furthermore, the organization actively engages in health equity initiatives specifically addressing Sexual and Reproductive Health and Rights (SRHR) and mental health alongside efforts to enhance political participation, civic engagement, accessible electoral systems, and the pursuit of inclusive climate justice and Disaster Risk Reduction (DRR).

1.2 Disability and Sexual and Reproductive Health Rights in Nepal

There are various legal and policy frameworks mandating protection of SRHR of PWDs in Nepal. As per the safe motherhood and reproductive health rights Act 2018, service providers should provide services such as family planning, reproductive health, safe motherhood, safe abortion, emergency obstetric and neonatal care and reproductive health in a non-discriminatory manner.[1] Despite of this substantive legal arrangement, The National Health Policy 2019 however lacks a particular focus on SRHR aspects of disability population apart from incorporating the provision for making disability friendly infrastructures and mechanism at all levels.[2] The Disability Management Prevention, Treatment and Rehabilitation policy 2017 and its plan covering period of 10 years from 2017 to 2026 aims to make disability friendly maternity services available to women with disabilities in 5 years' time period and also make all health facilities disability inclusive.[3] Additionally, the National Guidelines for Disability Inclusive Health Services, 2019 is the most progressive law to ensure disability inclusive service provision. The guideline promotes

1. *Safe Motherhood and Reproductive Health Rights Act, 2075 (2018), (Section 3, Subsection 9, Sections 13, 15 & 16)*
2. *Ministry of Health and Population. National Health Policy, 2076. (2019). (Section 6.15)*
3. *See Strategy 3 and the 10-Year Action Plan matrix: Disability Management (Prevention, Treatment and Rehabilitation) Policy, Strategy and 10-Year Action Plan (2073–2082). Ministry of Health and Population.*

inclusive and accessible infrastructure and services focusing on SRHR, inclusion of disability disaggregated indicators, availing SRH services for PWDs in all health facilities and hospitals and social audit of the inclusive health services.[4] The disability specific law, Act Relating to Rights of persons with disability 2017 specifically mandates actions to protect the rights of PWDs , access to free health services, and right to obtain information in accessible format, and directs the government to reduce existing accessibility related barriers.[5]

In spite of these legal and policy frameworks, the SRH rights of PWD is still remains neglected by the family, society and the state level. The young persons with disabilities remain one of the most marginalized groups in regard to their SRHR.[6] Despite progressive constitutional provisions[7] and legal commitments, significant barriers persist, including widespread social stigma, inaccessible education, and inadequate service provision. A pervasive misconception exists that PWDs are either asexual, hypo-sexual, or incapable of making informed choices about their bodies.[8] Consequently, their sexual needs are frequently viewed as a burden by immediate families and the government, leading to attempts to constrain their sexual behaviors.[9]

While good SRH is defined as a state of complete physical, mental, and social well-being in all matters related to the reproductive system[10] , the demand for SRH services among young people in Nepal is significantly underserved.[11] Essential services such as family planning, contraceptives, and counseling in sexually transmitted infections are unavailable to a large percentage of the adult population.[12] A situation that is even more acute for those with disabilities.[13] Although there is no specific official data on the unmet need for family planning among young people with disabilities, the national unmet need stands at 21%.[14] It is safe to assume this figure is considerably higher for the disability community.

---

4. Ministry of Health and Population. (2019). Guideline on Disability Inclusive Health Services, 2076. See sections 4, 6, 10 and 11,),

5. Act Relating to Rights of Persons with Disabilities, 2074 (2017), (Sections 8, 16, 18, 28, 32, 33, 34)

6. UNFPA (2018), Young Persons with Disabilities: Global Study on Ending Gender-Based Violence and Realizing Sexual and Reproductive Health and Rights — Summary Brief, p. 33, Retrieved from: https://www.unfpa.org/sites/default/files/resource-pdf/UNFPAGlobal_Study_on_Disability_-_Summary.pdf

7. Constitution of Nepal, Art. 18

8. Committee on the Rights of Persons with Disabilities (CRPD), General Comment No. 3 (2016) on women and girls with disabilities, UN Doc. CRPD/C/GC/3, para. 38. Retrieved from: https://docs.un.org/en/CRPD/C/GC/3

9. Devkota, H. R., Kett, M., & Groce, N. (2019). Societal attitude and behaviors towards women with disabilities in rural Nepal: pregnancy, childbirth and motherhood. BMC Pregnancy and Childbirth, 19(20). https://pmc.ncbi.nlm.nih.gov/articles/PMC6327527/

10. World Health Organization (2006), Report of a technical consultation on sexual health, Geneva: WHO, p. 5. Retrieved from: https://www.who.int/teams/sexual-and-reproductive-health-and-research-%28srh%29/areas-of-work/sexual-health See also: United Nations (1994), Programme of Action of the International Conference on Population and Development,Para 7.2 https://www.un.org/en/development/desa/population/publications/ICPD_programme_of_action_en.pdf

11. Sedhai, S. (2023). Unmet Contraceptive Need among Currently Married Adolescents in Nepal. Adhyayan Journal, https://doi.org/10.3126/aj.v10i10.57349

12. Thapa, N. R. (2020). Factors influencing the use of reproductive health services among young women in Nepal: analysis of the 2016 Nepal Demographic and Health Survey. Reproductive Health, https://doi.org/10.1186/s12978-020-00954-3

13. UNFPA (2018), Young Persons with Disabilities: Global Study on Ending Gender-Based Violence and Realizing Sexual and Reproductive Health and Rights Summary Brief, p. 33, Retrieved from: https://www.unfpa.org/sites/default/files/resource-pdf/UNFPA Global Study on Disability Summary.pdf

14. Ministry of Health and Population (Nepal), New ERA, & ICF. (2023). Nepal Demographic and Health Survey 2022 Summary Report (p. 7). Retrieved from: https://www.dhsprogram.com/pubs/pdf/SR275/SR275.pdf

A paradox exists in service delivery. While nearly 99% of health facilities in federal and provincial hospitals offer family planning services five or more days a week, PWDs remain unable to access them. A joint study conducted by BYAN indicated " 96.5% of respondents were unaware of modern family planning methods, and 39% were unaware of the legal status of abortion. Additionally, around 80% held one or more myths or misconceptions associated with family planning and abortion.[15] The low usage of these services is ultimately attributed to a combination of inaccessible infrastructure, the negative attitudes of service providers, and the absence of essential support such as sign language interpreters. Disability, when intersected with gender and geographical remoteness, multiplies the discrimination faced by these individuals.[16] Furthermore, young persons with disabilities often lack a mechanism to voice their concerns and remain unaware of their SRH rights. [17]

1.3 Project Action for Change

To address the aforementioned pertinent gaps, BYAN implemented a project titled "Action for Change: An initiative for the promotion of inclusive SRH and FP services for persons with disabilities", by placing young people with diverse disabilities at the center of a national movement for inclusive SRHR. The project was implemented in Kathmandu, Bara and Surkhet districts from February 2023 to December 2025. This multi-year initiative attempted to address gaps in equal SRH rights and service provision for the PWDs, aiming to empower and engage them to access SRH services and meaningfully understand and enjoy their sexuality. Executed through a strategic partnership between BYAN and CBM Global, the project constituted a specialized intervention designed to optimize the accessibility and provision of SRHR and FP services for PWDs. In the individual level, BYAN worked to aware and empower the persons with diverse disabilities and their parents to exercise their SRHR. It tried to improve knowledge on SRHR by developing disability-friendly health education,

15. Gaihre, R., Rajbhandary, R., Lohani, S., Giri, R., & Sapkota, S. (2018). Understanding the sexual and reproductive health needs of young persons with disabilities in Nepal. Sunaulo Pariwar Nepal, Blind Youth Association Nepal, & Marie Stopes International.
See also: Blind Youth Association Nepal, Position paper on Disability and SRHR, p. 15. Retrieved from: https://www.byanepal.org/wp-content/uploads/2024/12/A5_Position-Paper-on-SRHR-Disability-8_18_2020.pdf
16. Committee on the Rights of Persons with Disabilities. (2016). General Comment No. 3 (2016) on women and girls with disabilities. U.N. Doc. CRPD/C/GC/3, (Para 17)
17. Dhungana, G. P., et al. (2021). Factors affecting utilization of sexual and reproductive health services among women with disabilities – a mixed-method study from Ilam district, Nepal. BMC Health Services Research. Retrieved from: https://pmc.ncbi.nlm.nih.gov/articles/PMC8705122/

information and communication materials, promoting open discussion and providing required individual counseling to normalize the SRHR issue among the persons with diverse disabilities.

In the systemic level, it advocated for policy change and systemic reform for the inclusive SRHR and service for all. Importantly, BYAN worked with the local levels to develop model health facilities by presenting an example of accessible infrastructures and disability-friendly etiquettes of health professionals and technical staff. This initiative aimed to increase trust of the PWDs as rights holders and service recipients in the government health facilities. In the institutional level, it significantly worked to strengthen the capacity and visibility of the OPDs, by contributing to movement building in the discourse of disability rights and inclusive SRHR in Nepal.

1.4 Objective

As a collection of best practices and impact stories, this report aims to document the journey and achievements of the project 'Action for Change'. It will summarize and analyze the impact, effectiveness, and sustainability of the project interventions. The report therefore aims to:

1. Highlight BYAN's best practices and success stories during the implementation of the project 'Action for Change,
2. Document positive impacts on beneficiaries, communities, and stakeholders through the project,
3. Identify challenges and gaps encountered during project implementation period, and
4. Provide insights and recommendations to guide awareness, sensitization, advocacy and policy-making process and movement building efforts for inclusive SRHR and CSE initiatives in Nepal.

1.5 Methodology

The report follows qualitative method of study in summarizing and analyzing the project journey, impact, effectiveness, and sustainability. Information was collected through primary and secondary sources.

1.5.1 Desk Review

As a secondary source, review of project reports (baseline study report, quarterly reports, annual reports, and endline evaluation report was made to get acquainted with the pre-project scenario, beneficiary's needs, project achievements and outcomes, key milestones and success stories. Legislative and policy review was conducted to incorporate right based insights on the SRHR for the PWDs. reports, scholarly journals/articles were studied for the conceptual frameworks and context on the SRHR and CSE and disability prospective.

1.5.2 In-depth Interview

This report is based on the qualitative insights of the project stakeholders in presenting the success stories and best practices. As the primary source of information, in depth interviews were conducted with the peer educators, community of practitioners (COP) and beneficiaries of various training and workshops by the project. Target groups such as OPD leaders working

as the COP members, young people with disabilities, and parents of youths with disabilities. In this process, 6 peer educators, representing 2 youths from each district were interviewed to collect their journey of understanding SRHR, training and counseling provided by them to the other young people with disabilities and stories of change. 3 interviews were taken with the beneficiaries, who accessed the training and awareness, and felt real change in their life. 6 members of community of practitioners, representing 2 OPD leaders from cross disability section from each district were interviewed to collect information on the cross-sectional collaboration among the people with diverse disabilities. In this way, a total of 15 in-depth interviews were conducted with the project target groups. The respondents included Six persons with visual impairments (4 males, 2 females), three persons with physical disabilities (2 males, 1 female), and two deaf individuals (1 male, 1 female). Additionally, the study engaged two females with intellectual disabilities and three parents of persons with intellectual disabilities (1 male, 2 females). Notably, the male parent respondent also identified as a person with a physical disability, overlapping the respondent number. These interviews helped to generate case stories and testimonials for the report.

1.5.3 KII

A total of 9 KIIs were conducted with the project stakeholders, which comprised the local government representative's, public health facility staff and executive members and staff of the project implementor, The BYAN. In this process, 3 interviews from the local levels (2 from Jeetpursimara Sub-metropolitan City and 1 from Birendranagar Municipality), and 3 interviews with the public health service provider of model health facilities (2 from Urban Health promotion center Dumarwana, Jeetpursimara, and 1 from Birendranagar Municipal Hospital, Birendranagar) were conducted to understand the collaboration, success, challenges and sustainability of the initiatives aimed at their institutions. Lastly, 2 interviews with the BYAN executive committee and 1 project staff were conducted to demonstrate BYAN's journey of starting the SRHR initiative, to accessing the project from CBM, changes and best practices, and recommendation for endorsement and sustainability of these actions.

1.6 Ethical Protocols and Confidentiality

Given the sensitivity of the subject matter, this study adhered to the highest ethical standards and was guided by a strict "Do No Harm" principle. A reinforced ethical framework was applied throughout the study to safeguard participant dignity, safety, and autonomy.

Participation in this study was entirely voluntary. All participants were provided with clear and accessible information regarding the purpose of the study, the nature of their participation, and the intended use of the information collected. Free, prior, and informed consent was obtained from all participants, both verbally and in writing, prior to their engagement.

Participants were explicitly informed of their right to decline participation, refuse to answer any question, withdraw at any stage, or pause the interaction without any negative consequences. Only individuals aged 18 years and above and capable of providing informed consent or decision making by themselves or with the help of support were included in the study.

All study instruments and engagement protocols were reviewed and finalized jointly by the BYAN and the Samanyayik study team to ensure ethical appropriateness, cultural sensitivity, and community accountability.

Strict measures were implemented to protect participant confidentiality and anonymity. Some case narratives and quotations were anonymized and carefully reviewed to prevent direct or indirect identification, including through combinations of personal, geographic, or contextual details.

All data were stored in secure, password-protected systems accessible only to the core study team. Any private or identifying information was handled with extreme care and will be destroyed after report approval in accordance with ethical protocols.

All information collected was used solely for the purpose of this study. Under no circumstances was data shared, reused, or disclosed beyond the agreed scope. Supporting materials, including consent records and internal documentation, were stored securely in line with organizational confidentiality standards and applicable data protection requirements. Upon completion of the study, records were formally transferred to the BYAN for secure retention.

1.7 Limitations

Since the report is based on qualitative information collected during the study, it may not be construed as a final account of the beneficiaries and the stakeholders. The respondents have been interviewed through the purposive selection method. It was challenging to find the respondent's appropriate time, reach out to their venue for the in-depth interview and KII, setting an appropriate interview environment, and allocating sufficient time to facilitate long conversation and secure comprehensive narratives. Consequently, given these specific constraints and the qualitative nature of the enquiry, the results and analysis presented herein are indicative of the specific participants involved and should not be construed as statistically generalizable to the broader population.

CHAPTER TWO

ACHIEVEMENTS AND BEST PRACTICES

Project A4C envisioned to empower Persons living with all forms of disabilities to exercise their rights and make informed health life choices in a supportive social, institutional & legal environment. In the institutional level, it significantly worked to strengthen the capacity and visibility of the OPDs, by contributing to movement building in the discourse of disability rights and inclusive SRHR in Nepal. One of BYAN's core strengths is its capacity to elevate the voices of young people with disabilities, while generating wider public support for inclusion. Through the A4C initiative and other complementary nature of programs, BYAN implemented media sensitization campaigns, consistently utilizing mass media such as radio and television, digital platforms for social media engagement, and convened youth conference, multi-stakeholder dialogues, rallies, and public demonstrations.

The project worked with young people with disabilities as a primary target group at the individual level, which included persons from underrepresented gender and impairment groups such as those with psychosocial disabilities, intellectual/ developmental disabilities, and deaf blindness. A core component of this project involved developing peer Educators on Family Planning and SRHR from among the beneficiaries. In the institutional level, the intervention largely focused on strengthening the capacity of OPDs, specifically the BYAN chapters and their leaders. The project also worked to develop the advocacy capacity of other OPD leaders.

Key accomplishments of the project include federal, provincial, and local sensitization workshops and policy dialogues, advocacy actions resulting in tangible outcomes, developing and printing accessible materials, revision of training manuals, and increased media engagement and partnerships with other CSOs. Engagement with all levels of government has opened up. The number of invitations from local governments in all working municipalities has increased, and participation and attendance of government representatives in the BYAN programs has been achieved. BYAN has also been recognized as an expert organization in disability SRHR and has been invited to various official government meetings for suggestions as well as an expert insight. Additionally, the project

- Established and institutionalized the Communities of practitioners (CoP), representing the organizations of people with diverse disabilities, disability rights experts and local level representatives,

- Developed the accessible and disability friendly model health facilities three local levels: namely the Urban Health Promotion Center Dumaruwana in Jitpursimara Sub-Metropolitan City Bara, Budhanilkantha hospital in Budhanilkantha Municipality Kathmandu and Municipal Hospital in Birendranagar, Surkhet

- Developed facilitator guidebooks and IEC materials, which were available in many formats, and were accessible for the visually impaired, the hearing impaired, and those with intellectual disabilities.

- Supported the Family Welfare Division, Government of Nepal in the implementation of guideline on disability friendly reproductive health and safe motherhood service 2022, by orienting and localizing its contents to the health professionals and government stakeholders

- Established mandate for embossed/tactile indicators on oral contraceptive pills, and

- Secured budget allocations from the local, provincial and federal governments for disability-sensitive programs.

Through these sustained efforts, BYAN has emerged as a leading expert organization in disability-inclusive SRHR. It is now widely recognized by government institutions, civil society organizations, and international development partners, including UN agencies, as a reliable technical partner and a key driver of inclusive SRHR programming.
In light with these achievements, this section therefore presents brief consolidation of the best practices initiated by BYAN through the project's A4C.

2.1 From recipients of grants to Recognition of OPD power

The unique aspect of project 'Action for Change' is its operation in the power shift model, where the beneficiaries had chance to design their own project for their own goodwill. The project was designed with the norm that power should be shifted to and recognized within the implementing partners or OPDs. As per this framework, project design process incorporated the principle that those who live with the problem are best positioned to design the solution.[18] This practice aligns with the human rights model in dealing with the OPDs , as Including and empowering the OPDs themselves in the project designing to implementation with full autonomy aligns with the major principle of the disability movement, "Nothing about us, without us".[19] The institutionalization of power shifting practices among OPDs create an enabling environment where those organizations are given more autonomy to control the results of the programs. Its uniqueness lies in the fact that the beneficiaries or the implementing partners are the ones who design the projects and activities according to their own needs and own the implementation

18. Disability Rights Fund, DECIDING TOGETHER: SHIFTING POWER AND RESOURCES THROUGH PARTICIPATORY GRANTMAKING, doi.org/gd57bh
19. Charlton, J. I. (1998), Disability oppression and empowerment (p. 3). University of California Press.

process. Instead of sticking with the issue flagged by the funding partner, this project followed a rigorous consultation process among the OPDs, disability rights activists and experts representing diverse regions to identify the issue and design the activities, incorporating their views/opinions in the program finalization.

BYAN crucially benefited from the partnership with CBM Under this Power Shift model. During the inception phase, the organization was directly involved in designing the entire project cycle together with the CBM, rather than merely applying and executing the project activities. It helped the organization in need assessment, enhanced its technical ability to frame rights-based activities and action plans. During the execution period, CBM rigorously supported the BYAN with their technical and administrative support throughout the implementation cycle. This enhanced the organization's technical, administrative and financial capacity to manage a large-scale project effectively, thereby increasing its ability to deliver the intended outcomes.

2.2 Developing Accessible Health Facilities through Collaboration

CRPD guarantees PWDs a right to easy access buildings, roads, transportation and other indoor and outdoor facilities, including schools, housing, medical facilities and workplaces.[20] The convention lays down the obligation upon the state to provide signage in Braille and in easy to read and understand forms in the buildings and other facilities open to the public.[21] Absence of access to the health facilities in an easy and unhindered manner for the PWDs violates their confidential information relating to health and wellbeing.[22] Due to the lack of accessible health facilities, they are deprived of obtaining proper care and treatment in their SRH issues.[23]

Priya, one of the beneficiaries from Madhesh Province, who participated in the trainings conducted by BYAN narrated that 'the visually impaired individuals are compelled to take

20. United Nations. (2006). Convention on the Rights of Persons with Disabilities. Article 9, Paragraph 1 (a)
21. IBID, Article 9, Paragraph 2 (d)
22. Committee on the Rights of Persons with Disabilities. (2014). General Comment No. 2 (2014) on Article 9 Accessibility. U.N. Doc. CRPD/C/GC/2. (See Paragraph 40.
23. Prayatna Nepal (2022). Disability and sexual and reproductive health rights (SRHR)A study on barriers in accessing sexual and reproductive health services. Retrieved from: https://www.prayatnanepal.org/publication/disability-and-sexual-and-reproductive-health-rights-srhr

assistance from the other persons to go to the health facilities, since those facilities are not reachable by them with their own. In such cases, going to the health facilities to access the for SRH services by taking someone's support implies revealing their issues to others.

> "There are certain subjects we may wish not to share with others, preferring to share them directly with the doctor. However, since we need to request friends to accompany us, saying "I have such and such task, many confidential matters inadvertently become public. My menstruation was not happening on time. Since I was unmarried, I had concerns about whether a child had been conceived. I could not share this with anyone. I went to the hospital but returned eventually because I could not tell my problem to the doctor."

In the words of Madan Karki, a person with physical disability, who also worked as the peer educator in Surkhet, 'accessing the health facilities for a wheelchair user is difficult for the persons with physical disabilities'. In his words, 'Going there in a wheelchair is a struggle. Even after reaching there, the environment is not comfortable enough for them to present their issues, leading to deprivation of services.'

Witnessing these issues, BYAN developed and acted in an idea of the model health facilities for the persons with diverse disabilities through project A4C'. This project has contributed to developing a total of three health facilities that are accessible and friendly to the PWDs. With the technical assistance of BYAN and engagement of the engineers, the health facilities of Urban Health Promotion Center Dumaruwana in Jeetpursimara Sub-Metropolitan City Bara, municipal hospitals of Birendranagar Municipality Surkhet and Budhanilkantha Municipality Kathmandu have been modified to make the facilities accessible for the PWDs. In this process, BYAN signed the partnership agreement (MOU) with the Jeetpursimara Sub-Metropolitan City to share the construction cost. BYAN also collaborated with a CSO named CDS Park Mugu, to share the construction cost for the modification of the municipal hospital of Birendranagar Municipality.

Accessibility within the health facilities was secured with the active involvement of the persons with different disabilities through the team of Community of Practitioners. The COP members engaged in the accessibility audit in the health facilities. In each project district, 3 accessibility audits were executed, by engaging persons with diverse impairment types and genders. Before conducting the accessibility audit, extensive feasibility studies were conducted in all three project districts. Subsequently, a questionnaire for the audit was prepared using checklists developed by the National Federation of the Disabled Nepal (NFDN), CBM Global and CMC Nepal. The technical persons, disability rights experts along with the engineers submitted reports based on the 'RECU' principle, offering recommendations for short-term, mid-term, and long-term changes in health facilities. They ensured time to time monitoring and provided their expert advice to ensure full accessibility. The construction was smooth and accessibility principles

materialized pursuant to the feasibility studies, accessibility audits, expert recommendations and monitoring.

> "The toilet bathroom of Dumurwana hospital was narrow and difficult for wheelchair maneuvering. We advised the hospital staff to reconstruct to widen the periphery inside. We also suggested placing the windows and door latches in the lower section and installing signboards featuring large letters and pictorial/symbolic representations, and changes have occurred accordingly."
>
> -Khem Kumari Poudel, Parent of Person with Intellectual Disability, COP Member, Bara.

In terms of infrastructural accessibility, wheelchair ramps, accessible toilets and tactile paths have been installed in every service area of those health facilities. The parking area and waiting area have been made accessible; easily reachable to the wheelchair, crutch, white cane and tricycle users. Every entrance and room features sign board in a large print and braille signages. The low vision reflective and non-slippery tape in the stairways of the health center have been installed to ensure accessibility for the low vision/partially sighted individuals.

Key materials installed to improve information and communication related accessibility include orientation maps with symbols, Braille, and audio-visual aids for individuals with visual impairments. A visible Citizen Charter display unit with a monitor has been placed in a prominent area, ensuring that important hospital policies and services are communicated in audio, video and sign language to facilitate those with hearing or visual impairments and individuals with intellectual disabilities. Furthermore, a sound system has been introduced to provide information about the hospital's services and its surroundings.

These accessibility features have enabled the persons with disabilities to independently identify the location of the dispensary, the examination room, the laboratory, and the maternity ward in the health facility premise. They can now easily and independently navigate to the entire premises of the health facility with the help of their assistive devices such as white cane, wheelchairs, tricycles, and Crutches. Upon reaching the OPD, they can clearly understand which service is available in which department, by touching and reading the installed indicators. This accessibility allows them to approach the OPD easily, maintain their privacy, and confidently share their issues with health professionals. In the words of Dr. Yam Prasad Adhikari, the in charge of Birendranagar Municipal Hospital, Previously, it was uncomfortable for wheelchair users and visually impaired individuals to reach the doctor or nurse. After BYAN constructed these disability-friendly infrastructures, it has become easy for patients to register and navigate to the health facility premises independently. This has made it easier for service users compared to before. And it is making the service providers easier as well to deliver their

service to the patients with disabilities.'

Not only building accessible infrastructures and information-communication, BYAN also worked to train the health professionals. A total of 159 Service providers were reached to increase their knowledge & skills on inclusive SRH & FP related services. They have been sensitized about the concept of disabilities, models of disability, the ten types of disabilities and their accessibility and accommodation requirements, the disability-friendly SRH rights and services, national guidelines on disability-friendly safe motherhood and reproductive health, disability etiquette, legal frameworks, and the use of inclusive IEC materials, etc. Significant changes have been witnessed among those health personnels who participated in the sensitization workshops and training.

> "I, along with almost all my colleagues, have completed training conducted by BYAN. The training covered essential skills on how to treat patients with disabilities, how to communicate effectively, how to behave respectfully, and how to understand their specific difficulties. We have learned to use respectful terminology to ensure their dignity is not compromised. The training has impressed upon me the need to understand the psychology of patients so that they feel confident enough to open up completely. We health professionals and staff maintain a highly positive attitude towards PWDs. While we serve all patients, we provide the highest priority to PWD. The goal is to create an environment of confidentiality where they can share their internal health issues with doctors and nurses without hesitation."
>
> -Dipendra Kumar Shah, In-Charge Urban Health Promotion Center, Dumarwana.

The rate of visiting the health facilities of PWDs in the project implementation districts has increased to 71% from 49% of the baseline statistics. A total of 185 PWDs have obtained SRH services from those facilities After developing them in an accessible model. According to Bishna Kumari Mahatara, the peer educator in Surkhet, accessing services has become much less difficult for PWDs like her following the establishment of the Model Health Center. Previously, Health personnels would ask the volunteer accompanying her, "What has happened to her?" instead of addressing the PWDs directly. Now they ask the service seekers themselves about their problems. In her words, "Now, they give us priority and do not hesitate to provide services directly. It is much easier now compared to the pre-project period."

2.3 Meaningful Government Actions on SRHR

One of the key achievements of project A4C' stands is realization and incorporation of accessibility features on the SRHR for the PWDs by the government entities. The government agencies not only have endorsed policies and accessibility features in their programs, but they also have operationalized those features, taking the ownership of BYAN's advocacy and sensitization efforts. Some of those major achievements have been highlighted in this section.

2.3.1 Creating Oral Contraceptive Pills for Visually Impaired Women

Government has made the positive action towards making the oral contraceptive pills accessible for the women with visual impairments. The Family Welfare Division under the

Ministry of Health and Population provisioned for the tactile embossed contraceptive pills. All the contraceptive pills being made by Nepal CRS Company, a government run company thus have tactile embossed marks. The hormonal pill and the iron pill contain indicates by making an embossed indication or some signal. As the pills have specific embossed mark in a designated area, it will be easier for the visually impaired women to plan the consumption of those pills by starting from the embossed area. As in the words of Narayani, while all the pills previously felt uniform in their surfaces, there is now tactile signage on one corner indicating where to start. This allows totally blind woman like her to identify the starting point independently. Now the visually impaired women can independently access the family planning and birth control measures without requiring any third-party assistance. This accessibility feature makes the visually impaired women to use their right to have a free and informed choice with privacy over the birth control and their bodily autonomy.

2.3.2 Proactive Initiation of Printing Accessible IEC Materials

During the project implementation period, BYAN actively consulted with the various government agencies to initiate the policy changes in the field of inclusive SRHR for all. Family Welfare Division (FWD), National Health Education, Information and Communication Center (NHEICC), National Health Training Center (NHTC), Center for Education and Human Resource Development (CEHRD) and Curriculum Development Center (CDC) proactively collaborated with the organization to formally integrate disability-inclusive SRHR within government frameworks. Through the targeted efforts such as disability sensitization sessions for government employees and contributions to policy amendment and curriculum revision workshops from BYAN, the A4C project has secured strengthened institutional commitments from the government entities to embed accessibility and equity aspects in their policy and programmatic elements.

As a result, NHEICC has printed large-font Family Planning Flip Charts, the Handbook on Comprehensive Sexuality Education for Adolescents with learning difficulties and has produced audio sets of booklets on Adolescent Sexual and Reproductive Health. NHEICC has also initiated actions for developing Accessible Communication Guideline for PWDs, allocating the budget in the Fiscal Year of 2082/83. Similarly, FWD has been continuing the disability specific program by allocating the budget for the implementation of the Disability-friendly Safe-Motherhood and Reproductive Health Service Guideline. The NHTC has revised the training manual for Adolescent Sexual and Reproductive Health. It has integrated one dedicated session on Disability-Friendly Health Services in its five-day Adolescent-Friendly Reproductive Health Training Manual. They have also started integrating designated sessions on disability-friendly service during their staff induction training. Breast Cancer awareness materials have been developed in collaboration with NHEICC.

The endorsement of accessibility requirements of persons with diverse disabilities from the

government level resembles remarkable success of project A4C. These steps are the milestones in ensuring systemic inclusion of the PWDs through the right to information and accessibility as envisioned by the UNCRPD. These results could be made possible from the co-creation by BYAN and the government agencies. Whereas previously disability rights were perceived merely in the form of charity of distribution of assistive devices, financial aid and relief, these concrete achievements in the field of SRHR demonstrate government's progressing efforts towards the rights-based initiatives for the persons with diverse disabilities.

2.3.3 Government Commitments in the Disability inclusive SRHR and FP issues

During the project implementation, a total of 218 government personnel and service providers (at federal, provincial and local level) were made aware and sensitized on inclusive SRH and FP policy and programming. The sustained advocacy efforts, policy dialogues and strategic coordination meetings, federal, provincial, and local government bodies resulted in concrete policy and budgetary commitments from the government levels. As a result, a total of 9 Actions (policies, plan, laws, forums, budget allocations and strategies) were initiated by Local, Province, and Federal government for disability friendly SRH and FP Services. During the project implementation period, OPDs and PWDs received a total of 50 partnership or invitations in planning process from the Local, Province and Federal government. Referring to some instances, local governments in Kathmandu, Bara, and Surkhet have secured specific funding for capacity building and development. Notably, the Jeetpursimara Sub-Metropolitan City Health Section supported with NPR 50,000 allocation for inclusive SRHR training, while Bheriganga Municipality in Surkhet committed NPR 100,000 towards health provider orientation, the development of accessible IEC materials, and dedicated budget lines. Additionally, the local government in Jeetpursimara allocated NPR 1300000 for the construction of a disability-friendly washroom, complementing BYAN's technical assistance for the project. Accompanying these local initiatives, the FWD supported the localization of disability-friendly guidelines by conducting sensitization training for health providers across three districts.

Training to health service providers

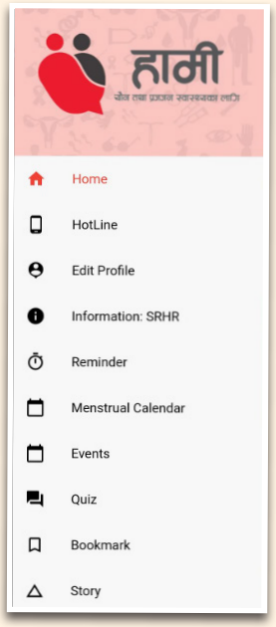
2.4 BYAN's Continued Commitment in Creating Multi-Format Accessible Materials

As a deep commitment of BYAN towards access to information for all types of PWDs, the organization also ensured development and dissemination of IEC materials on SRHR and FP, targeting the persons with visual impairments, physical disabilities, intellectual and psychosocial

Surkhet- CSOs Meeting with INF

disabilities and person with deaf, and hard of hearing. Those materials were developed and disseminated in multiple accessible formats including Braille, large prints, sign language, easy-to-understand booklets, and pictorial communication cards. To cite some important works, BYAN developed and disseminated breast cancer awareness materials in accessible formats to ensure easy access and inclusivity of PWDs. In collaboration with the NHEICC, BYAN adapted the original flipchart content into large print and Braille formats. BYAN also developed and disseminated Facilitator Guidebook on SRHR for fostering inclusive and effective peer education. Crucially, the organization developed a 'Glossary of Sign Language on SRHR and CSE,' in consultation and collaboration with the National Deaf Federation Nepal (NDFN), experts and individuals living with deaf and the sign language interpreters. Working with the persons with intellectual disability, the easy-to-understand guidebook was developed in consultation with the Easy-to-Read Checking Group, and final printing was made in various accessible formats. The guidebook has been available in Braille, large print, standard print, and easy-to-understand format color copies. An audio version has also been developed, ensuring inclusive access for all.

Similarly, BYAN also printed Toolkit on sexual and reproductive health guideline in large print. A fully accessible information video was produced with audio description, sign language interpretation, captioning, and animated content targeting the individuals with intellectual disabilities. Accessible flipcharts were printed and distributed to the same target group.



Notably, BYAN has also used the mobile technology to ensure the information relating to the SRHR in the hands of every PWDs in Nepal. As it had already developed a mobile app called 'Hami for SRHR', this project has contributed to updating the knowledge and information in the app. Updates were made in the app through the collaboration with Marie Stopes International (MSI). The updated version comprises improved features in the app about SRHR. Mainly, the app integrates latest information from government agencies, providing users with real-time updates. Now, it includes an "Easy Mode" designed for individuals with intellectual disabilities, offering easy-to-understand contents. A total of 423 individuals has downloaded the app. The app was especially useful for peer educators. They shared that " the app was of great help, since information about SRHR was repeatedly consulted by the participants during the training and counseling sessions. ".

The successful deliberation of these outcomes resulted from collaborative partnerships with key stakeholders, including the Parents Federation of Persons with Intellectual Disabilities (PFPID) Nepal, the Autism Care Nepal Society, and the Easy Checking Group, which comprises self-advocates with intellectual disabilities. Adhering to the principle of "Nothing about us without us," BYAN engaged directly with the primary beneficiaries throughout the design and creation phases. Extensive, multi-level consultations were conducted with youth with intellectual disabilities and autism to verify the accessibility of the information. The materials were finalized by assessing comprehension of the beneficiaries at every stage of development.

These content deliverables also satisfy the essential teaching and orientation requirements of FP and SRHR.

Offering the IEC materials as per the requirements of diversity within the disabilities ensured that young people with visual, hearing, intellectual, and autism-related disabilities can access SRHR information in ways suited to their communication needs. Harikrishna Bhatta, one of the project beneficiaries of trainings and workshop in Surkhet defines the accessible publications as “Double Access” to the persons with different disabilities. To put in the words of Bhatta, “he had read many types of curricular and extra-curricular books previously. However, he had not heard about the single book, which was designed both in braille and large prints.”

> “The book currently in my hand is a flip chart about breast cancer. On the one side, the text is provided in Braille, and on the other side, it has been designed to be accessible for friends with low vision through the large print. This publication offers dual accessibility.” says Bhatta.

2.5 Inclusive Mentoring and Leadership opportunity for youths from cross-disability section

Young people with disabilities were the primary target groups of the project A4C at the individual level. 80% focus was on the youths with disabilities of this entire project. A core part of the project was development of Peer Educators on SRHR and FP as the peer counsellors from among those direct beneficiaries. Recognizing the different identities, those peer educators were chosen to represent different types of impairment, making the cohort inclusive of persons from underrepresented impairment types, such as psychosocial disability, intellectual/developmental disability, deaf blindness, in addition to recruiting the youths with visual impairment, physical disabilities, multiple disabilities, deaf, and parents of youths with disabilities. With an effort to address gender and disability related multi layered compounded discrimination encountered by women, the project included over 50% women as the peer educators. This initiative was designed to equip PWDs with the necessary skills to operate as peer counselors. By implementing a peer-based model for SRHR training and counseling, the project anticipated a significant improvement in SRHR awareness and attitudes among young people with disabilities.

SRHR TOT to Peer educators

After selection, Training of Trainers (TOT) programs on SRHR were conducted in Kathmandu, Birendranagar (Surkhet), and Simara (Bara), for total of those 75 peer educators, representing 25 participants from each district. To enhance participation, a one-day preparatory session was organized for

individuals with Intellectual disability, psychosocial disability, deafblind, multiple disability and their parents prior to the four-day TOTs. The training covered key SRHR topics such as family planning, menstruation, pregnancy, contraception, STIs/STDs, maternal and newborn health, safe abortion services, reproductive health morbidity, gender-based violence, adolescent sexual and reproductive health, and facilitation skills, using youth-friendly techniques like discussions, role-playing, and games. The TOTs empowered participants as peer educators for advocacy on disability-inclusive SRHR, marking a crucial step toward advancing the disability rights movement in Nepal. Beyond initial capacity development, these facilitators received ongoing mentorship, professional exposure, and platforms to apply their knowledge during the project implementation period. Those trained peer educators were successfully mobilized to facilitate sessions on SRHR, FP and CSE to their peers. A total of 30 peer education sessions were successfully completed by 75 peer educators across three districts. Along with the peer training sessions, counseling sessions were also conducted by them. Total 2125 PWDs have been reached through the peer led sessions and counselling. Facilitators adapted inclusive methodologies to cater to participants' diverse needs. The participants of the peer education felt the training sessions more relatable and empowering. Consequently, the initiative reached over peers through various organizational, school and community-based sessions.

Counselling session by peer educators

This continuous engagement transformed the facilitators from just empowered individuals into effective advocates who amplified the community's voice and became a source of inspiration for other youths. Harikrishna Bhatta, one of the beneficiaries who accessed the training from the peer educator remembers,

> "The training was facilitated by women. I was astonished to see that women could speak so openly on these matters. Previously, even our blind friends who were educated in Kathmandu would not speak on these topics, yet here, women delivered the training with great openness and confidence."

The peer educators including Bishna Mahatara, Madan Karki, Sanyukta Shrestha, Samir Desemaru and Shibendra Yadav have assumed active advocacy roles at their local and national forums. As the BYAN's president Mr. Ram Chandra Gaihre notes that the Peer Educators prepared by this project are now being invited by other organizations as experts, champions and SRHR promoters. Their evolution represents a significant contribution to the broader disability

inclusion movement, as these young leaders now actively identify and challenge accessibility barriers with distinct clarity and purpose.

To put in the words of Manamaya Koirala, parent of intellectual disability from Surkhet, 'When they visited homes of different PWDs Acting as Peer Educators as their friends, the beneficiaries shared problems they were too ashamed to tell in the health institutions. One person teaching 20 people at home proved effective because many still hesitate to share problems in the public space. Visiting homes ensured privacy, allowing them to tell their problems to the peer educators. The peer educators taught them what they had learned about reproductive health, family planning, and HIV/AIDS.' This process also built the capacity of peer educators.

> "Previously, I could not introduce myself or say what I wanted in the programs or the large gatherings. My capacity has increased substantially after learning and teaching 20 households." Koirala says.
>
> "As we entered the training, the trainer assigned the names of reproductive organs and FP devices such as condom to our group tables. We were compelled to say the names of these organs when calling each other. This process made us close to one another, and gradually, the shame vanished. We learned a lot in those four days. When it was our turn to teach, we provided sessions of three to four hours to individuals and groups. Previously, we would attend programs, sit all day, and return home with no visible achievement. But after this SRHR training, we had to go to the field and speak to others. We visited the homes of PWDs and conducted sessions with families and individuals. As trainers, we felt the need for preparation to be more mature and confident than the trainees. We used the booklet and Hami for SRHR app developed by BYAN to find ways to explain concepts more easily. It was also rewarding. In some places, parents used us as examples to motivate their children, saying, "Look, he has come this far in a wheelchair to teach." That made us happy. Previously, we paid no attention to this subject during conversations. Initially, we lacked courage to speak. Now, we advise each other easily. Alongside this, our speaking skills have been developed. We learned how to coordinate with others and impress them with our points. The small funds provided during the work also served as motivation for us. It created an environment where we felt we could work and earn."
>
> - Naman, peer educator, Surkhet.

2.6 Cross-disability Collaboration through Community of Practitioners

The operational model of the project A4C Is formation of a COP to initiate and continue discourse on the SRHR and FP needs among PWDs. BYAN created a total of three COPs by including the representatives of a diverse range of stakeholders working or willing to work towards the goal of SRHR rights for PWDs with their diversities. The COP comprised 7 members in each project implementation district, representing 1 severe physical disability, moderate physical disability, deaf, parents of psychosocial and intellectual disability, self-advocates, BYAN's representative and one government representative. The deputy mayor of Jeetpursimara Sub-Metropolitan City Bara and the Birendranagar Municipality Surkhet, and the chief of the Family Welfare Division Kathmandu served as the COP members. The rationale behind including the members of the government stakeholders was to ensure ownership towards the project from the government level and collaborate in making a health institution accessible and inclusive. The COP also mandatorily comprised participation of women with disabilities. The aim of forming COP was to create a united and empowered OPDs which are jointly working towards realization of sexual and reproductive health rights of people living with disability.

BYAN adopted the cross-disability work modality, realizing that the expertise and engagement of persons with diverse kinds of disabilities as a prerequisite to achieving successful, comprehensive and sustainable accessibility actions. The practice behind this was to recognize that disability is diverse, and the issues within it are also diverse. The COP was successful to ensure everyone is informed about the issues of all types of disabilities and to center diversity of disability while advocating for accessibility and inclusion in any actions/programs. In the words of the BYAN's chief adviser Kaladhar Bhandari, a COP member:

Surkhet Monitoring visit Birendranagar Nagar Hospital

"Traditionally, there was a practice where organizations run by persons with physical disabilities would work only for persons with physical disabilities, and those run by persons with visual impairments would work only for their specific group. Moving away from this trend, BYAN initially planned to work for " visually impaired youth," and accordingly, organization worked for youth with all types of disabilities in Nepal. While implementing the A4C project with CBM's support, BYAN wanted everyone to feel ownership of the program. Although BYAN implemented the project, it established a COP with the message that this is a shared project, and everyone should be involved with the same feeling of ownership."

> According to the BYAN's president Ramchandra Gaihre, "Since BYAN was an organization run by the blind and partially sighted youths, and the project was dedicated not only to youth with visual impairments but to persons with all types of disabilities, the activities designed and implemented by the BYAN were well-accepted and owned by other OPDs and their beneficiary groups. This cross disability working modality has established organization very positively among the other OPDs."

The COP conducted a series of joint monitoring activities of public spaces, especially the accessibility auditing of health facilities to identify the gaps in ensuring equal access of services for PWDs. According to the Health In charges of Municipal Hospital Birendranagar, Surkhet, and Urban Health Promotion Center Dumaruwana in Jeetpursimara, Bara, “the inclusion of persons with disability in the accessibility audit ensured that infrastructure supported just will be utilized properly as they also used the infrastructure themselves in the auditing phase”.

Along with the accessibility auditing, the COP also helped to steer the project activities in the smooth and right direction. The COP members used to hold COP meetings every three months. In those meetings, they used to review the work done in the past three months. When selecting Peer Educators, they discussed in the COP on maintaining the diversity of disability and selecting candidates for the peer educators and SRHR advocates accordingly. The COP also engaged in extensive discussions on training the Peer Educators selected from diverse backgrounds, deploying them to villages, and equipping them with knowledge on all disability issues so they could be capable of providing training elsewhere. The discussions, advocacy, and interactions within the COP had a significant impact on issues such as collective advocacy initiative, mobilization of the young people and exploring the gaps and paving the way forward.

Accessibility audit

2.7 Strengthened BYAN Capacity and Disability Movement Building

The project worked to capacitate and strengthen BYAN and its district chapters, which are early adopters in mainstreaming the ‘cross-disability’ principle within their programs. Despite BYAN working in the field of SRH for a long time, it was not able to work strongly in building the organization capacity in the issue. This project aimed to strengthen the organizational capacity through SRH and FP lens so that BYAN can set an example by institutionalizing SRH and FP in its policies and be a role model for other OPDs as well. In this process, organizational and individual assessments were conducted to analyze the capacity, knowledge, and skills within BYAN and its chapters, and the strengths, weaknesses, opportunities, and threats of BYAN’s three chapters namely Kathmandu, Bara and Surkhet were identify. The assessment helped BYAN to understand the current capacity of its chapters and determine the activities to address future capacity development needs to achieve its organizational goals.

These assessments identified specific technical gaps and challenges that were addressed through the project intervention. Based on the findings, an Organizational Development Toolkit was developed, and support was provided to the BYAN members and its staff. The toolkit covered major areas including organizational strategy and planning, financial management, partnership management, youth-friendly approaches to SRHR, and media and visibility strategy. BYAN adopted and amended critical organizational frameworks to enhance internal governance. This included updates to the organizational statute, the GEDSI policy, SOPs, the fundraising plan, and the MEAL framework. The project also worked with those local chapters to extend their membership base. A total of 130 new members has been increased in district Chapters within the project duration. According to the endline survey conducted by BYAN, the percentage of PWDs reporting affiliation with local OPDs has increased from 36% in the baseline to 48% in the endline.

To capacitate the central and district chapter members, organizational development training sessions were conducted in Kathmandu, Bara and Surkhet. The training focused on essential topics such as organizational principles, BYAN's policies, working areas, proposal and report writing, compliance and documentation, branding, visibility, and advocacy tools and skill. The initiative has changed the landscape of disability advocacy by empowering BYAN chapters to take ownership of the movement beyond simple project implementation. As a concrete example of organizational progress, a total of 37 Advocacy actions were developed and implemented by BYAN & its chapters.

President Ramchandra Gaihre receiving the token of love

Mr. Kaladhar Bhandari, who oversaw and delivered the trainings related to the organizational development to the BYAN chapters explained the impact that:

> "After the establishment of the organization, BYAN set up district chapters. However, there was a lack of knowledge on how to operate these chapters, conduct meetings, communicate effectively, advocate successfully, implement policies, and understand the roles and duties of the executive committee. Previously, even if the chapters were registered, there was little knowledge about overall operations, resource mobilization from the local level, or government priorities regarding resource allocation. The Organizational Development training provided information on those matters, allowing them to understand policies and learn to successfully implement programs designed for them. BYAN provided various training courses for organizational strengthening. The organization built local leadership and implemented the project through the local chapters. The strength of BYAN was that

Mr. Kaladhar Bhandari delivering the trainings

the organization allowed the district chapters to implement the project at their own level. This Organizational Development training created a sense of ownership and a drive to implement the project effectively. This instilled a sense of ownership; they realized that the project was their own. If it succeeded, they would succeed; if it failed, they would bear the responsibility."

Along with strengthening BYAN's internal and external capacity, project A4C also contributed to galvanizing the local disability movement. Local disability rights movements largely depend upon the activeness of local OPDs.[24] Realizing this fact, the project capacitated a total of 59 BYAN chapters & OPD leaders on the SRHR and FP issues.

2.8 Visibility and National and International Representation

The significant impact of project A4C was the heightened visibility and engagement of BYAN central and chapter members in local, national and international forums. All of these exposures, visibility and participation indicate BYAN's steady progress in the path of strengthened and empowered organization.

2.8.1 National Level Engagement and Visibility

In national level, BYAN hosted the National Conference of Youth with Disabilities in December 2024, attended by over 100 youth of diverse disabilities nationwide. Hosting the Disability Youth Conference was the first initiation in Nepal, as the OPDs, CSOs and the government entities were not creating a national forum to the young people with disabilities prior to the conference, who are underrepresented in both the youth and disability movement. This conference therefore was a milestone in area of rights of youths with disabilities, as the event provided

24. United Nations Partnership on the Rights of Persons with Disabilities. (2020). Guidance notes on effective and meaningful participation of persons with disabilities. UNPRPD. Retrieved from: https://unprpd.org/new/wp-content/uploads/2024/03/OPD-participation-guidance-note.pdf

an opportunity where they could discuss the existing scenario in realizing their rights, share their real lived experience, decide the collective actions and strategies in asserting their stake in the mainstream disability movement and urging the concerned stakeholders to effectively respect, protect, promote and fulfil their obligation towards the community. The conference was timely and strategically aligned with the Global Disability Summit to amplify local voices on an international scale, as it was organized at the time when the GDS secretariate had asked for the input in the Youth Call to Action. The outcomes of the conference were instrumental in shaping the Call to Action, as many of its action points have been reflected in the final GDS Call to Actions.

BYAN also utilized major platforms like the first Deafblind International Regional Conference in Asia-Pacific, which was organized in Pokhara Nepal. It hosted a specialized pre-conference focused on the SRHR needs of the deafblind community. This initiative was critical, as youth living with deaf blindness remain one of the most underrepresented groups within the disability community. By facilitating presentations from youth champions, self-help advocates and rights activists, the conference provided an avenue to share and document the demands on the ensuring rights for the community. The pre-conference acted to issue a Call to Action, which was reflected in the subsequent conference document. Advocating for the rights and ensuring space for the youths with deaf blindness in the pre-conference was a crucial moment in BYAN's promise to work with the critically underrepresented group.

Conference of youth with disabilities

Similarly, BYAN co-organized the first CSE conference and the organization worked as the accessibility and disability expert for the conference under the joint support of ministry of health and population, and ministry of education at the federal level. These opportunities positioned BYAN at the center of a mainstream national agenda, effectively moving the organization's role from raising demands to delivering national-level solutions. This strategic shift for BYAN from traditional advocacy to technical leadership indicates that young people with disabilities possess the professional capacity to guide state mechanisms, rather than merely participating as beneficiaries.

Over time, BYAN has successfully established and strengthened networks, alliances, and partnerships that have significantly influenced Nepal's SRHR and disability landscape. BYAN was the member of CSE coalition until September 2025 and is leading the coalition as the co-chair from November 2025. It is a partner in the Menstrual Hygiene Management Partners Alliance. The organization formally became a network member of the NGO Federation Nepal. Civil Society Organizations (CSOs) have been effectively sensitized regarding inclusive SRH and FP policies. MOUs were signed with MSI, FPAN, and CDS-PARK, advancing collaborative SRHR initiatives. These advocacy efforts have yielded tangible results, including budget allocations for the BYAN from the FPAN-Kathmandu and MSI. A major partnership was achieved with CDS Park Mugu while developing accessible municipal hospital in Birendranagar municipality. BYAN co-organized the Gender Equality Carnival in collaboration with People in Need and Hami

Daju Bhai, bringing together stakeholders, including CSOs, government representatives, youth groups, INGOs, and UN bodies. These examples of collaboration, partnership and leadership reflect BYAN's identity as a trusted and capable organization in the national civil society movement.

In the local level, the local chapters actively launched and participated in the major public events with their proactive initiation, including the rally and programs in International Day of Persons with disabilities, International Youth Day, blood donation campaign, campaigns against violence against women, oratory competition, etc. These initiatives extended beyond awareness-raising by directly confronting deep-rooted stigma, strengthening community solidarity, and affirming young people with disabilities as leaders and agents of change in the social causes and leader of SRHR discourse.

Beyond public advocacy, they have gained recognition within local governance and CSO movement. Municipalities are frequently inviting them to policy discussions. Notably, some BYAN chapter members and other OPD leaders who are working as the COP members have been positioned as the formal member in the 'Local Level Disability Coordination Committees,' led by Deputy Mayors/Vice Chairs. These portray a shift toward institutional inclusion of disability community.

2.8.2 International Representation and Active Contribution

Between 2023 and 2025, BYAN significantly expanded its international participation and visibility by engaging in a wide range of high-level intergovernmental processes and technical learning exchanges, ensuring that the voices of Nepali youth with disabilities were represented in both regional and global policy arenas. In the Asia-Pacific region, the organization prioritized the review of the Sustainable Development Goals by participating in the Asia-Pacific Forum on Sustainable Development (APFSD) in Bangkok for three consecutive years. This was complemented by continuous engagement in the civil society space through the Asia Pacific Regional Fora, which the organization attended annually from 2023 to 2025. BYAN also contributed to specific high-level thematic reviews in Bangkok, including the Asia-Pacific Population Conference (APPC) and the Beijing+30 review process in 2025, advocating for the inclusion of disability in population and gender equality frameworks. Beyond the regional level, the organization expanded its reach to global platforms.

Representation at the Global Disability Summit.

This included attending the International Conference on Family Planning (ICFP) in Colombia to mainstream disability into the global reproductive health agenda and family planning frameworks.

The organization took its advocacy to the global stage by attending the Global Disability Summit in Germany in April 2025. BYAN hosted there an exhibition booth that displayed its inclusive IEC materials on SRHR, inclusive education, and accessible communication, drawing over 700 visitors. BYAN staffs, including the president Mr. Ramchandra Gaihre represented the organization in various sessions and side events, advocating for inclusive education, political participation, and financial accessibility. BYAN also worked as the drafting member in declaring the Youth Call to Action, many provisions raised by the organization have been incorporated in the final document. BYAN engaged with global leaders and youth delegations, the summit provided a platform for sharing good practices and building new partnerships, reinforcing BYAN's commitment to youth-led advocacy and implementation of the Amman-Berlin Declaration, Youth Call to Action, and Lalitpur Declaration.

BYAN visited CBM Global Kenya

Parallel to these advocacy efforts, BYAN focused on institutional learning and technical capacity during the project implementation period. Its staffs also took part in Disability SRHR Residential Training in Sri Lanka in 2025. The training brought together participants from Sri Lanka, India, Pakistan, Bhutan, Nepal, and Maldives to engage in discussions on disability justice, gender, sexuality, reproductive autonomy, and access to justice. The project also provided space for cross-country learning and collaboration by conducting international exchange visits. BYAN visited CBM Global Kenya office and office of Northern Nomadic Disabled Persons' Organization (NONDO, an NGO that advocates for the rights, inclusion, and participation of persons with disability) in Kenya. Members of NONDO and CBM Global Kenya also visited BYAN office. Participation in these platforms has strengthened BYAN's international visibility, enabled the sharing of Nepal's experiences, highlighted persistent gaps, and reinforced calls for accountability.

CHAPTER THREE

TRANSFORMATIVE OUTCOMES THROUGH KEY SUCCESS STORIES

BYAN has evolved from a targeted initiative into a premier advocate for the rights and empowerment of young people with disabilities in its 13 years of inception. The organization has evolved as a national leader in championing the right to a dignified and adequate standard of living for the PWDs by advocating for their inclusion and empowerment. While its initial works focused on education, employment, and leadership for the visually impaired youths, it also gradually developed organizational capacity in promoting rights-based and inclusive approach for the youths from the cross-disability section. The trajectory of the organization shifted significantly towards the disability inclusive SRHR and FP service in 2016, after identifying a critical deficiency in Menstrual Hygiene Management awareness among youths with disabilities. The organization expanded its working mandate in SRHR in 2017/18 to the youths with all kinds of disabilities after recognizing that systemic barriers to SRHR access affected all disability clusters. Supported by partners such as the NERF, MSI, Amplify Change, and FP2020, the organization filled a void in the sector by delivering large-scale interventions involving policy advocacy, service provider training, capacity building, and awareness campaigns.

These collective efforts yielded a monumental policy victory in 2022 through the endorsement of the Disability-Friendly Safe Motherhood and Reproductive Health Service Guideline by the Ministry of Health and Population. This guideline stands as a testament to BYAN's persistent advocacy in institutionalizing systemic inclusion of unique requirements of PWDs in the broader SRHR movement. In that same year, BYAN joined into the Right Here Right Now (RHRN) coalition, a global movement on young people's SRHR. The project contributed to imparting knowledge and information on SRHR, provided accessible CSE sessions for young people with disabilities, developed and disseminated inclusive IEC materials, and built the capacity of youth clubs, parents, and teachers. The project was a milestone to take action for adolescents with disabilities, especially those with intellectual disabilities and autism, who were underrepresented in the existing interventions.

In this pretext, the organization also initiated project "Action for Change: An initiative for the promotion of inclusive SRH and FP services for PWDs in support with the CBM Global Disability Inclusion. The project tried to address systemic gaps in realization of SRHR rights among PWDs and the urgent need to make SRHR services accessible to them, sticking with the human rights frameworks and commitments enshrined in the national legislations through the Act Relating to the Rights of Persons with Disabilities 2017 and other legal and policy frameworks, and the state obligation through the UNCRPD and Sustainable Development Goals (SDGs). Project

Surkhet Monitoring visit Birendranagar Nagar Hospital

activities aligned with the UNCRPD principles of non-discrimination (principle 2), respecting diversity of human experience (principle 4), accessibility (principle 6) and equality between men and women (principle 7). The project reflects Equality and nondiscrimination (UNCRPD articles 5), awareness raising (article 8), accessibility (article 9), freedom from exploitation (article 16), respect for home and the family (article 23), and right to health (article 25). Likewise, the project design takes into account priorities of SDGs mainly Goal 3: Healthy lives and well-being for all, Goal 5: Gender Equality, Goal 11: Make cities inclusive and resilient, and Goal 16: Inclusive societies and access to justice. The project has adopted 4As (Accessibility, Availability, Acceptability and Affordability) principles as defined by the Economic, Social, and Cultural Rights Committee.[25] The project activities were developed to increase accessibility of PWDs on resources/information on SRHR and FP and advocate for availability of disability friendly services. The project also worked to increase acceptability of PWDs with their choices on expression of sexuality and family life.

Surkhet TOT on SRHR

A total of 2200 persons with different disabilities, their parents and care givers were reached by the project during its implementation. PWDs have increasing confidence in discussing and expressing their sexual preferences and in asserting their entitlement to SRH and FP services with dignity and respect. Both knowledge of SRH rights and demand for related services have increased substantially among PWDs and their parents. Compared to baseline findings, awareness of SRH rights among PWDs rose from 36 percent to 70 percent, while the proportion of PWDs reporting no knowledge declined sharply from 64 percent to 30 percent. Similarly, knowledge levels among parents increased from 41 percent at baseline to 67 percent at endline. PWDs demonstrated improved knowledge across specific thematic areas, including menstruation management, sexual behavior (such as distinguishing between good touch and bad touch), use of urine bags and menstrual pads, condom use, personal hygiene, and temporary family planning methods. Health service providers also

25. Committee on Economic, Social and Cultural Rights. (2000). General Comment No. 14: The right to the highest attainable standard of health (Art. 12 of the Covenant). (Para 12), U.N. Doc. E/C.12/2000/4. Retrieved from: https://www.ohchr.org/sites/default/files/Documents/Issues/Women/WRGS/Health/GC14.pdf

Surkhet TOT on SRHR

reported a considerable increase over the past two years in demand for both temporary and permanent family planning methods. This rise reflects greater exercise of the right to access family planning and contraception, along with improved utilization of maternal health services, STI screening, and reproductive health education. In the project intervention areas, access to family planning–related services among PWDs increased significantly from a baseline level of 21 percent to 62 percent. Additionally, 73 percent of respondents reported gaining new knowledge related to family planning services over the past two years.

In line with the achievements and best practices discussed in the preceding chapter, this booklet therefore documents the transformative outcomes achieved by BYAN at the individual, community, institutional, and movement levels. It presents compelling accounts of peer educators, reflections from parents, perspectives from key stakeholders, and insights from BYAN's project team, illustrating how lives have been positively transformed and opportunities expanded. In order to uphold privacy and confidentiality, certain personal details and identities have been anonymized by replacing them with their pseudo names.

3.1 From Inferiority to Agency: Journey of Addressing Discriminatory Treatment and Access

For PWDs in Nepal, accessing healthcare is not simply a logistical challenge, it isa psychological battle against a system that fundamentally questions their right to care. This environment creates a formidable psychological barrier where PWDs often face derogatory language, dismissal, and the refusal of services. The prevailing medical model views them as objects of charity rather than rights-holders, leading to a dynamic where service providers feel entitled to question the necessity of SRHR services for this demographic. Beyond the structural and institutional barriers lay the pervasive societal bias regarding the sexuality of PWDs. The prevailing social assumption is deeply stigmatizing, as it presumes that PWDs are asexual or Hypersexual, lack capacity for marriage, or reproductive potential. This stigmatization manifested in public mockery and teasing, which enforced a culture of silence and shame.

The psychological damage of systemic discrimination is articulated in the testimony of Singharaj. His narrative provides insight into the internal dialogue of PWDs prior to the project's intervention, a dialogue defined by shame, awkwardness, and internalized inferiority. Singharaj described his previous reluctance to engage with the health system:

> "Previously, I visited health institutions very rarely. I felt shy and awkward, and the staff would speak using harsh words. They would imply, why do people like you need services?"

This rhetorical question "Why do people like you need services?" is indicative of the dehumanizing attitude prevalent among untrained health professionals.[26] He further revealed the specific stigma regarding reproductive rights, noting that even when he accompanied others, he felt a profound sense of inferiority due to comments such as, "Why do such people need to have children?" Such comments are reflective of a disturbing eugenics mindset often present in society, which questions the reproductive rights of PWDs.[27] Reflecting on his past inability to respond, Singharaj noted, "At that time, I could not say anything". This silence was the ultimate product of systemic exclusion.

Peer to peer counselling to persons with disabilities

Complementing Singharaj's Experience, Ramhari discussed the prevailing societal perspective against the enjoyment of SRHR and service of PWDs, noting that people often questioned the ability of visually impaired persons to procreate or sustain a marriage. He described instances where others would look at them with a cursory glance and mockingly ask if 'people like them' could truly get married. This external mockery had a devastating internal effect. It led to self-censorship, where individuals felt ashamed to seek information for fear of being labeled "vulgar" or "obscene". The social cost of asking about SRHR was too high, reinforcing the ignorance forced upon them. The intersection of gender and disability made this stigma even more acute for women. Narayani articulated the double bind faced by women with disabilities.

> "Despite reading about it, I felt ashamed to discuss these matters with others. As a woman, talking about these topics invited accusations of speaking vulgarly or obscenely. Moreover, the societal perspective toward PWDs was discriminatory, with people behaving as if to ask, 'Why do you people need this information? Due to this behavior, despite having some knowledge, we remained backward."

26. Hunt X. Swartz L. Braathen S. H. Carew M. T. & Rohleder P. (2018). The sexual and reproductive rights and benefit of the doubt: mental health professionals' views of sexuality and intellectual disability. Disability and Rehabilitation, 40(22), 2663–2670. https://doi.org/10.1080/09638288.2017.1356385

27. Robyn M. Powell, Confronting Eugenics Means Finally Confronting Its Ableist Roots, 27 Wm. & Mary J. Race, Gender, & Soc. Just. 607 (2021), https://scholarship.law.wm.edu/wmjowl/vol27/iss3/2

In this situation, through the interventions of project A4C, beneficiaries have transitioned from a state of enforced passivity to one of vocal assertiveness, empowered to challenge these malpractice instances directly. The intervention broke this culture of silence by validating their rights. Peer educators and participants now possess the vocabulary and confidence to discuss SRHR openly. This transformation is evident from Singharaj's current outlook:

> "Gradually, through A4C project, I gained the knowledge that I must do something, speak up, and state my problems. I realized that we are also members of this society and deserve information on this subject".

This realization that he is an equal member of this society is the foundational outcome of the project. The shift from I could not say anything to I must speak up represents the restoration of human dignity and agency.

Meeting with the peer educators

This change is further reflected in the account of Priya, a young woman from Madheshi community. Following the training and the push for independent accessibility, her perspective shifted fundamentally. Regarding SRH, she admitted that her previous perception was that it was a subject to be hidden due to social shame. However, she stated that after undergoing training, she realized it was a normal issue like any other. She learned the importance of articulating these problems and noted that she no longer considered SRHR a strictly private matter to be suffered in silence; she now feels comfortable sharing her issues and listening to others. She can now counsel her students effectively by encouraging them to share their problems without hesitation. She noted that students had begun sharing issues regarding menstruation with her, to which she responded by providing as much support as possible. This reclaiming of agency allows beneficiaries to view SRHR discussions as a standard part of healthcare rather than a source of social shame.

The personal transformation of Indra serves as a prime example of this growth. Indra openly admitted that prior to the project, he was unable to communicate clearly with friends about SRHR or even general topics due to a lack of confidence and vocabulary. The training provided by BYAN did more than teach him biology; it gave him the language of rights. Indra specifically highlighted that the training clarified the nuanced concept of "Good Touch, Bad Touch" in relation to intent. This is a critical distinction for the safety of PWDs, who are often vulnerable to

abuse disguised as care. Indra and his peers are now able to discuss these effective protection mechanisms within the sector, transforming them from potential victims into knowledgeable advocates.

The impact of this attitudinal shift extended beyond individuals to the community level, transforming regions that previously lacked open discussion. Sudhir Chaudhari, the president of Bara district chapter highlighted this prior landscape in the Bara district, noting a distinct difference between the northern and southern regions. Chaudhari noted that in the southern region of the Bara district, compared to the north, there was a noticeable absence of individuals who could speak openly about SRH. He explained that when attempting to discuss these subjects, people would often feel shy or even run away out of embarrassment. Furthermore, when shown materials such as contraceptives or other health-related devices, they would become constricted and withdrawn due to shame. However, the sustained engagement of peer educators led to a measurable cultural shift. Previously hesitant villagers now trust peer educators and actively accessed health posts, overcoming the shyness that once prevented them from even speaking to their parents. Dilip Kumar Jha, a COP member in Bara observed that prior to the project, villagers would not even come out when called. Now, he noted that the trust established has eliminated this previous shyness. He reported that community members now independently visit health posts to discuss their issues and purchase SRHR and FP materials, a significant change from the past when they felt too shy to even share such matters with others.

3.2 Model of SRHR Knowledge Transfer

The baseline data collected prior to the A4C project revealed a systemic failure in both the educational and physical infrastructure of Nepal regarding persons with disabilities. This dual failure where teachers often skipped SRHR topics or hid diagrams, and where health facilities imposed severe physical restrictions resulted in a target population with minimal understanding of their own bodies and rights. The project addressed these gaps through revolutionary pedagogical methods and physical interventions, transforming abstract rights into tangible access. The pre-intervention educational context was described vividly by the beneficiaries. Naman reflected on the inadequacies of the school environment, noting that health lessons were often limited to general information and induced such shyness that students frequently wished for the classes to end quickly rather than engaging with the material. This avoidance by educators created a vacuum of knowledge.

Pratibha validated these findings, describing the limitations she faced:

> “Before this project, I had very little knowledge about this subject. I had asked about topics included in the school curriculum, but the knowledge transfer was limited because teachers did not teach using full sign language.”

This lack of full communication meant that deaf students were physically present in class but intellectually excluded from the curriculum. To counter this exclusion, the project introduced disability-inclusive pedagogical methods along with sign language glossary and sign language

interpreted videos that revolutionized learning for the beneficiaries with hearing disabilities. For visually impaired participants, the ability to touch and feel devices such as femidoms, tampons, and menstrual cups transformed abstract concepts into practical, usable knowledge. Ramhari provided a powerful testimony regarding this shift. He noted the contrast with his school days:

TOT on SRHR

> “Even in schools, teachers would hide diagrams related to this subject in textbooks from others, or we would tear the pages out relating to the SRHR chapter. Teachers and students would skip those topics, and if the subject arose, we would often mock or ridicule the teachers and the content. But, after receiving this training, we realized that this is not a subject to be ashamed of rather, it is our fundamental right.” “I learned about the femidom, about which I had read about it in books but had no practical knowledge of what it was or how it looked. They demonstrated it directly to us. This remains an immortal memory for me. I also touched a tampon for the first time.”

Beyond general education, the project facilitated specific, life-changing skills for women with visual impairments. Participants learned about tactile signage on contraceptive pills, which enables independent use. Narayani noted that while she had long known about BYAN’s advocacy regarding accessible contraceptives, the training provided her first opportunity to understand their physical design. She explained the technical significance of this innovation learning to identify the tactile signage on the corner of the packaging now allowed her to determine the starting point and use the pills independently. This seemingly small detail restored her bodily autonomy, removing the need to ask a sighted person to administer her birth control. Furthermore, she described a significant personal change resulting from the session. After physically handling a menstrual cup and learning its proper usage, she adopted it for her own hygiene. She found it extremely comfortable and effective for eliminating difficulties while traveling, illustrating how accessible education translates directly into improved quality of life and mobility for women with disabilities.

For the Deaf community, the project utilized visual materials to bridge the communication gap, clarifying complex concepts like family planning and gender-based violence. Ramesh emphasized the cultural necessity of this approach:

> “In the deaf culture, our practice relies heavily on visual aids. My friends and colleagues have understood these concepts through visual materials. Through the training, I learned about social and cultural aspects, family planning materials, gender issues, sexual behavior, and violence. Previously, I did not have a proper understanding of FP materials. I have now realized their critical importance.”

This access to visual information also corrected medical misconceptions. Yamraj admitted that he had previously labored under the misconception that the Copper-T intrauterine device was either placed in the arm or ingested. He explained that he had been confused as to whether it was intended for the arm or a reproductive organ but stated that the training clearly resolved this ambiguity for him. Correcting such fundamental errors is critical for ensuring safe and effective family planning.

3.3 Behavioral Change: Menstrual Hygiene Management and Family Planning

The interventions of the A4C project catalyzed deep behavioral shifts within the beneficiary communities. Prior to the project, menstrual hygiene management was poor, often limited to the use of cotton cloths, while family communication regarding these topics was trivialized or non-existent. However, the project drove significant changes, including the adoption of modern hygiene products and strategic family planning.

SRH and FP session for persons with disabilities, parents and their supporters by PE

The shift from traditional to modern hygiene practices is exemplified by Megha, a parent of child with intellectual disability. She illustrated this shift by noting that while they previously relied solely on pads and cotton clothes, they later became aware of the availability of tampons and menstrual cups. Megha reported that she has since taught her daughter daily living skills and hygiene management during menstruation, concluding that these interventions have brought about a positive change in their practices. This intergenerational transfer of knowledge ensures that the project's impact extends beyond the immediate participants to their families.

- **Maintaining Health and Hygiene:** Pratibha's narrative highlights the establishment of critical health awareness regarding breast and cervical cancer:

> "A new learning for me was understanding breast cancer and cervical cancer. Previously, I had no knowledge of these conditions. Now, I am maintaining my health and hygiene. While participating in the SRHR training, we learned about various family planning methods, ranging from condoms to pills. We also understood the menstrual cycle, menstrual pads, and menstrual cups. As I entered adolescence, I did not know much about the need for hygiene. There was minimal communication with my family, and the issue was treated as trivial. I had not understood it deeply."

The training provided her a comprehensive education that filled these gaps. This transition from treating hygiene as trivial to actively maintaining health demonstrates a fundamental shift in self-worth and health literacy.

- **Regaining Daily Hygiene and Family Support:** Devi Acharya, a COP member, and participant in BYAN's training on CRPD, SDG and SRHR in 2024, identified a critical need of training the women with physical disabilities on the SRHR, specially, health and hygiene management issue. She then initiated a collaborative advocacy effort with partners to secure a small grant dedicated to that topic. She successfully utilized these resources to design and facilitate a targeted SRHR training program specifically for women with severe disabilities and wheelchair users. Devi recounted the experience of a participant she invited to the programs, illustrating how the training addressed complex, intersecting health needs. The SRHR training coincided with Bowel and Bladder management training. A participant with physical disability from spinal cord injury was boycotted by her family due to her disability after an accident. She also had no idea about managing Bowel and Bladder and maintaining her daily hygiene. After the crucial knowledge gained from the event, the participant then was able to make her husband understand about the disability and was also able to convince the family for the acceptability of her disability.

- **Strategic Family Planning:** In the realm of family planning, the project empowered couples to implement birth spacing strategies, such as maintaining a 5-year gap, as a direct result of the training. Indra attested to this impact, stating that the training had made it significantly easier for his family to plan their future. He explained that while the prevailing social norm was to have another child within two to three years. His son was 2 years old, but his parents were pressurizing him and his wife for a second child. The influence of the training nonetheless enabled them to maintain a five-year gap. He emphasized that this decision was a "strong change" in his life, allowing his family to prioritize the well-being of both mother and child over societal pressure.
  Peer educators also played a frontline role in managing family planning crises. Ramesh successfully counseled friends on proper contraceptive use and managed pregnancy scares by facilitating access to pregnancy test kits and medical advice.

"Through peer counseling, I was able to directly address critical gaps in family planning and crisis response. In one instance, I guided a friend via video call who already had five children, since he had not accessed any information and awareness in the sign language on the proper use of condoms and birth control. Initially, it was extremely difficult to make him understand the issues involving the family planning and protected sexual intercourse. But he was not grasping any contents, as he had not learned the sign language terminologies in those issues. Later, I virtually demonstrated pictorial information developed by BYAN to him. He could understand the issues through pictorial communication. Now, this has significantly improved his daily life.
A 20-year-old female friend approached me asking about the ways of identifying pregnancy. The couple had engaged in sexual intercourse, but both of them had no information in sign language about using contraception. I informed the couple about the pregnancy test kit and method of using it. I also instructed them in interpreting the lines shown in the testing kit, while also counseling them on the importance of avoiding unprotected intercourse in the future."

These interventions by peer educators like Ramesh did not just provide information; they directly prevented unwanted pregnancies and empowered individuals to take control of their reproductive futures in moments of crisis.

3.4 Elimination of Harmful Practices

Young people with disabilities are compelled to rely on the sources such as in their informal networks due to the absence of disability friendly accessible, age appropriate and scientifically reliable information.[28] These networks, despite proving a compatible avenue in gaining information sometime might lead to generating incorrect belief and practices, spreading false information and harboring myths and misconceptions in the issues of SRHR and FP, which sometimes could turn to life threatening situation.[29] In this pretext, along with generating awareness on health and hygiene and contributing to transforming knowledge, the project A4C was also successful in debunking false information in SRHR and preventing some harmful practices that flourished in the vacuum of accurate SRHR information.

- **Preventing Unsafe Abortions: Intervention by Indra**
  Indra cited a specific instance in Sarlahi district in Madhesh Province, where his one visually impaired female friend adopted dangerous practices of abortion due to lack of information on the use of temporary contraception, protected sexual intercourse and safe abortion. He shared that the couple had sexual intercourse without the use of condom, and the lady did not use any oral contraceptive tablets to prevent unwanted pregnancy, rather she attempted to use 4-6 deworming tablets at once owing to false information that would induce abortion. This instance highlights the severe consequence for young people in their health and safety in the absence of accurate knowledge and accessible information. The social stigma associated with access to SRHR and CSE knowledge and information is also responsible factor in resulting such situations, because the lady, who was unmarried at that time, recourse to the risky and life-threatening method of terminating her pregnancy to avoid social exposure, instead of visiting the safe abortion clinic.
  This situation was shared by the partner of that lady To Indra, who was working as the peer educator, asking for his advice. As soon he shared the information, Shiva helped the couple by providing information about the misconception relating to pregnancy termination using high dose of deworming tablets and its risk factors.

> “I was able to convince the couple using the pregnancy testing kit and interpreting the result. Later, the male friend communicated to me that the test showed negative result. Both of them have reported me that now they only have protected sexual relation. In this way, I believe that I saved my female friend from the serious harm to her health by preventing the potential life-threatening conduct.” Said Indra.

28. Gaihre, R., Rajbhandary, R., Lohani, S., Giri, R., & Sapkota, S. (2018). Understanding the sexual and reproductive health needs of young persons with disabilities in Nepal. Sunaulo Pariwar Nepal, Blind Youth Association Nepal, & Marie Stopes International.
29. United Nations Population Fund (UNFPA), & Women Enabled International. (2018). Women and Young Persons with Disabilities: Guidelines for Providing Rights-Based and Gender-Responsive Services to Address Gender-Based Violence and Sexual and Reproductive Health and Rights. Retrieved from: https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA-WEI_Guidelines_Disability_GBV_SRHR_FINAL_19-11-18_0.pdf

- **Knowing Consent and Bodily Autonomy: Story of Parent of Woman with Intellectual Disability**

During BYAN's A4C activities, 21-year-old Lajima sat quietly through most of the peer-educator training. Lajima, who was a woman with intellectual disability, often spoke in soft, slow mumbles, sometimes only a few words at a time. During a session on contraception, she suddenly held out her arm and whispered that she "had the same thing" inside her hand. Bit by bit, the story emerged: years earlier, worried because Lajima sometimes wandered after school and faced harassment from men who drank or used drugs, her parents had put a contraceptive implant on her forearm, taking her to a nearby hospital. Lajima never knew what it was for. Through the patient discussions on body privacy, good and bad touch, and menstrual care, Lajima began to understand her own rights. Her father now plans to remove the implant, thanking BYAN and the BYAN team for helping his family to convince the bodily rights and autonomy of his daughter.

- **Dismantling Superstition and Menstrual Exile**

  Deep-seated cultural superstitions previously forced women into menstrual exile (isolation or cowsheds) and restricted their social mobility. However, beneficiaries have increasingly rejected these practices, prioritizing scientific understanding over superstition to reintegrate into family activities.

  Pratibha illustrated this cultural shift within the Deaf community. She explained that while her friends were previously conditioned to observe strict taboos like staying in isolation, education helped them recognize these as misconceptions. Consequently, they now mingle freely and enter the kitchen during menstruation.

  Echoing this transformation, Narayani admitted she previously stayed in isolation for several days. However, she stated that post-training, she ceased following these practices, dismissing warnings of sin from elders as she now recognized the restrictions were baseless results of a lack of education.

  Sudhir Chaudhari further confirmed this progress in Bara, noting that women who once restricted themselves to small areas now understood menstruation as a natural process. They shifted their focus from social withdrawal to maintaining personal hygiene and sanitation, marking a profound cultural evolution.

3.5 Stories of Empowerment, Leadership and Professional Growth

The A4C project catalyzed a profound shift in the self-conception of its beneficiaries, moving them from passive recipients of aid to active leaders and professionals. This empowerment was not limited to acquiring SRHR knowledge; it extended into the development of professional skills, economic independence, and the confidence to navigate complex social hierarchies. Individuals who were once unable to speak on general matters evolved into capable Peer Educators conducting home visits, counseling peers, and challenging the status quo. The stories presented below help to understand the real impact in the leadership and empowerment of the youths with disabilities in the project implementation areas.

- **Knowing the Rights: A Story of Inclusion and Confidence**
  Leena, a young woman with intellectual disability from Bhaktapur, had never heard about SRHR before, and didn't know what her rights were. When she participated in training designed for persons like her, she felt included, especially because a one-day preparatory session was provided and all materials were made accessible in easy-to-understand formats, which helped her understand a lot about the contents and messages of the program.
  Before this, there had been no books or training on SRHR for individuals with intellectual disabilities, so she didn't know why it was important. During the training, Leena learned about menstrual hygiene management, bodily autonomy, reproductive organs, and safe and unsafe touch, which made her feel empowered.
  Working as a peer educator gave her the chance to share what she had learned with her friends, teaching them about their bodies, rights, and personal safety. This experience not only increased her knowledge and confidence but also allowed her to actively support and empower other individuals with intellectual disabilities, making her feel valued and included.

- **Breaking Barriers, Igniting Change**

SRH and FP session for persons with disabilities, parents and their supporters by PE

Richa, a young woman from Bara is an example of strength and inspiration. Despite being visually impaired and brought up in a middle-class family, Richa pursued a remarkable journey of disability advocacy, by continuing her studies while actively engaging as a member of BYAN Bara. She encountered numerous challenges; particularly surrounding societal stigmas related to menstruation and SRH. Initially, she found it scary to speak publicly and was hesitant to confide in her closest confidants about her struggles. Also, she was unknown about the disability rights and legal provisions. But her involvement with BYAN Bara proved to be transformative. Through BYAN's events focusing on disability rights, Richa gradually found her voice and

gained confidence. While initially hesitant to actively participate in advocacy meetings and events, the initiation of the A for C project in Bara marked a turning point for her. She began engaging regularly, further enhancing her confidence. The unwavering support and mentorship from the BYAN Bara team played a pivotal role in her growth.
Presently, Richa is a regular participant in advocacy meetings, fearlessly raising her voice alongside her team members. She has undergone training to operate the Hami for SRHR mobile application and has taken the initiative to educate and orient her peers on its usage. Her dedication has driven her into the role of a young advocate for SRHR, earning admiration from her juniors, who now view her as an exemplary figure. Hailing from the Madheshi community and being visually impaired, Richa faced significant societal barriers and communal biases. Yet, she has transcended these obstacles, emerging as a young advocate for SRHR in Bara district. Her unwavering determination and remarkable journey serve as a testament to her strength, resilience, and the transformative power of active engagement and support from communities like BYAN Bara.

- **Disability, Rights and Self-Empowerment:**
  Gobinda, 32, from Birendranagar-4, Surkhet has lived with psychosocial disability since childhood. With limited knowledge about disability and rights, he spent many years in silence. His life changed after participating in a five-day SRHR training under the A4C project. The training inspired self-identity, confidence, and social responsibility. Gobinda became a Peer Educator, conducting SRHR training for 20 people with psychosocial disabilities and offering individual counseling. His work spreads the message that SRHR is a human right and persons with disabilities deserve equal access. Today, he is an active SRHR advocate collaborating with government and non-government organizations. His story proves that disability is not a weakness but a journey of awareness, dignity, and empowerment, transforming personal struggle into social change.

- **A Journey to Confidence and Advocacy:**
  Ms. Lakshmi is a woman with a physical disability originally from Kalikot. She was married and had been managing her daily household chores. Unfortunately, she fell from a tree while cutting grass, resulting in damage to her back. She was initially taken to the provincial hospital and later transferred to Bir Hospital in Kathmandu. After undergoing six months of treatment, she was discharged and became fully dependent on a wheelchair. She then relocated to Surkhet, hoping for support from the government and other agencies, but received none. Eventually, she connected with OPDs and gradually participated in their events when invited.

  In this context, the A4C Project was initiated in Surkhet, with one of its major activities being the formulation of COP, by including representative from different disability groups and stakeholders. Lakshmi was recommended by an organization to contribute her lived experience to facilitate the smooth operation of the project. She actively participated in various events, gradually familiarizing herself with disability rights, SRHR and FP. Over time, she started voicing concerns in meetings and participated in Health Institutions Accessibility Audits, providing insights on accessibility from the perspective of physical disabilities. BYAN conducted a two-day Bridge CRPD-SDG and SRHR training, in which Lakshmi actively participated, finding the sessions insightful. She shared that the training boosted her confidence to speak out on SRH issues of persons with disabilities.

Before joining BYAN, Lakshmi was afraid to interact with others and hesitant to discuss SRH issues. Now, she shows confidence and vocalizes her opinions in meetings, contributing based on her understanding. She acknowledges that without BYAN's opportunities, she would still be confined to her home and expresses deep gratitude for the opportunities provided. Lakshmi's journey is just one among many cases touched by the A4C project.

- **The Journey from absence of information to friendly communication**

Pratibha, a deaf woman from Kathmandu, had always felt excluded from important conversations around SRHR. She grew up in a society where such topics were rarely discussed openly, especially within the deaf community. Communication barriers and the lack of accessible materials in sign language made it even harder for her to access critical information about her rights and well-being. Pratibha often felt that she was missing out on knowledge that could help her lead a healthy and informed life. She noted that the scarcity of sign language interpreters in hospitals created significant communication barriers. This was not merely an inconvenience; it compromised the quality of care. She observed that hospital staff and doctors appeared to provide less assistance to deaf individuals compared to hearing patients. She explained that because deaf patients could not hear when they were being called or told to wait, medical personnel failed to allocate sufficient time to communicate with them effectively. Furthermore, she added that this lack of communication often extended to the family environment as well, resulting in confusion and a lack of clear understanding regarding their own health and bodies.

Pratibha's journey began when she joined the A4C project as a peer educator. During the training, she was introduced to various accessible IEC materials, including those that were adapted into sign language. This was a significant breakthrough for her. For the first time, Pratibha had access to SRHR resources in formats she could understand and use to educate others in her community. She received mentorship and was trained to facilitate group sessions and one-on-one counseling for other deaf individuals, sharing important SRHR information in sign language. The project not only helped her gain knowledge but also gave her the confidence to communicate openly about SRHR with her peers. Her involvement in the project had a profound impact on her and the community. She led several SRHR sessions, where she shared her own journey and learned how to communicate effectively about topics that were once considered taboo. Through her leadership, other deaf individuals began to openly discuss SRHR, creating a more inclusive and supportive environment. Pratibha felt empowered to break the silence surrounding these issues and became a source of inspiration for others. Her work as a peer educator helped foster a stronger sense of community among deaf individuals, where they could share their concerns and learn from one another.

The project's intervention in providing sign-language based SRHR education allowed deaf women to finally access the information necessary to manage their health and advocate for

interpreters in clinical settings. Pratibha's story highlights the importance of accessibility and inclusivity in SRHR education for marginalized communities. It reinforces the idea that with the right support, individuals with disabilities can be powerful agents of change in their own communities. The project showed the necessity of tailoring materials to meet the specific needs of different disability groups, ensuring that everyone, regardless of their communication barriers, can access vital information. Additionally, Pratibha's journey underlines the significance of providing mentorship and training to individuals with disabilities, empowering them to take leadership roles and advocate for their own rights.

- **From Restriction to Professional Advocate**
  For over a decade, Narayani, a visually impaired woman from a remote village in Surkhet, lived a life confined within the four walls of her home. She was often underestimated by her community and even her family, who believed her disability made her incapable of contributing meaningfully to society. One of her biggest challenges was the stigma around disability, especially when it came to sensitive topics like SRHR which she had never been able to access or discuss openly.

Narayani's life took a positive turn when she became a part of the A4C project. She participated in the peer educator training, which equipped her with the knowledge and skills to lead SRHR sessions and offer counseling. With the support of accessible IEC materials, including Braille documents and tactile diagrams, Narayani gained the confidence to start facilitating group sessions for others with disabilities in her community. Through the project, she learned how to engage her peers and provide vital information on SRHR, despite the challenges her disability posed. As a result of her participation in the program, Narayani became a role model within her community. She not only successfully led sessions on SRHR but also provided counseling for a young woman who had recently lost her vision and was struggling to adapt. Narayani's personal experience and empathetic approach helped the young woman feel understood and supported. Through this interaction, she also gained confidence in her own abilities, learning to navigate her role as a peer educator and gain respect within her community. Her story inspired many others with disabilities to step out of their comfort zones and take an active role in their own empowerment.

One of the most innovative outcomes of the project was the connection between SRHR knowledge and the digital economy. Narayani detailed how the project facilitated her online freelance career. Initially, she lacked the employment history required to boost her Upwork profile, a common barrier for persons with disabilities who are often excluded from the traditional labor market. However, the project provided a unique solution. She secured an assignment related to the SRHR project that involved detailed writing on temporary contraceptive methods. Upon its successful completion and approval, her profile was established, leading to further work opportunities.

The story of Narayani highlights the importance of providing training, support, and accessible materials to empower individuals with disabilities. With the right tools, confidence can be built, and a sense of purpose and belonging can be restored. Through her journey, we learned that even individuals who face significant barriers can make profound impacts when given the opportunity and resources to lead. Additionally, her success underscores the need for community-based approaches to disability inclusion, where individuals with disabilities are seen as capable leaders and change-makers.

3.6 Institutional Transformation

The impact of the project extended beyond individuals to the institutional level, fundamentally altering how government and non-government agencies engage with the disability sector. The president at BYAN Bara chapter Sudhir Chaudhari highlighted a broader shift in governance. He noted that while government and non-government agencies were previously unwilling to collaborate with the disability sector, stakeholders now actively invite them to meetings and consultation seminars. This "signaling a transformation in institutional willingness to listen" represents a move from tokenism to genuine partnership.

> In the words of Sudhir Chaudhari:
> "Institutionally, this organization previously operated within a very small scope and limited area. Its identity was not fully established, and we were limited to being a "Briefcase-based organization, carrying documents in a bag without a fixed location. The organization had no distinct identity. Now, we have established a physical office and stabilized the organization."
>
> "Previously, the board committee members of our organization were hesitant to discuss health matters. They were unable to speak openly. Now, they are able to express their opinions, thoughts, and problems openly. This is a major aspect of our progress."
>
> "Previously, members could not speak openly during institutional decision-making processes, now they are also participating actively in such opportunities and they have become proficient in institutional rules and regulations. The number of members was previously low; although still limited, the membership numbers have increased."

- **Unifying the Disability Movement:** The project also fostered internal cohesion within the disability movement to advocate for collective rights. The COP MEMBER Dilip Jha reflected on this shift in his personal life, noting that while he had previously focused solely on his specific disability, the project provided him with significant experience that highlighted the necessity of working on behalf of all ten types of disabilities collectively.

Kaladhar Bhandari, Chief Adviser to BYAN, explained the strategic advantage of this cross-disability approach from his involvement in COP.

> "The COP included representation from all types of disabilities. As a person with visual impairment, I can speak to my issues, but I cannot speak authoritatively on the issues of other disabilities. However, when I, as a person with visual impairment, spoke about the contexts of persons with intellectual disabilities, autism, or other disabilities, stakeholders and policymakers received it more warmly, recognizing that we were focusing on issues beyond our own."

This solidarity made their advocacy more persuasive to policymakers, who saw a united front rather than fragmented interest groups.

3.7 Changing Local Levels and Health Professionals' Mindset

Systemic change is perhaps most visible in the transformation of physical infrastructure and the professional attitudes of health workers. The project succeeded in embedding accessibility into the built environment and the ethos of medical practice.

Dr. Yam Prasad Adhikari provided a candid assessment of the shift in medical ethics and behavior. To put in his words:

> "Health workers must provide services in a way that does not hurt the self-esteem of patients. Lately, there has been a significant change in the behavior of health workers. They realized, 'Oh, we were mistaken; the constitution mandates these rights."

This realization that dignified care is a constitutional mandate, not a charitable option has led to concrete operational changes. Dr. Adhikari noted that at the municipal hospital, priority is now given to persons with disabilities in lab testing and other services.

> "They are providing free services for many lab tests. The impact of this is visible in other surrounding health institutions and among health professionals as well. For instance, some free lab services are now being made available there as well."

- **Local level Commitments Towards Accessibility:** Local governments responded to BYAN's advocacy by allocating their own budgets for accessible infrastructure, proving the sustainability of the intervention. The Ward Chairperson of Jeetpursimara Municipality stated that they were preparing to construct necessary infrastructure by arranging funds from both the ward and the municipality. He noted that an accessible

toilet was currently under construction and mentioned that the ward had allocated a budget of two hundred thousand rupees for disability-related matters, which included a decision to purchase a tricycle.

Deputy Mayor Bhola Prasad Adhikari informed that new Simara City Hospital building was being built to be completely disability friendly. Construction was underway to ensure full accessibility, including installing ramps and elevators.

SRHR training for Health service provider

Similarly, Deputy Mayor Nilkantha Khanal of Birendranagar Municipality affirmed a systemic approach to accessibility. He stated that they tend to engage in discussions with stakeholders at the start of the fiscal year to ensure that any physical infrastructure would be environmentally friendly and accessible to all. Regarding the Municipal Hospital, he acknowledged the feedback provided by the project team and expressed appreciation for BYAN's technical support in auditing the facility's accessibility. Khanal affirmed their commitment to making the nearly completed municipal building accessible and noted that work was also progressing on the 15-bed hospital in Latikoili, asked for the same advice and accessibility auditing.

The comprehensive evidence presented in this chapter demonstrates that the Action for Change project has achieved transformative outcomes across individual, community, and institutional levels. From the personal victories of Narayani and Indra to the systemic reforms in Budhanilkantha, Jeetpursimara and Birendranagar, these stories confirm that the A4C project has moved beyond theoretical support to deliver concrete, verifiable improvements in the lives of persons with disabilities. The engagement of government stakeholders, the mobilization of local budgets, and the unified voice of the Community of Practitioners ensure that these changes are not temporary, but sustainable pillars of a more inclusive society.

CHAPTER FOUR

NAVIGATING THE PATH TO INCLUSION: CHALLENGES, LESSONS LEARNED, AND STRATEGIC RECOMMENDATIONS

The implementation of the project Action for Change: An initiative for the promotion of inclusive SRH and FP services for persons with disabilities represents a significant intervention in the socio-political landscape of Nepal. As documented in the preceding chapters, the project has achieved transformative milestones in establishing model health facilities, mobilizing youth leadership, and influencing policy frameworks at the local and federal levels. Nonetheless, the journey toward dismantling systemic barriers and ensuring SRHR for persons with disabilities was not beyond the challenging path. The project also encountered complex challenges that arise from the intersection of deep-seated cultural taboos, infrastructural deficits, bureaucratic hurdles, and the inherent difficulties of implementing a rights-based model in a resource-constrained environment. This chapter thus serves as a critical reflection on the operational reality of the project duration by examining the structural, environmental, and human resource impediments that BYAN navigated. Furthermore, it synthesizes the adaptive strategies employed by the project team transforming obstacles into lessons and outlines a comprehensive set of recommendations. These insights are intended not only to ensure the sustainability of the current intervention but to serve as a foundational guide for future programming by government entities, development partners, and OPDs.

4.1 Challenges

The challenges encountered during the project lifecycle were multifaceted, stemming from external environmental factors, internal capacity constraints, socio-cultural resistance, and governance hurdles. The following sections provide these challenges, categorized by their systemic nature.

4.1.1 Socio-Cultural and Economic Barriers

- **Deep-Rooted Taboos and Trust Deficits:** SRHR remains a sensitive, often stigmatized subject in Nepalese society, particularly in the Madhesh Province (Bara) and Karnali Province (Surkhet). Peer educators faced an uphill battle in simply initiating conversations. In Bara, specifically, cultural conservatism meant that discussing sexuality, menstruation, or family planning was seen as “vulgar.” Peer educators reported that women confined to their households were often initially disinterested or discomfort of the conversation.

- **The Allowance Culture and Financial Expectations:** A profound challenge deeply rooted in the development context of Nepal is the expectation of financial gain for participation in social programs. Peer educators reported that a major barrier to accessing beneficiaries was the expectation of monetary support. Community members often assumed that because an organization was visiting them, they would receive a per diem, snacks, or direct financial assistance. In the absence of such distribution, peer educators found it difficult to convince friends and community members to participate in counseling sessions. This “allowance culture” commodifies social change and creates a transactional relationship that undermines the spirit of disability movement.

- **Challenges in Mobilizing of Diverse Peer Educators:** The project's ambitious goal to mobilize 75 peer educators across three districts encountered significant challenge. A specific operational challenge was the reluctance of some peer educators to actually conduct the sessions after receiving the training. This reluctance stemmed from a mix of confidence issues, family pressure, and the formidable nature of discussing taboo subjects in their communities. This hesitation led to disruptions in the planned schedule of sessions, impacting the timely delivery of project objectives and requiring intensive mentorship from BYAN district chapters to keep the educators motivated.

- **Intersectionality gaps:** While the project achieved gender parity among its peer educators, it struggled to ensure gender balance in its engagement with government stakeholders. Due to the patriarchal structure of the Nepalese civil service, the vast majority of government officials are male. Consequently, policy dialogues often lacked the presence of female decision-makers.

4.1.2 Environmental and Infrastructural Impediments

The Impact of Adverse Weather on Accessibility Initiatives: The physical implementation of these accessibility features was severely dictated by environmental conditions. A major challenge arose during the construction phase at the Budhanilkantha Health Post in Kathmandu, where the installation of tactile paths was extensively delayed. The project timeline coincided with a period of continuous and heavy monsoon rainfall.

The installation of tactile paving requires dry ground conditions for proper grip and stability. The persistent rain rendered the site unworkable, forcing the project management to pause activities to prevent the wastage of materials and ensure the durability of the infrastructure. This unavoidable delay necessitated a rescheduling of construction work to the dry season, requiring BYAN to engage in renegotiations and extended coordination with local authorities to align the new timeline with municipal expectations.

Beyond infrastructure construction, environmental factors significantly impacted the soft components of the project, specifically the community-based peer counseling sessions. The project design relied heavily on Peer Educators visiting beneficiaries in their homes However, in the rural and semi-urban areas of Surkhet and Bara, the monsoon season exacerbated existing infrastructural deficits.

Peer educators reported that the physical act of reaching beneficiaries became a profound challenge. For educators with physical disabilities (wheelchair users) and visual impairments, the muddy, unpaved roads and lack of accessible transportation during the rainy season created a barrier that often-halted field activities. One Peer Educator noted that while their own home was modified for accessibility, the homes of beneficiaries were not. Consequently, during the rain, they were often forced to ask beneficiaries to come out to the road or a public platform (Chautari) to conduct sessions. This compromise, born of necessity, occasionally conflicted with the need for absolute privacy in SRHR counseling.

4.1.3 Human Resource Constraints

The Challenge of Specialized Recruitment (M&E): A robust MEAL framework is essential for demonstrating the impact of rights-based interventions. However, the project faced a persistent challenge in recruiting a qualified M&E expert in its first year of implementation. This posed challenge in effective tracking and directing the project implementation. The primary obstacle was financial. The budget allocated for the M&E position was insufficient to attract experienced professionals in a competitive labor market. High-quality M&E experts often command compensation packages that exceed the standard constraints of NGO project budgets. This gap deterred qualified candidates from accepting the role, leading to delays in essential tasks such as operational research and the finalization of the MEAL framework. The inability to fill this post posed a risk to the rigorous documentation of the project's success. To mitigate this, the organization has had to look forward to potential synergies with the 'Amplify Change' project, which the BYAN was operating in the similar theme.

Furthermore, challenges arose in procuring external experts who possessed both technical subject matter expertise and disability inclusion competency for the development of MEAL framework. The same challenge also was encountered in delivering the SRHR training. A pertinent example occurred in Kathmandu during the SRHR Training of Trainers (ToT). The expert selected to lead the session, while possessing deep knowledge of SRHR, lacked the pedagogical skills to deliver the training inclusively. The trainer struggled to adapt methodologies to a cross-disability group that included individuals with visual, hearing, and physical impairments. This inability to accommodate diverse learning styles and backgrounds reduced the effectiveness of the session, highlighting a broader scarcity of inclusive trainers in the national market.

Advocacy through media was a key strategy of the project. However, engagement with journalists in Surkhet revealed a significant capacity gap in the media sector. Journalists demonstrated a lack of sufficient knowledge about disability rights and frequently failed to use appropriate, rights-based terminology when discussing persons with disabilities. Despite sensitization efforts, the persistence of charity-based or derogatory language in media reporting hindered the project's goal of shifting the public narrative. This challenge suggests that short-term sensitization is insufficient to overturn deeply ingrained societal biases held by media professionals.

4.1.4 Technical Gaps

- **Digital Accessibility Barriers:** In an era of digital transformation, the project attempted to utilize online tools for efficiency, but this often clashed with the reality of the digital divide. During refresher trainings conducted via Zoom, participants with disabilities faced severe accessibility barriers. Many peer educators encountered compatibility issues between the conferencing platform and their assistive technologies (such as screen readers). Coupled with unstable internet connections in rural areas, these technical barriers prevented full engagement in virtual capacity development activities.
- **Challenges in Assistive Technology Implementation:** The project's innovative attempt to use mobile technology the 'Hami for SRHR' App faced a reality check in the field. The application was designed to provide accessible SRHR information. However, the login mechanism required a Gmail account. In rural Nepal, where digital literacy is low and many users access the internet solely through mobile data for social media, possessing

a functional email account is rare. This technical oversight effectively locked out a significant portion of the target demographic. Furthermore, the app lacked a backend system for regular updates, leading to content stagnation.

- **The Unfeasibility of Accessible Pregnancy Kits:** One of the project's specific objectives was to collaborate with manufacturers to pilot disability-friendly SRH materials, specifically accessible pregnancy test kits with tactile, audio or vibration features. However, during the implementation phase, this activity proved unfeasible. Consultations revealed that in the Nepalese context, most SRH materials and tests are administered by health service providers rather than being self-administered. This systemic reality limited the scope for introducing self-testing innovations. Additionally, while the option of importing accessible kits from abroad was considered, it was deemed unsustainable as it would be expensive and would not create a local supply chain. Consequently, this activity had to be abandoned.

4.1.5 Governance and Bureaucratic Impediments

- **Political disagreements and changes within the local government structure:** The establishment of the Model Health Facility at the Urban Health Promotion Center in Jeetpursimara was envisioned as a cornerstone of the project's systemic impact. However, this initiative faced significant hurdles related to local infrastructure governance. Despite BYAN fulfilling its technical and financial obligations promptly, the development of the UHPC was troubled by slow progress in general infrastructure work, which was under the purview of the local municipality. These delays were not merely administrative but were rooted in political disagreements and changes within the local government structure. The political instability led to a stagnation of decision-making processes, causing delay in the timeline for the installation of disability-friendly amenities (such as accessible toilets). The project team had to exert significant effort in advocacy, eventually necessitating direct intervention from the municipal leadership to unblock the process. This experience underscored the vulnerability of project timelines to external political dynamics that are often beyond the control of the implementing partner.

- **Instability and Staff Turnover:** The sustainability of the project relies on government ownership, yet the volatility of government staffing posed a continuous challenge. Frequent transfers of staff created a revolving door of leadership that erased institutional memory. For example, the project team invested significant time in building a rapport with the Chief of the Family Welfare Division. When this leadership changed, the established relationship evaporated, necessitating a restart of advocacy efforts with the new appointee. This cycle of building and rebuilding relationships consumed valuable project time and delayed collaborative actions.

- **The Gap Between Commitment and Contract:** A recurrent theme in engagement with government bodies was the discrepancy between verbal support and formal commitment. While federal and local government entities frequently provided oral assurances of their support for BYAN's initiatives, finalizing these commitments into written, actionable agreements was arduous. The bureaucratic lethargy meant that paperwork dragged on for months. This lack of formal agreement made implementation precarious; without

a signed document, verbal promises were often forgotten during staff transitions or budget reviews. Along with the other nonrealization of such promises, the project encountered hurdles in installing the accessibility features in Budhanilkantha hospital of the Budhanilkantha municipality. Initially, the municipality had promised to share the construction cost for ensuring accessibility features in the hospital. But later they did not show willingness to contribute from their end. BYAN, therefore had to bear the full construction cost to complete the accessibility amenities.

- **Budgetary Delays and Financial Coordination:** The fiscal operations of the project were frequently disrupted by the timing of government budget releases. Late budget disbursements at the local level meant that planned activities, which relied on government co-funding or collaboration, had to be postponed. This was particularly evident in Bara during the joint celebration of International Youth Day. Although the local government agreed to collaborate, the actual financial transaction and release of funds were procedurally complex and delayed. These financial bottlenecks disrupted the procurement of resources and forced the project to constantly readjust its implementation calendar.

- **Political Unrest:** The project encountered notable challenges due to the GenZ movement protest all over Nepal and the destruction of infrastructure and vandalism in Birendranagar Municipality, Surkhet, and Jeetpursimara Sub-Metropolitan City, Bara. Additionally, this created significant backsliding in the progress which BYAN had already achieved.

4.2 Lessons Learned

The best practices secured by project A4C and challenges navigated by BYAN during the project implementation have generated a wealth of institutional knowledge. These lessons are vital for the growth of BYAN as an organization and for the broader disability rights movement in Nepal.

- **The Power of Tangible Models for Advocacy:** The project learned that advocacy is most effective when backed by concrete evidence. The initiative to establish model health institutions (such as the UHPC in Dumarwana and the municipal hospital in Birendranagar and Budhanilkantha) served as powerful proof of concept. It demonstrated to skeptics in the government that "accessibility" is not an abstract or impossibly expensive concept but a practical, achievable standard. Local government ownership and co-financing strengthen sustainability, showing that integrating activities into municipal plans and budgets ensures longer-term impact. These facilities have become living evidence that can be used to persuade other local levels to replicate the model. The lesson here is that theoretical advocacy must be paired with tangible implementation to drive systemic change.

- **Strategic Responsiveness and Financial Flexibility:** The failure of the accessible pregnancy kit activity provided a crucial lesson in adaptive management. Rather than letting the allocated budget lapse, the project demonstrated swiftness by seeking approval to reallocate the funds providing technical support for a disability-friendly washroom. This strategic shift ensured that resources were not wasted but were redirected to an

area where they could yield immediate, sustainable impact. This experience underscores the importance of having flexible budget frameworks and contingency plans that allow implementing partners to adapt to technical or environmental roadblocks without halting the project.

- **The Necessity of Continuous Government Engagement:** The difficulties with staff turnover and verbal commitments taught the project team that engagement with the government cannot be a one-off event; it must be a continuous process of follow-up. The project learned that persistence is policy. Regular follow-ups, even when repetitive, were the only way to convert verbal promises into action. Furthermore, the lesson emerged that relationship-building must be institutional, not just personal. Relying on a relationship with a single official is a risk; relationships must be built with the office or department to survive staff transitions. Early formalization and clear coordination mechanisms improve efficiency, reduce delays and enhance accountability in partnerships with government stakeholders.

- **The Complexity of Cross-Disability and Governmental Coordination:** The formation of the COP was a lesson in the logistical complexity of true inclusion. While the COP successfully brought together diverse disability groups, ensuring the consistent participation of government representative was difficult due to their conflicting schedules. In Kathmandu, for instance, the government representative missed meetings despite being willing to support. The lesson learned is that while formal structures like COPs are essential, they must be flexible. Rigid attendance requirements may alienate busy officials; therefore, flexible consultation mechanisms are necessary to keep high-level stakeholders engaged. Similarly, including the representatives of the respective agencies, instead of particular individuals might enhance the institutional engagement despite the conflicting schedule of a particular official.

- **Understanding the "Demand Side" in Peer Education:** The operational challenges in peer education revealed that understanding the diverse needs of the target population is critical. The one size fits all approach to training (e.g. using a non-inclusive expert) failed. The project learned that early and intentional accessibility planning is essential for meaningful inclusion, ensuring full participation through accessible logistics, materials, and communication support. Training must be tailored using sign language, Braille, and simplified text to be effective. Moreover, the project validated that for sensitive topics like SRHR, one-on-one counseling is far more effective than group sessions. The privacy afforded by individual counseling allowed beneficiaries to overcome the "shyness" and fear of stigma that paralyzed group discussions

Capacity building of both service providers and persons with disabilities is effective, as it improves inclusive service delivery while empowering rights holders to claim SRHR services. Use of accessible IEC materials and inclusive approaches enhances reach and quality, establishing a replicable model for disability-inclusive health communication.

4.3 Recommendations

Based on the analysis of the challenges faced and the lessons derived, this report proposes the following comprehensive recommendations. These are divided into general strategic recommendations for the sector and specific operational recommendations for future programming.

4.3.1 General Recommendations for Systemic Sustainability

Embed Disability-Inclusive SRHR in National Systems, including in the education curriculum, manual operation, programs, policies, action plans, targets and strategies: sustainability cannot rely on NGO projects alone. It is recommended that BYAN and its partners advocate for the integration of accessible SRHR materials (Braille, sign language, PEC systems etc.) directly into Nepal's national education curriculum. The CDC, NHTC and other concerned entities must own these materials. If the state education system adopts these tools, it will not require relying on short term external projects, ensuring that generations of students with disabilities receive SRHR education as a right, not a project deliverable. Similarly, the government ministries and concerned entities must prioritize the accessibility and disability inclusive SRHR in their plans, programs, policies and budget frameworks.

- **Strengthen Multi-Sectoral Partnerships:** The isolated approach to development must be broken. It is recommended to expand collaborations beyond the Ministry of Health to include the Ministry of Education and local school boards. By institutionalizing inclusive SRHR education in schools, the movement can address the root cause of the information gap. This requires building on the current actions of BYAN and CBM to push for a formal, multi-sectoral strategy that binds different government departments to a common goal of inclusion.

- **Promote Intersectional Advocacy and Data Justice:** Every program must prioritize the intersection of gender, disability, and sexual orientation, gender identities and expressions. Policies and training modules must be updated to explicitly address the needs of women and girls with disabilities, who face double discrimination. Crucially, data collection methods must be revised to include indicators for sexual and gender minorities. Data justice means ensuring that all identities are visible in the statistics; without this, the specific needs of LGBTQIA+ persons with disabilities will remain unaddressed and unfunded.

- **Scale Public Awareness through Cultural Shifts:** To combat the deep-seated taboos and the "shyness" encountered in the field, it is recommended to scale up public awareness campaigns using modern platforms. Leveraging social media platforms by engaging influencers and utilization of youth festivals can help normalize SRHR discussions. The goal is to shift the cultural narrative from one of shame to one of health and rights. Campaigns should specifically target the misconceptions that persons with disabilities are asexual, hypersexual or incapable of marriage, directly challenging the societal stigma.

- **Formalize Government Partnerships:** To mitigate the risks associated with staff turnover and verbal commitments, it is recommended to establish formal Memorandums

of Understanding (MOUs) or Letters of Commitment with government stakeholders at the very beginning of any intervention. These documents should outline roles and responsibilities clearly, ensuring that commitments survive the transfer of individual officials.

4.3.2 Specific Operational Recommendations for Future Projects

Expansion of Accessible Infrastructure: The success of the three model health facilities must be replicated. It is recommended that future projects or government budgets focus on constructing additional accessible health facilities nationwide. These should not just have ramps, elevators and tactile paths, but be equipped with comprehensive communication aids like accessible IEC materials; including tactile models and easy-to-understand booklets. Specifically, the project recommends that maintenance protocols be established for existing structures to ensure they remain functional and safe over time.

- **Expand the Peer-Led Training Model:** The current training duration for the beneficiaries by the peer educators was identified as insufficient. Future iterations of the project must increase the length of the Training sessions. A single day is not enough to get acquainted with the complex SRHR knowledge and skills. Extended training will build greater confidence in the beneficiaries. Furthermore, the model should evolve from sporadic sessions to a permanent presence. It is recommended to advocate for the appointment of a dedicated Ward-Level Peer Educator at the community level in each local ward. This individual would work continuously on disability issues, visiting homes regularly. A permanent presence would build deeper trust, overcome the "stranger danger" aspect of home visits, and ensure sustainable behavioral change that a one-off workshop cannot achieve.

- **Expand sensitization training to support staff:** Guards, receptionists, office assistance and similar support staffs also need to be sensitized on the disability inclusive behavior, as they are often the first barrier.

  Increase engagement with the Local level disability coordination committees, as these entities are the dedicated institutions under the local levels to address the disability specific concerns.

- **Targeting Hard to Reach:** The project must expand its geographical focus. The current intervention was centered in relatively accessible areas. There is a moral and programmatic imperative to take this wave of awareness to remote, off-road areas in the Karnali province. Future projects should budget for the high logistical costs of reaching these areas, recognizing that the most marginalized persons with disabilities live where the roads end.

- **Family, Caregiver and community engagement and Involvement:** SRHR interventions often focus solely on the individual, but the individual lives within a family structure that may be restrictive. Future projects should explicitly target parents and caregivers. Developing standardized training modules for parents of youth with intellectual, psychosocial and autism-related disabilities is crucial. If the family understands the SRHR needs of their child, the barriers to access such as being locked in the home or denied hygiene products will diminish. Including the communities in these kinds of initiatives also can create a sense of empathy and ownership in the disability inclusive SRHR issues.

- **Digital and Technical Overhaul:** The 'Hami for SRHR' App requires a technical overhaul to improve accessibility. It is recommended to modify the login system to allow access via phone numbers, removing the barrier of email requirements. Additionally, the app needs a sustainable content management strategy to ensure that information remains updated.

- **Succession Planning and Institutional Memory:** To ensure the sustainability of local chapters, the BYAN Central Office must provide robust support in documentation and legal compliance. Since local chapters often lack the capacity to maintain centralized records, there is a risk that project achievements will die out locally when the project ends. A centralized repository of best practices and legal documents should be maintained and handed over to the local chapters. Furthermore, peer educator networks should include succession planning; if a leader marries or moves away, a system must be in place to train their replacement immediately, ensuring no community is left without a focal point.

Conclusion

The A4C project demonstrates that disability-inclusive SRHR programming is achievable and effective when grounded in human rights principles, community participation, and system-level engagement. The project addressed structural, social, and institutional barriers that have historically excluded PWDs from SRHR information and services. By implementing a Power Shift model that placed young people with disabilities at the center of the design and implementation process, the project moved beyond traditional charity-based approaches to establish a framework of agency and ownership. The findings indicate measurable improvements in SRHR awareness, confidence, and service utilization among PWDs, alongside increased sensitivity and accountability within health facilities. Through the mobilization of Peer Educators and the COP, beneficiaries transitioned from a state of shame and limited knowledge to one of informed advocacy. The project effectively facilitated knowledge transfer on critical issues including menstrual hygiene, family planning, and bodily autonomy empowering PWDs to make independent health decisions and challenge harmful traditional practices. The use of accessible materials and disability-responsive service practices contributed to more inclusive service environments.

Importantly, the project contributed to strengthening local-level ownership, particularly through collaboration with municipal authorities and health institutions, which supported alignment with local plans, budgets, and service delivery mechanisms. While progress was made, institutional change requires sustained engagement beyond project timelines. The experiences and lessons documented in this report provide a strong foundation for future programming, emphasizing the need for long-term investment, institutionalization of inclusive practices, and continued leadership of PWDs. Strengthening coordination among stakeholders and scaling proven models will be essential to ensuring that SRHR services in Nepal are equally available, acceptable, accessible and inclusive for all.