Nepal

NEPAL

NEPAL

CONTENTS

EXECUTIVE SUMMARY

The State of the World Population Report 2003 (UNFPA) estimates that Nepal's maternal mortality rate (MMR) has doubled in the past seven years and stands at 905 per 100,000. After Afghanistan, which has a mortality rate of 1,276 per 100,000, Nepal has the second highest mortality rate in South Asia.

The present moment is critical for Nepal in terms of its adolescent population. Inadequate health facilities and the practice of early marriage have contributed to the increase in the mortality rate. The present trend indicates the necessity of encouraging adolescents, particularly girls, to become actively involved in reproductive health programmes, and putting pressure on Government to invest more in this critical sector. The fear and violence created by nine years of insurgency has had a negative impact on Nepal's limited health infrastructure. Health centres are non-functional as many trained medical staff have left; in certain areas buildings have been destroyed, rural health posts no longer exist, those left standing have no infrastructure, and there is a scarcity of medical facilities for pregnant women.

Nepali women are among the most disadvantaged people on the planet in terms of health and medical facilities. Most of them are denied the right to security in, and control over, their bodies, as well as the right not to be alienated from their sexual and reproductive capacities. Women have been blatantly denied the integrity of their physical person – for example, freedom from sexual violence, from false imprisonment in the home, from unsafe contraceptive methods, from unwanted pregnancies or coerced child-bearing, and from unwanted medical intervention.

Women using local family planning clinics suffer from untreated gynaecological infections or diseases: the reality is that they are viewed as contraceptive acceptors, not as whole women. Family planning programmes often emphasise medically efficient methods of contraception to the exclusion of barrier methods. This failure to offer women protection against STDs and HIV infection results in their exposure to morbidity, infertility, or death. Women are also the victims of the side effects of contraceptives. Their concerns about irregular bleeding while using contraceptives are often dismissed and their requests for removal of implants are often not honoured. In addition, there is little respect for differences among women with respect to values, culture, religion, sexual orientation, and family or medical conditions. When disseminating contraceptives clinic staff do not always understand the meaning that menstrual blood has in local cultures, and how frequent bleeding--a common side effect of some devices--may result in the exclusion of women from sex, rituals, or community life.

Population policies traditionally demand that women bear the medical risks and social responsibilities for avoiding unwanted pregnancies. Equal emphasis is never put on male responsibilities for controlling fertility and using contraceptives. In addition, women have little or no ability to determine when, whether, why, with whom, and how to express their sexuality, nor do they have the right to decide whether, how, when and how many children to bear. Population policies are not based on the principle of respect for the sexual and bodily integrity of girls and women. As a result, many women are compelled to bear a child or are prevented from doing so against their will.

Despite its legalisation, post-abortion complications are still a major problem in Nepal, with 20-27 percent of maternal deaths in hospitals caused by such complications. Studies show that five percent of maternal deaths in villages are

caused by unsafe abortion. The Ministry of Health has recently extended its post-abortion care programme to 19 hospitals. These efforts are yet to yield results since most women die before reaching hospital. Records for 2002 maintained by the National Maternity Hospital in Kathmandu show that nearly ten percent of the 18,000 patients admitted to hospital were abortion-related cases.

According to a government survey, three in four women dying of delivery complications were illiterate. Educated women had better access to a doctor or medical worker. As a result, the UNFPA report stresses the need to invest in girls' education. The report shows that 76 percent of females above 15 years are illiterate, against 43 percent of the male population group. Maternal morbidity and mortality are closely related to literacy.

Even during periods of normalcy, only a small percentage of the population in rural Nepal has access to health facilities. Assistance during delivery from a doctor, trained nurse or midwife is relatively low. According to the Nepal Demographic and Health Survey (NDHS) 2001, conducted by the Health Ministry's family health division, just over one in ten births is attended by a trained doctor or paramedic. Nearly one in four is attended by only relatives or friends. Nine percent of births are not attended by anyone at all. For all their village wisdom, untrained midwifery can be disastrous for the mother. The maternal mortality and morbidity study shows that the majority of maternal deaths are caused by postnatal complications. This is a failure of the State's policies and programmes to do with women and health. The concept and the roadmap seem perfect in formulating programmes, but their implementation has always been weak. Clearly, some drastic steps are needed if things are to improve.

Introduction

Brief History of SRHR and Population Policies

Sex, sexuality and reproductive health have traditionally been taboo subjects in Nepal. When the Family Planning Association was established and the Contraceptive Retail Sales Project was launched about two decades ago, Reproductive Health (RH) was conceptualised narrowly as relating only to the supply of contraceptives and sterilisation. Only after the Fourth World Conference on Women adopted the Beijing Platform for Action (BPFA), and the ICPD Cairo adopted its Plan of Action (PoA) has sexual and reproductive health been considered as a right and activities implemented with this approach. Before ICPD the Government did not regard health as a priority area. Even the PFA became popular only because of a massive campaign during its preparatory phase, the active participation of many women from the grassroots at the Conference, the large participation of women from all over the country in the mini Beijing conference held thereafter and its promotion by UN organisations. With ICPD, however, there were no specific organisations or activists who promoted the PoA.

The Family Planning Association was involved in the Beijing process to discuss rights, but as its focus of activities is FP, with a need-based approach, it was only involved in providing FP information and services. Later, after ICPD, it changed its approach from a needs-based one to a rights-based one.

However, Beijing has made more of a difference than Cairo, because Beijing was highlighted by the media and at the grassroots level. There are fewer women's health rights groups than women's rights group because there are

fewer consultations and discussions on sexual and reproductive health rights. Even many people at the Ministry of Population and Environment (MoPE) do not know about ICPD or Cairo. However a number of people from governmental and non-governmental sectors are aware of the Beijing Conference and the Beijing Platform for Action (BPFA).

ICPD and its Influence on Government Policies

Widespread poverty and high population growth has been the major challenge to Nepal's socio-economic development efforts. According to MoPE, His Majesty's Government of Nepal (HMG) is committed to implementing the recommendations of ICPD, Cairo and has made this a priority. Efforts have been ongoing since the Ninth Five Year National Plan (1997-2002) to integrate population factors into development planning, and to improve access to quality reproductive health services, as well as focus on the empowerment of women, increasing literacy status and promoting higher levels of income. The adolescent sex and reproductive health programme entered the government agenda only after the Ninth Five Year Plan.

The impact of ICPD is clearly reflected in certain key policies. These include: the National RH Policy (1998), the National Policy and Strategy for Reproductive Health (2000), the Mainstreaming Gender Programme, the Health Sector Reform (2003), the Community Health Insurance Policy Guidelines (2003), and the Neonatal Health Care Strategies (2005). Also included under this head are: the Second Long Term Health Plan (SLTHP, 2002-2017), the Revision of legal age at marriage, the law to combat trafficking of girls and women for commercial sex related policies related to HIV/AIDS, sex education in formal and non-formal educational institutions, the National Standard & Clinical Protocols for FP & RH, the National Adolescent Health Programme, the Amendment to the Civil Code (Muluki Ain, that legalised abortion in September 2002), and the National Safe Abortion Policy (2003) and Directives (2004).

Efforts to Monitor PFA and Rationale for this Initiative

The Government's efforts in monitoring international instruments such as the PFA and ICPD Programme of Action, however, remain weak. The slow progress and low level of achievements, the lack of information about these instruments within and beyond Government circles, and the lack of mechanisms to monitor provide clear evidence of this. A number of UN Agencies and INGOs are supporting the efforts of NGOs and GOs towards the effective realisation of the above instruments. Prominent contributors to this initiative are UNFPA, UNIFEM, UNDP, USAID, CCO, PLAN, GTZ, the British Embassy and OXFAM-GB.

The purpose of NGO involvement – and of this study - in monitoring the PFA and the ICPD is to assess the progress of policies, laws, programmes and services at the local and national levels since 1994, in understanding, acceptance and implementation of the PoA, ICPD, and its gender equality and SRHR objectives, and also to assess the outcomes of these changes on women's SRHR, their status and their lives, including adolescent lives. As well, by comparing the government data to data generated by NGOs, the latter can step up advocacy for effective SRHR policy formulation, implementation and assessment.

Specific Objectives

The following are the specific objectives of this country study:

1. To assess progress in policies, laws, programmes and services at the local and national levels over the last ten years, in understanding, accepting and implementing the critical ICPD gender equality and SRHR objectives;
2. To assess the outcome of these changes on women's health, women's status and women's lives, including adolescents;
3. To identify and analyse the main barriers and facilitating factors in the PoA, ICPD implementation as perceived by NGOs and government in relation to:
    a. The political, economic and social context of the country,
    b. Institutional factors, lack of governmental action/inertia, regulation, enforcement,
    c. Effectiveness of NGOs and civil society participation and advocacy,
    d. Presence of ICPD adversaries (threats or enemies),
    e. Impact of health sector reform (e.g. decentralisation, financing, community participation, accountability),
    f. Donor policies;
4. To analyse the differences in the government's assessment of ICPD progress in the government country reports to the Fifth Asian and Pacific Population Conference (APPC) and UNFPA Field Inquiry 2003 Reports compared to the country study assessment; and
5. To recommend critical actions to be taken by the government, NGOs and donors at local, national and regional levels.

Methodology

This study looks at monitoring and advocacy on SRHR within the context of ICPD at Ten in Nepal. It is based on an analysis of secondary data, key informant interviews with policy makers, government personnel, and service providers, planning meetings, questionnaires, particularly administered to women survivors imprisoned for abortion, focus group discussions and consultations and surveys of service providers.

Two broad methodological approaches were used for this study:
a. Secondary and primary data collection and analyses to measure progress with respect to three ICPD goals namely gender equality, social equality and equity; reduction of maternal mortality and promoting safe motherhood and safe abortion and promotion and protection of sexual health and rights, safe contraception as well as prevention and treatment of HIV/AIDS and reproductive cancers. In addition to this data on two crosscutting issues, young peoples' right to access to information and services, and the impact of health sector reform on access to sexual and reproductive health and rights have also been analysed.
b. Government reports on ICPD implementation progress were compared to the findings of this study.

The Beyond Beijing Committee regarded this country study as an excellent opportunity for bringing different stakeholders including community-based NGOs together in assessing ICPD progress. The participants included women's rights NGOs, human rights NGOs, NGOs working in the health sector including FPAN as well as medical and health associations. Another significant preparatory activity was the participation of BBC executive and staff members in a regional meeting in Malaysia. Similarly, participation of BBC executive members and staff members at strategic planning meetings at Langkawi had an added value in the collection of feedback towards the finalisation of the report.

Details of Desk Research

Data from existing published or unpublished reports by governmental agencies, NGOs, the UN and research organisations, were collected and analysed. The key sources of secondary data were the Fifth Asian and Pacific Population Conference, the Nepal Country Report, HMG/N, the National Demographic Surveys, reports to CEDAW by the Government report and NGOs, Government: ICPD and Beijing Plus Five and Ten Country Reports for the Fifth Asian and Pacific Population Conference in 2002 (APPC) and the UNFPA Country Field Inquiry Questionnaire (FIQ) of 2003.

Details of Field Based Research

In-depth interviews were carried out with five key people from both government agencies and NGOs, interviewees were selected keeping in mind their ability to give a national policy or programme perspective. In addition, women imprisoned for abortion were interviewed.

Structured large group meetings with grassroots men, women and adolescents, service providers, and providers of technical and financial assistance from NGOs, INGOs and GOs were conducted to document actual situations, opinions, events, examples of violations, etc. Two regional level consultations were organized to collect and share information at the grassroots level, Four focus group discussions were also held. Each had 12 women participants from local NGOs, CBOs and health facilities. One facilitator/moderator initiated discussions with questions relating to SRHR in their local areas, and notes were kept of each meeting. The facilitator/moderator asked tag questions for in-depth discussions.

The Team

The Country Study Team included the Executive and Staff Members of BBC, and consultants, three men and four women from a multi-disciplinary background. Human Rights, Sociology, Human Resource Development, Research, and Administrattion. Ethnically, the team is composed of four Newars and three Brahmin/Chhetris (all upper caste).

The major constraint faced by the team during the study was political instability, particularly the frequent strikes and long closures of businesses and institutions in the country, all of which made travel and data collection extremely difficult.

Country Context

Landlocked between India and China, the tiny Himalayan Kingdom of Nepal is a country of natural bounty and cultural beauty. Its spectacular mountain terrain and unique landscape, its flora and fauna blend with diverse rich cultures to attract visitors from all over the world. Ironically, this very terrain also creates obstacles to health care for Nepali people, and particularly women and female children. Those who live in remote mountain villages are often at least a day's walk from health care facilities.

The HMG/N has been a proponent of quality family planning and has been committed to educating women about contraception. However, many women

marry young, and there is much emphasis on having children, especially sons. The birth rate remains relatively high, and Nepal has one of the highest maternal mortality rates in the world. This is due in part to deaths from unsafe abortion. A bill legalising abortion has recently been passed by the parliament and maternal mortality is expected to go down.

Sex, sexuality and reproductive health were social taboos in Nepal prior to the establishment of FPAN by the late Princess Prexhya Rajya Laxmi Devi Shah and three prominent medical doctors. The Contraceptive Retail Sales Project was launched by the CRS Company and funded by USAID about two decades ago. The RH concept initially focused only on supplying contraceptives and performing sterilisations; sexual and reproductive health was not a priority and it was not recognised as a right. It was only after the Fourth World Conference on Women adopted the Platform for Action that sexual and reproductive health as a right was envisioned and activities initiated with this approach. Moreover, prior to ICPD, health was not regarded a priority sector by the Government. Even today, ten years after ICPD, there is not much knowledge about it in the Ministry of Health in Nepal.

The HMG/N participated in ICPD in Cairo, ICPD +5 and several related regional seminars. As a result, policies and laws were changed to some extent and programmes were developed (see box), but the implementation and monitoring mechanisms remained poor, and therefore change was slow to come. Nonetheless, some efforts have been made since the Ninth Five Year Plan to integrate population factors into development planning and to improve access to quality reproductive health services.

The Government needs to change policies and legislation in many spheres: e.g. SRH as well as HIV/AIDS free service, property rights, free education to girls, more flexibility in abortion, revision of legal age at marriage, initiate and strengthen rehabilitation programmes for survivors, participation of more women in legislation, representation of women at a senior level in the civil service, etc. In order to do this, a team of experts was appointed to assess the outcome of IPCD but this was not very participatory in nature. As well, Government sanctioned an assessment budget but the various stakeholders were not involved in preparation of the report, leaving this exercise too, incomplete.

Efforts have been made since the Ninth Five Year National Plan (1997-2002) to integrate population factors into development planning. The efforts were aimed at improving access to quality reproductive health services, empowerment of women, increasing literacy status and promoting higher level of income. A sex and reproductive health programme for adolescents was conceptualised in the Ninth Five Year Plan. The impact of ICPD, Cairo is clear on National RH Policy (1998), the National Policy and Strategy for Reproductive Health in 2000, the Health Sector Reform 2003, the Neonatal Health Care Strategies 2005, The Second Long Term Health Plan, 2002-2017 (SLTHP), revision of legal marriage age, laws to combat trafficking, sex education in formal and informal educational institutions, the national standard and clinical protocols for FP and & RH, a National Adolescent Health Programme, the amendment of the Civil Code (that legalised abortion) in September 2002,and the National Safe Abortion Policy of 2003 & Directives of 2004

NGOs, women's health groups, networks, professional councils and social movements were actively involved in pressing for policy changes in the aftermath of ICPD, demanding changes in government policies and monitoring implementation of the PoA (for example advocacy campaigns launched by BBC, LAC, CREPHA, FPAN, NANGAN, SAMANATA, FWLD, etc.). Some groups are involved in property rights campaigns, HIV/AIDS, Safe Motherhood, FP, Abortion, Adolescent Programmes, etc. Many NGOs implementing health projects are involved in providing SRH services along with information on SRHR. INGO/Donor agencies (UNFPA, UNIFEM, USAID, Lutheran World Service, PLAN International Nepal, Action Aid Nepal, World Bank and so on) are providing financial and technical support to the NGOs and to the government for this.

Clearly, a fair amount needs to be done if real change is to take place. According to the Centre for Research on Environment Health and Population Activities (CREHPA) 'there are still major concerns and steep mountains to climb beyond ICPD in SRHR'. The following reasons are cited for this.

Socio-Demographic Problems

- Low literacy rate among the female population and the high female dropout rate
- Early marriage and early (adolescent) motherhood
- Slow decline in TFR and the modest CPR
- Rural to urban and trans-country migration
- Human trafficking
- Increase in commercial sex and sexual exploitation
- Risky drug- injecting behaviour among young people
- Malnutrition
- Poor health management and lack of health personnel in health facilities
- Public private partnership in specialised and super specialised care
- Lack of health financing, prepaid and community financing, including health insurance

Sexual and RH related Problems

- High maternal mortality rates
- KAP-Gap (Knowledge, Attitude and Practice-Gap) in pregnancy and childbirth
- Unsafe abortions
- RTIs, UTIs and UPs
- Increased premarital sex, promiscuity and related high-risk behaviour
- Increased incidences of STIs and HIV/AIDS

Concerns relating to Gender Equity and SRH Rights

- Persistent son preference
- Low self-esteem of daughters and women in general
- Sexual abuse, non-consensual sex and sexual violence including trafficking of girls and women
- STI and HIV/AIDS endemic among the sub-population (sex workers, clients of sex workers, drug users and migrant population)
- Women being imprisoned for abortion
- Sex determination tests and termination of female foetuses
- Poor neonatal health, particularly among females

The national budget for the fiscal year 2004/05 announced on 17 June 2004 placed a higher priority on security than it did on health. The budget allocated

for National Security is Nepali Rupees 8 thousand million whereas that for overall health is Nepali Rupees 6.55 thousand million, which is Nepali Rupees 1.45 thousand million less. This health budget includes infrastructure, equipment, personnel, administrative, general medicine and specific health care/services including epidemics, RH, STI and HIV/AIDS, cancer, ophthalmology, and so on. Clearly, the Government's commitment to giving a high precedence to SRHR does not seem serious given that such a small percentage of the National budget is to be used for it. In the last fiscal year the Government spent Nepali Rupees 7.18 thousand million on National Security and only Nepali Rupees five thousand million, which was Nepali Rupees 2.18 thousand million less, on health. (Ministry of Finance, HMG/N)

Assessing Progress in Achieving ICPD, Cairo Goals And Objectives

The Key Findings

In the last decade, shifts in the conceptualisation of Women in Development (WID) and/or Gender in Development (GAD) issues are reflected in new approaches to the state as a vehicle for change. The understanding of mainstreaming gender has broadened from a mere inclusion of gender-based projects and programmes to a consideration of gender issues across all sectors, ministries and departments. Transforming government structures to be sensitive to this is a slow process.

Nepal's commitment to the ICPD-Programme of Action, the BPFA and ICPD+5 through the establishment of various mechanisms is a significant achievement. Its results are visible in the increase in SRHR awareness and services, the reform of health services, government laws and policies in relation to sexual and reproductive health and rights, provision of village health workers and mother and child workers in each ward and the approval of poverty alleviation as the top priority agenda item in the recent National Plans. Similarly, initiation of micro-credit and group-credit programmes for women, launching of savings and credit programmes in rural communities, launching of immunisation, vitamin A and polio vaccination programmes to reduce child mortality and eradicate polio as well as training on Safe Motherhood are also significant steps towards the effective realisation of these commitments. Increased publicity and availability of family planning means and services, expansion of ambulance service and, most importantly, the recent revision of the law on abortion have been crucial factors in the realm of attitudinal as well as behavioural change. In addition, according to MoH data there has been a decrease in IMR, U5MR MMR and TFR, an increase in LE and CPR, delivery with attendance, immunisation coverage, and expansion of health infrastructure. Important though these achievements are, they are, however, overshadowed by persistent poverty, the unmet basic needs of a large number of people, an increase in STI and HIV/AIDS, lack of mechanisms for providing services in rural areas, continuing gender, ethnic and other forms of discrimination, lack of transparent policy, low priority of programmes targetted to adolescents and youth, and ineffective and weak performance of government policies and programmes.

As well, there are some important findings that contrast with Government and other official reports, which point to lesser progress towards achieving ICPD goals. A NDHS/UNFPA study has revealed that the CPR increased only by 10.4 from 1999 to 2000. Development expenditure has been unequally distributed across geographical regions and this has affected delivery of services such as health facilities, services and infrastructure. Further, the study also states that the capacity of the local government bodies to plan, implement, supervise and

monitor development interventions is limited and weak. This is primarily because devolution of power has taken place only on paper and the trend of general resource management is still non-participatory denying access and information to the beneficiary. Community people are often denied access to participation in the planning, execution and evaluation of programmes that are meant for them.

According to the NDHS a quality assurance unit (for RH services) has been put in place but it does not cover all aspects of RH yet; instead its focus is still on FP and there are very limited mechanisms for the participation of adolescents and youths in SRH policy and programme development and implementation. Lack of political will on the part of political parties to keep their promises to promote good governance and transparency has slowed the pace of development.

Patriarchy is the most significant among the barriers to implementing ICPD-Cairo. The other major barrier is the 'Three Delays': the first is delay in deciding/seeking, the second in reaching and the third in receiving treatment. Other barriers include the underprivileged status of women, illiteracy, early marriage, polygamy, teenage pregnancy, high fertility, and low health seeking behaviour, which stems from the system of patriarchy and class/ethnic inequalities. Mechanisms to provide necessary information and service as per the age group are lacking or insufficient.

The ever-escalating conflict has had a negative impact on SRHR, for example it has led to unwanted pregnancy amongst young women, rape, scarcity of information and services, destruction of service delivery centres, absence of service providers, etc. Another crucial factor leading to denial of women's dignity and respect for fundamental freedom is domestic violence, which has been regarded as a private affair with a deeply ingrained socio-cultural bias. Violence against women both in the family and the community has been aggravated in the absence of law or administrative measures to protect them.

Best Practices

In recent years women's health has become a core item on the agenda of the National Health Policy. Reproductive health has been included in the Tenth Plan, and training provided to female health workers. A special programme has been implemented to control the spread of HIV/AIDS and choice in contraceptives has been provided at all levels. MCH, Safe Motherhood programmes and family planning programmes have been launched. The social climate is changing and women are getting more access to education, employment and healthcare services.

However, a general trend of investing less in women's health than in men's health still prevails. Various myths and traditional practices related to the reproductive health of women are still strong which perpetuate discrimination against and suppression of women. Additionally, 'illegal' and unsafe abortions are jeopardising the lives and health of more and more women. Health services are becoming very expensive because of privatisation. Meanwhile, traditional medicinal practices are vanishing and this has resulted in large swathes of population having to do without any health care at all. The focus of family planning is only directed towards population control and not holistic family care. Forced prostitution and rape continues to be a social problem and health posts are often not accessible.

Despite these adverse circumstances women are gradually beginning to participate in healthcare services from the local to the central levels and family planning is becoming popular even at the village level. Various research reports demonstrate that condom use is increasing because of publicity about the

consequences of HIV/AIDS. Supply and demand for both maternal and child health services is increasing and more recently, the fundamental sexual and reproductive rights of women are beginning to be recognised.

Main Achievements and Shortcomings

There are nearly 5,000 maternal deaths in Nepal every year and maternal mortality is the leading cause of reproductive age (15-49) death. Direct causes account for 70 percent of all maternal deaths, of which PPH are 46 percent, obstructed labour 16 percent, pre-eclampsia/eclampsia 14 percent, puerperal sepsis 12 percent, abortion complications 5 percent and APH 5 percent. The major cause of maternal mortality is lack of efficient and effective service, 67.4 percent of pregnant women die at home, 11.4 percent on the way to a health facility and 21 percent in health facilities. Among hospital deaths avoidable factors are present in 79 percent cases. Ninety percent of deaths happen in rural areas, out of which 62 percent happen after delivery. CPR is 39 percent, and among married adolescents it is 2.12 percent. CAC and PAC services are less accessible to all districts. Similarly, KAP gap in pregnancy and childbirth is high. (Ganga Shakya, MoH). Postnatal care, i.e. percentage of first visit to health service by delivered women, is 12.6 (data released by MoH, 2002).

The introduction and reform of certain policies and laws resulted in a number of changes: the IMR and CMR went down; there was an increase in awareness of the importance of reforming the environment. As well, village health workers/mother and child workers were put in place in each VDC, immunisation was carried out, vitamin A and polio vaccination programmes launched to reduce child mortality and training was given on Safe Motherhood, and more publicity given to the full range of family planning services, as well as the expansion of ambulance services and the revision of the law on abortion. According to Safe Motherhood Network (an NGO) the IMR dropped by 38, U5MR dropped by 74, MMR dropped by 311, LE54 increased by 8 years, TFR decreased by 1.7, CPR increased by 14.9 percent, delivery with attendance increased by 31.5 and immunisation coverage increased by 22.9 between 1991 and 2001. MoH data presented at the ICPD at Ten National Consultation indicates that the IMR was 102 in 1991 and dropped to 64 in 2001; similarly MMR was 850 and came down to 539 in 2001. The infrastructure has expanded during the same period. There are 3170 Sub-Health Posts, 650 Health Posts, 200 Primary Health Clinics and 70 hospitals in 75 districts spread over 3912 VDCs throughout the country. But only the district hospitals and the maternity hospital provide services on EOC (certain private clinics/nursing homes offer EOC services but these are unaffordable by common people). Many NGOs are in agreement with some of these findings, such as, for example the greater awareness of the need to reform health services, but they have also identified other areas that need attention, such as poverty alleviation, micro credit schemes, freeing bonded labour etc.

The following are the policies adopted by Government to address key issues and challenges in ICPD implementation:

- Health Sector Reform 2003
- Community Health Insurance Policy Guidelines 2003
- Neonatal Health Care Strategies 2005
- The Second Long Term Health Plan 2002-2017 (SLTHP)
- Amendment of Civil Code (*Muluki Ain 2020*) that legalised abortion in September 2002
- National Safe Abortion Policy 2003 & Directives 2004.

Table 1. Life expectancy at birth (%)

Year	Total	Male	Female
1991	54.3	55.0	53.5
1998	57.5	57.8	57.2
2001	60.8	60.8	61.0
2002	61.9	61.8	62.2

Source: Central Bureau of Statistics, HMG/N

In addition, the Government established the Ministry of Women, Children and Social Welfare, and the Women Commission as mechanisms for promoting women's rights. The MoPE performs as a focal point for ICPD. There is increase in advocacy of SRH Rights and expansion of SRH services overall, although the health insurance policy – which has been adopted – is not implemented properly as a result of which SRH services are not yet covered by insurance.

Overall, in Nepal, gender discrimination and the low socio-economic, socio-political and socio-cultural status of women are the main hurdles for meeting ICPD goals. The three delays: delay in deciding, delay in reaching and delay in receiving treatment, act as barriers in implementation. On an average it takes three to four hours of consultation to identify problems, another five to six hours to arrange for transport to take people to health centres or hospitals, and at least two hours after that to get attention and then treatment (Nepal Country Profile/HMG). The slow functioning of government machinery, the labyrinthine bureaucracy, corruption, and lack of transparency and good governance are all factors that hinder smooth implementation. Lack of political commitment and will contribute to slow progress. Thus the study's findings show that while there has been some progress, and the pace of change is faster than in the period between 1994-99, there are still many gaps in planning and implementation, and some of the difficulties can be attributed to the general situation of political instability.

Gender Equality, Social Equality and Equity

One of the achievements of ICPD is clearly that life expectancy has increased and the ratio of female enrolment at primary and secondary education levels has gone up. Gender equity as a concept has been introduced in a number of public and private institutions as a result of a Mainstreaming Gender Equity Programme that operates in collaboration with UNDP, and in which NGOs, civil society groups and government organisations are also involved. These ideas have also found some exposure in the media. In addition, a variety of programmes for promoting gender equality, social equality, and equity, have been put in place by the government, like Jagriti (Awareness), and others. While increasing violence against women – as seen in the growing incidence of sexual harassment, rape, trafficking in girls and women – is a cause for concern, on the more positive side there is evidence that the women NGOs are increasing in number and laws, such as the Civil Code are being revised to give women better rights in relation to abortion, property and so on. However, equality and equity have a long way to go: women's participation in decision-making for example, still remains very low: only 5.8 percent in the House of Representatives. Similarly, representation of women in the District Council was 1.5 percent, District Development Committee 6.7 percent, the Municipalities 19.5 percent, and VDC 7.7 percent (CBS 2001). The literacy rate is also poor. Total female literacy is at 42.5 percent, of which 44.7 percent is in the eastern region, 41.4 percent in the central, 49.0 percent in

the western, 37.4 percent in the midwestern and 32.8 percent in the far-western region. It has been reported that 9.2 percent of women have never been to school, likewise those who attended primary level school are 45.9 percent and at secondary level, the figure is 30.3 percent, whereas high school graduates are 8.1 percent and higher education is 5.3 percent. (CBS 2001).

Status of Labour Participation

Nepal's labour force is still concentrated in agriculture, with slightly more than 60 percent of the economically active men and nearly 73 percent of economically active women being involved in it. This proportion was lower in 2001 as compared to a decade ago in 1991, and the non-agricultural sector has increased by about 18 percentage points. The actual proportion of women in the non-agricultural workforce has gone up to 34 percent from 20 percent in 1991; this is reflective of the increase in the numbers of women workers in all sectors. Nevertheless, women's concentration in agriculture is still more than that of men. In the non-agricultural sector, the largest proportionate increases have been in electricity, gas and water, manufacturing and trade and relative services. The increase in the electricity gas and water sectors from 6.4 percent to almost 78 percent however is because household level collectors of water and fuel have been counted as economically active in the 2001 census and included in this category.

The development of major export industries such as carpets, garments and woollen goods has opened up new avenues of formal employment for women. Increased tourism and hotels have also added to women's engagement in trade and related services. However, it is important to remember that this increase in the service sector could be due to the better definition of economic activity to include roadside tea stalls, village level guest houses, pubs etc., and taking into account the multiple activities people have to perform for survival in developing countries. Although women in Nepal have always minded the shops, earlier they declared themselves as 'housewives'.

Table 2. Female Proportion in the Labour Force by Development Regions

Regions	Agriculture & related	Non- agriculture		
		Total	Manufacturing	Other
Eastern	46.2	36.4	46.1	33.3
Central	42.6	29.5	42.5	24.6
Western	54.5	38.4	50.7	34.2
Mid- western	47.9	39.9	56.4	34.0
Far- western	53.8	34.7	57.7	27.3
Nepal	48.1	34.4	47.4	29.7
Urban	5.8	19.4	15.9	21.3
Rural	94.2	80.6	84.1	78.7

Source: CBS, HMG/N

The percentage of economically active women as per the CBS, 2000 is 57.4 whereas that of men is 36.5. The sectoral workforce of females compared to males is as below:

Table 3. Sector-wise Labour Force

Sector	Male %	Female %
Agriculture, Forestry and Fishing	60.25	72.83
Mining and Quarrying	0.18	0.13
Manufacturing	8.15	9.67
Electricity, Gas and Water	0.59	2.68
Construction	4.20	1.19
Commerce	10.72	8.94
Transport and Communication	2.78	0.14
Finance and Business	1.17	0.25
Personal and Community Services	9.63	2.88
Others	2.09	1.07
Industry not stated	0.23	0.22

CBS, 2001

Table 4. Percentage Distribution of Marital Status of Adolescents, Youth and Young by Sex, Nepal 2001

Marital Status	Sex	Adolescents (10-19 yrs)	Youth (15-24 yrs)	Young (10-24 yrs)
Single	**Both Sexes**	88.82	57.19	73.95
	Female	83.61	44.85	65.61
	Male	93.90	70.34	82.41
Married	**Both Sexes**	10.72	41.49	25.24
	Female	16.04	54.40	33.90
	Male	5.53	27.74	16.45
Not Reported	**Both Sexes**	0.31	1.01	0.60
	Female	0.16	0.38	0.23
	Male	0.45	1.68	0.89

Source: Central Bureau of Statistics, HMG/N.

The Nepal HDI is 0.463, the GDI is 0.441 and the gap between the two is 0.012, which is almost equal to the South Asia average (Human Development in South Asia 2000), which is a decreasing trend.

The Government has no specific and holistic policy on gender empowerment and equity; and the issue receives only fragmented attention. The Constitution of Nepal, The Civil Code (which is regarded as second to the constitution), and other laws have 119 stipulations/provisions that are extremely discriminatory (ICPD at Ten National Consultation).

Reducing Maternal Mortality, Promoting Safe Motherhood and Safe Abortion

The decrease in Nepal's Maternal Mortality Rate is a significant development. The mean age at marriage for females increased from 18.1 years in 1991 to 20.3 years in 2001 (Hari Khanal, 2004). HMG/N has been implementing integrated health service programmes from national to VDC levels. Safe Motherhood Networks and Mother's Groups have been promoted by NGOs and GOs throughout the country. The number of people accessing health services from service delivery points is on the increase, and because of women's empowerment programmes their mobility has increased. However, the number of males visiting the health services is high compared to females. Similarly, there are very few service centres in remote geographical areas – particularly the mountain districts, and disaggregated data on ethnic and gender perspectives is lacking. The nutrition status of women and girls is very critical. In a paper presented at the ICPD at Ten National Consultation (2004), Munu Thapa asserts that 25 percent of women and girls are feeble, one out of seven women is a dwarf, 75 percent of women are anaemic and 16 percent of pregnant women suffer from night blindness. The situation of maternity care is also very poor, as shown in the table below:

A report by Mesko Natasha shows that giving birth in rural areas is risky both for mothers and their babies – there is no certainty about who provides care and how quickly help will be forthcoming when there are complications, and this affects the health of both mother and child. In rural Nepal, where birth attendants are often untrained, it is important to note the practices that are are used and what the obstacles to seeking professional care are. Women commonly conceal their pregnancy and do not seek antenatal care; preparations for birth are minimal and are seen as 'tempting fate'. Half of the women who sought care at a government facility did so only after a delay of 48 hours or more.

Table 5. Maternity Care

First antenatal visit as percentage of expected pregnancies	34.9 %
Average number of visits per pregnant women	1.7
Percentage birth in the health institutions	9 %
Delivery assistance ratio by health personnel	13 %
By TBA	23 %
By relative & other	55 %
By none	9 %
Clean home delivery kits used at home of births	9 %

Source: Annual Report-2001/02, Demographic Health Survey

Safe Abortion Programmes are promoted by NGOs and GOs. Training to upgrade the KAP is provided to health practitioners, and efforts to increase the number of health practitioners have multiplied. The legalisation of abortion and the introduction of Integrated Health Service Policies have contributed to the promotion of safe motherhood. Abortion is the major cause of maternal mortality (5/1,000 women) in Nepal: 117 abortions occur per 1,000 women in the age group 15-49. In maternity hospitals 20 per cent of the deaths are due to abortion-related complications. (Satyal, 2004) and 20-60 percent of 'gynae' admissions at hospitals are due to unsafe abortions (CREPHA). The average cost of abortion is NRs 3918, which is very high for the ordinary Nepali (CREPHA). Three out of four pregnant women are anaemic. However, according to paper presented by

Renuka Gurung from CREPHA at the ICPD at Ten National Consultation only some 22 percent of urban adults are even aware of the policy on abortion.

Until September 2002, abortion in Nepal was considered a criminal act provided for under the Homicide Chapter of the Country Code, 2020 (Muluki Ain) and was illegal even in cases of rape or incest. But the illegality of abortion did not discourage the demand for it; and instead, it drove it underground. An estimated one-third of rural women and one-fifth of urban women in Nepal reported experiencing unwanted pregnancies, helping to fuel a clandestine market for abortion services. Despite the landmark reform of the abortion law, many barriers remain to the availability of safe abortion services as well as basic reproductive health services like family planning. This is especially so for rural and low-income women, because poverty, lack of education, lack of availability of services all act as obstacles. Although about 40 percent of married women in Nepal have access to modern contraceptives, the most widely used method is sterilisation.

The situation is more challenging for adolescents. Early marriage is common: Nepali women marry, on average, at age 18. Once they marry they are expected to bear children right away. Thirteen percent of girls in Nepal give birth before they reach age 20. However, these young women often still do not have access to reproductive health services, leaving them on their own to manage their fertility and well being. A study by Marion Gibbon in 2001 in Bardiya district found that reproductive health and education services are scarce in rural Nepal. These have resulted in low contraceptive use, high levels of birth complications and increased cases of sexually transmitted infections and HIV/AIDS.

HMG/N is the signatory to most UN Treaties/Conventions/Conferences relating to human rights, gender, and development. As a signatory to CEDAW-1979 and BPFA-1995 and the state party to ICPD-1994, HMG/N has treaty obligations to guarantee women's reproductive health rights. It has no reservations to any international treaties.

Reproductive Health Policy and Services

The National Health Policy 1991, the Second Long Term Health Plans 1997-2017 and the Corresponding Periodic Plans (eighth, ninth and tenth) of HGM/N accept reproductive health as a part of essential health care policy and as a priority issue to enhance the status of women's health. Accordingly, the strategies adopted for SRHR are the National Reproductive Health Strategy, National Adolescent Health and Development Strategy and the National Reproductive Health Research Strategy. Similarly, policies adopted for SRHR are the National Safe Motherhood Plan (2002-2017), the Reproductive Health Clinical Protocols, the Reproductive Health Programme Operation Management Guidelines and Abortion Act 2001 and the Abortion Act Protocol 2003. The reproductive health service providers are primary health care outreach sites (15,364); Trained TBA15 (603); FCHVs (48,047); sub-health posts with maternity and child health worker's service (3,132); health posts with ANM services (705); Primary Health Centres with nurse and delivery bed service (178); district hospitals with medical doctor services (78) (15-25 beds); maternity hospital (1) (with 300 beds); and private nursing homes. These latter also provide services relating to reproductive health including antenatal, delivery and prenatal. The RH services that provide infrastructure throughout the country are sub health posts (98 percent), health posts with ANMs (92 percent), primary health centres with nurse and delivery beds (85 percent), district hospitals with medical doctors (89 percent) and only one maternity hospital, which accounts for 4,212 people per service unit (inclusive of district and central hospitals providing RH services).

In 2002, owing to strategic advocacy by women's rights groups, a bill on abortion was taken to the house during the 21st session and the chapter on homicide in the Civil Code was amended. Provisions outlined in the new legislation are as follows:

1. Any woman can have an abortion within 12 weeks of pregnancy.
2. In cases of rape and incest, an abortion is allowed within 18 weeks of pregnancy.
3. If the mother's health is endangered, or if the doctor foresees any complications of pregnancy or deformities in the child, then an abortion can be obtained with a doctor's recommendation at any time during the pregnancy.
4. Abortion based on sex selection will be punished. A person involved in detecting the sex of a foetus with the knowledge that it may be aborted on the basis of sex will be regarded as an accomplice to the crime. Accomplices will be imprisoned for 3-6 months while the ones who have the abortion are punishable by incarceration of one year.

Promoting and Protecting Sexual Health and Rights; Safe Contraception; Preventing and Treating HIV/AIDS and Reproductive Cancers

SRH was endorsed in the Ninth Plan and it was incorporated in the school curriculum. Services such as contraceptives (particularly condoms) are provided and counselling or awareness-raising is also in place for both married and unmarried adolescents. Health centres have been expanded, Centres for control and treatment of STI and HIV/AIDS have been established. SRH was integrated in Health Programmes, including abortion, and coordination mechanisms in RH were developed. According to MoH data, only about 50 percent of females as compared to 72 percent of males have some knowledge about HIV/AIDS. Cancer screening facilities are not easily available in Nepal. Although policy and programmes for adolescent SRHR are developed by GOs and NGOs, and sample studies at district levels have been, no national survey has been yet carried out as an activity to follow up ICPD, Cairo.

Knowledge on family planning is nearly universal among the Nepali women and men. People know a fair amount about modern methods and are familiar with things such as safe sterilisations, pills and condoms. Using contraception is usually a joint decision among couples, and at present it is 39 percent among currently married non-pregnant women, with the increase largely being attributed to an increase in female sterilisation. The percentage of couples adopting male contraception is 31 (NFHS, 1996). Prenatal care is negligible, though it is crucial for safe motherhood. The Government sector is the major source of contraceptive supplies (82 percent) and the Family Planning Association supplies five percent while seven percent are supplied by the private medical sector, through social marketing and franchising by contraceptive retail services.

Contraceptives are distributed free of cost from Government and NGO SRH and general health programmes and are easily available at the drug and general stores; the cost varies according to the brand. The cheapest brand of condom costs Nepali Rupee one per piece (market price in 2004).

Currently 28 percent of married women face an unmet need for family planning services, whereas the unmet need among the 15-19 age group (the proportion of 15-19 with an unmet need for contraception) is 36 percent and the unmet need among the 45-49 age group 12 percent.

The incidence of RTI is 72/1000 (CREHPA, 2000). In a study reported by *The Counrty Profile on Women's Health and Development, 2001*, out of a sample of 1666 people, 2.4 percent were found to be HIV positive and 1.98 percent had STIs. The establishing of a national institute for preventing and treating HIV/AIDS and reproductive cancers are significant achievements, as is the implementation of integrated health service programmes for HIV/AIDS from national levels to VDC. The Integrated Health Programme delivers services at the VDC level and is targetted to the general population. A few SRHR service centres for adolescents have been established. The trend of HIV/AIDS is shown in the table below.

Table 6. Detection of HIV/AIDS by Sex (1988-2001)

Year	Total Sample	HIV Positive		AIDS (Out of Total HIV)	
		Male	Female	Male	Female
1988-95	150428	186	159	22	29
1996	10475	50	85	13	18
1997	9475	394	95	76	24
1998	3611	166	54	38	16
1999	5170	174	48	35	19
2000	3039	301	95	117	48
2001	1470	264	60	62	23
Total	183668	1535	596	363	177

Source: NDHS, Department of Health, HMG/N

Cross-cutting Issues

Young People

The concept of sexual and reproductive health has increasingly become acceptable. Not only is it now visible in school curricula, but SRHR counselling is being provided through integrated health service programmes. The Tenth National Plan has provided for education/services to young people on reproductive health and rights.

According to the Nepal Family Health Survey (NFHS), adolescents and young people constitute the largest segment of Nepal's population (32.48 percent) and the figure is projected to be 37.97 percent by the end of the 2008. Similarly, 50 percent of the 15-19 year old adolescent girls and 12 percent of adolescents boys are already married. About 21 percent of adolescent women (aged 15-19) are already mothers or pregnant with their first child. Twenty percent of adolescents start to bear children in rural areas, whereas 13 percent in urban, in the hills this figure is 17 percent, in the mountains 20 percent and in the Terai region, 26 percent.

The CPR is only 12 percent among adolescents and 23.4 percent among youth (20-24 age group); 40.7 percent of adolescent mothers do not receive antenatal care and 85.9 percent of adolescent mothers deliver their babies at home. A trained health worker assists in only 13 percent of these deliveries. There is a higher incidence of anaemia, hypertensive disorders, abnormal and premature deliveries and greater foetal demise in adolescent mothers compared

to older mothers. Out of all reproductive suicides, 27.5 percent were found in the adolescent age group.

The nutritional status of adolescents is also a cause of concern. NFHS revealed that 30.6 percent of girls had a low Body Mass Index, which is indicative of a high prevalence of chronic energy deficiency among adolescent girls. According to a study on the nutritious status of adolescent girls conducted in three districts of Nepal, 40 percent had iodine deficiency and 47.4 percent had nutritional anaemia. A majority of adolescents (64 percent) had their first sexual intercourse when they were between 15-17 years of age. The mean age of first sexual intercourse among males was 16.4 years while among female was 16 years. Of all the HIV cases, 13 percent were found in the 14-19 year age group and 70 percent of them were female. Young people aged 16-19 constituted 22.5 percent of the total drug abusers. The prevalence of HIV among high-risk population such as intravenous drug users, female sex workers and migrant men is much higher.

A significant proportion of maternal deaths (28.5 percent) occur in the adolescent age group. Adolescents and youth are scattered in the community and they are mobile. HIV/AIDS infection is 9 percent in the age group 14-19 and 53 percent in the age group 20-29. Sixty two percent of HIV, including AIDS, is found in adolescents and youth groups. Sixty six percent of adolescent girls between 10-19 years of age are illiterate whereas only 24 percent of adolescent boys are illiterate. (Hari Khanal, 2004)

Health Sector Reform

The Government has enacted and/or reformed policies and laws pertaining to SRHR and achieved some progress in the implementation of ICPD and PFA. There are still many issues of concern, however, that require serious attention. For example, there are only 3168 Sub-Health Posts throughout the country and these are poorly equipped. Unequal distribution of development expenditures across geographical areas is common, e.g. urban vs. rural areas and plains vs. mountains, easily accessible vs. remote areas. There are still new settlements to be developed for internally displaced populations with adequate basic infrastructure, social services and income generating activities. Specific policy and service delivery points that cater to the ever-increasing slum areas (because of growing urbanisation) are non-existent. The capacity of local government bodies to plan, implement, supervise and monitor development interventions is very limited and weak.

Domestic violence remains one of the most serious problems in Nepal and still needs to be addressed by effective intervention. There is a wide gap between urban and rural areas in educational attainment; 34 percent of males and 63 percent of females in rural areas have never attended schools. Access to primary education remains unevenly distributed by region and district, caste status, income level and gender. The quality assurance unit has been put in place but does not cover all aspects of RH. There are very limited mechanisms for the participation of adolescents and youth in policy and programme development. Government capacity to deliver services and monitoring is a major constraint. Several interventions in compliance with MDG and ICPD goals have not reached the target groups sufficiently. Lack of political will and failure of political parties to keep their promises, especially to promote good governance and transparency, has further slowed down the pace of development.

Main Implementation Barriers and Facilitating Factors

The Key Barriers

The most significant barrier for the effective implementation and realisation of the PFA is patriarchy. The gender discrimination and low socio-economic, socio-political and socio-cultural status of women are the root causes that contribute to this.

The other major barriers are the 'Three Delays' mentioned above: because of the delay in seeking/deciding to seek help, 90 percent of deliveries take place at home, where attendance of a skilled health personnel is only three percent and is the cause of 67 percent of maternal deaths. The second, that is delay in physical access to services results in 11 percent of maternal deaths. The third delay in receiving treatment because of lack of skilled health personnel, accounts for 22 percent of maternal deaths at health services.

The other underlying barriers include poor health status, illiteracy, early marriage, polygamy, teenage pregnancy, high fertility, and low health seeking behaviour of women.

A study by T. Leone, Z. Matthews, and G. Dalla Zuanna in 2003 reported that gender discrimination is a key demographic feature of South Asia but gender bias in Nepal has received little attention. The study states that geographic and economic barriers to contraceptive service use in Nepal are well known, but the additional barrier of sex preference is strong. The policy imperatives do not really address the need for improvement of women's status and education and the importance of raising the value of girls in society.

The global and Asian crisis has affected the implementation of ICPD goals because of a decrease in funding support from donor agencies. Privatisation and liberalisation of health services, food security and drugs have had a negative impact on the programmes and have increased the feminisation of poverty. This is also true for US Global Gag Rule and World Bank supported population programmes. Political instability and armed conflict are two other major structural barriers.

Remoteness and geographical hindrances have caused regional differences in the ability to access available resources and have led to increased inequalities and discrimination. The lack of good governance, commitment and transparency as well as rampant corruption has had a negative impact on implementation. Other factors that have hindered the process are: a lack of clear-cut effective SRHR policies and programmes, lack of participation of adolescents and youth in planning and programming, failure to involve young people in the existing SRHR promotional activities, and lack of awareness or sensitivity among educators, providers of health and social services, religious and youth leaders and parents about the special problems of young people. There has been no involvement of young people in any educational programmes or services that are provided for their age groups. Similarly, the unavailability of trained human resources to provide special services and resource constraints have been a problem. Limited access to food and health care for adolescent girls and low levels of literacy among them have been stumbling blocks for their development. Unacceptably high maternal mortality rates due to too early and too frequent pregnancies have contributed to the MMR and IMR. There is a very low level of contraceptive prevalence among adolescents as also an increasing incidence of STD cases among the 15-19 age group.

The main focus of IEC messages has been on family planning. Adolescent services have been restricted to married people, school health programmes have not been implemented since 1999, reproductive health services for the elderly are available only in Kathmandu, and there is a 50 percent shortage of funds for reproductive health. When this is combined with gender insensitivity among policy makers and providers and weak infrastructure, these act as real barriers to ICPD implementation (UNFPA, 1999).

Rampant privatisation of health facilities has raised the cost of services and led to unsafe abortions. The UNFPA report states that the incapacity of the Government to deliver health services to achieve MDG and ICPD goals is a major constraint, and several interventions (e.g. access to information and services to adolescents to regularise menstruation, FP, etc.). Programmes have not reached target groups sufficiently in compliance with MDG and ICPD goals. The UNFPA report further states that coordination is weak and the capacity to integrate population and gender issues in sectoral policies and programmes is still inadequate.

Women's low participation in the decision-making process, due to the patriarchal social system and structure is the main challenge in meeting the ICPD goals and objectives. Due to the absence of women at the decision-making level, gender inequality continues to exist in all sectors. The participation of female candidates in elections is minimal. Even though the law does not discriminate with respect to voting rights, some women have still been denied the right to vote during elections. There have been only an inconsequential number of women at different levels of governmental administration.

Despite the significant progress that has resulted from organised advocacy in favour of women's empowerment and their meaningful participation in decision-making, equality continues to elude the majority of women. Even though some constitutional and administrative measures have been adopted to ensure women's equality, de facto discrimination persists. Voting rights and policies regarding equal wages have not always resulted in better conditions for women, nor have they always improved the quality of their lives. Constitutional equality and unequivocal action programmes exist on paper, yet statistics expose a harsh image of the lives of Nepali women. In a global study of women's status, which was based on levels of representation and decision-making power in the social-political arena, Nepali women received one of the lowest scores.

Civil society groups in Nepal have been engaged in relentless promotion of women's equality and empowerment in decision-making through education, training, research and publicity campaigns for more than a decade. While the Government has made promises, these have yet to become a reality. Thus, in the ten years after Beijing, Nepal has witnessed continued discrimination against women, which has often been flagrant. Yet, looking back over these years, some progress in terms of gender mainstreaming has been made. This new sense of awareness has been primarily achieved through the concerted efforts of civil society institutions.

Women have remained voiceless and their representation in social, economic and political life has been minimal. Problems related to women in power and decision-making have qualitative and quantitative dimensions. The first dimension involves the capacity of women to assert and exercise their rights, and the lack of an enabling environment in which to do this. While some quantitative improvements have been made with the introduction of reservations in local elections, the overall participation of women in decision-making positions is very low and remains unsatisfactory. The statutory provisions alone do not adequately facilitate

women's entry into these positions. Quantitative growth has been horizontal and only observed at the lowest levels of representation. Higher levels, of both local and national politics, are still regarded as the 'male sector'. Thus far, the political parties and legislatures have failed to substantiate their commitment to ensuring women's access to powerful decision-making positions.

The other challenges are armed insurgency, which has resulted in a large proportion of the population living under the poverty line, lack of information and awareness, poor implementation and monitoring on the part of the government, ineffective and weak performance of government policies and programmes, lack of skilled human resources in the concerned sectors, geographical hindrances and remoteness – all of which impede information flow and programme implementation.

To this can be added the increasing incidences of HIV/AIDS and other infectious diseases, lack of transparency in policy, and inefficient and ineffective efforts to reproductive health rights. Continuing gender discrimination, discriminatory laws, policies and practices, and attitudinal issues are tough challenges. There exists a lack of public private partnership in specialised and super specialised care for integrated services. The Government has announced policies on health financing, including health insurance, but access to information and services on providing loans or prepaid service or insurance to health services including maternity care to the grassroots remains a challenge.

Facilitating Factors

The major facilitating factors are the strengthening of institutional arrangements, for example coordination between programmes of different line ministries by MoPE, the establishment of MOWCSW and the Women's Commission, the designation of RH as a priority area by the NPC, the active involvement of NGOs and the emergence of networks in SRH and networks like NANGAN, SMN, etc., the increased awareness of women's SRH as a right, and the increased responsibility of men. More people are aware about SRH as a right and men are becoming more responsible. Although decentralisation is a facilitating factor it is nominal, mainly because the service providers at the district and grassroots level have to rely on central departments.

The Government of Nepal has appointed MoPE as the focal point for ICPD, which is coordinating different line ministries. MOWCSW and the Women Commission have been established to facilitate empowerment of women and gender equity and equality. The National Planning Commission has prioritised RH as an area to be given attention to. The revision of the legal age at marriage, the law to combat trafficking, and sex education in formal and non-formal educational institutions have facilitated the implementation of ICPD Cairo. The formulation of a National RH Policy (1998), National Standard and Clinical Protocols for FP and RH and National Adolescent Health Programmes by HMG/N have further enhanced the process. In line with the overall approach of the ICPD, the Government of Nepal recognised the need for improving reproductive health services through various programmes. Eventually, HMG/N formulated the National Policy and Strategy for Reproductive Health in 2000.

Increase in literacy and school enrolment of females has improved access to SRHR. The Government regulates equal remuneration for equal work. There have been some improvements in inheritance and property rights of women. Progressive policies emerging in the area of poverty eradication, gender, education, water, other social equity issues, bridging inter-regional disparities etc. have played in promoting the SRHR situation of the country.

Increasingly women are becoming aware about SRH as a right. Women's organisations like BBC, LAC, SAMANATA, FWLD, Didi Bahini, WOREC, etc. and Human Rights Organisations like HURON, HimRights, INSEC, INHURED, RRN, GRINSO, CWIN, etc., have been active in advocacy, lobbying and other awareness raising programmes. Sister organisations of different political parties have contributed by extending their physical and moral support to different activities for empowering and changing the situation as well as raising the status of women. The women's movement in Nepal has taken up the ICPD agenda, which is reflected in the declarations of the sister organisations of the major political parties, NGOs working in health sector, women's NGOs/CBOs, etc. All these institutions have supported the ICPD agenda.

Future Concerns

Growing US influence, particularly the imposition of Mexican City Policy popularly known as *Global Gag Rule* on government policies and services has cut funding support, (On January 22, 2001, newly inaugurated President George W. Bush issued an executive memorandum reinstating the global gag rule on international family planning assistance. This was a highly divisive attack on reproductive rights). Donor agencies have other conditions attached to agreements on the programme such as political conditions which are then used to impose budget cuts.

The escalation of political movement against the government by opposition parties and the growing armed conflict have led to an economic crisis and created obstacles to accessing and providing services. Violence against women in armed conflict situations has become one of the most massive-scale violations of human rights, in terms of the atrocities and the number of persons affected. Rape has been committed against women in conflict situations and its use as a strategy of war has confirmed the treatment of women as objects in a terrible way. The logic of war dictates that the women of the enemy are the objects of targetted aggression. They are raped in order to destroy their dignity as women and to demoralise and humiliate the male enemy. The sufferings of the women are never of concern; indeed, none of the advocacy in the past referred to the defence of women or to rehabilitating the lost dignity and integrity of the women who have been raped.

Women as victims are never considered heroes; they become a by-product of the war. Those few women who have become combatants and decided to take the struggle in their own hands are rarely praised. On those occasions where the rape cases are used for war propaganda, the women are shown as victims: their injury or death does not lead to the prosecution of the perpetrators.

Based on the 2003 report of the National Women Commission, women account for around 33 percent of the Maoist militia a in some districts, while the figure is as high as 50 percent in the most highly mobilised Maoist districts. The report also states that 50 percent of cadres at the lower level, 30 percent of soldiers and 10 percent of members of the Central Committee of the party are women.

Forced recruitment of young women by the Maoists is another serious issue. Many young women have been displaced from their homes and forced to stay away because of constant threats of recruitment and indoctrination. There have been reports of women being forced to carry guns and satisfy the sexual appetites of the insurgents. On the other side, the security forces have sexually harassed and exploited many innocent women. The perpetrators of such crimes are often let off scot-free and enjoy full impunity.

The violence has resulted in dehumanisation, serious physical and mental stress on women, and concomitant increases in sexual violence. Many women have also suffered loss of family and home. The majority of internal refugees are women and children. Most of the women who could not stand the harassment and associated economic hardships have moved to urban areas.

Finally, it is essential for all concerned to place the further implementation of the ICPD Programme of Action within the larger framework of the Millennium Development Goals (MDGs). MDGs provide the international benchmarks for assessing future progress on eradication of poverty and economic and social development; and while we must not forget the specific ICPD goals on reproductive health, consideration of the ICPD goals and objectives in the context of MDGs may provide us many more opportunities to draw the attention of governments, civil society and the international community to their relevance and importance under the broader framework. Further work also needs to be done on updating the ICPD resource estimates, based on country level assessments of needs and requirements in the areas of commodities and services in order to create more opportunities to strengthen and deepen the support to achieve the goals and objectives set in Cairo.

Challenges And Recommendations

Common Challenges

- Adoption of policies to implement the Cairo Programme's vision for reproductive health and self-determination that will seriously address and advance the vision with appropriate institutional mechanisms;
- Formulation of a national agenda on linking human rights principles to reproductive health and self-determination as a key force in developing strategies to implement the Cairo Programme;
- Enactment of legislation with an accountability framework for the Government's commitments (including its financial commitments) in the Cairo Programme through the use of effective legal mechanisms;
- Formulation of a programme of action to implement effective strategies in domestic policy objectives that encourage the empowerment of women and the prevention of infringements of women's human rights as well as identifying priorities that will advance beyond Cairo.
- Creation of appropriate, transparent and accountable institutions that ensure women's direct and meaningful participation in decision-making processes regarding policy framing and decision-making on education, health, politics, economy, property and employment.
- Reduction of extensive poverty, hunger and malnutrition with a view to bringing more and more people above the poverty line and working to create conditions for fulfilment of the basic needs of people.
- Investment of resources as a priority concern for combating the prevalence of STI and HIV/AIDS and other infectious diseases along with prevention and management of RTIs, STDs, HIV/AIDS and other reproductive health conditions.
- Creation of an enabling environment for conflict transformation with women's participation in community and national spheres.
- Working to create public-private partnerships in specialised and super specialised care, health financing, prepaid and community financing, including health insurance.
- Establishment of a system to inform, educate and counsel as

appropriate on human sexuality, reproductive health and responsible parenthood for couples and individuals.

- Repealing of discriminatory laws relating to women with a definite timeline and enactment of laws and regulations in compliance with international standards and norms.
- Mandatory deputation of skilled medical professionals in geographically remote districts.
- Strict prohibition on the operation of private clinic by health workers in service.
- Restraining of uncontrolled and unmanaged privatisation of health services through evolving legislation on regulation of the private health sector or accreditation mechanisms.
- Management of adequate medical and human resources for potential seasonal epidemics and effective service mechanisms for emergency disasters.

Recommendations

Inclusion of Human Rights in Reproductive Rights and Self-Determination

The Cairo Programme uses the language and principles of human rights to add meaning to specific human rights. As human rights laws are applied more vigorously to reproductive interests, a variety of ways of applying them will emerge to advance reproductive interests. Which human rights are invoked, or how they are shown to have been violated, depends on the particular facts of an alleged violation, and on the underlying causes of reproductive ill health. The list below is a selection of some of the key rights, certainly not an exhaustive list, which may be developed to advance reproductive interests:

On Life and Survival: The Cairo Programme recognises that women's survival of pregnancy is an issue of women being "equal in dignity and right". This right can clearly be applied to state obligations, for example, to reduce maternal mortality. In order for states to effectively meet their obligations to reduce maternal mortality, strategies must address the complex causes of maternal mortality, which include lack of trained birth attendants, lack of effective means of birth spacing and fertility control, unsafe abortion and disparities between rich and poor countries.

On Liberty and Security of Person: Nepal should apply this right to protect women against violations of these human rights which include female genital mutilation, government regulation of population size, such as compelled sterilisation and abortion, and criminal sanctions against contraception, voluntary sterilisation and abortion. Women's rights to have informed free choice in family planning programmes also form a part of this human right. Finally, governments must apply the right to liberty and security in order to identify, condemn and redress violations of the right to freedom from torture and from inhuman and degrading treatment, which include sexual torture, involuntary disappearance, sexual slavery, rape, sexual abuse and forced pregnancy. The call for clear recognition that rape is a deliberate act of aggression and that women who have been raped must have access to services required for their healing, including abortion if so desired, is also a necessary step towards implementing this human right.

On the Highest Attainable Standard of Health: This right incorporates state obligations to provide and maintain affordable, accessible and acceptable services throughout the life cycle, which are based upon gender sensitive

standards for delivery of quality services. This should also include an obligation to encouraging and supporting choice in health services (i.e. contraception, midwives, breastfeeding etc.). States must implement their agreement in the Cairo Programme to provide, through primary health care services, reproductive health to all individuals of appropriate ages as soon as possible, which will include family planning services, universal access to a full range of safe and reliable family planning methods and to related reproductive health services which are not against the law and programmes to prevent STDs including HIV/AIDS and to provide services to treat and counsel those who are afflicted. Finally, the recommendation arising from the ACPD regional consultation that strategies must be holistic (i.e. ensure access to complementary medicine, medical and STD supplies, safe workplaces, clean water etc) and address the social determinants of health, (which include status of women, class, early marriage, nutrition, and access to education and employment) further informs this right.

On the Benefits of Scientific Progress: This right includes state obligations to give high priority to reproductive health research, including: access to new male contraceptives; HIV infection and other STDs in women; women-controlled methods of protection; and on male and female attitudes and practices. It similarly requires action-oriented research on affordable methods, controlled by women, to prevent HIV and other STDs, on strategies empowering women to protect themselves from STDs, including HIV/AIDS, and on methods of care, support and treatment of women, ensuring their involvement in all aspects of such research.

On Receiving and Imparting Information: This right can strengthen state obligations to remove legal, medical, clinical and regulatory barriers to reproductive health information. Clearly, the Cairo Programme called for state action on this issue; nonetheless, it remains a criminal offence in many countries.

On Education: Research has consistently shown that women's education strongly influences improved reproductive health, including infant survival and healthy growth of children. This human right supports state obligations to fund and implement strategic programmes which: improve women's education and literacy levels; ensure access to universal primary education; eliminate all barriers that impede the schooling of married and/or pregnant girls and young mothers; and address adolescent sexuality through quality educational programmes in sexual and reproductive health and provide contraceptive counselling and services, including services related to STDs. The recommendation arising from the national consultation that there be national standards and enforcement mechanisms for reproductive and sexual health education in schools is also a key factor in meeting state obligations.

On Family and Private Life: This right includes state obligations to provide related information, education and services to protect the founding of families; generate social support for the enforcement of laws on the minimum age of marriage, in particular by providing educational and employment alternatives to premature marriage; and to prevent or redress public officials' intrusions to ensure women's autonomous and confidential choice in reproductive matters.

On Non-discrimination: There are clear state obligations to remedy the lack of adequate and appropriate services for many groups who have traditionally been disempowered. Strategies that are aimed at meeting the special needs of these groups are imperative. Some of the recommendations that came out of the regional consultations include calls for strategies to focus on culturally sensitive reproductive health information and services as well as clear action on meeting

the Cairo priorities on indigenous sexual and reproductive health.

On Sex: The Government must take immediate steps to meet their commitments to eliminate all forms of discrimination against the girl child and the resulting effects of such discrimination such as female infanticide and prenatal sex selection. This right also includes state obligations to implement strategies designed to eliminate violence or abuse against women (including refugee women who are in danger of sexual violence) and support to women who are in abusive situations. The recommendations, arising from the regional consultations, that Nepal must promote the enactment of legislation domestically and in other countries to benefit women in areas like marriage and divorce laws (including raising the legal marriage age), inheritance and property law, reproductive rights, violence, and education is also key to effecting this human right.

On Age: Often adolescents are not provided with adequate access to reproductive health as adults, nor are programmes tailored to meet their needs, simply because of their young age. Given the high rates of adolescent pregnancy the Government must immediately take steps to remove cultural and social barriers to reproductive health education, information, confidential counselling and care for adolescents.

On Disability: Addressing disability discrimination means that the Government must take steps to provide quality reproductive health care that meets the special needs of the disabled. Strategies should take into account, as is suggested in one of the recommendations from the national consultation, the unique sexual and reproductive health needs of people with disabilities, their caregivers and intimate partners. Furthermore, there must be implementation of programmes that are aimed towards eliminating discrimination against persons infected with HIV and their families; strengthening services to detect HIV infection, ensuring confidentiality, and designing special programmes to provide care and the necessary emotional support to men and women affected by AIDS and to counsel their families and near relations.

On Responsiveness: Reproductive rights and self-determination will mean very little to the well being of women and men if national, regional and international human rights instruments are not effectively used to ensure government compliance of their commitments made in Cairo and Beijing. These instruments must be used to hold the Government accountable, legally and politically, for violations if reproductive rights are to be advanced beyond Cairo and Beijing.

Accountability: Advancement of Reproductive Rights and Self-Determination within the Human Rights Framework

Although both the Cairo Programme and the Beijing Platform provide points of advancement for identifying key steps that states have agreed to take to achieve reproductive rights within a specific time period, both documents lack mechanisms for holding the Government legally accountable. There are mechanisms that do exist, however, national laws and constitutions as well as in regional and international human rights treaties (to many of which Nepal is a signatory) include legal obligations that can be effectively applied to reproductive health and self-determination. It is imperative that Nepal begin to use such mechanisms domestically, and encourage the application and interpretation of these mechanisms internationally, in order to make solid steps towards implementing the agreed upon goals within the Cairo programme for reproductive health with the following steps:
Enactment of legislation, both its strategic and agenda commitments made in the

Cairo Programme and actively take steps to promptly remedy domestic situations which do not comply with Cairo Programme;

Adoption of significant steps towards promoting international acceptance on including the Cairo Programme's reproductive rights and self-determination principles within the meaning of specific human rights set out in national laws and constitutions as well as in regional and international human rights treaties and implement those rights within Nepal. One method would be to encourage committees under human rights conventions to include reproductive rights and self-determination in their General Comments, which are states in their reporting obligations under the conventions;

Recognition, institutionalisation and assistance with complaints before international and national legal tribunals on violations of reproductive health rights;

Ensuring of full and clear disclosure in state reporting obligations under human rights conventions and require a plan of action for areas of concern to UN committees;

Formulation of i) a detailed domestic National Programme of Action; ii) a Framework on Sexual and Reproductive Health and iii) a Strategy for Reproductive Health with clear indicators, benchmarks, and implementation strategies.

Employing Strategies for the Effective Protection and Promotion of Reproductive Rights

In order to advance beyond the Cairo Programme in implementing reproductive rights and self-determination, the Government is urged to undertake effective action on implementing the following strategies by:

Developing and implementing strategies that ensure women access to legal services that educate them about their rights, counsel them if their rights have been violated, recommend individual and collective remedies for violations of rights, and advise on preventative action that the Government can take in anticipation of rights violations;

Encouraging the development and effectiveness of mechanisms that assist in identifying whether state machineries are in compliance or violation of human rights in relation to reproductive rights and self-determination;
Advancing steps to implement the Beijing Platform recommendation of the creation of independent Ombudspersons, Rights Advocates or Defenders, with power to investigate alleged violations of reproductive rights, issue periodic reports, advise governmental and other agencies and make recommendations for reforms;

Guaranteeing that health professions develop, disseminate and implement ethical codes to ensure practitioners' conformity with human rights, ethical and professional standards;

Supporting the development of an effective alliance of health and legal professionals that could encourage governments, for instance, to enact reproductive health laws that give force to the human rights that serve reproductive health and self-determination and

Enacting legislation that requires that social, economic, political or other relevant policies, developed by either public or private agencies, are accompanied by reproductive rights impact assessments.

Overall Conclusion

The broad-based, comprehensive definition of reproductive health that was agreed to by consensus at Cairo has been increasingly adopted at the national level. This has led to intensification of efforts to integrate family planning programmes with those relating to child survival, maternal health, adolescent health, and prevention and treatment of sexually transmitted diseases, including HIV/AIDS. Many of these efforts are undertaken by non-governmental organisations and/or the private sector. The availability of contraceptive supplies and services has improved with the United Nations Population Fund (UNFPA) and several bilateral agencies and foundations playing a major role in this regard. However, ground reality point out a huge unmet need for family planning information and services. Issues of affordability, accessibility and availability of services are not being fully addressed; and lack of adequately trained personnel, poor infrastructure, and shortage of financial resources place enormous burden on the country in providing such information and services.

Progress has also been registered in the area of child survival. Infant mortality and child mortality have declined. But lack of basic sanitation and of safe water are two of the main factors that contribute to diarrhoeal disease leading to child mortality; and at the current rate of progress will not reach the ICPD goal on infant and child mortality by 2015. In the area of maternal mortality, the gap remains very wide; and unfortunately, Nepal is not expected to reach the ICPD goals. On HIV/AIDS, more funds are becoming available annually since 1994; but given the enormity of the problem, funding of HIV/AIDS programmes remains inadequate.

Some of the other issues that have come to the fore in the last ten years are aging, urbanisation, refugees and internal displacement. Gender issues are receiving much more attention; and the government is increasingly accepting that education and empowerment of women and improvement of their political, social, and economic and health status is a highly important end in itself. But the record of action taken in response to Cairo and Beijing conferences can only be described as a mixed and patchy one.

The National Human Rights Commission has yet to adopt an appropriate policy for reproductive and sexual health issues as rights. The Government has not yet adopted the Health Sector Reform Package. As stated earlier, the unprecedented political instability and insurgency have hampered the improvement in the SRHR situation and obstructed people from accessing it. Women have a low status in the society as a result of the patriarchal driven norms, which affect their ability and right to decide, access to information and services on SRHR. Although the Government has developed the Adolescent Health and Development Strategy, and Young People Development Programme, it has not yet initiated the process of implementing these. The lack of good governance is a stumbling block to the implementation of ICPD. Although poverty alleviation is the top priority of the government, very little concrete progress has been achieved so far. The management and monitoring mechanisms and systems are unsatisfactory. Coordination between the government line agencies, local government bodies, INGOs and NGOs requires further encouragement. The participation of adolescents, youths and the target groups of SRHR regarding concerned policy formulation and programming also needs to be encouraged.

The national population strategy was developed during the sixth plan period and is considered a milestone in the development of population policy in Nepal. This strategy had considered population growth in terms of long-term perspectives and has set quantitative targets with respect to fertility reduction and population growth rates. It also took note of the importance of integrating

population concerns into development activities. The strategies on population set during the sixth plan were adopted in the seventh plan to a greater extent although they could not be implemented in the absence of substantive programmes. The ICPD called for a broad and holistic approach to population. As a consequence, many of the ICPD concerns were reflected in the population policies of the ninth Plan.

Although the overall direction and quality of sexual and reproductive health policy, programmes and outcomes since ICPD are positive and improving, the pace of change has been rather slow. The government has formulated policies on SRHR in line with the ICPD. It has recognised that all individuals have the right of informed choice, to decide the number and spacing of their children, and to have access to information, education, and counselling. Legalisation of abortion is a historical achievement for Nepal, but all sectors now need to ensure that women have access to legal, affordable and safe abortion services. The Government has formulated a national HIV/AIDS strategy and is implementing it to reduce and prevent STI and HIV/AIDS. The HMG/N has adopted the Local Self Governance Act and Decentralisation policy according to which different village assemblies approve the health plan of the VDC. Sub-health posts are being handed over to the VDCs. The Government is also aware of the RH needs of adolescents and has recently decided to allow single women to have access to family planning services. Achievements so far include: revision of the legal age at marriage; a law to combat trafficking; sex education in formal and non-formal educational institutions; a National RH Policy (1998); National Standard & Clinical Protocols for FP & RH; a National Adolescent Health Programme; Amendment of the Civil Code (Muluki Ain 2020) that legalised abortion in September 2002; and a National Safe Abortion Policy 2003 & Directives 2004. These are, however, modest achievements and the country is still far from achieving its Millennium Development Goals. There is no doubt that the odds are formidable, but it is also true that a fair amount of work in these areas has been done by NGOs, INGOs and others, and HMK/N should build upon these achievements. In doing so, it is important to involve men, while working to improve the status of women in society, and it is also important to work closely with village development committees and other agencies so that the infrastructure will remain intact even if specific projects are phased out.

References

- *Nepal Country Paper,* HMG/N. Fifth Asian and Pacific Population Conference.

- *Summary of PoA*, ICPD Cairo.
- Maternal Mortality and Morbidity Study, Family Health Division, HMG/N.

- **UNFPA** *Field Inquiry Questionnaire*.

- **UNFPA** The South Asia Conference on Adolescents.

- *A Gift for an RH Project, Nepal: Endline Evaluation*, CREPHA.

- *Against Unsafe Abortion*, CREPHA.

- **HMG/N MoH** Nepal Country Profile on Women, Health and Development.
- **HMG/N** *Census 1991*, Central Bureau of Statistics, NPC.

- **HMG/N** *Census 2001*, Central Bureau of Statistics.

- **HMG/N, 1996** *Nepal Family Health Survey* (NFHS).

- **HMG/N, MoH** *Annual Report: Department of Health Services 2001/*02.

- **HMG/N, MoH** *Nepal 2001 Demographic Health Survey: Key Findings*, DoH Services 2001.

- **HMG/N**, *Tenth Plan 2002-2007*, National Planning Commission.

- **HMG/N, MoH** *Reproductive Health Documentation 2002/03*, DoH Services.

- **Tamang, Anand**. "Making ICPD Plan of Action a Reality in Nepal", paper presented at the *ICPD at Ten National Consultation, Centre for Research on Environment Health and Population Activities (CREHPA).*

- **Shakya, Ganga**. "The National Safe Motherhood Programme", Family Health Division, paper presented at the *ICPD+10 National Consultation, HMG/ Nepal*.

- **Gurung, Gita** Paper presented at the *ICPD+ 10 National Consultation, HMG/N*.

- **Khanal, Hari**. "Adolescents and Youth Programmes in Nepal," paper presented at the] *ICPD 10 National Consultation, FPAN*.

- **Thapa, Munu**. "Safe Motherhood and Nutrition," paper presented at the *ICPD+ 10 National Consultation, HMG/N, MoH, Nutrition Section.*

- **Gurung, Ram**. "HIV/AIDS versus NGOs," paper presented at the *ICPD 10 National Consultation, NANGAN & NGO IEC Coordination Committee*.

- **Bhattrai, Sanju**. "Country's Realities," paper presented at the *ICPD 10 National Consultation, SMN*.
- **Mesko, Natasha**. 2003. *Care for Perinatal Illness in Rural Nepal: A Descriptive Study with Cross-sectional and Qualitative Components*. BMC International Health and Human Rights, 2003.

- **Gibbon, Maria**. 2000. *Community Based Distribution Project, Babai, Bardiya District, Nepal: End of Project Evaluation Report.*

- **Leone, T**. et al. 2003. *Impact and Determinants of Sex Preference in Nepal, International Family Planning Perspectives 2003*.

Abbreviations / Acronyms

ARROW	Asian-Pacific Resource and Research Centre for Women
BBC	Beyond Beijing Committee
BCC	Behaviour Change Communication
BPFA	Beijing Platform for Action
CAC	Comprehensive Abortion Care
CBS	Central Bureau of Statistics, National Planning Commission, Nepal
CCO	Canadian Cooperation Office
CPR	Contraceptive Prevalence Rate

CREHPA	Centre for Research on Environment Health and Population Activities
CRS	Contraceptive Retail Sales
CWIN	Child Workers in Nepal
FP	Family Planning
FPAN	Family Planning Association of Nepal
GDI	Gender Development Index
GO(s)	Government Organisation(s)
GRINSO	Group for International Solidarity
GTZ	German Technical Assistance,
HimRights	Himalayan Human Rights Monitors
HMG/N	His Majesty's Government of Nepal
HDI	Human Development Index
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
INHURED	International Institute for Human Rights, Environment and Development
INSEC	A National Human Rights NGO
IMR	Infant Mortality Rate
LACC	Legal Aid and Consultancy Centre
LE	Life Expectancy
LWFD	Forum for Women, Law and Development
MDG	Millennium Development Goal
MMR	Maternal Mortality Rate
MoF	Ministry of Finance
MoPE	Ministry of Population and Environment
NANGAN	A network of NGOs working in the field of prevention of HIV/AIDS
NDHS	National Demographic Health Survey
NGO(s)	Non Government Organisation(s)
NPC	National Planning Commission
PAC	Post Abortion Care
PFA	Platform for Action (BPFA)
PLAN	PLAN International Nepal
PoA	Plan of Action
RH	Reproductive Health
RTI	Reproductive Tract Infection
SDP	Service Delivery Point
SLTHP	Second Long Term Health Plan 2002-2017 of HMG/N
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
TFR	Total Fertility Rate
U5MR	Under Five Mortality Rate
UNDP	United Nations Development Fund
UNFPA	United Nation's Fund for Population Activities
UNIFEM	United Nation's Development Fund for Women
USAID	United States Aid for International Development
VDC	Village Development Committee
VHW(s)	Village Health Worker(s)
WHV(s)	Women Health Volunteer(s)

Annexures
Charts

Health indicators, 2002

Indicator	Value	Uncertainty Interval
Life expectancy at birth (years)		
Total population	60.1	
Males	59.9	58.9 - 61.0
Females	60.2	59.2 - 61.1
Child mortality (probability of dying under age 5 years) (per 1000)		
Males	81	77 - 85
Females	87	83 - 91
Adult mortality (probability of dying between 15 and 59) (per 1000)		
Males	301	277 - 325
Females	290	271 - 310
Healthy life expectancy at birth (years)		
Total population	51.8	
Males	52.5	51.3 - 53.6
Females	51.1	50.2 - 52.3
Healthy life expectancy at age 60 (years)		
Males at age 60	10.5	10.3 - 10.8
Females at age 60	10.8	10.5 - 11.0
Expectation of lost healthy years at birth due to poor health (years)		
Males	7.4	
Females	9.1	
Percentage of total life expectancy lost due to poor health (%)		
Males	12.4	
Females	15.1	

Demography and Reproductive Health Status in Nepal (in millions)

POPULATION, HOUSEHOLD AND DENSITY

Region	Population			No. of Household	Average HH Size	Population Density
	Total	Male	Female			
Total	23.15 (100.00)	11.56 (100.00)	11.59 (100.00)	4253220	5.44	157
Mountain	1.68 (7.29)	0.83 (7.17)	0.85 (7.33)	319887	5.28	33
Hill	10.24 (44.28)	5.02 (43.43)	5.24 (45.21)	1982753	5.17	167
Terai	11.21 (48.43)	5.71 (49.40)	5.50 (47.46)	1980580	5.75	330

Source: Population Census 2001, National Report, HMG/N CBS, June 2002

Donor Funded Programmes with Government and NGOs Relating to SRHR Post 1994

Programmes	Specific		Specific	Coverage	Target Group
	SRHR	Health			
Safe Motherhood	√		Reduce MMR	National	Women
Mainstreaming Gender	√		Improve women's situation and status	National	National Men and Women
Micro Credit and Income Generation	√		Improve women's situation and status	National	Community
SRHR Programme for Adolescents	√		Create awareness and provide service	National, only in some districts	Adolescents and youths
Programme on Safe Abortion (CAC)		√	Increase safe abortion access and create enabling environment for women and couples to make informed decision	National but service in some districts only	Women
Programme on Infertility		√	Counselling and service delivery	National but service in some districts only	Men and Women
Programme on STI and HIV/ AIDS		√	Counselling and service delivery	National but service in some cities only	Adults and adolescents
Neonatal Care Programme		√	Counselling and service delivery	National but service in some districts only	Women
Family Planning Services	√		Counselling and service delivery	National but service in some districts only	Men and Women
Programme for the Elderly		√	Counselling and service delivery	National but service in some districts only	Elderly Men and Women
BCC/IEC Programme	√		Create awareness on SRHR	National	Adults and adolescents

List of People Interviewed

Mr. Laxmi Raj Pathak, Director Family Health Division
Dr. Renu Rajbhandary, Human Rights Commission
Ms. Sharada Sharma, Director, Women Section, FPAN
Ms. Renuka Gurung, Programme Officer, CREHPA
Dr. Indira Satyal, Maternity Hospital

Special Interviewees
Ram Kumari Tamang
Bishnu Maya Khatri
Sharmila Gurung
Kalawati Rai
Meena Bista
Dan Maya Subba
Chhakali Rana
Sunita Gautam
Shilpa Shreshtha
Chatra Niraula
Bina Chaudhari
Krishna Kala Joshi

ICPD goals vis a vis HMG/N

The Safe Motherhood Plan of Action (2002-17)

Goal: Improved maternal and neonatal health (Reduce MMR to 250/100,000)
Purpose: Sustained increase in utilisation of quality maternal health services (Emergency obstetric Care, Skilled attendance, FP)
Outputs:

- Increased equity and availability of quality maternal health services (skilled attendance, EmOC, FP)
- Increased access to:
  - Maternal health information (Birth Preparedness Package including emergency transport and fund)
  - Participation of local governments and communities
  - Legal and social status of women improved

Target for Safe motherhood

Indicators	2001	2006	2017
MMR per 100,000 live birth	539	300(Tenth Plan)	250
NNMR per1000 live birth	39	32 (Tenth Plan)	
TFR	4.1	3.5 (Tenth Plan)	2.3
CPR	39.3%	47%(Tenth Plan)	65%
ANC 1 visit	49 %	60%	80%
ANC 4 visit	14.3%	18%	40%
Delivery by skilled attendant	12.7%	18%	40%
Institutional delivery	9%	12%	22%
PNC	13%	22%	40%
Met need for EOC	5%	10%(SM districts)	
CEOC sites in districts	24 districts (32 hospitals	33 districts	63 districts

Prospective HMG/N Plan

Indicators	1991	1997	2001	2007	2017
•IMR	102	75	64	45	34
•U5MR	165	104	91	85	62
•MMR	850	750	539	300	250
•LE	54	57	61	65	68
•TFR	5.8	4.2	4.1	3.5	2.5
•CPR	24.1	28	39	47	65
•Delivery attendants increased by			31.5		95
•Immunisation coverage	37.2		60.1	100	100

Acknowledgment

The Beyond Beijing Committee (BBC) has been in the forefront of a civil society campaign to prepare for the Fourth World Conference on Women, Beijing 1995 and it is currently spearheading various activities to carry on the spirit of Beijing. BBC is dedicated to conducting a nationwide campaign to eliminate all forms of discrimination against women through research, training, education and monitoring the implementation of various national and international instruments relating to women's human rights. More specifically, it has been continuously monitoring the implementation of the BPFA since 1995. It has also been involved with ICPD, 1994 and participated in various events organised for ICPD+5 preparations. For BBC, the BPFA is one of the principal documents being used as a tool to empower women and launch a campaign to ensure women's rights, put pressure on government for implementation, monitor progress and raise issues from grassroots to national and international levels. Obviously, the ICPD Programme of Action falls within the mandate and scope of the organisation. Hence, it took up the task researching and writing this Country Study.

BBC used different methods to gather information on the implementation of the ICPD in Nepal. It conducted two different consultations in western and western parts of Nepal. We were surprised to find that none of the participants in the event had heard of the ICPD and they were excited to learn about it. Later, the collated reports from these two regions were presented at the ICPD+10 National Consultation where BBC worked hard to ensure wide-ranging participation. Other participants were from ministries of health and population/environment, women's organisations, including indigenous dalits, and handicapped, university and college student unions, adolescent peer groups, representations from metropolitan cities working on reproductive health issues, etc. The diversity of participation enriched our learning experiences from all aspects. The Ministry of Population and Environment was enormously cooperative and extended its support for the success of the consultation. We included resource persons namely Ananda Tamang, Gita Gurung, Renuka Gurung, Ganga Shakya, Hari Khanal, Munu Thapa, Ram Gurung and Sanju Bhattrai from major NGOs and GOs working on this issue as to incorporate broad spectrum of views. Secondary data analysis, interview and focus group discussions comprised the other tools used for the study.

BBC would like to extend its gratitude to Ms. Barbara Klugman, the Ford Foundation (New York) and ARROW for their support in this endeavour. We are also grateful to the participants of the regional meeting in Malaysia and the strategic planning meeting at Langkawi, which contributed respectively as preparatory activities and a process for feedback. BBC thanks Dr. Gopal Krishna Siwakoti, Chitra Niraula and Sirjana Kafle for providing support in recording the proceedings and editing the first draft of the report. Similarly, we would like to extend our sincere thanks to the participants of the consultations and the respondents from GOs, NGOs and INGOs, who greatly contributed to the success of this country study. The BBC team is obliged to Ananda Tamang for the feedback offered during the peer review of the final report.

We would like to thank the resource persons, facilitators, HimRights and BBC executive and staff members and volunteers for the successful completion of the country study. We hope the solidarity support will be extended in the days to come, too.