COUNTRY PROFILE

ON UNIVERSAL ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH: NEPAL

This project is funded by the European Union

Introduction

Nepal is a land-locked country located at the foothills of the Himalayas. It lies between 26º 22' to 30º 27' North latitudes and 80º 4' to 88 º 12' East longitudes with elevation ranging from 60 to 8,848 meters. The country is bordered by India to the east, south, west, and China to the north. Nepal is rectangular in shape and stretches 885 kilometers in length (east to west) and 193 kilometers in width (north to south). The total land area of the country is 147,181 square kilometers. Nepal is divided into three distinct ecological regions: Mountainous region, Hilly region and the Terai (or plains) region (SDINN, 2008) and five development regions according to its accessibility/remoteness: Far Western Development Region, Mid-Western Development Region, Western Development Region, Central Development Region, and Eastern Development Region.

According to the 2011 census, population of Nepal stood at 26.6 million; with an increase of 3.5 million since the last census of 2001. Upon observing, we find that the population has more than doubled in the last 40 years. The population grew at a rapid rate between 1971 and 1981 from 2.1 percent to 2.6 percent but it receded to just over 2 percent in 1991 and 1.4 percent in 2011. The population density of Nepal is estimated at 181 per square kilometers. The total male population according to the 2011 census was 12.8 million whereas the total female population was 13.6 million. In 2011, approximately 20.7 percentage of the total population was in between 0-9 year age, and 23.5 percentage of the total population belonged to 10-19 age group. Young adults aged 20–34 years comprised 24.1 percentage and adults aged 35–59 years comprised 22.4 percentage of the total population respectively. Persons of 60 years of age and above comprised 7.3 percentage of the population (NPCS & CBS, 2011).

Among 13.6 million women, about 49 percent are in reproductive age (NPCS & CBS, 2011). Nepal was able to achieve greatly in terms of human and gender development indicators. The Gender Development Indicators (GDI) increased from 0.312 in the 1990s to 0.912 in 2013 in Nepal (UNDP, 2014), and female/male disparities have also noticeably reduced. There has been significant progress in women's access to education and health resources (UNFPA, 2007).

Nepal recently emerged from a decade-long armed conflict (1996-2006). This conflict had an effect on both the population's health and the health care system. Over 1,000 health posts in rural areas were destroyed, more than a dozen health workers were killed and many others were harassed, kidnapped, threatened or persecuted. The conflict aggravated the already poor health services as one third of Nepal's health centers lie in rural areas where the fighting was particularly fierce. Consequently, health centers often operated without health staff. Torture and sexual-abuse related to insurgency were also prominent and the conflict hindered health programs implemented by non-governmental organizations (NGOs) too (Devkota & Teijlingen, 2010). The Shah Dynasty that unified and ruled Nepal for the last 240 years, often through bloodshed came to a peaceful end in 2008. On May 28, 2008, Nepal was declared a Federal Democratic Republic (Dhakal, 2008).

Even during the conflict period with minimal economic growth and poor health care services, socio-economic and health indicators have improved progressively and continue to do so in post conflict times. Some of the important factors that have contributed in improvisation of sexual and reproductive health and rights (SRHR) are:

a) People's acute consciousness and desire to improve their own and family health;

b) Women have been found to be resourceful in making all kinds of arrangements to access education and health care services for their children and for themselves. Even during the conflict times women have negotiated with Maoists for the security, education and health of

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their children – although there is no systematic study, number of cases have been reported in the experiences of different Non Governmental Organizations (NGOs), International Non Governmental Organizations(INGOs) and local institutes;

c) It has been reported that local health workers have played an important role in providing health care services even in absence of government health officials and local institutional health care services and

d) Indeed, remittance is one of the significant factors but only to the extent that people are health conscious to make the choice to spend it on health care. In rural Nepal, it is apparent that women have made the decision to spend part of the remittances that they receive on education and health care of their children. With overwhelming majority of the male migrants in rural households, women significantly appear as decision makers.

Despite the political unrest, Nepal was successful in receiving Millennium Development Goal (MDG) award in 2010 (Baral, 2009). Maternal Mortality Ratio (MMR) has been significantly declined from 270 in 2005 to 190 in 2013 per 100,000 live births in Southern Asia (DRHR, 2014). Despite these achievements, women still face difficulties as some of the malpractices even exist today. They are commonly known as dowry, son preference, social acceptance of domestic and public violence against women, polygamy, early widowhood and associated exclusion like the payment of dowry (reinforced by new consumerism), *Deuki* (an ancient custom practiced in the far western regions of Nepal in which a young girl is offered to the local Hindu temple to gain religious merit), *Chhaupadi* (women are secluded, excluded and discriminated during their menstruation and post-partum period by forcing them to stay in the nearby shed and not allowed to enter their own home) and *Boksi* (witch or a woman who practices black magic). These factors continue to restrict women in accessing the services provided in their communities.

Health workers as well as teachers are seen to be reluctant to discuss issues on sexual and reproductive health (SRH) (Pokhrel, Kulczycki & Shakya, 2006). Government of Nepal (GoN) has included chapters related to sexual and reproductive health (SRH) in their selective course books to educate students and their parents where it is often taken as a taboo. The teacher's capacity of knowledge regarding sexual and reproductive health seems to be significantly inadequate because of which they make students read these chapters on their own. Consequently, adolescents and young people are not well-informed on sexual and reproductive health (Pokhrel, Kulczycki & Shakya, 2006).

Based on data from the World Health Organization (WHO), the life expectancy of males and females in Nepal in 2012 was 67 and 69 years respectively. In 2012, the Nepali Gross National Income (GNI), when expressed as per capita purchasing power parity (PPP) converted to US dollars, was $1,470. The mortality rate for children less than five years of age was 42 per 1,000 live births. For males and females between 15 and 60 years of age, the mortality rate was 183 and 157 per 1,000, respectively. The total expenditure on health per capita was $68 (2011, US dollars). In 2012, health expenditures comprised 5.5% of Gross Domestic Product (GDP) (WHO, 2012).

Nepal Health Sector Program (NHSP-2), 2010/15 projects that the share of total government budget for health will rise from around 7 percentage in fiscal year (FY) 2010/11 to 9.6 percentage in FY 2014/15. In FY 2010/11, GoN allocated 7.1 percentage of the total national budget to the health sector. The national budget, including the health budget, increased from 6.2 percentage in 2009/10 to 7.1 percentage in 2010/11. Of the total budget, 33.5 percentage was allocated to the health sector in 2010/11 which was a steep increase from 19.4 percentage in 2009/10 (MoHP, 2011).

This profile will discuss the current status of SRH in Nepal as well as current legislation, policies and strategies pertaining to sexual and reproductive health in Nepal. It will examine the status of implementation and enforcement of the laws, policies and strategies and make recommendations to assess sexual and reproductive health in the country.

The data were collected through literature review; assessment and/or analysis of governmental and other reports and data; and by interviewing key persons of different NGOs, INGOs and government agencies working in SRHR.

Status of Sexual and Reproductive Health Services in Nepal

Government of Nepal (GoN) has ratified major International Human Rights treaties, including the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR). These international treaties require governments to respect, protect and fulfill women's SRHR. Further, Nepal has pledged to effectively implement important global and regional policy commitments on SRHR and gender equality notably the Program of Action (PoA) of the International Conference on Population and Development (ICPD) and the Beijing Platform for Action (BPfA).

In 2007, GoN promulgated the Interim Constitution which expresses a firm commitment to promote women's dignity and gender equality by explicitly recognizing reproductive rights as a critical component of women's fundamental rights. Article 20(2) of the Interim Constitution states- "Every woman shall have the right to reproductive health and other reproductive matters." Women's reproductive rights are further supported by Article 16(2) of the Interim Constitution which guarantees that basic health care shall be provided free of charge to all citizens.

In addition, Nepal has introduced numerous national policies concerning SRHR, viz.: National Reproductive Health Strategy, 1998; Safe Motherhood Policy, 1998; Safe Abortion Policy, 2003; National Adolescent Health and Development Strategy, 2000 and its Implementation Guidelines, 2008; National Strategy on Family Planning, 2012; Health Sector, Gender Equality and Social Inclusion Strategy, 2009 and its Operational Guidelines, 2013, Gender Equity and Social Inclusion (GESI) Social Service Unit Guidelines and One Stop Crisis Management Centre Guidelines.

In this country profile on universal access to sexual and reproductive health, we observe the key indicators within sexual and reproductive health, viz. i) Contraception ii) Maternal Mortality Ratio (MMR) iii) Sexual and Reproductive Health of the Adolescents and Young People iv) HIV and AIDS and v) Health Financing

Contraception

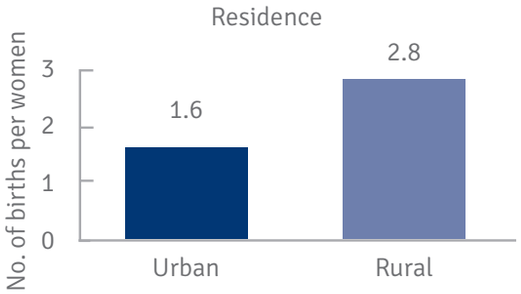
The ICPD PoA states that- people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. The PoA reiterated the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice (World Youth Alliance, 2012).

In this section, we look at the key indicators, viz. i) Total Fertility Rate (TFR), which is an indicator of good or poor reproductive health as a high fertility rate (> 5 births) represents a high risk of reproductive ill health; ii) Contraceptive Prevalence Rate (CPR), which is a proxy measure of access to reproductive health services, assuming there is no coercion for acceptance of birth control through government policy and iii) Unmet need for contraception, which is also a proxy indicator of access to reproductive health services.

Family Planning Association of Nepal (FPAN) commenced the Family Planning Program in Nepal in 1959. Initially, the services were limited to Kathmandu Valley. The current use of contraception increased over the years since 1996. The use of contraception by non-pregnant women below 25 years of age was 26 percent, while older non pregnant women dominated the scene by using it till 42 percent (Regmi, 2012).The purpose of implementing contraceptive services was to prevent unwanted pregnancies and improve women's control over her fertility.

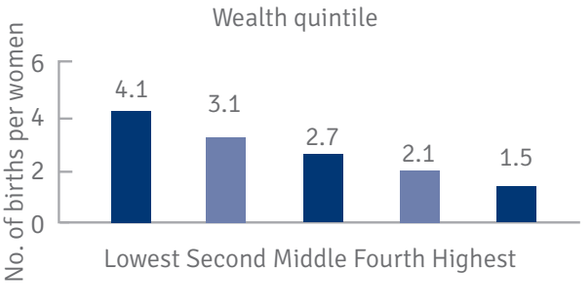
Fertility rate has been decreasing for the last two decades. In 1996, fertility rate was 4.6 births per woman while in 2011; it descended to 2.6 births per woman. This meets the goal of Second Long Term Health Plan (SLTHP) i.e., 3.05. Though the trend of Total Fertility Rate (TFR) is decreasing, there are considerable differences in the fertility rates across different ecological zones. According to Nepal Demographic and Health Survey (NDHS), 2011, conducted by the Ministry of Health and Population (MoHP), fertility rate ranges from 2.5 births per woman in the Terai to 3.4 births per woman in the mountainous region. The government's aim, as per the twelfth year plan, is to reduce TFR from 2.5 to 2.1, which is yet to be achieved (MoHP, 2012).

Figure 1. TFR According to residence



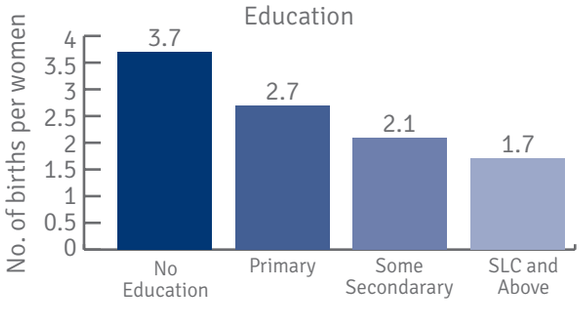
(Source: MoHP, 2012)

Figure 2. TFR According to wealth quintile



(Source: MoHP, 2012)

Figure 3. TFR according to mother's education



(Source: MoHP, 2012)

Annual report of 2009/10 published by Department of Health Services states that TFR reduced from 3.1 children per women in 2006 to 3.0 by the end of the Three Year Interim Plan (2008/09 to 2010/11). It aims to reduce the ratio further to 2.5 by 2015 (MDG).

Fertility differentials across rural-urban residence show a significantly higher fertility in the rural areas (2.8 births per woman), in comparison to the urban areas (1.6 births per woman). Fertility is seen to be inversely related to the level of education with 3.7 births per woman with no education, compared to 1.7 births among women with a School Leaving Certificate (SLC) or above. Women in the lowest quintile are observed to have 4.1 births compared to 1.5 births among women in the highest quintile. Differentials are also observed across ecological zones of Nepal (MoHP, 2012).

The reasons behind declining fertility rate include extended spousal separation (migrants seeking work in foreign countries), late marriage and the availability of safe abortion services (MoHP, 2012). There are other many factors that have contributed in reduction of fertility such as education, women's own awareness and decision making abilities and effects of family planning services.

Contraceptive Prevalence Rate (CPR)

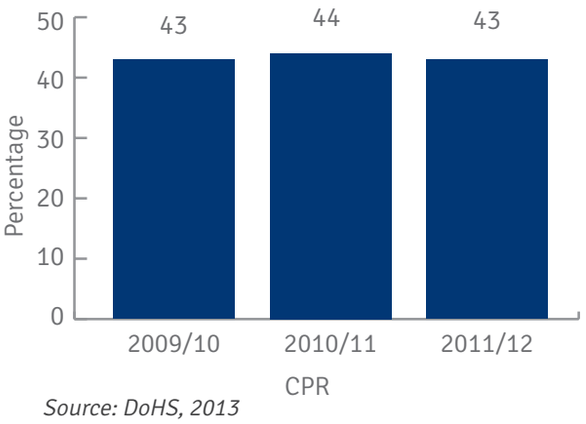
At the national level, CPR has increased from 41.7 percent in FY 2007/08 AD to 43.5 percent in FY 2009/10. On the other hand, the aim of CPR is to increase from 48 percent in 2006 to 51 percent by the end of 2010/11 (3 year Interim Plan Period), and to 67 percent by 2015 as targeted by MDG. But in FY 2000/01, the CPR has increased slightly to 44 percent and again it regained the same level in FY 2011/12 to 43 percent. One of the reasons for static CPR would be that those couples who do not live together for long duration due to employment, are less likely to use family planning than those couples who are in immediate need could access the services (DoHS, 2013).

Pursuant to the Nepal Demographic and Health Survey (NDHS), 2011, 49.7 percent of currently married women are using a method of contraception, with 43 percent using a modern method of contraception and 7 percent using a traditional method (MoHP, 2012).

An examination of trends in the use of contraception among currently married women reveals an increased use of contraception from 28.5 percent in 1996 to 49.7 percent in 2011. However, the use of contraception remained stagnant between 2006 and 2011 at 48.0 percent and 49.7 percent, respectively. Some of the main factors contributing to stagnation in CPR are; high spousal separation due to migration, Increase in traditional methods, Increase in access and use of abortion, Increase in use of emergency contraception (Shrestha, Shrestha, & Ghimire, 2012).

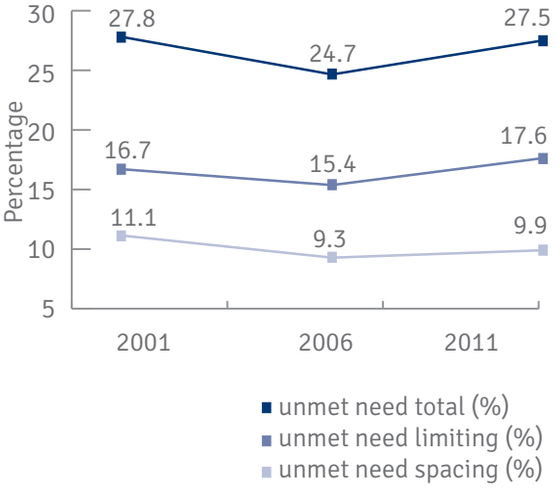
In 2011, female sterilization (15.2%) remained the most widely used method of contraception, among currently married women, followed by

Figure 4. Contraceptive Prevalance Rate



Source: DoHS, 2013

Figure 5. Unmet need for contraception



Source: DoHS, Annual Report

injectable (9.2%). The use of female sterilization and injectable is observed to have declined in 2011 as compared to 2006. Another trend has been an increase in the use of temporary methods such as implants and intra uterine device (IUD) in 2011 compared to 2006, reflecting the declining use of permanent methods such as female sterilization. Male sterilization has increased over the years from 5.4 percent in 1996 to 7.8 percent in 2011. The use of condoms has also swelled from 1.9 percent in 1996 to 4.3 percent in 2011. Moreover, according to the Second Long Term Health Plan (SLTHP), the CPR is to increase to 58.2 percent by 2017, a target which appears challenging to meet. Programs relating to improving the use of contraceptives should be encouraged by government sectors and aim to cover women of all reproductive ages, including adolescents, irrespective of their marital status and geographical difficulty. The policy for unmarried adolescents is still not addressed by National Policy on Family Planning, 2001, which needs to be reviewed.

Unmet Need for Contraception

As shown in Figure 5, the unmet need for contraception has been observed to fluctuate. Unmet need declined from 27.8 percent in 2001 to 24.7 percent in 2006 and again increased to 27.5 percent in 2011(MoHP, 2012). This suggests, either the family planning program is increasingly providing spacing methods, or couples do not want permanent sterilization, despite having the desired number of children (Tamang, Subedi, & Packer, 2010).

Unmet need for family planning has been observed to decline with age from 42 percent among women aged 15-19 to 13 percent among older women. Unmet need is higher in rural areas than in urban areas. As per the data, it is highest in the western hill sub region (36 %) followed by western region (34 %) and finally hilly region (30 %). These needs are lowest among women with no educational background (23%) and highest among women with a minimum of secondary education background (33%) (MoHP, 2012).

A study concluded that, despite having high levels of awareness about family planning methods, a significant level of unmet needs exist among women of reproductive age. Fear of side effects, opposition of family members (husband) and inconvenience in use are the main contributors to the unmet need (Paudel & Budhathoki, 2011).

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Laxmi Ghalan, of Morang, aged 27, with two sons had a happy family life. Both the sons were born at home. They decided to have no more children and wished to adopt permanent family planning method. Unfortunately they had no idea regarding contraception and its availability. There were no health facilities nearby. The sub-health post was situated at two hours far from their home. Despite strong desire for adopting family planning method, she conceived for the third time.

They decided to abort the pregnancy by any means. They aborted with the help of Sudeni (traditional mid wife) after three months of pregnancy. After two days, she felt severe unbearable pain in her lower abdomen. She was taken to the district hospital where she was operated twice. She died after 21st day of her second operation. The doctor at the hospital said that she died due to incomplete abortion done by Sudeni.

-Beyond Beijing Committee, SRHR Country Position Paper Nepal, 2005

In terms of access to reproductive health services among Lesbians, a study conducted with in-depth interview and focus group discussions on Lesbians in Nepal, revealed that health workers often attach stigma to lesbians due to dogmatic superstitions. So, they may be reluctant to use the available health services, which could lead to unhealthy reproductive life (Pathak et al., 2010).

Among migrants, a study conducted to find out the use of contraceptives showed that only 61percent of migrants used condoms as a means of contraception (Dahal, Pokharel, & Yadav, 2013).

Given the above data on contraception, it is important that access to contraceptives, both spacing and limiting methods, has increase so as to improve the unmet need for contraception and thereby enhance women's control over her fertility.

Maternal Health

Improving maternal health has been recognized as a national health agenda of Government of Nepal (GoN) since 1991. Nepal has agreed to achieve MDGs by the year 2015 and correspondingly has now committed to reduce MMR by 3 quarters between 1990 and 2015. Improving maternal health has been a priority program and is focused in the different development plans. There have been many notable improvements in this connection. However, several issues and challenges are still hindering the full fledged achievement of MDG-5 goals in Nepal. In the following section, we look at key indicators relating to maternal health. These indicators include i) Maternal Mortality Ratio (MMR) ii) Perinatal Mortality Rate (PMR) iii) Infant Mortality Rate(IMR) iv) Antenatal coverage v) Proportion of birth attended by skilled birth attendant (SBA) and vi) Post natal care (PNC) coverage .

Maternal Mortality Ratio (MMR)

Maternal Mortality Ratio (MMR) is a key indicator for measuring socio-cultural and economic inequalities that adversely affect women and girls and impede progress in the development goals set for 2015. In more than two decades, MMR has been on a steady decline.

The World Health Organization (WHO), United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), the World Bank and the United Nations Population Division (UNDP) estimated maternal mortality ratios in Nepal in (2013) showing a steep decline in maternal mortality ratio from 790 maternal deaths per 100,000 live births (1990) to 190 maternal deaths per 100,000 live births in 2013 (Ravindran, 2013).

The Nepal Demographic and Health Survey (NDHS), 2006 reported a Maternal Mortality Ratio (MMR) of 281 deaths per 100,000 live births in Nepal. This survey used sisterhood method. Further, the Maternal Mortality and Morbidity Study 2008/09 conducted in around eight districts of Nepal, revealed a MMR of 229 deaths per 100,000 live births (MoHP, 2012) indicating a fall in maternal mortality over the years in Nepal.

This implies progress has been made in maternal health in terms of service delivery. There are many factors which may have contributed to this decline. The increase in the percentage of pregnant women with four Antenatal care (ANC) visits, the

Table 1. Maternal Mortality Ratio

Reference Year	Ratio Per 100,000	Source
1991	515	NFHS,1991,MOH
1990-1996	539	NFHS,1996,MOH
1998	596-683	MMMS,1998,MOH
2006	281	NDHS,2006
2009	229	MMMS,2008/09,M0HP
2013	190	Department of Reproductive Health, 2014

percentage of births delivered at health facilities, the percentage of births assisted at delivery by a SBA and the percentage of women receiving postnatal care including improved quality of care may have all contributed to this decline in maternal mortality in Nepal (MoHP, 2007).

Still, there is a wide variation of MMR among different ethnic and geographical areas. The Maternal Mortality and Morbidity Study 2008/09 revealed that Muslim religion has highest MMR i.e., 318 followed by 307 in Terai/ Madhesis and other ethnicities. Despite improvements, maternal mortality ratio continues to remain as a formidable challenge in Nepal.

Uterine Prolapse (UP) is also another contributing factor to increase maternal mortality. While UP is not an MDG indicator, it is indirectly related to the goal (DoHS, 2013).

A study undertaken in Kaski District revealed that out of 300 women, 11.7 percent complained of UP and more than 72 percent of women were treated with ring pessary (Tamrakar, 2012). This data clearly suggests that UP remains one of the major health risks that women have been experiencing. For Nepali women, gender discrimination is both a cause and a consequence of uterine prolapse. Nepali women experience high rates of uterine prolapse and many of them face it at a younger age because gender discrimination in their daily lives exposes them to multiple risk factors for the condition. Gender discrimination limits their ability to control sexuality and make choices related to reproduction, including use of contraception; to challenge early marriages; to ensure adequate antenatal care; and to access sufficient nutritious food. It also put them at risk of domestic violence including marital rape (Amnesty International, 2014).

The "Aama Surakshya" program that helped to increase ANC visit and institutional delivery was established in 2005 under Maternity Incentives Scheme (MIS). It was later named as the Safe Delivery Incentives Program (SDIP). It provides incentives to women for carrying out deliveries health facilities in order to improve the health outcomes of both mothers and babies. Furthermore in January 2009, user fees were removed for all types of delivery in government health facilities nationwide and the scheme was extended to include some accredited non-state hospitals (MoHP, 2012).

Women's awareness regarding cash incentive during pregnancy rose from 14 percent in 2005 to 64 percent, in 2010. The study found that 71

... progress has been made in maternal health in terms of service delivery. However, there is a wide variation of MMR among different ethnic and geographical areas.

Figure 6. PMR according to mother's age

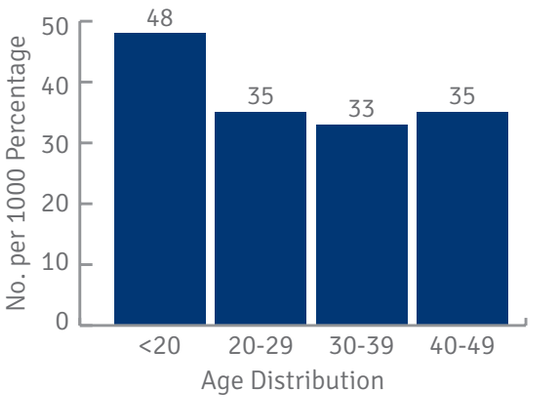


Figure 7. PMR according to residence

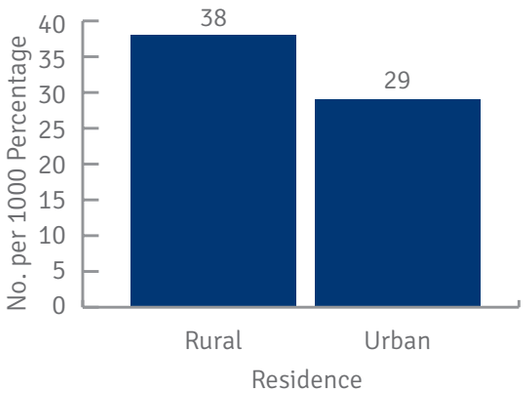
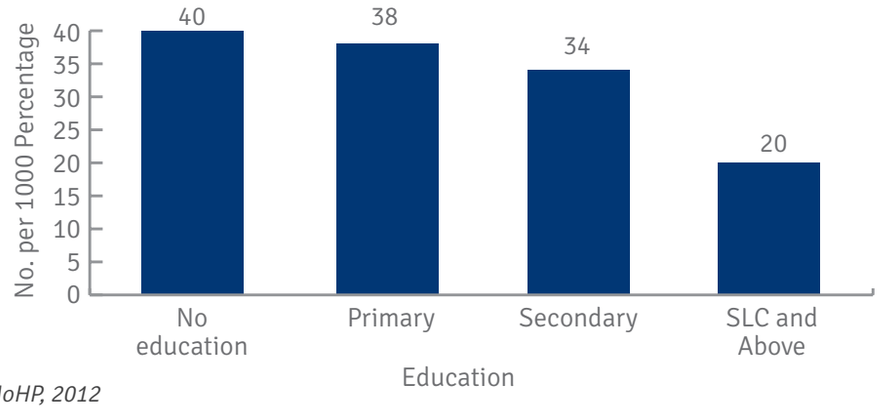


Figure 8. PMR in accordance with mother's education



Source: MoHP, 2012

percent of mothers received payment to cover the cost of transportation to a health facility. 73 percent of rural women received transportation incentives compared to 60 percent of urban woman (Upreti et al., 2012)

Perinatal Mortality Rate (PMR)

Perinatal Mortality Rate is a good indicator of both the status of maternal health and nutrition as well as the quality of obstetric care sought by pregnant women (Ravindran, 2013). The PMR is higher among mothers who are below the age of 20. Those tender mothers get pregnant again in less than 15 months of their first delivery. PMR is higher in rural than in urban areas as well as higher in the mountain zone than in the hill and Terai zones. It is twice as high among women with no education compared to women who have passed SLC or have gained higher level of education. Perinatal mortality declined from 47 percent in 2001 to 45 percent in 2006, which is 45 to 37 deaths per 1,000 pregnancies in the last 10 years (MoHP, 2012).

Infant Mortality Rate (IMR)

One of the major factors contributing to Infant Mortality rate (IMR) is low birth weight which can directly be attributed to less than optimal maternal health, nutrition and care during delivery. It is an indicator of maternal health as well (Ravindran, 2013). Infant mortality rate is also a very reliable indicator of country's socio-economic development, quality of life and its health status. In Nepal, infant mortality rate in the past five years is 46 per 1,000 live births.

IMR is higher in rural than in urban areas, i.e., higher in the mountain zone than in the hill and Terai zones. It is also higher among women with no education as compared to other women who passed SLC or higher level of education. According to this mortality level, one in every 22 Nepalese child dies before reaching age one (MoHP, 2012). The total infant mortality rate is 40.43 deaths/1,000 live births (Nepal Demographics Profile, 2014). The aim of Second Long Term Health Plan (SLTHP) is to reduce the infant mortality rate to 34.4 per thousand live births that should be accomplished by the end of 2017.

Figure 9. IMR according to Residence

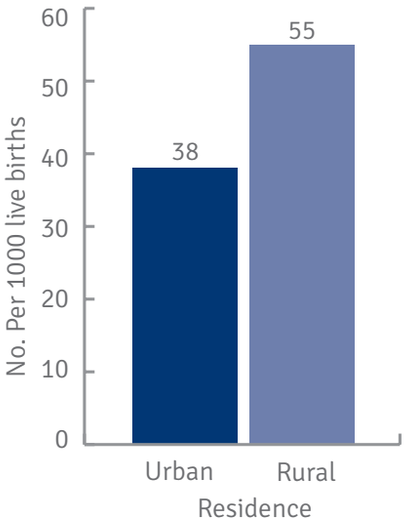


Figure 10. IMR according to Mother's education

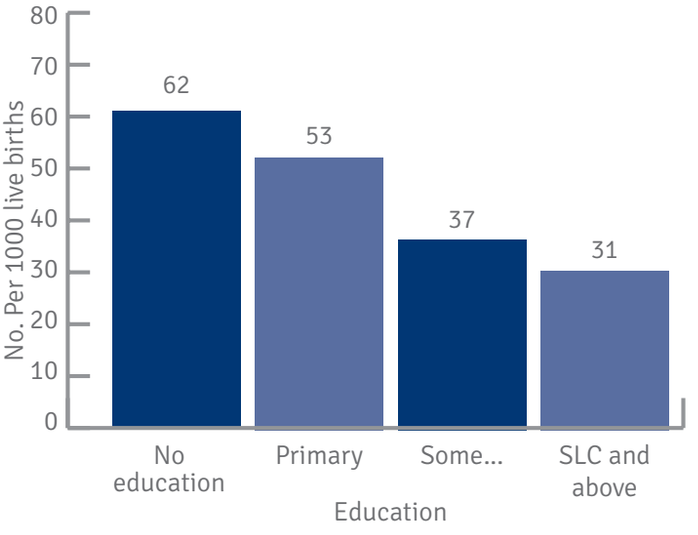
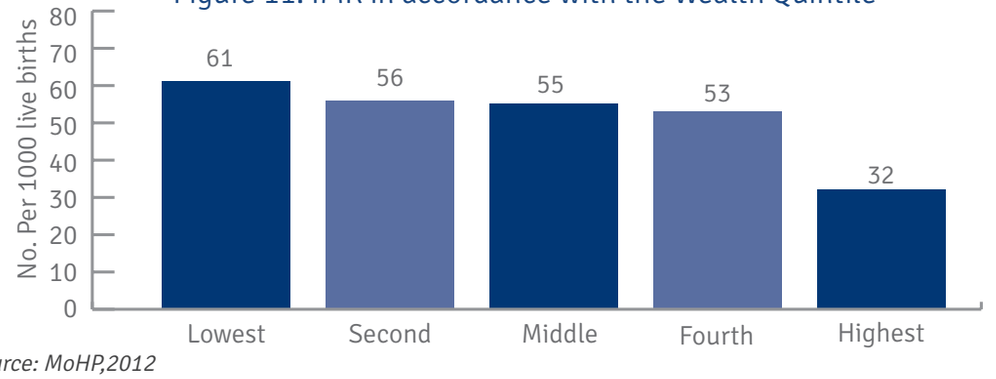


Figure 11. IMR in accordance with the Wealth Quintile



Source: MoHP,2012

IMR depends upon the accessibility of services which has been displayed expressly, according to the residence in the figure above. Mother's education also determines the infant care; if mothers are educated the infants get prompt treatment. Wealth quintile is also the underlying factor for infant mortality. Higher the wealth quintile, lower the infant mortality.

Ante Natal Care Coverage

Measurement of antenatal care that women receive is an important indicator of the woman's access to health care services (Ravindran, 2013). There has been a significant improvement over the past ten years, in the proportion of mothers, who get antenatal care from skilled birth attendants (Doctor, nurse and midwife). It increased from 24 percent in 1991 to 28 percent in 2001 and it rose up to 44 percent in 2006 (MoHP, 2007). The Annual Report of 2011/12 revealed that 1st ANC visit declined from 87 to 83 percent, whereas 4th visit was static, at 57 percent (DoHS, 2013). The study on "Utilization of Antenatal Care Services in Rural Area of Nepal" states that the number of Dalit and Janajati mothers (others) was significantly lower than the average visits of ANC (Dahal, 2013).

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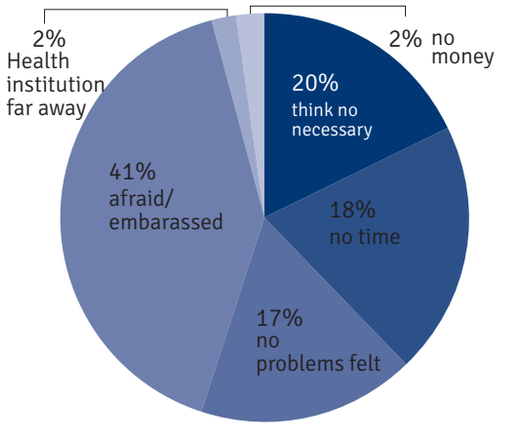
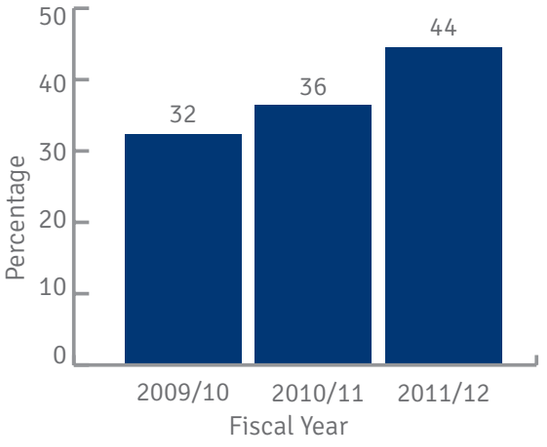
Figure 12. Reasons for non-attendance of ANC (N=41) multiple response



Source: Kathmandu, University Medical Journal

Figure 13. Births attended by SBA



Source: DoHS,2013

In addition, 26 percent of mothers received antenatal care from trained health workers. The survey revealed that 15 percent of woman did not received any antenatal care for births in five years (MoHP, 2012). The government's aim in Second Long Term Health Plan (SLTHP) is to increase the percentage of pregnant woman attending a minimum of 4 ANC visits to 80 percent, which seems to be challenging. However, this achievement is imperative to improve maternal health of pregnant women.

Proportion of Birth attended by Skilled Birth Attendants (SBA)

Across countries and over time, there is a significant association between the proportion of births delivered by skilled birth attendants and maternal mortality ratio (Ravindran, 2013). For this reason, this indicator helps to understand and ensure the safe delivery practices. The proportion of births attended by SBA seems to be increasing but the aim of MDG is yet to be achieved which is 60 percentage.

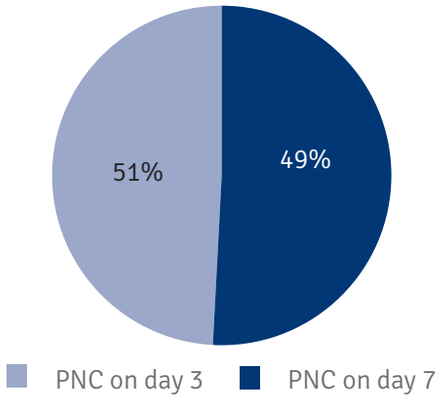
The proportion of women who deliver with the help of a SBA has increased five-folds in the last two decades, from 7 percent, in 1990 to 36 percent, in 2011. In mid-2013, it reached 50 percent (FHD, 2013); making it likely that Nepal will achieve its goal of 60 percent by 2015. Although Nepal is likely to achieve both of its MMR and attended-birth goals, progress has not been uniform. Disparities exist between rural and urban settings and across ecological and development regions (NPC & United Nations Country Team of Nepal, 2013). Only 32.3 percent of rural women's delivery is assisted by SBA whereas 36.2 percent is assisted by SBA during delivery in central region (MoHP, 2012)
This is a daunting challenge because as per the internationally accepted definition, only a limited number of health workers in Nepal qualify as SBAs. Furthermore, inequity in access to SBAs owing to the diverse geography and the economic status has proven to be barriers in achieving the MDG indicators.

In a country like Nepal, low use of SBAs during pregnancy is not only caused by economic, geographic, cultural and religious reasons but also by institutional problems. Different research projects came to a collective conclusion that it resulted due to poor quality services, their unavailability and inaccessibility, minimal staff support, lack of medicine as well as equipment and dysfunctional referral systems (Baral, Lyons, Skinner, & Teijlingen, 2010).

Post Natal Care Coverage/ Post Natal Care within 48 Hours of Delivery by a Skilled Health Provider

Postpartum care is crucial because a significant proportion of maternal and new born deaths occur during delivery or in the postpartum period (Ravindran, 2013). Postnatal care is not commonly practiced in Nepal. Even in places where it is adopted, it seems to be very poor. Adequate utilization of postnatal care can help reduce mortality and morbidity among mothers and their babies. Less than one in five women (19%) received care within 48 hours of giving birth. Lack of awareness has been the main barrier to the utilization of postnatal care. The women's occupation/ethnicity, the number of pregnancies, the husband's socio-economic status, occupation

Figure 14. Postnatal care visit by FCHVs



Source: DoHS,2013

Sushma Chhetri, a 19-year-old school girl and a resident of Jamuni VDC-5, Bardiya, belonged to a farmer family. In her free time, she used to help her mother with household chores.

She felt in love with a boy from the same village and kept a physical relationship with him. They did not have any idea regarding contraceptives that resulted into pregnancy. When she told him about her pregnancy, he ran away from the village. Three months after the conception, her parents came to know about this and forced her to abort. The first attempt of abortion failed but they attempted again within the next 60 days.

By then, everyone in the village had come to know about this. The villagers' maltreatment toward her completely shattered her and her family. She was so traumatized by the whole episode that she consumed a bottle of Metacid, a powerful insecticide, and committed suicide.

and education were significantly associated with the effective utilization of postnatal care. This is an important message to both service providers and health-policy makers. Therefore, there is an urgent need to assess the actual quality of postnatal care. Furthermore, there appears to be a need for awareness-raising programs highlighting the availability of current postnatal care of sufficient quality (Dhakal et al., 2007).

Sexual and Reproductive Health of the Adolescents and Young People

The Program of Action (PoA) adopted at the International Conference on Population and Development (ICPD) in Cairo in 1994 stimulated considerable interest among international agencies, governments, non-governmental organizations and donors in the formulation of policies and programs to meet the needs of adolescents in developing countries and to protect their rights. Among other recommendations, the Cairo agreement urged governments to provide adolescent girls and boys with the necessary sexual and reproductive health information and services to enable them to deal in a "positive and responsible way" with their sexuality (WHO, 2011).

In Nepal, 36 percent of the youth are between the ages of 10-24 years (MoHP, 2012). The sex ratio for young people aged between 15-24 years is 84 male per 100 female. There is poor communication among youth when it comes to discussions about sexual health. The 51.80 percent young girls (10-24 years) were reported having discussed about the issues related to marriage, pregnancy, menstruation, love, family planning, sexual intercourse, wet dreams and puberty which is proven to be more than that of young boys i.e., 48.2 percent (MoHP, 2012). Moreover, on an average young male aged 15 to 24 had 2.6 numbers of sexual partners in lifetime (MoHP, 2012).

Despite the youths occupying a huge chunk of population, young people are facing significant challenges when it comes to their SRHR. The SRHR programs contribute in reducing the adolescent fertility rate (AFR) among 15-19 years old, in increasing the contraceptive prevalence rate among 15-19 years and also in increasing the satisfaction of young people with health services (MoHP/GIZ, 2011). For the pursuit of better services, the strategy has been devised in a participatory manner involving a wide range of stakeholders, called as National Reproductive Health Commodity Strategy (RHCS) (2007-2011), so as to ensure a secure supply and choice of quality contraceptives and other reproductive health commodities to meet every person's needs at the right time and in the right place.

In this section, the indicators discussed will be listed as: a) adolescent birth rate and b) availability and range of adolescent sexual and reproductive health.

Adolescent Birth rate

The Adolescent Fertility Rate (births per 1,000 women aged 15-19) in Nepal was 89.63 as of 2011. Over the past 14 years, this indicator reached a maximum value of 129.10 in 1997 and a minimum value of 89.63 in 2011 (Nepal - Adolescent fertility rate, 2011).

Fertility is considerably higher in rural areas (87%) than in urban areas (42%) (MoHP, 2012). This indicates child marriage occurs more often in rural areas than in urban areas.

Availability and Range of Adolescent Sexual and Reproductive Health Services

The available range of adolescent sexual and reproductive health (ASRH) services indicates access to health services for adolescents, irrespective of marital status (Ravindran, 2013). The range of adolescent and sexual reproductive health services are in primary, secondary and tertiary level with the availability of psychosocial counseling, contraceptives and HIV treatment and prevention, regardless of marital status.

Even in areas where health services are easily accessible, the quality of services for adolescents' needs to be improved. The studies conducted in four districts among intervention and control groups disclose that significant number of respondents had to walk less than an hour to reach the nearest health facility (intervention-90.2%; control-89.9%). However, majority of them thought that the health facility was not friendly as there were no separate rooms for adolescents (intervention-63.8%, control-76.9%). In addition, the other unfavorable reasons included: lack of privacy maintenance by health facility (intervention-54.6%; control-59.3%), lack of functional toilet (intervention-42.8%; control-62.8%) and no Information, Education and Communication (IEC) materials displayed in the waiting area. About one third of the participants still felt uncomfortable discussing their sexual health problems with health care providers (intervention-30.5%; control-34.3%) (Teijlingen, Simkada, & Achary, 2012). According to Annual Report 2011/12, ASRH program implemented until 2011/12 in 38 districts are supported by Family Health Division (FHD) for ensuring sustainability of the program (DoHS, 2013).

HIV and AIDS

National AIDS Policy of 1995 was revised in the year of 2011 and is now known as "The National Policy on HIV and STI, 2011". This policy elucidates the roles and linkages of structures such as National AIDS Council (NAC), HIV/AIDS and Sexually Transmitted Infection (STI) Control Board (HSCB) and National Centre for AIDS and STD Control (NCASC). For better execution of this policy, the following four policy directives have to be instituted: (1) amendment of the Cabinet Formation Order on the creation of HSCB, (2) operational guideline for the National AIDS Committee (NAC), (3) directives for the Monitoring and Evaluation (M&E) of HIV and AIDS response and (4) operational guideline for the District AIDS Coordination Committee (DACC) (NCASC, 2012).

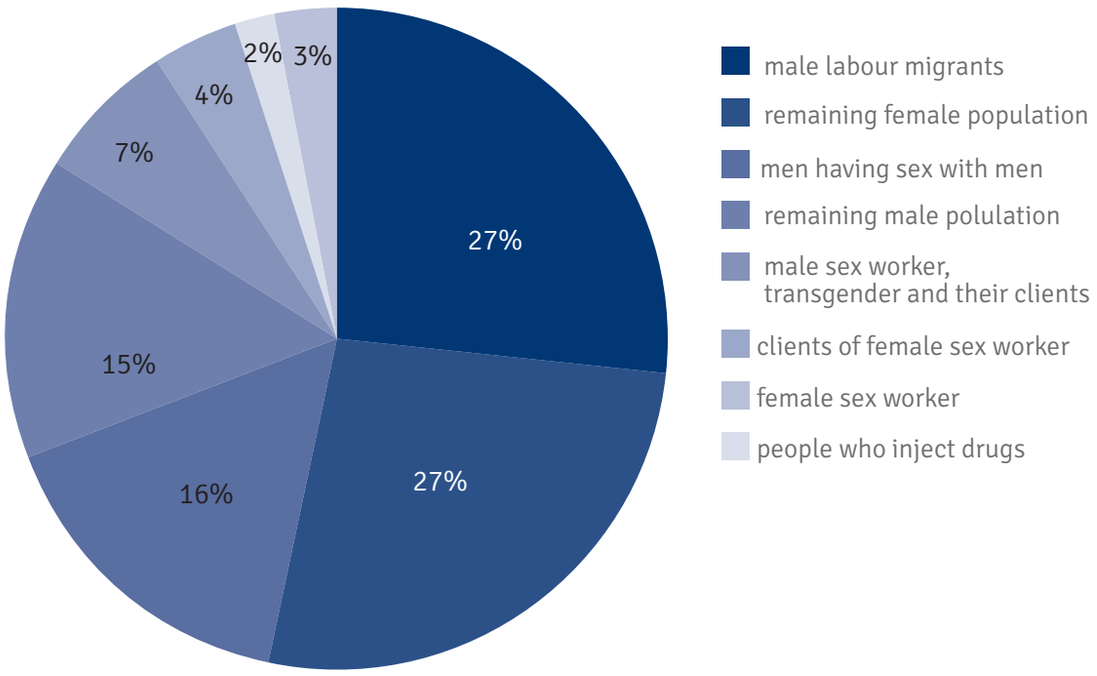
In this section, we will look at the following indicators relating to HIV and AIDS: a) prevalence and burden, b) availability for services and HIV and AIDS and c) availability of Sexual and Reproductive Health Services at different levels of care.

HIV Prevalence and Burden

As of 2011, there were approximately 50,200 adults and children living with HIV in Nepal with an estimated overall prevalence of 0.30 percent among the adult (15–49 years) population. The prevalence of HIV infection among adult (15–49 years) males (58%) and females belonging to the reproductive age group (28%) was the highest, whereas children aged under 15 years accounted for approximately 8 percent of the total infected population in 2011 (NCASC, 2012).

The prevalence of HIV among adults (age group of 15 to 49) decreased to 0.33 percent in 2010, from 0.39 in 2009, according to a forthcoming report of the National Centre for AIDS and STD Control (NCASC). The drop in the prevalence rate

Figure 15. Estimated HIV infections by risk groups, 2011



Source: DoHS, 2013

in Nepal also implies that the estimated number of HIV infections in the country has decreased significantly. In 2009, the NCASC had estimated that there were 63,528 HIV infected persons in Nepal. The number has gone down to 55,626 now but to meet MDG, Nepal has to bring down the prevalence rate to 0.30 by 2015 which is achievable through awareness, behavioral changes of people and specific attention to groups that are at most risk (Gautam, 2011).

Availability of Services for HIV and AIDS

According to National Centre for AIDS and STD Control (NCASC), 2013, there have been 44 Antiretroviral Therapy (ART) sites in 38 districts and 62 Prevention of Mother to Child Transmission (PMTCT) sites in response to HIV and AIDS for service delivery, which almost cover the targeted people within catchment area (NCASC, 2013).

HIV Counseling and Testing (HCT) offer an important entry point to prevention, care and support services. HCT service is the process of providing people with professional counseling before and after an HIV test. The last five years data from HIV tests and counseling services shows a trend of increased number of people getting tested and counseled. However, it is critical to have more HIV tests conducted among key populations at higher risks to HIV and effectively counseled (DoHS, 2013).

By 2012, total 7,142 patients with advanced HIV infection were on treatment in 39 ART centers across the country. Government of Nepal is providing free of cost ART service for all those in need under the National ART guideline (DoHS, 2013).
The existing socio-cultural frameworks of Nepal do not provide an environment of safe disclosure for

Table 2. Program coverage by service delivery points (service sites) in Nepal

Sites for Sexually Transmitted Infections	219+ sites in 75 districts
Antiretroviral Therapy sites	39 sites in 33 districts
Opportunistic Infection sites	50 sites
Community Care Centre sites	30 sites
Prevention of Mother to Child Transmission Sites	41 sites
District AIDS Coordination Committee (DACC)	50 districts

Source: DoHS, 2013

Table 3. Service Statistics on HIV Testing and Counseling in Nepal: 2008 - July 2012

Indicator	2008	2009	2010	2011	July 2012
Pretest Counseling	65,167	71,377	115,013	101,063	70,513
Tested for HIV	53,309	62,672	106,325	95,501	67,275
HIV Positive	2,387	2,110	2,015	2,060	1,465
Post test counseled	51,845	61,170	104,666	94,190	65,971

Source: NCASC HIV testing and counseling program monitoring report, 2012.

a people living with HIV. Thus, there is an urgent need to address those issues and challenges and strengthen the whole spectrums of health systems through collaborative approach to achieve the millennium development goals (Wasti, Simkhada, Randall, & Teijlingen, 2009).

Availability of Sexual and Reproductive Health Services at Different Levels of Care

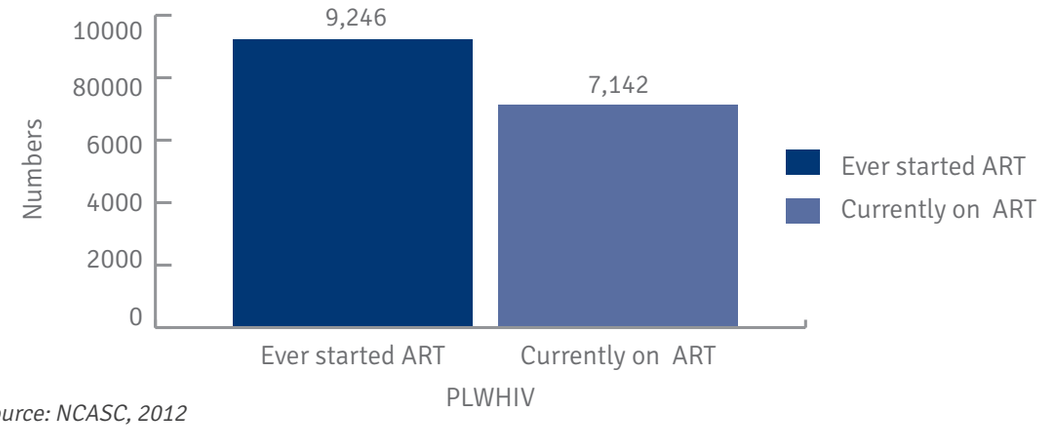
The Interim Constitution of Nepal 2006 has emphasized that every citizen shall have the rights to basic health services free of cost. Corollary to this constitutional spirit, GoN has decided to provide essential health care services (emergency and in-patient services) free of charge to poor, destitute, disabled, senior citizens and Female Community Health Volunteers (FCHVs) at up to 25 bedded district hospitals and Primary Health Care Centers (PHCCs) (December 15, 2006) and all citizens at Sub health post(SHP)/ Health post(HP) (8 October, 2007) (DoHS,2013).

Screening for cervical and breast cancer is available in few government hospitals like Bir Hospital and Tribhuvan university Teaching Hospitals in Kathmandu, Bhaktapur Cancer Hospital in Bhaktapur and B.P. Koirala Memorial Cancer Hospital in Bharatpur. Moreover, the free health camps provide screening services aimed to improve the accessibility of health services for women in Nepal. By providing free screening camps for the women, Nepal hopes to increase the number of women that are safe from these diseases by enhancing awareness in lowering the stigma associated with women's health issues, thus empowering the women to take charge of their own health as well as make time to prioritize preventative medicine (Shrestha, 2011).

Maternal health care is provided by the government through health posts, sub–health posts and primary health care centers. At the secondary level, there are district hospitals and zonal hospitals, regional and central hospitals and one specialized maternity hospital are at the tertiary level. The government currently deems that the numbers of facilities offering specialized maternal, newborn and child health care to be adequate. At the same time, it recognizes a need to strengthen capacity, especially in terms of quality of care and management of major obstetric complications.

FCHVs are the primary source of providing general information on family planning, maternal and child care as well as distributing pills and condoms at the community level. Pills and condoms are

Figure 16. Cumulative number of people with advanced HIV infection ever started and on ART, as of July 2012



Source: NCASC, 2012

available at all level of health care in Nepal whereas Norplant and Depo-Provera are provided at Health Post level. The entire methods of sterilization are available at Tertiary Hospitals (Tamang, Subedi, & Packer, 2010). There are numerous private and non-government organizations such as the FPAN, working on family planning services.

Safe abortion was legalized in 2002 subject to certain preconditions. Medical abortion is available at all levels of care except Sub- Health Post, whereas Surgical abortion is available in PHCC and Tertiary Hospitals. There are a number of private agencies and NGOs such as Marie Stopes, FPAN, etc. that have been providing safe abortion services.

Health Financing

Health financing is instrumental in ensuring that health services are provided to the entire nations. In this section, we consider key health financing indicators such as; a) Government spending on health as a proportion of Gross Domestic Product (GDP), b) Government spending on health in its annual budget and c) Out-of-pocket expenditure.

Government Spending on Health as a Proportion of Gross Domestic Product (GDP)

In comparison to its South-Asian neighbors, Nepal spends a higher share of its GDP on health expenditures. Pursuant to the UNDP Human Development Report, 2003, Nepal spent 5.6 percent of its GDP on health in 2000. In comparison, India, the next highest spender in the region, spent 5.1 percent of its GDP on health over the same period. Despite these expenses, Nepal ranks poorly in the region across key health indicators. One of the failures of health expenditures in Nepal has been the inability of health spending in reaching out to the poor and disadvantaged with affordable access to health services (MoH, 2004).

Government Spending on Health in its Annual Budget

A total of NRs. 27.27 billion was allocated to the health sector in 2011/12, out of which 91.4 percent (NRs 24.93 billion) was disbursed to the Ministry of Health and Population (MoHP). The budget allocated to Ministry of Finance (MoF), Nepal (NRs. 1.65 billion) is a reserve fund for employee and retirement benefits. The growth in budgets for the three major recipients, viz. Ministries of Health and Population, Home Affairs and Local Development (MoHP, MoHA and MoLD) has been far lesser from 2010/11 to 2011/12 (4.7%, 9.2% and 4.5%, respectively), compared to the growth in budget from 2009/10 to 2010/11 (33.7%, 28.8% and 16.4% respectively (Tiwari et al., 2012).

Out-of Pocket Expenditure

Out-of-pocket health expenditure (% of total expenditure on health) in Nepal was 54.7 as of 2011. Its highest value over the past 11 years was 75.1 in 2000, while its lowest value was 49 in the years 2010 and 2012 (WHO, 2014).

The 2011 Nepal Demographic and Health Survey (NDHS) also underscored the reliance of the poor on public health systems. Among women delivering children in health facilities, 84 percent of the poorest quintile used government services and 10 percent used the private sector. The out of pocket costs related to emergency obstetric care were the highest; 9 percent of the total health care expenditure went on the payments for obstetric care alone. Out of pocket expenditure on family planning and related care was modest accounting for about 7 percent of overall SRH spending. This is attributed to the supply of contraceptives and related services free of charge mainly from public facilities (Puri et al., 2008).

Table 4. Out- of pocket expenditure

Indicator	2000	2005	2010	2012
Total expenditure on health as percentage of Gross domestic product	5	5.7	5.9	5.5
General government expenditure on health as % of total expenditure	25	27.7	41.6	39.5
Private expenditure on health as % of total expenditure on health	75	72.3	58.4	60.5
Out of pocket expenditure as percentage of Total health expenditure	69	53	49	49

Source: National Health Accounts, Global Health Observatory database WHO

Recommendations

In the light of above analysis, we would make the following recommendations to be implemented by the Government of Nepal:

- Spread awareness about the contraceptive needs of sexually active individuals as well as undertake rapid study on the causes of stagnated CPR to take effective measures.
- Implement the policies framed, pertaining so as to address access to contraceptives, regardless of marital status.
- Address the unmet needs for contraception among women with highest unmet needs including women living in western region and with secondary level of education.
- Conduct research to discover the gaps in unmet needs for contraception, especially among less educated women.
- Train health workers on stigma and discrimination, as their negative attitudes contraception could discourage adoloscent as well as LGBTIs from seeking services of contraception.
- Raise awareness among both male and female population so as to alleviate low institutional deliveries, poor maternal education and gap in continuum of quality care of infants, as well as in highlighting the availability of current postnatal care of sufficient quality.
- Ensure MMR is lowered across all groups, irrespective of background characteristics of residence, ethnicity, religion, and residence in rural and urban areas.
- Address uterine prolapse problems by conducting free screening health camps from government and non-government bodies aiming the groups at risk.
- Increase awareness through the use of mass media on cash incentive for ANC visit and institutional deliveries.
- Develop a specific guideline to minimize low use of SBA by empowering women, supplying adequate medicine, encouraging staffs for support and ensuring prompt and systematic referral system.
- Adopt laws to abolish malpractices like *Chhaupadi* and *Deuki* and other social evils existing in a particular community.
- Train teachers to provide comprehensive sexuality education, both in and out of school settings, across Nepal.
- Establish ART sites in the entire 75 districts, through encompassing PLWHIV in hostile geographical regions.
- Ensure private rooms for counseling, waiting and receiving contraception, so as to make health facilities adolescent friendly.
- Improve the effective coverage of proven prevention interventions, especially among new entrants of HIV in high-risk behaviors; and to sustain these measures for achieving the national aim of halving new HIV infections by 2015.
- Ensure adolescents friendly sexual and reproductive health services by providing training to service providers, disseminating appropriate information as well as organizing youth centric training and health programs.
- Ensure adolescent friendly health services across the entire 75 districts of country.
- Encourage government health staffs to cooperate with the clients so as to minimize out-of-pocket expenditure on private setting as well as to endorse proper management of public health facilities.
- Improve status of SRHR through empowerment of women so that they may induce institutional health officials respond to their demands/needs.
- Develop health care services as enterprise for sustainability and quality of care (there are plenty of health cooperatives that have emerged in rural areas as part of people's initiative to improve health). Such endeavours at the community level should be supported for broadening their coverage and quality of care.
- Provide services ensuring context specific rights-based continuum of quality care (CQC) for Sexual and Reproductive Health of both women and men.

References

Amnesty International. (2014). *Unnecessary Burden: Gender discrimination and Uterine prolapse in Nepal*. United Kingdom: Amnesty International.

Baral, N. (2009). *Nepal receives MDG award for reducing maternal mortality rate*. Retrieved from http://www.demotix.com/news

Baral,Y.R., Lyons,K., Skinner, J., & Teijlingen E.R.V. (2010). Determinants of skilled birth attendants for delivery in Nepal. *Kathmandu University Medical Journal (KUMJ)*. 8(31).

Dahal.R.K.(2013). Utilization of Antenatal Care services in Rural Area of Nepal. *International Journal of Collaborative Research on Internal Medicine and Public Health*.5(2)

Dahal S., Pokharel, P.K., & Yadav. B. K. (2013). Sexual behaviour and perceived risk of HIV/AIDS among returnee labour migrants from overseas in Nepal. *Health Science Journal. 7*(2).

Department of Reproductive Health and Research (DRHR). (2014). *Trends in maternal mortality:1990 to 2013*. Retrived from http://apps.who.int/iris/bitstream

Department of Health Services (DOHS) (2013). *Department of Health Services: Annual report 2068/69*. Kathmandu: DOHS.

Devkota, B., & Teijlingen, E. V. (2010). Understanding effects of armed conflict on health outcomes: The case of Nepal. *Conflict and Health, 4*.

Dhakal, A. (2008). The end of history : Rise and fall of the Shah Dynasty.*The Kathmandu Post*. Retrieved from http://devkit.wordpress.com

Dhakal, S., Chapman, G.N., Simkhada, P.P., Teijlingen, E.R.V., Stephens, J., & Raja, A.E. (2007**).** Utilisation of postnatal care among rural women in Nepal. *BMC Pregnancy and Childbirth. 7*(19).

Gautam, M. (2011). HIV prevalence rate drops, says NCASC. *Kathmandu Post*. Retrieved from http://www.ekantipur.com/the-kathmandu-post/2011/11/28

Ministry of Health (MoH). (2004). *Nepal Health Sector Programm : Implementation plan (NHSP-IP*). Kathmandu: Author.

Ministry of Health and Population (MoHP), New ERA & Macro International Inc. (2007). *Nepal Demographic Health Survey 2006*. Kathmandu: Author.

Ministry of Health and Population(MoHP), New Era & ICF International. (2012). *Nepal Demographic and Health Survey 2011*. Kathmandu: Author.

Ministry of Health and Population (MoHP). (2011). *Budget Analysis 2010/11* . Kathamdndu: MOHP.

Ministry of Health and Population (MoHP). (2012). *Nepal Adolescents and Youth Survey 2010/11*. Kathmandu: MoHP.

MoHP / GIZ Health Sector Support Program (HSSP). (2011). *Strengthening the health sector response towards sexual and reproductive health and rights (SRHR) of young people in Nepal: A component of the MoHP/GIZ Health Sector Support Program*. Kathmandu: Author.

National Centre for AIDS and STD Control (NCASC). (2012). *Nepal Country Progress Report 2012: To contribute to Global AIDS Response Progress Report 2012*. Kathmandu: NCASC.

National Centre for AIDS and STD Control (NCASC). (2013*). PMTCT Service Sites, 2013 & ART Sites, 2013*. Kathmandu: Author. Retrieved from http://www.ncasc.gov.np//uploaded/SDP/PMTCT_Sites_2013.pdf and http://www.ncasc.gov.np/uploaded/SDP/ART_Sites_Nepal_2013_1.pdf

National Planning Commission Secretariat (NPCS), & Central Bureau of Statistics (CBS). (2011). *National population and housing census 2011: National report*. Kathmandu:CBS.

National Planning Commission (NPC) & United Nations Country Team of Nepal. (2013). *Nepal millennium development goals: Progress report 2013*. Kathmandu: NPC & United Nations Country Team of Nepal.

Nepal-Adolescent fertility rate. (2011). Retrieved from http://www.indexmundi.com/facts/nepal/adolescent-fertility-rate

Nepal Demographics Profile. (2014). Retrieved from http://www.indexmundi.com/nepal

Pokharel, S., Kulczycki, A., & Shakya, S. (2006). School-based sex education in western Nepal:Uncomfortable for both teachers and students. *Reproductive Health Matters, 14*(28), 156-61.

Pathak, R., Regmi, P.R., Pant, P.R., Simkhada, P., Douglas, F., & Stephens, J. (2010). Gender identity: challenges to accessing social and health care services for lesbians in Nepal. *Global Journal of Health Science, 2*(2).

Paudel, I.S. & Budhathoki, S. (2011). Unmet needs for family planning in Sunsari, Eastern Nepal. *Health Renaissance, 9*, 3.

Puri, M., Horstman, R., Matthews, Z., Falkingham, J., Padmadas,S. &Devkota, S.(2008). Examining Out-of-Pocket Expenditures on Reproductive and Sexual Health among the Urban Population of Nepal. *Population Review*. *47*(2).

Ravindran, T. S. (2013). *Asian-Pacific Resource & Research Centre for Women (ARROW): An Advocate's Guide: Strategic Indicators for Universal Access to Sexual and Reproductive Health and Rights*. Kuala Lumpur: ARROW.

Regmi, G. (2012). *Family Planning*. Retrieved from http://cbs.gov.np

Shrestha, D.R., Shrestha,A., Ghimire J.(2012). Emerging challenges in family planning Program in Nepal. *JNHRC, 10*(2), 21.

Shrestha, S. (2011). *Free cervical and breast cancer screening for 1000 women in Nepal*. Kathmandu: The Nepal Network for Cancer Treatment and Research/ The Nepal Australian Cervical Cancer Foundation.

Sustainable Development Initiative Network-Nepal (SDINN).(2008). *Nutrition Survey Report of Jajarkot District*. Kathamdndu: SDINN.

Tamang, A., Subedi, G., & Packer, C. (2010). *The Status of Family Planning and Reproductive Health in Nepal*. Kathmandu: CREHPA.

Tamrakar, A. (2012). Prevalance of Uterine Prolapse and its associated factors in Kaski District of Nepal. *JHAS, 2*(1), 38-41.

Teijlingen,E.V., Simkada,P., & Acharya,D.R. (2012). *Sexual and reproductive health status and health service utilisation of adolescents in four districts in Nepal*. Kathmandu: GIZ, HSSP,GON.

Tiwari,S., Lekhak,S.C., Chandra,S., Baral, P., Adhikari, R., Poudel,R., Thapa,L.R.M.B., Lievens, T. (2012). *Budget analysis 2011/2012: Strengthening health systems–Improving services*. Kathmandu: Ministry of Health and Population & Nepal Health Sector Support Program.

UNDP (2014). Sustaining Human Progress: Reducing Vulnerabilities and Building Resilience. *Human Development Report 2014*. Retrieved from http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/NPL.pdf

UNFPA (2007). *Gender equality and empowerment of women in Nepal*. Kathmandu: UNFPA.

Upreti, S., Baral, S., Tiwari, T., Elsey, H., Aryal, S. Tandan, M. & Shrestha, S. (2011). *Free cervical and breast cancer screening for 1000 women in Nepal*. Retrieved from http://www.changemakers.com

Wasti, S.P., Simkhada P., Randall J., & Teijlingen, E. (2009). Issues and challenges of HIV/AIDS prevention and treatment Program in Nepal. *Global Journal of Health Science*, *1*(2).

World Health Organization (WHO). (2011). *The Sexual and Reproductive Health of Younger Adolescents. Research Issues in Developing Countries*. Geneva: WHO.

World Heath Organization (WHO). (2012). *Statistics*. Retrieved from http://www.who.int/countries/npl/en/

World Health Organization (WHO). (2014). *World Health Statistics 2014*: Health expenditure. Retrieved from http://apps.who.int/iris/bitstream

World Youth Alliance. (2012). Reproductive Health: White Paper. Newyork: Author.

About BBC

Beyond Beijing Committee (BBC) is a feminist human rights National Network Organization dedicated for achieving women rights, gender equality and sustainable development. It has grown from small seeds planted during the preparation for Pre-Beijing conference in 1994 by the then women rights activists and professionals of Nepal. Currently, it has over 182 NGOs members working for human rights of women and children. It is one of the founding members of South Asia Women Watch (SAWW) and Asia Pacific Women Watch (APWW). It is also the convener of Nepal Women Watch (NWW) formed in November, 2014.

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About the Country Profile

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