RIGHT TO INFORMATION ON FAMILY PLANNING AMONG YOUNG GIRLS IN THE CONTEXT OF NEPAL: A POLICY ANALYSIS

DISSERTATION SUBMITTED TO THE CENTRAL DEPARTMENT OF POPULATION STUDIES, FACULTY OF HUMANITIES AND SOCIAL SCIENCES IN PARTIAL FULFILLMENT OF THE COURSES FOR THE DEGREE OF MASTER OF ARTS IN POPULATION STUDIES

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AUGUST, 2010

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Recommendation

This is to certify that the dissertation entitled **"Right to Information on Family Planning among Young Girls in the Context of Nepal: A Policy Analysis"** is prepared by **Mr. Punya Prasad Bhandari** - under my supervision. He has collected the primary data for this purpose in some locations of Kathmandu and utilized the secondary data from various websites and publications and completed successfully the requirements for dissertation in Master of Arts in Population Studies.

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Acknowledgements

I would like to express my sincere thanks to my father Mr. Rudra Bhandari and my mother Ms. Laxmi Bhandari who ever encouraged being a potential student in life. I would sincerely thank Ms. Kamala Devi Lamichhane—my thesis supervisor, without her support this document would not have come to this shape. I would express my heartfelt thanks to Prof. Dr. K. P. Bista, Campus Chief, CDPS, for his utmost guidance to make me eligible to accomplish the Master's Degree in Humanities in Social Sciences. I would also thank Mr. Minraj Adhikari, external supervisor for his valuable comments over the document during my viva in Central Department of Population Studies (CDPS).

I am too grateful to Prof. Dr. Bal Kumar K.C. for his ideal support for me during my college days by sharing his long experience that he has in the field of population and development.

This time I would like to take a moment to thank my respectable teachers from the university, Mr. Bidhan Acharya, Dr. Govinda Subedi, Prof. Dr. Pushpa Lal Joshi, Dhanendra Veer Shakya, Prof. Dr. Ram Sharan Pathak for their support during my college days. In addition to this, the research is prepared with the due support of the colleagues of my work place. It would be almost impossible to complete it with out the relevant documents those used under the analysis. My colleague, Mr. Shiv Mani Risal has done a great job to find these documents.

I would like to express my sincere thanks to Ms. Marije Nederveen, Ms. Jessie Hexpor and Ms. Saskia Baker of Aim for Human Rights, the Netherlands for making us this important tool familiar among the organizations and people working for the betterment of women health rights situation in Nepal. In addition to this, Aim for Human Rights has provided us the opportunity to interact with the international participants during the HeRWAI (TOT) held in Republic of South Africa which could hone the understanding of the tool and make a swift use of this tool. Ms. Muna K.C., the wife of the researcher has greatly played a supportive role to make this research a grand success.

The post conflict situation of Nepal is really challenging in order to overcome the barriers of Human Rights violations. However the National Health Information Education Communication Center has supported us to reach the findings. The respondents from Kathmandu are very thankful to me as they have provided me their personal stories during the FGDs those were taken for the purpose of the research. Finally, the researcher pays a sincere thanks to everyone who directly and indirectly supported to bring this analysis to the end.

Punya Prasad Bhandari
August 2010

Abstract

Dramatically the use of family planning services and the knowledge about various methods of contraception among young girls has increased in the recent past years. The abortion service utilizing is also in peak as the current data revels that every ten percent of the total pregnancies are aborted by the women/girls. Since the legalization of abortion and wide availability of family planning services has made the sexual world more secure to most of the population of Nepal. To add over the instances, after the democratic movement of Nepal in 1990, more than 220 International Non-governmental Organizations and more than 50,000 Non-governmental Organizations have been established in Nepal (SWC, 2009). Some being as large as Family Planning Association of Nepal (FPAN) and some other being the United Nations including Marie Stopes International have their wide outreach in matters relating to family planning counseling and service delivery. Due the prevailing circumstances of both civil society organizations and the government organizations, the health services are reaching to most of the population of Nepal. On the contrary, the rural population still strives for basic health services as due to topography and some often low priority of both civil society organization and government organizations. However, there still requires several approach to cover the national population as Nepal has to reach 67% of Contraceptive Prevalence Rate by 2015 (ICPD, 1994).

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List of abbreviations used in the dissertation

AIDS	:	Acquired Immune Deficiency Syndrome
CEDAW	:	Convention on Elimination of all forms of Discrimination Against Women
CPR	:	Contraception Prevalence Rate
CRC	:	Child Right Convention
DFID	:	British International Funding Agency
DG	:	Director General
EU	:	European Union
FHD	:	Family Health Division
FP	:	Family Planning
FPAN	:	Family Planning Association of Nepal
GTZ	:	German Development Cooperation
HA	:	Health Assistant
HIV	:	Human Immunodeficiency Virus
HeRWAI	:	Health Rights of Women Assessment Instrument
ICESCR	:	International Covenant on Economic, Social and Cultural Rights
ICPD	:	International Conference on Population and Development
ILO	:	International Labour Organization
IMF	:	International Monetary Fund
MCHW	:	Maternal and Child Health Workers
MMR	:	Maternal Mortality Rate
MoH	:	Ministry of Health
NDHS	:	National Demographic Health Survey
NPC	:	National Planning Commission
PoA	:	Programme of Action
PRB	:	Population Reference Bureau
RH	:	Reproductive Health
SMNF	:	Safe Motherhood Network Federation
SRHR	:	Sexual and Reproductive Health and Rights
TOT	:	Training of Trainers
UP	:	Uterine Prolapse

UN	:	United Nations
UNDP	:	United Nations Development Programme
UNFPA	:	United Nations Population Fund
UNICEF	:	United Nations Children Emergency Fund
VHW	:	Village Health Workers
WHO	:	World Health Organization
WTO	:	World Trade Organization
YFS	:	Youth Friendly Services
YOAC	:	Youth Action Nepal

Right to Information of Family Planning among Young Girls in the Context of Nepal: A Policy Analysis

Chapter 1

Introduction

1.1 General background and rationale of the research

The empowerment and autonomy of women and the improvement of their political, social, economic and health status is highly important in itself. In addition, it is essential for the achievement of sustainable development. The full participation and partnership of both women and men is required in productive and reproductive life, including shared responsibilities for the care and nurturing of children and maintenance of the household. (ICPD, PoA 1994).

The Health Rights of Women Assessment Instrument (HeRWAI) is a strategic tool to enhance lobbying activities for better implementation of women's health rights. A HeRWAI analysis links what actually happens with what should happen according to the human rights obligations of a country. It examines local, national and international influences. The HeRWAI consists of six steps, which analyze a policy that influences women's health rights. Each step consists of information and questions to guide the analysis. Explanations, examples and checklists facilitate the answering of the questions. The analysis produces a set of recommendations to improve the impact of the policy, as well as an action plan to lobby for adoption of the recommendations and to raise awareness about the findings of the analysis.

The HeRWAI basically follows the advocacy of right based approach especially focusing the rights of women. Following the basic principle of Convention on the Elimination of All forms of Discrimination against Women (CEDAW), International Covenant on Economic, Social and Cultural Rights (ICESCR) this text is prepared.

The basic principle that underlies this tool is answering several sub questions that follow a major question in well formatted six steps guideline and reach to conclusion. Therefore, anyone who seeks the use of this tool should first be clear on what is the problem or a policy under analysis. Than should make a vigorous workout over the relevant documents that are available which support the procedure for analysis.

This tool can be used by any organizations working for the promotion of women health rights especially. However, other interested organizations working for health rights promotion and human rights promotion can use this tool.

After reaching a conclusion at the end of this analysis, any organizations can hold their government or the stakeholders responsible to the obligations that they have made to improve the health situations of women. It also provides a strategy to lobby and perform the advocacy activities within their community/ies.

The Nepali version of this tool is available. One can easily use this tool if it is the interest of any individual or organizations or agencies who especially work for research on women rights.

1.2 Statement of the problem

Socio-economic and demographic contextual analysis

Women in modern world are regarded as the co-partner of development. They are considered as one of the major contributors of work force. This has brought the lessening of the disparity between males and females in terms of raising their voice. The developed world has already acknowledged the prominent role of women in social and community development. On the contrary the third world is yet providing regard to the women with the dignified life. However, many a women have already proved that women are successful and are able to carry out what man can do.

In Nepalese context, it is found that women are more vulnerable to different physical, mental and social hazards as due to poor socio-economic situation of women as well as the corresponding family resulting the sever situation of overall women of the nation.

Concerning the decision making ability in a family of a Nepalese women, it is found that the property ownership is below 7% (NDHS 2006) and the literacy is just above 50%. The Contraceptive Prevalence Rate (CPR) is 48% among married couples (NDHS 2006).

Therefore, it is inevitable to detect the real situation of women especially in relation to the Right to Information of family planning methods and devices among young unmarried girls of some of the locations of Nepal.

1.3 Objectives

- To find out the level of understanding on Right to Information of Family Planning among young girls of Nepal
- To analyze the right to information on family planning services through the set of questions already developed in the HeRWAI tool.
- To provide a constructive feedback to the policy makers on the implementation of Right to Information of family planning among young girls of Nepal.

1.4 Problems/difficulties faced

Analyzing the qualitative data obtained from the discussion is sometimes difficult job because it often requires the tabulation of similar and like-minded responses to one single column. During the discussion, the researcher has particularly faced some difficulty to open up the young girls who could feel congenial to answers each of the sensitive question especially in relation to family planning. However, use of some amicable relationship techniques the researcher finally could open them up. Besides this, finding the answers to each of the questions of every chapters of HeRWAI tool is a really a challenging job.

1.5 Lesson learnt

Use of unmarried young girls sometime may create difficulty in deriving the responses from them because the young girls normally feel shy and may not share some useful information when asked about family planning or other similar kind of issues required for the research. Using an already set of tool such as HeRWAI for the analysis of women health right helps reaching to proper conclusion in the end. In the absence enough budget and to carry out such a rigorous research some time may lead to financial constraints.

1.6 Significance of the study

The research targets to inculcate the ground based information from the targeted respondents viz. the young girls and the further part of the research uses the already set tool the HeRWAI so that it gives a sense of incorporating the questions asked in every chapters which has helped to reach the logical end coming up with proper conclusion at the end of every chapters. This has resulted in the significance of the study much more. In addition to this, the research also has helped to explore the perception of women and their level of understanding on family planning verses the existing government plans and policies which thereby contribute for the betterment of women health in the long run.

The research also contributes the International Conference on Population and Development (ICPD, 5-13 September 1994) and the Millennium Development Goals (MDG 5b: Improve Maternal Health) to greater extent.

1.7 Limitations

Since 50.1 % of the country's population is composed of females (CBS 2001) and slightly less than 50% is of males. Most of the contraceptives are designed for women, and male contraceptive usage is quiet low, the research may not be highly generalized in terms of sample used in the research as well as the facts and figures extracted from the websites and other resource materials.

The use of HeRWAI tool is limited to analyzing the health rights of women it may sometime be limited to too big generalization in terms of other analysis.

The sample for Focused Group Discussion is very small; hence generalizing the information to the national population sometime may not be suitable.

Chapter 2

Literature Review

2.1 Available literature

Family planning continues to be a priority highlighted in the Tenth Development Plan (2002-2007). The objectives of the National Family Planning Program include gradually reducing the population growth rate: promoting the concept of a small family norm to the population in general and the rural population more specifically; increasing the availability of and the demand for family planning services; providing high quality services; and reducing unmet need. The National Family Planning Program also aims to expand and sustain adequate family planning services at the community level utilizing all health facilities (Ministry of Health and Population, 2006). To achieve this, mobile family planning camps have been launched in the more remote districts to increase people's access to family planning services, and the private sector and NGOs have been encouraged to play a more effective role in the national family planning program (National Planning Commission, 2002).

This chapter appraises the knowledge of various contraceptive methods and discusses past and current prevalence. For users of periodic abstinence (rhythm method), knowledge of the ovulatory cycle is examined, and for those relying on sterilization, the timing of method of adoption is reviewed. Special attention is focused on the source of contraception, informed choice, nonuse and intention to use contraceptive methods in the future. The chapter also contains information on exposure to family planning messages through the media, contact with family planning providers and husband's knowledge of wife's use of contraception. These topics are of practical use to policy and program administrators in formulating effective family planning strategies. Although the main focus of this chapter is on women, results from the male survey are also presented because men play an important role in the realization of reproductive goals. Wherever possible, comparisons are made with findings from previous surveys in order to evaluate family planning in Nepal over time.

2.2 Knowledge of contraceptive methods

Knowledge of contraceptive methods is an important precursor to use. The ability to spontaneously name or recognize a family planning method when it is described is a simple test of a respondent's knowledge but not necessarily an indication of the extent of knowledge. Information on knowledge of contraception was collected by first asking a respondent to name ways or methods by which a couple could delay or avoid pregnancy. If the respondent failed to mention a particular method spontaneously, the interviewer described the method and asked whether the respondent recognized it. The survey collected information on eight modern family planning methods—female and male sterilization, the pill, the IUD, injectables, implants, male condoms and emergency contraception—and two traditional methods—rhythm method and withdrawal. Folk methods, such as plants and herbs, could be mentioned spontaneously by respondents.

The below table clearly speaks on the information about knowledge of contraceptive methods is presented for all women and men as well as for currently married and never-married women and men by specific methods. Findings from the 2006 NDHS show that knowledge of at least one modern method of family planning in Nepal is almost universal among both women and men. The most widely known modern contraceptive methods among currently married women are: injectables (99 percent); female sterilization (99 percent); condoms (97 percent); male sterilization (96 percent); and contraceptive pill (95 percent). Eighty-four percent of married women know of implants, about two in three women have heard of the IUD, and 7 percent of women have heard of emergency contraception. This pattern is similar for all, currently married, and never-married men except that men are more likely than women to have heard of condoms, male sterilization, emergency contraception, and the IUD, and less likely to have heard of injectables, implants, and pills. A greater proportion of women and men reported knowing a modern method than a traditional method. Knowledge of any traditional method among all three groups of women ranges between 38-52 percent. Reported knowledge of traditional methods is much higher among men (70-79 percent). One of the reasons for the lower reported knowledge of traditional methods may be that these methods are not included in the government family planning program, and women may be reluctant to mention them because they are not widely accepted. Among currently

married women, there has been an increase since 2001 in the percentage who have heard of all modern methods except female and male sterilization. There is almost no difference in the percentage of respondents who have heard of at least one method of contraception by background characteristics (data not shown). The high level of knowledge could be attributed to the successful dissemination of family planning messages through the mass media.

The below table taken from the NDHS report shows the following indication of knowledge of family planning methods among women of all age groups:

Knowledge of contraceptive methods

Percentage of all respondents, currently married and never married respondents age 15-49 who know any contraceptive method, by specific method, and man number of methods known, Nepal 2006

Method	Women			Men		
	All women	Currently married women	Never married women	All men	Currently married men	Never married men
Any method	**99.8**	**99.9**	**99.7**	**99.9**	**99.9**	**99.8**
Any modern method	**99.8**	**99.9**	**99.7**	**99.9**	**99.9**	**99.8**
Female sterilization	98.3	98.7	96.6	97.6	98.9	95.0
Male sterilization	95.2	96.3	90.9	97.9	99.0	95.8
Pill	94.5	95.4	91.1	91.6	93.2	88.5
IUD	66.4	67.2	65.7	68.2	68.8	67.6
Injectables	98.5	98.8	97.1	95.3	95.8	94.4
Implant	81.1	83.5	73.4	74.1	75.2	73.5
Condoms	96.3	96.8	94.7	99.7	99.8	99.4
Emergency contraception	7.4	6.5	11.3	16.8	15.1	20.5
Any traditional method	**48.4**	**51.6**	**38.3**	**75.8**	**7.52**	**69.8**
Rhythm method	33.8	34.5	32.4	63.7	68.1	55.7
Withdrawal	35.6	39.8	20.7	67.6	71.3	60.7
Folk method	1.6	1.5	2.0	3.7	3.1	5.1
Mean number of methods known by respondents 15-49	7.1	7.2	6.8	7.8	7.9	7.6
Number of respondents	10793	8257	2149	3854	2598	1207
Mean number of methods known by respondents 15-59	**Na**	**Na**	**Na**	**7.7**	**7.8**	**7.5**
Number of respondents	Na	Na	Na	4397	3102	1210

Na=Not applicable

(Source: NDHS 2006)

Nepal's population is characterized by a young age structure, largely because of past high fertility. According to the Population Census of 2001, adolescents and youth between 10 and 24 years of age constitute about 32.5% of the total estimated population. The young population will be the main source of population growth over the next 20-25 years before it may begin to decline. Nepal's young people are characterized by low school enrolment, early marriage and early childbearing. Twenty-one percent of adolescent girls aged 15-19 years old are mothers or pregnant with their first child (National Demographic & Health Survey (NDHS 2006). 86% of adolescent mothers deliver their babies at home.

Approximately 22% of married girls are unwillingly pregnant (RHIYA baseline 2004). Contraceptive use among adolescents is as low as 14% (NDHS 2006). The unmet need for FP is estimated at 25% for married girls. Maternal mortality is high in Nepal at 281 deaths per 100,000 live births of which one fifth accounts for adolescent girls (NDHS, 2006). About 50 % of the young people have had their first sexual experience by the age of 16 or below and only 15% of them used a condom the first time they had sex (Reproductive Health Initiative for Youth (RHIYA) Baseline 2004). A study among unmarried 12-18 year old adolescents revealed that 22% of the boys and 9% of the girls indicated they had had sex, and 52% boys and 32% girls indicated having had sex with more than one partner (UNICEF/UNAIDS 2001). 16% of young people have had sex with an unknown girl or a sex worker (RHIYA 2004). The study also revealed that 13% of sexually active boys and 13% of girls at one time contracted a sexually transmitted disease (STD). Every year around 12,000 Nepalese girls are trafficked to India of which most end up in brothels and engaged in commercial sex trade.

Besides these statistical facts, there are several other socio-economic instances which at a time support young people to have their protected SRHR situation and at other time they are largely brought under trouble. Several national and international agencies, different NGO(s) and INGO(s) and others have played vital roles regarding population and development. The have been working on several agendas and agreements to uplift the quality of life of the people and world wide control over its growth as well.

The second Asian conference which was held in Tokyo, Japan in November 1972 was the first conference which declared the links between population and development as each were the complimentary of each other. Likewise the Bucharest conference 1974, The Regional Post World Population Conference Consultation Bangkok 1975, The ESCAP Committee on Population in 1976, The Third Asian and Pacific Population Conference at Colombo 1982, Mexico Conference 1984 and Amsterdam Declaration 1989 had joint stress on populatio0n and its development.

"To concretize and make the works effective, a development strategy must reflect population concerns among its primary objectives. Similarly, a population strategy must also reflect population and development concerns. It must link population programs to the programs of health, education, housing, and employment among others. Indeed, it is only through such linkages that sustain and thus, the sustainable development can be achieved"(Source: The Amsterdam Declaration 1989).

The National Youth Policy under the chapter Health and Family Welfare in its chapters states the following status to be guaranteed by the government of Nepal with regard to health and HIV and AIDS:

2.3 Health and family welfare

2.3.1 Basic health service

- Guarantying basic health services for youth and maintaining access to health related information.
- Incorporating safe drinking water, healthy lifestyles, nutrition, health, environment, risk free activities in the primary level education and providing orientation.
- Imparting skill based education and health education to the youth unable to acquire formal education.
- Imparting sexual health and protection related education among youth and setting free against all kinds of sexual violence by encouraging safe sex behaviour and practice.

2.4 HIV and AIDS

- Protecting all the youth against all the risky behaviours of HIV through awareness programmes.
- Implementation of sex education for youth and establishment of health related counseling centers to free the youth from the risk of unsafe sex, sexually transmitted infections and other diseases.
- Establishment of Voluntary Counseling and Testing Centers for the HIV infected youth and distribution of anti-retroviral medicine making it regular, free and easily available.
- Creating favourable and respectable environment by providing skill based training to the HIV infected free of discrimination and violence for day-to-day livelihood.

(Source: National Youth Policy 2009)

2.5 The Millennium Development Goals (MDGs)

2.5.1 Goal 5: Improve Maternal Health

2.5.1.1 Target 6: Reduce by three quarters, between 1990 and 2015, the MMR

INDICATORS	**1990**	**1995**	**2000**	**2005**	**2015**	
					Target	Will development goal be reached?
Maternal Mortality Ratio (MMR)	850[a] or 515[b]	539[c]	415[d]	281 [j]	213 or 134[e]	Potentially
Percentage of deliveries attended by health care providers (doctors, nurses, and auxiliary nurse midwives)	7[b]	9[c]	11[f]	20[g4]	60[h]	
Contraceptive prevalence rate (percent)	24[b]	29[c]	39[i]	48 (2003-05)	67[i]	

(Source: a. UNDP Human Development Report 1992 (1988 data) b. NFFS 1991 c. NFHS 1996 d. NPC 2002 e. Heat Sector Strategy - An Agenda for Reform, MOH 2004 f. NDHS 2001 g. CBS 2004 h. MOH 2005 i. MOH 1993, Safe Motherhood Plan of Action (1994-1997) j. NDHS 2006.)

2.5.1.2 Status and trend

It should be highlighted at the outset that data on maternal mortality is highly problematic in Nepal, as measurement of the maternal mortality ratio (MMR) suffers gravely from under-reporting and misclassification, and even household surveys are subject to wide margins of uncertainty due to such issues as variability of the sample, the small number of events, and differences in methodology.

The baseline figure for the MMR itself is conflicting. While the survey-based MMR for 1991 for the period of 10-14 years before the survey was 515 deaths per 100,000 live births, another source indicated a figure as high as 850. The ratio for 1990 to 1996 was 539 deaths per 100,000 live births, for the period 0-6 years before the survey. Then the available figure is the National Planning Commission estimation of 415 in 2002. Now National Demographic Health Survey 2006 has estimated maternal mortality ratio of 281 per 100,000 live births. Therefore, it is difficult to draw any precise conclusions about the trend in maternal mortality in Nepal. Available data suggested that the target of reducing maternal mortality is achievable. However, such assessment suffers from serious data problems.

More recently, deliveries by skilled birth attendants (SBAs) have been proposed as a proxy indicator for the maternal mortality ratio. This indicator shows an increase from 7.4 percent deliveries (by skilled attendants and other health workers) to 19.8 percent in 2004. The rate of progress suggests that there is a significant challenge in meeting the target for this indicator by 2015.

In Nepal, over 80 percent of deliveries take place at home. Most of the births are assisted by family members and neighbours, with only one-fifth of deliveries attended by health workers (CBS 2004). Births attended by skilled birth attendants (doctors, nurses, and auxiliary nurse midwives) are as low as 11 percent (NDHS 2001). Another 10 percent of

births were attended by traditional birth attendants (TBAs), who may be trained or untrained; however they do not qualify as skilled birth attendants. There was a gradual increase in the number of deliveries conducted by trained TBAs from 2 percent in 1995 to more than 11 percent in 2003/04. It was found that some ethnic groups prefer TBAs for delivery. Home deliveries are usually opted for in anticipation of the care and support from family and community. Besides, pregnancy and childbirth are still perceived as natural phenomena, not requiring formal health services (UNICEF 1998).

The causes of maternal deaths are severe bleeding, sepsis, toxaemia, obstructed labour, and the consequences of abortion. Unsafe abortion and maternal death can be due to a lack of access to reproductive health care, including family planning. Most maternal deaths can be prevented if women have access to essential obstetric care services.

Antenatal attendance is low with only 14 of women attending the recommended four antenatal visits, and only about one seventh of adolescent mothers attending the antenatal clinic. Only 17 percent of women receive a postnatal check within 48 hours (NDHS 2001) which indicates an opportunity lost in monitoring the health of the mother and the newborn.

Family planning, a pillar of reproductive health, has affirmed its unequivocal contribution to mothers' health and the reduction of sickness and death. Although universal awareness was presumed, the NLSS 2004 reported that only 77 percent of married women between 15 and 49 years, had knowledge of any modern family planning method. There is higher awareness among the rich and educated urbanites. About 46 percent reported having used family planning methods, and 39 percent currently use some form of contraceptive. The most popular method is surgical contraception, followed by three-monthly injections of Depo Provera.

Although the total demand for contraception was 67 percent, only 39 percent of the demand could be met. The use in urban area is 1.7 times higher than in rural areas. Only 9 percent of adolescents between the ages of 15 and 19 are currently using modern methods, although 40 percent are already mothers. Thus, the need to address the issue of adolescent sexual and reproductive health is critical in bringing about behavioural

changes towards responsible parenthood. The present trend shows that the CPR has been increasing at a rather modest pace, with a high level of unmet demand, underlining the need for greater attention to access to achieve the target of 67 percent in 2017, as stated in the Safe Motherhood Plan of Action.

2.5.1.3 Supportive Environment

The Second Long Term Health Plan (1997-2017), the Health Sector Strategy 2002, and the Nepal Health Sector Strategy Implementation Plan all support the goal of, "Achieving the health sector MDGs with improved health outcomes for the poor and those living in remote areas and a consequent reduction in poverty." Safe motherhood and neonatal health are key elements of the essential health care package. In addition, the Vulnerable Community Development Plan (2004) addresses social exclusion issues in the health services and its effects and implications for vulnerable groups.

The National Reproductive Health Strategy was formulated and adopted in 1996 to strengthen and expand basic maternity care services, including family planning, improved access, coverage and quality of overall reproductive health programme, and the promotion of research and inter-sectoral collaboration and the upliftment of women's status. The National Adolescent Health and Development Strategy 2000 aims to improve the access and coverage of the overall programme with quality assurance for adolescents - who make up more than one-fifth of the population - covering information, education, and counseling on human sexuality towards developing responsible sexual behaviour and responsible parenthood.

The Safe Motherhood approach has been adopted for improving maternal health in a holistic way, and the National Maternity Care Guidelines were developed in 1996. Since then several policy documents guiding the implementation of the National Safe Motherhood Plan have been developed - the Safe Motherhood Policy, the Fifteen-year Safe Motherhood Programme Plan, the National Safe Motherhood Training and Information Education and Communication Strategy, and the National Neonatal Strategy, defining the basic care for women and newborns during pregnancy, delivery, and the post-natal period at all levels. The primary intervention for reducing maternal mortality is universal access to assistance at birth by a skilled birth attendant and provision of

Essential Obstetric Care (EOC) supported by access to family planning and management of unwanted pregnancies.

Some vital ongoing measures supported by the National Safe Motherhood Programme include measures to increase the availability of essential obstetric care (EOC) services through the establishment of pilot EOC facilities in 15 districts; and a gradual increase in the utilization of Comprehensive and Basic EOC, in particular among marginalized groups. The programme has also supported complementary community awareness-raising programmes consisting of birth preparedness activities to reduce the 'first two delays' to accessing EOC. Community EOC funds have been raised through community support and transport schemes developed. The National Safe Motherhood Programme focuses on neonatal service provision within the Safe Motherhood training package.

The Ministry of Health (MOH) has prioritized skilled birth attendance as the major strategy for reducing maternal deaths. While the national SBA policy was drafted only in July 2005, NG has provided cost-sharing incentives to promote SBAs with the provision of nationwide transport for delivery in health institutions, free delivery services in 25 of the poorest and most conflict-affected districts, and incentives to health workers providing delivery services in institutions and for home births. The abortion bill was passed in 2002 and the implementation of comprehensive abortion care services has been vigorous with services now available in 65 districts.

I/NGOs and the private sector, including social marketing organizations, have contributed significantly to family planning and maternal-child health programmes. The public-private partnership has increased access to reproductive health services, and more focus on rural areas is called for. Media coverage on the issues governing maternal mortality has also helped mobilize public opinion in support of gender equity to improve maternal health and reduce maternal mortality. At the community level, mothers' groups have been mobilized to set up emergency funds, particularly where female community health volunteers are active. In the Tharu community, the community leader (bhala-manas) has organized the bullock cart ambulance to ferry pregnant woman to the health facility. Support groups have been formed and some even organize adult literacy classes. There are possibilities for community empowerment and mobilization, where positive change will reduce maternal illnesses and death.

2.5.1.4 Challenges

The fact that more than 80 percent of deliveries take place at home is a serious obstacle to reducing maternal and neonatal mortality. Despite a network of health institutions available all over the country, many problems remain. These include poor quality of health infrastructure and services, in particular delivery by skilled attendants and EOC; unsatisfactory access to reproductive health information and services; low level of access to and quality of antenatal and postnatal care, and non-affordability of delivery in hospitals and primary institutions. All of these results in many women delivering with family members and some with no assistance whatsoever. The policy of promoting public-private partnerships has limited benefits due to concentration of private services in lucrative areas. Lack of stringent measures for quality control and pricing for life-saving interventions in response to complications pushes the poor to desperate financial decisions.

As the focus of the National Safe Motherhood Programme for many years has been on TBA training, the paradigm shift to skilled attendance and EOC is fairly recent. Many vital policy issues are only just being addressed, such as the skilled birth attendance policy. The proportion of SBA-attended births is an important indicator in assessing progress in improving maternal health. However, the definition and the core competencies of a skilled birth attendant have been the subject of much debate. The indictor that has been in use in the national Health Management Information System (HMIS) is, "Deliveries by a trained health worker," and includes skilled birth attendants (doctors, nurses, and auxiliary nurse midwives) and other health workers, who do not meet the criteria of 'skilled birth attendant'. Although the government has initiated new strategies to promote skilled birth attendance through providing free delivery services in 25 of the poorest districts, this remains a challenge in the remainder of the country. While human resource availability at health facilities is a problem, more serious is its unequal distribution, with most skilled attendants concentrated in Kathmandu and the other larger cities. In this regard, it is expected that a human resource development plan will be developed, but difficulties in its implementation are anticipated, especially in fulfilling vacant positions in the rural and remote areas. Given the slow acceptance of skilled birth

attendance as the primary intervention for reducing maternal deaths, no programme interventions in support of this strategy have been implemented. WHO has set the target of SBA attendance during delivery of 50 by 2010 and 60 percent by 2015 for countries with very high maternal mortality ratio. Even this appears ambitious in Nepal's case.

As discussed above, most maternal deaths are preventable with the provision of skilled attendance during delivery, a well-organized referral system to basic and/or comprehensive obstetric care, safe abortion, a sound efficient family planning programme, and a strong health system. In addition, efforts are required to make families aware of the importance of pregnancy and delivery-related services and to bring about behavioural changes. Implementing these interventions, however, implies that a significant amount of resources will need to be allocated. The projected cost estimate for maternal health intervention packages is Rs. 899.7 million (US$ 12.9 million) for 2005. This will double to Rs. 1,828.9 million (US$ 26.1 million) in 2010, and will more than triple in 2015 to Rs. 2,755.1 million (US$ 39.4 million).

Another challenge is to increase contraceptive use and to involve men in promoting and supporting the reproductive health decisions of their wives and children. This is not easy in a patriarchal social structure with persistent gender discrimination. It is also critical to provide adolescents with sexual and reproductive health knowledge and information to bring behavioural changes toward responsible parenthood.

In recent years, the conflict has impeded progress, leaving many health facilities vacant or unsupervised. There are reports of insurgents looting medicines from pharmacies or porters carrying supplies. Frequent strikes and roadblocks are reported to have resulted in the deaths of pregnant women who were delayed on their way to hospitals. According to a study (Thomas and Aitken 2004) on the impact of the conflict on safe motherhood, an additional 10 percent delay was added to the normal delay women experienced in seeking and receiving essential obstetric care (EOC).

2.5.2 Goal 6: Combat HIV, Malaria and other Diseases

2.5.2.1 Target 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS

INDICATORS	1990	1995	2000	2005	2015	
					Target	Will development goal be reached?
HIV prevalence among 15-49 years of age (percent) NA	NA	NA	0.29[a]	0.5[b]		Unlikely
Contraceptive prevalence rate including condom use (percent)	24[c]	29[c]	39[c]	NA		

(Source: a. National Centre for AIDS and STD Control (1999 data). b. UNAIDS, FHI/NCASC 2003. c. NDHS 2001.)

2.5.2.2 Status and trend

Although the estimated prevalence rate of HIV infection is 0.5 percent in the age group 15-49 (UNAIDS, FHI/NCASC 2003), with a male to female ratio of 3 to 1, epidemiological data suggests that Nepal has entered the stage of a concentrated epidemic. This means that the HIV/AIDS prevalence consistently exceeds 5 percent in some sub-populations such as female sex workers (FSW) and injecting drug users (IDU). Among high-risk groups, seasonal labour migrants make up 40 percent of the nation's HIV-infected population, followed by clients of sex workers (18 percent) (FHI/ NCASC 2003 estimate). The number of children orphaned by HIV/AIDS is estimated to be 13,000 (UNICEF 2002).

The dynamic of the epidemic follows a predictable course. A rapid increase occurs in the most vulnerable group, e.g. the FSWs and IDUs as the first step. It spreads via the 'bridge population' of the clients of female sex workers (such as truck drivers, labour migrants, the uniformed services, businessmen, students, and partners of injecting drug users). HIV /AIDS spreads from this bridge population to the general population including the wives and the partners of the clients. Men who have sex with men (MSM) are also considered a

high-risk group, as they may be married and by engaging in unprotected sex, may consequently infect their wives as well. Though small in number, blood or organ recipients also expose themselves to the risk of HIV infection.

The interaction of these high-risk groups with a much larger and low-risk general population through unprotected sex has the potential to cause an explosive epidemic that may, within a decade, affect the economically productivity in the age group 15-49. It has been estimated that by the end of the decade, 100,000-200,000 young adults will be infected by HIV, and 10,000-15,000 may die of AIDS, making it the leading cause of death among the 15-49 age group (Chin 2000). Children separated from families are also subject to sexual exploitation and exposure to HIV/AIDS (Cross and Osborne 2002). In Nepal, there are 80,000 migrant children in the cities (ILO 1995) engaging in work such as rag picking, stone quarry labour, and domestic labour (CWIN 2002). Key facts and figures regarding HIV /AIDS in these sub-populations are summarized below:

2.5.2.3 Female sex workers (FSWs)

HIV prevalence among FSWs: about 2 percent in the Kathmandu Valley (FHI 2004); and 3 in 16 Terai highway districts between Jhapa and Rupandehi (NCASC/FHI 2003). Consistent condom use among FSWs: about 56 percent with clients; less than 20 percent with husbands and boyfriends (FHI/CREHA 2004). An estimated 50 percent of Nepalese FSWs in Mumbai brothels are HIV positive (FHI 2004). The number of ex-FSWs returning with HIV infection: 5000-25,000 in the Kathmandu Valley (CREHPA/New ERA 2001, Seddon 1998); 300 in Pokhara; and 700-6900 near highways (CREHPA 2003, SC-US 2002, ADRA 2003). About 58 percent of street FSWs and 25 percent of brothel-based FSWs are illiterate (NCASC/FHI 2005), which limits their access to prevention information, **treatment, and care services.**

2.5.2.4 Injecting drug users (IDUs)

HIV prevalence among IDUs - 68 percent in Kathmandu; 22 percent in Pokhara; and 35 in Jhapa (FHI 2000, 2003, 2004) with nationwide prevalence of 35 percent (FHI/ NCASC 2003 estimate). IDUs make up 14 percent of Nepal's HIV cases (NCASC 2004), but some estimates suggest IDUs account for one-third of HIV infections in the country (FHI 2004).

2.5.2.5 Clients of female sex workers

An estimated 600,000 to 1.3 million Nepalese migrate to India for seasonal work (CBS 2001). As much as 10 percent of those men migrating to Mumbai have been found to be infected with HIV (Poudel et al 2003). HIV prevalence among migrant labourers returning from Mumbai is estimated at 7.7 percent (FHI 2002). An estimated 75 percent of all truckers and 51 percent of migrant workers reported having sex with FSWs, of which only 40 percent used condoms. HIV infection varied from 1.5 to 4 percent (FHI 1999).

2.5.2.6 Young people

15 percent of 14-year-olds and 50 percent of those aged 19 have had sexual encounters, according to a study of young factory workers (Puri 2002). Adolescents with risk-taking behaviour such as substance abuse, multiple partners, irregular condom use, unsafe abortions, and forced sex were found by the same study (Puri 2002). Vulnerability to HIV continues especially among mobile populations, such as seasonal labour migrants and their spouses, trafficked women and girls, and children outside the family system. Knowledge about HIV /AIDS is higher among the younger and more educated population. While the condoms are used for contraception by 2.9 percent of currently married women and 6 percent of currently married men, with 39 percent having used contraception at some time, inconsistent condom use is a serious problem. In terms of gender differences, men have more knowledge of HIV /AIDS (72 percent) than women (50 percent). However, the percentage of women who have heard of HIV/ AIDS nearly doubled from 27 percent in 1996 to 51 percent in 2001 (NDHS 2001).

Unfortunately, those infected with HIV are subject to stigmatization and exclusion. There is an acute lack of HIV /AIDS counseling, care, and support. Most of the 62,000 people living with HIV /AIDS are not aware that they are infected and may engage in unsafe sex. Possible stigmatization and exclusion prevent them from taking advantage of the voluntary counseling and testing (VCT) services provided in 23 sites (3 government, 20 NGO sites targeting the high risk groups) including Youth Friendly Services (YFS); and Sexual and Reproductive Health Services and Information, and seeking treatment if infected. Some NGOs also provide partial (non-comprehensive) VCT services. For the

Prevention of Mother to Child Transmission (PMTCT), a national programme was recently launched in three government hospital sites. In terms of antiretroviral therapy (ART) programme, about 100 people are receiving the therapy, which is available only in two hospitals. A target of 3000 patients provided with ART has been set under the Government National Operational Plan for 2005.

The trend shows that unless programmes are implemented on a war footing, a generalized epidemic with high mortality in the most economically productive group will begin and will start a vicious circle. The spread of HIV/ AIDS will increase poverty and vulnerability, which in turn causes more infection and has serious impacts on the country's socioeconomic condition. The achievement of the Goal on HIV /AIDS appears very remote.

2.5.2.7 Supportive environment

The Nepal Health Sector Strategy Implementation Plan (2004-2009) has set the goal of, "achieving the health sector MDGs in Nepal with improved health outcomes for the poor and those living in remote areas and a consequent reduction in poverty." It includes the Essential Health Care Package that promotes AIDS /STD (sexually transmitted diseases) control. In addition, the National Policy on AIDS and STD Control was adopted in 1995, with 12 key policy statements focusing mainly on multi-sectoral, preventive activities in partnership with NGOs in an integrated and decentralized manner. It underlined the promotion of safe sexual behaviour, counseling, confidentiality, and screening of blood for transfusion without any discrimination in terms of age, sex, and infection. The national strategy on HIV/ AIDS 2002-2006 has the overall objective of containing the HIV/AIDS epidemic among vulnerable groups, and focuses on young people, mobile populations, FSWs, MSMs, IDUs, and children. In the strategy, five priority areas are clearly identified: 1) prevention of STI/HIV infection among vulnerable groups; 2) prevention of new infection among young people; 3) ensuring treatment, care, and support services; 4) expansion of the monitoring and evaluation framework through evidence-based effective surveillance and research; and 5) the establishment of an effective and efficient management system for an expanded response.

Various efforts have been undertaken to establish an adequate institutional framework to address the threat of HIV/AIDS. Nepal has established a high-level National AIDS Council (NAC), to be chaired by the Prime Minister to generate a multi-sectoral response. Its National AIDS Coordination Committee (NACC) came under the Health Minister, who approved work plans and guided the implementation of the national strategy for 2002-2006. The steering committee, chaired by the Health Secretary, reviewed programme activities, while programme implementation was delegated to the National Centre for AIDS and STD Control (NCASC), supported by external development partners (EDP). There is continuing effort to maintain relationship and communications between the government, the NGO community, and the donor community as well as among NGOs to make progress for the development of new coordination and institutional capacity development mechanisms for a national response to the HIV epidemic.

The National Action Plan for 2005-2006 is expected to produce greater impact in terms of access to services and involvement of multiple partners, especially in affected communities. Approximately 65 percent of the resources needed for the Action Plan have already been pledged by external development partners, such as DFID, the Global Fund to fight AIDS, TB and Malaria, USAID, and the UN System. This support will make possible the scale-up of targeted prevention interventions, which will pursue a comprehensive package of services that include peer education, STI management, voluntary counseling and testing, condom distribution, and community sensitization, among the priority communities. In addition, increased resources for HIV treatment, care, and support will expand the numbers of people with HIV who need to receive antiretroviral treatment to 30 percent.

The Plan will also aim to strengthen government and non-government implementation capacities. Improved facilities and equipment and better trained staff in HIV and AIDS at the district level will be an important aspect in the implementation of the Plan, in order to ensure that communities receive quality health care. Civil society organizations are key stakeholders in the implementation. Institutional development activities that will build on their existing technical experience and will improve resource mobilization and management will be a major focus in the annual plan.

2.5.2.8 Challenges

The original HIV surveillance system was introduced in 1991 in 7 sites. It covered 5 population sub-groups (FSW, patients with sexually transmitted infections, IDU, antenatal care attendants, and tuberculosis patients) at six-monthly intervals. However, the sites, the interval between the rounds, and the subgroups targeted were changed after a few rounds. Since 1995 the surveillance has been limited to the patients with STI and no round has been conducted for the past two years (UNICEF 2005). However, the government adopted a second generation surveillance system that has monitored sub-groups (IDUs, FSWs, truckers, male clients of FSWs, MSM and migrants) in Nepal since 1998, and has also collected both behavioural and sero-prevalence (i.e., testing positive for HIV antibodies) data.

People living with HIV /AIDS (PLWHA) have limited access to care, support services, and treatment; and have less opportunities for creating sustainable livelihoods. A comprehensive care and support service package for PLWHA is missing. Few organizations provide community care and support. PLWHA that have some resources often run community care centers providing nutrition, referral, HIV testing, counseling, and psychological support for PLWHA and their families.

Lack of educational awareness among women has been posing a significant challenge for the prevention of HIV /AIDS infection among women. Many women do not have control over their bodies and thus are subject to pressure to engage in unprotected sex. Furthermore, as a result of the breakdown of family units and social networks caused by the conflict, it is anticipated that the pressure on women who are now heading households has intensified, which could put them at a higher risk of exposure to HIV/AIDS through unprotected sex in exchange for money. The ongoing large-scale movement of the population, especially male youths, adds further complications.

Despite policy commitment to multi-sectoral programmes and NCASC serving as the technical review authority which advises on policy and funding issues and acts as secretariat to the NACC, HIV /AIDS is still seen as a 'medical' issue, resulting in limited

involvement from other ministries. While the fund flow continues from foreign sources, the capacity for multi-sectoral involvement, especially among ministries, and the monitoring and evaluation system seem structurally inadequate. This is a critical gap given the multi-faceted problem of HIV /AIDS.

Improved coordination and the increased efficiency and effectiveness of various programmes are urgently called for, as the estimated resource requirement is very high. The figure derived by an exercise in 2002 on the resource requirement of the national HIV/AIDS strategy for the period 2003-2006 was US$ 51 million, depending how the strategy was operationalised (Country Report for Nepal Jan-Dec 2002 for UN General Assembly Special Sessions - mimeographed). For the period of 2005-2015, the total cost involved for HIV /AIDS interventions is estimated to be Rs. 4830 million (World Bank 2004). A positive development in this respect is that US$ 14.7 million has been pledged for the annual estimated budget of US$ 22 million, which leaves a gap of $7.4 million for the period between July 2005June 2006 (MoH 2005). In the absence of a national HIV /AIDS sub-account as part of overall National Health Accounts (NHA), monitoring the flow of resources is yet another challenging task.
(Source: http://www.searo.who.int/en/Section313/Section1523_10656.htm)

2.6 Basic health indicators including the U.N. Millennium Development Goals
Country reported data for basic health indicators including health related MDG indicators

Indicator	**Latest available data**	**Year**	**Source**	**Remarks**
POPULATION AND VITAL STATISTICS				
Total population (in millions)	25.8	2006	14	
Population density (persons per sq km)	175	2001	1	
Sex ratio (males per 100 females)	100	2001	1	
Population under 15 years (%)	39.3	2001	1	
Population 60 years and above (%)	6.5	2001	1	
Crude birth rate (per 1000 population)	28.4	2003-05	14	
Crude death rate (per 1000 population)	9.9	2003-05	6	

Natural (population) growth rate (%)	2.25	2001	13	
Total fertility rate	3.1	2003-05	14	
Urban population (%)	14.2	2001	2	
SOCIO-ECONOMIC SITUATION				
Gross national product per capita (US $)	300	2004/5	13	
Adult literacy rate (%) Total M F	 53.7 65.1 42.5	2001	5	
Prevalence of low birth weight (weight <2500 grams at birth) (%)	14.3	2006	14	
Prevalence of underweight (weight-for-age) in children <5 years of age (%)	38.6	2006	14	
HEALTH SYSTEM				
INPUTS				
Facilities				
Hospital beds per 10,000 population	4.26	2001/02	15	Computed
Number of PHCCs/Health centers	193	2001/02	10	
Human resources				
Physicians per 10,000 population	2	2004	15	
Nurses per 10,000 population: Professional nurses	2		15	
Budgetary resources				
Total Expenditure on Health (THE) as % of Gross Domestic Product (GDP)	5.3	2003	15	
Public Expenditure on Health (PHE) as % of Total Expenditure on Health (THE)	28	2003	15	
Private Expenditure on Health (PvtHE) as % of Total Expenditure on Health (THE)	72	2003	15	

FUNCTIONS

Pregnant women attended by trained personnel during pregnancy (%)	44	2003-04	15	
Deliveries attended by trained personnel (%)	20	2005	13	
Women of childbearing age using family planning (%)	48	2003-05	6	
Infants reaching their first birthday that have been fully immunized against poliomyelitis (%)	78	2005	16	
Infants reaching their first birthday that have been fully immunized against measles (%)	74	2005	16	
Infants reaching their first birthday that have been fully immunized against tuberculosis (%)	87	2005	16	
Women that have been immunized with tetanus toxoid (TT) during pregnancy (%)	30	2002/3	10	
Environment				
Population with safe drinking water available in the home or with reasonable access (%)	81	2005	13	
Population with adequate excreta (sanitary) disposal facilities available (%)	39	2005	13	
OUTCOMES				
Life expectancy at birth (years): Male Female Total	 60 61 61	2001	7	
Infant mortality rate (per 1000 live births)	48	2006	14	
Under-five mortality rate (per 1000 live births)	61	2006	14	
Maternal mortality ratio (per 100,000 live births)	281	2008	15	

Out-of-Pocket Spending on Health (OOPS) as % of Private Expenditure on Health (PvtHE)	92	2003	15	
GENDER EQUITY				
Life expectancy at birth ratio (females as a % of males)	100	2003	2	Computed value
Seats held in Parliament (% of women)	5.8	2000	13	
Female share in employment (non-agricultural sector) %	18	2000	13	
Ratio of earned income (females as a % of males)	0.50	1991-2001	3	
Adult literacy ratio (females as a % of males)	65.5	2001	5	Computed value
Primary school enrolment ratio (females as a % of males)	86	2004	13	
Secondary school enrolment ratio (females as a % of males)	78	2002/03	8	Computed value

(Source: http://www.searo.who.int/en/Section313/Section1523_6870.htm)

2.7 Overview of women's health in Nepal

Women in Nepal face discrimination and marginalization in the family, society, and state. As a result, in a country where the health system is already poor, the level of women's health and education is particularly low. To compound the problem, many districts of Nepal are remote, making access to health services and information very limited. In fact, only 15% of the Nepali population has access to health services.

Reproductive and maternal health is of particular concern among Nepali women. In rural Nepal, the key role of a woman is bearing children, particularly sons. Early and excessive childbearing weakens women, many of whom die or are chronically disabled from complications of pregnancy. It is not uncommon for Nepali women to experience a prolapsed uterus following birth. The prolapse is often due to recommencing, too soon, the expected workload, which is demanding and strenuous. Often, the prolapse remains untreated for an extended amount of time. Pregnancy is taken as a natural process and God's gift for which medical care is regarded as unnecessary. In fact, the Human

Development Report (1996) reported that only 6% of births are attended by trained personnel.

Undeniably, there are other women's health issues that need attention. There is a high incidence of HIV/AIDS in Nepal, and the discriminatory nature of the society greatly hinders a woman's ability to protect her form such diseases, even from her husband. The discrimination propagates low levels of self worth and body awareness. Nutrition, as well, needs attention as chronic malnutrition occurs in 63% of the population. In most of rural Nepal, people have very little knowledge about the causes and preventive measures of various health and nutritional problems and in the national health policy and programs, women's health issues remain inappropriately addressed. Therefore, it is imperative to provide primary health care facilities and to make communities aware of their basic rights to health. It is also of fundamental importance that the Nepali woman is well educated on health issues so that she may be empowered to take control over her body and so that her family may benefit and learn from her knowledge. Considering the conditions that Nepali women face, it is critical that women are educated about and have full access to appropriate knowledge and skills for self-help, such as information about locally available medicinal herbs and plants and the traditional techniques of their usage. It is also vital that women have access to and control over healthcare services from a women's rights perspective. (Source: http://www.worecnepal.org/programs/womens-health)

Between 1976 and 1991, awareness of at least one modern contraceptive method among currently married women of reproductive age in Nepal increased from 21% to 93%. The largest increase in awareness occurred for spacing methods (2.6-7.2%, vs. 2-2.2% for permanent methods). Knowledge remained highest among permanent methods, however (in 1991, 85-89% vs. 19-66%). Among women familiar with any modern method, 24.1% currently used a method in 1991. The current contraceptive prevalence rate was linked to a reduction of around 1.5 potential births. Permanent methods remained the most popular contraceptive method used among currently married women (in 1991, 7.5-12.1% vs. 0.2-7.5%). During 1981-1991, contraceptive use increased on average 1.6%/year. The percentage of women who knew where to obtain family planning methods increased more than two-fold (33-74%), likely reflecting a combination of new service outlets and increased knowledge about existing and new service outlets. In 1991, for 75% of currently married women, service outlets were still at least one hour from their homes.

Public health facilities, especially hospitals and health posts, were the main source of contraceptive methods (93%). In the private sector, pharmacies were the main source of oral contraceptives and condoms while hospitals were for other methods. In 1991, 86% of current users had never switched contraceptive methods. As each contraceptive method became available, a new pool of users emerged. Between 1976 and 1991, the desired family size fell by 0.8 children. These statistics suggest that Nepal has begun its fertility transition and an accelerated increase in contraceptive use. Nepal's family planning program is now challenged to expand and strengthen consistent quality services to meet the increased demand for contraceptives.
(Source: http://www.ncbi.nlm.nih.gov/pubmed/12154949)

2.8 Family planning in Nepal: a field example for urgency

The right or better the duty to measures of population control has to be encountered into the list of human rights. If you take the example of the small Himalayan country Nepal the annual population growth rate is still at 2.6%, one of the highest rates in Asia. Drastic steps towards a reduction of this rate were neither taken by the former Panchayat governments, that reigned Nepal for almost 30 years, nor by the party politicians of the interim government, which was in power from April 1990 to May 1991. Even the then new Nepali Congress government of Prime Minister Girija Prasad Koirala, that was brought to power by the first free and democratic parliamentary elections for 32 years, which were held on 12 May 1991, so far did not announce any corresponding measures, even though they should stand in the first line. The internationally recognized human right on food and labour as well as the right to live in an environment fit for human habitation cannot be realized in Nepal, if the population explosion is not stopped immediately and in a solid way.

Here the Nepalese state was challenged. A specific public relations work was needed on a national level. It was not enough to bring sketches on the radio or in newspapers. One must had to go to the people directly. And it was a prerogative, that the needed contraceptives are always available in sufficient amount. Compared to Europe they are rather cheap today, but for most Nepali they were still too expensive. It should be considered, if contraceptives can be given free of charge to people, who are willing to practice population control methods. If in the newest budget one can put 48.5 million Rs.

at the disposal of the royal family, of which after all 13.18% (c. 6.4 million Rs.) are taken from foreign aid (grants), then must there be also something left for family planning. But contraceptives free of charge should be made dependent from the engagement of the recipient. Proved family planning must be rewarded.

But also legal changes are necessary to reduce the population growth rate. The marriage of minors arranged by their parents is a common practice in Nepal. The earlier these children get children of their own the higher will be the number of children at the end of their child-bearing age. Here the Nepalese state has to intervene, if it wants to call herself a democratic state. This practice can no longer be treated as a trivial offence but must be made a punishable offence. Firstly should it not be allowed to marry children against their own will, since it is a fundamental right of every human being to decide upon this by her/him. Secondly must the marriageable age be raised; the marriage of persons below the age of 18 should only be allowed in exceptional cases. And the marrying age must be equal for boys and girls, since according to article 11 of the then constitution there shall be no legal differences on grounds of sex. For many ethnic groups of Nepal, especially for the Hindu castes, such regulations of course would mean an intervention into their traditional practices. But under the current population situation the Nepalese government cannot show consideration for it, if the fundamental right of all Nepalese people to live in an environment fit for human habitation shall be safeguarded in the long term. But also the donor countries should put pressure on the Nepalese government to make population control a priority part of all development projects.
(Source: http://www.nepalresearch.com/publications/family_planning.htm)

Chapter 3

Methodology

3. Methodology

This research aims at the used of primary and qualitative data and the secondary qualitative information available for its analysis. To make the research more authentic, two methodologies are adopted.

3.1 Focused Group Discussions (FGDs)

To make the research process enriched with adequate information and sufficient data, the researcher organized two FGDs in Kathmandu valley among young girls of age 15-24. To reach with expected result of the discussion the researcher designed two such discussions which brought the 10 young girls residing in Kathmandu in each discussion so that they could contribute with their ideas and understanding on Right to Information on Family Planning methods and devices.

3.2 Use of HeRWAI tool

HeRWAI tool is especially designed to reach a feasible conclusion and come up with appropriate recommendation to take immediate actions on the fulfilment of gaps identified. *Aim* has developed HeRWAI in cooperation with a number of organizations. The copy right for HeRWAI lies with *Aim*, but *Aim* encourages the use of HeRWAI by other organizations where ever it can. Therefore, *Aim* initiated the training of trainers to increase the use of HeRWAI in a more structured and sustainable way. Local and regional trainers on HeRWAI have knowledge of their political situation, access to networks on the local level, are familiar with the work of the local organizations and bring their own experience with HeRWAI to the table that will benefit the implementation of HeRWAI overall. Moreover, *Aim* encourages trainers to generate income for their organization by giving HeRWAI trainings and overall have them implemented in the most cost effective manner. HeRWAI was developed on the initiative

of *Aim for human rights* (under the former name of Humanistic Committee on Human Rights). Part of *Aim's* mission is to strengthen the capacity of other organizations/individual and researchers who are active on the issue of human rights impact assessment tailored to their specific needs.

3.3 Synchronizing and soothing the information

At the end of the analysis, the researcher has synchronized the available information and the analysis putting them under the similar page. Further, the researcher has drawn the conclusion on the basis of the derived conclusions of these tow techniques.

3.4 The research design

Defining each and each and every questions designed in the HeRWAI tool and reaching to a conclusion seems profoundly challenging. It is so because, deriving the appropriate answers to all the questions is itself a challenging job. Besides that linking the findings of the Focused Group Discussion (FGDs) and to the conclusion drawn form the HeRWAI analysis has made this research work more valid in terms of generalization. Based on the two research methodology viz. Focused Group Discussion (FGDs) and the HeRWAI analysis, the research has been designed.

3.5 Sampling

Simple random sampling is the technique used in this research. Through this technique, two Focused Group Discussions are carried out in Kathmandu among the young girls. In each of the discussion, there were ten young girls. These young girls are the students of some colleges around Kathmandu valley. Each of the discussions is carried up to one hour. Enough questions are asked to the discussion participants so that the researcher could derive the sufficient information required for the research.

3.6 Questionnaire preparation

The researcher has furnished the questionnaire for the Focused Group Discussion (FGD) in such a way that the respondents of the discussion have given plentiful information required for the analysis and merging them to a single recommendation. (See Annex 1)

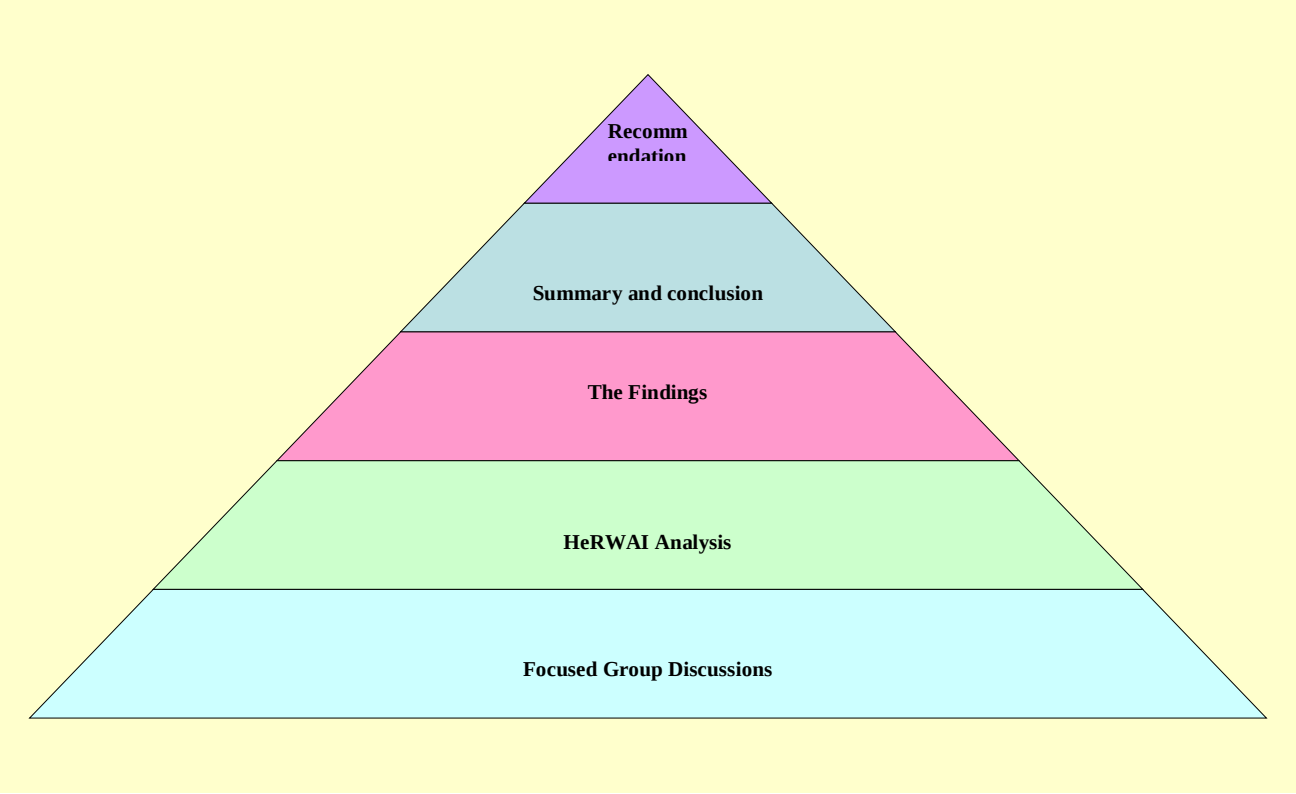
3.7 Data analysis technique

The secondary data available for the HeRWAI analysis have been analyzed on the basis of research question already set in the HeRWAI tool. Further, rest of the qualitative information is analyzed as per the requirement of the research such as the information derived from the Focused Group Discussions.

3.8 The research plan

This chapter basically demonstrates the flow chart of activities for the undertaken research. In the first phase, the researcher organized two focused group discussions using the formatted FGD questionnaire. On the basis of the questionnaire, the researcher acquired the qualitative information from young college going girls. In the second phase of the research, the HeRWAI tool is used to analyze the right to information on family planning among young girls residing around Kathmandu valley and studying in the colleges that are located here. A summary is drawn on the basis of these two methodologies and finally a conclusion is drawn on the bases of these two facts findings. The research pyramid shows the flow of activities and procedure under taken and consideration made in order to accomplish the research in the desired direction.

3.9 The research pyramid



Chapter 4

Analysis of the Policy

(In this chapter the researcher inculcates the summary of the Focused Group Discussions that was carried among the young girls residing currently in Kathmandu studying at various colleges of the valley.)

4.1 The FGDs

In order to carry out the FGDs, the researcher assembled the young girls who were studying at various colleges around the valley residing in Kathmandu around Anamnagar location on January 2010. He took two such FGDs among such heterogeneous group of girls who were form 19-25 age groups but studying at different colleges and different faculties.

4.1.1 The summary of FGD

Most of the young girls are familiar about the existing health care providing institutions around their localities but they had different opinion regarding the poorly educated young girls of Nepal. They said that the uneducated girls do not know about the health care providing institutions and the services available there. In case of use of family planning devices among young girls, they said that, most of the young girls do not know and have poor decision making power to choose and to convince their husband or co-partner for the use of it. They also said that they can not force their husband to use it because it seems for them that there is no trust in their relationship and there is probable chance of being betrayed. Further, they also said that they have herd about 'Right to Health' and 'Right to Information'. But most of the Nepalese women have poor control of their body and it is controlled by others. Many young girls before their marriage in the lack of family planning devices get pregnant unwanted and engage or are forcefully made to abort the unwanted pregnancy in an unsafe way.

Due to lack of money and inaccessible health care centers many young girls do not visit to health posts and some often if they are unmarried they rarely visit to health care

centers to acquire those services. Someone of the group said that they have used the family planning services when they needed but young unmarried girls have no such choices often because they are lured, forced or compelled to keep sexual relations with their partners without condoms or other family planning methods.

They also said that many services in the health care institutions are free such as condoms are freely available but the supply in the rural areas is very poor so that may have unsafe sexual relation with their copartners and come under the risk of STI, HIV and unwanted pregnancy.

To some extent, the Nepalese society is slowly and gradually accepting those facilities however they highly recommended the concerned authority to make the supply of family planning widely and also urged the public media homes for the promotion of those services so that all should play a crucial role to make the family planning services accessible, affordable and acceptable to all in order to reduce the risk of STI, HIV and unwanted pregnancy.

4.2 Use of HeRWAI tool for the policy analysis

4.2.1 Step1: Policy Identification

(In this section the researcher identifies the policy to be analyzed and answers each of the questions and comes to the logical end with a conclusion (see annex1). In this section there are varied steps which have question asked and explanation has been illustrated. For example: S1/Q2 refers to Step 1 and Question number 2)

4.2.2 Policy under analysis

The **'Family planning counseling information, education, communication and services (emphasizing the prevention of unwanted pregnancies) policy'** is selected as the basis of the research. In fact, the situation of young girls and women has yet to be improved because the TFR is 3.1 (NDHS 2006) which is still high vis-à-vis women's health in particular. This policy has been selected because the Contraceptive Prevalence Rate (CPR) is 37, unmet demand of contraception is 27% among the married couples, unsafe abortion is comparatively high because the recorded data is unavailable and Maternal Mortality is 281 (NDHS 2006).

There are several Non-governmental Organizations, International Non-Governmental Organization including bilateral and UN line agencies acting in the field of family planning promotion in Nepal. However, the health of the people should be ensured by the government of Nepal. Hence, the government of Nepal is highly responsible towards the implementation of this policy. Since the International Conference on Population and Development (ICPD, Cairo, 1994) and the situation of Millennium Development Goals (MDGs), the Government of Nepal has made several commitments to international platforms which basically support or ensure at the improvement of Sexual and Reproductive Health and Rights situation of the Nepalese people. Hence, the government of Nepal aims to improve the reproductive health conditions of mothers/women.

As per ICPD 1994, MDG and the Second Long-term Health Plan, the government of Nepal has committed to increase the Contraceptive Prevalence Rate to 67 % among married couples. During the decades of 90, it was around 27% (NPC, 2000). Currently it is 48% (NDHS, 2006). Hence, a simple conclusion can be drawn that the effect is significantly improving. However, it is not improved as desired. The health care delivery system of the government of Nepal is highly structured system responsible to ensure the family planning information and services among the people. Yes the government of Nepal has set up health care providing institutions with information centers in them to provide family planning counseling information, education, communication and communication departments. Ministry of Health, Department of Health Services and Family Health Division are responsible for these programmes at the central level and at the grassroots, District Hospitals, Health Centers, Health posts, Sub-health posts are responsible to execute family planning related programmes.

The National Reproductive Health Strategy, HIV and AIDS strategy, Second Long-term Health Plan, Adolescents Health Development Strategy, Safe Motherhood Policy are some of the documents those spell out the programme implementation. There are no such reservations included in those policy and strategies.

4.2.3 Groups affected by the policy

The government aims to reach the married women especially with this policy. However, the policy does not have a landmark or restrictions those prevent the unmarried girls of the usage of family planning. The policy positively affects women of reproductive age groups, but especially targets married women. In fact, there is no such positive and negative affecting indication over the policy. But in reality, many married and unmarried couples are in remote locations whose accessibility over the services is significantly poor or relatively unsatisfactory. It is also a matter of grave concern that women in remote areas are not allowed to go to the health centers due to family pressure and their husband or partners are unaware of their partners' health. Hence, women have no decision making power within their families, girls having coital partners and young girls engaged in sex trade are greatly affected due to the lack of information on these available services.

The affected groups basically do not even know the types of family planning methods, devices and services that are available. The underlying fact over it is that the women are denied their right to information on family planning. Hence they perform the unsafe sexual behaviour; in case of unwanted pregnancy they perform unsafe abortion practices etc. In many instances the women who are deprived of their rights even don't know about the denial of the rights. They remain silent as they have no choices regarding the family planning usage. Having control of their bodies by their husbands has greatly made them vulnerable to several health hazards. Concerning to this regard ‘Right to Health and Right to Information’ are badly affected among those young women who are compelled to conceive or engage in unsafe abortion practices.

4.2.4 Conclusions of the first step

It is right of every one to get the information on health and right to acquire the health services. The family planning services and the information regarding it is almost poor in rural areas of Nepal. Hence, the government seems to fail to achieve the commitment made during the International Conference on Population and Development (ICPD-1994) and Beijing Conference-1995. The ICPD Programme of Action (PoA) 1994 says 'Reproductive health is the state of physical, mental and social well-being and not merely the absence of disease and infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that the people are able to have a satisfying sex life and that they have capability to reproduce and the

freedom to decide if when and how often to do so. Implicit in this last condition are 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 for regulation of fertility which are not against the law and the right of access to appropriate health care services that will enable women to go safely through pregnancy and child birth and provide couples with the best chance of having healthy infant. (Source: ICPD, PoA, 1994)

Further it says that, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. (ICPD, PoA, 1994)

4.3 Step 2: Government commitments

(In this section, the researcher tries to explore the commitments made by the government are various international arenas such as ICPD, Beijing etc. and hence this section interrelates the commitments along with the selected policy of analysis)

4.3.1 Exploring the government's commitment

4.3.2 Relevant treaties and consensus documents

The government of Nepal has ratified Convention on Elimination of All forms of Discrimination Against Women (CEDAW), International Covenant on Economic, Social and Cultural Rights are ratified. Further some consensus documents on Sexual and Reproductive Health and Rights (SRHR) are signified by the government of Nepal such as ICPD (PoA), Beijing Declaration etc. In all of those documents the government of Nepal has made no limitations or reservations. The Programme of Action (PoA) of ICPD and Beijing Declaration are supported by the government of Nepal.

According to the legal provision of Nepal, the agreements made in several national and international treaties which get the legal status as other legal documents of Nepal. But if some of the articles mentioned in them describe negatively or miss-lead the meaning, or misinterpret the definition of the original law, the treaties remain neutral and non-effective. The government has signed and ratified several other agreements but they do not negatively influence the policy. The Child Right Conventions (CRC), Labour Conventions and Millennium Development Goals are some other agreements.

4.3.3 Saying of national legislation about women's right to health

The constitution of Nepal has put the right to health under 'Fundamental Rights' and the health legislation says that everyone has the right to enjoy the highest attainable to health. Hence, 'Right to Health' is fundamental right. The law exists which prohibits the discrimination of women. For example, the interim constitution of Nepal respects all citizen as equal citizens and no one is privileged, it is not allowed to discriminate any one on the basis of class, ethnicity, sex, occupation, creed, religious belief, place of birth or any of the cause. If discriminated with any of these, legally, it a punishable offence (The Civil Code of Nepal). However, 'Right to food, Right to education, Right to Information and Right to Communication' are some other laws which are relevant to the policy.

Before 2002 Nepal had a discriminatory law which prohibited women to seek the abortion services and was a punishable offence. Since, 2002, the abortion was also legalized under some certain conditions such as legal consent of the women who wish to abort her pregnancy. As explained earlier, Nepalese society is the heterogeneity of several caste, class, religion, geographical diversity and language speaking people. Most of the tribes and race of people living have discrimination against for the shake of social practices. To some extent, the social taboo exists in some communities who acquire family planning services. Further, a women during her menstruation is kept in 'Chhaupadi' in mid-west and far-west region of Nepal, women are denied to take to the hospital during delivery services as due to cultural taboo and make the women deliver her baby at home in the presence of unskilled persons of her family. Hence, the demographic indicator states that the Maternal Mortality Rate in Nepal is 281 (UNDP, 2009)

4.3.4 National health strategy and other relevant polices in Nepal

The government of Nepal has health strategy for example: Second Long-term Health Plan; Sexual and Reproductive Health Strategy; Adolescents Health Development Strategy; Safe Motherhood Policy; Abortion Policy etc. Further the government of Nepal has set some benchmarks of success. For example: reduction of Maternal Mortality Rate to 213 by 2015, Increase in Contraceptive Prevalence Rate to 67% among married couples by 2005, reduction of IMR and CMR to 25 and 35 by the same duration etc.

'Information, education and counseling, as appropriate on human sexuality, Reproductive Health (RH) and responsible parenthood for individuals, couples and adolescents' is another policy which is relevant to the policy under analysis. Further, some other policies such as Safe Motherhood Policy, HIV and AIDS strategy, Adolescent Health Development Strategy etc. might be some other policy documents those are quiet relevant to analyze along with this selected policy.

4.3.5 Organized participation of the civil society

The civil society organizations of Nepal have played a crucial role in policy advocacy such as Safe Motherhood Policy bill was submitted by couple of organizations. Similarly HIV and AIDS Strategy were promulgated through the direct support of civil society organizations. Further, civil society organizations can lobby with the government and the concerned society by submitting a petition, call for meeting, discussion programmes etc. to influence the policy making or in legislation.

In many cases, people whose rights are gravely violated, they go to the court and the police for verdict but in case of other mild violation of rights people of Nepal basically do not complain. Some often, a group of delegates go to Ministry of Health (MoH), Family Health Division (FHD) or National Planning Commission (NPC).

4.3.6 Conclusion of step 2

The government of Nepal seems to be highly dedicated to the supply and delivery of family planning services as per the commitment made during different bi, and multilateral agreements treaties and the consensus documents. The government of Nepal is also increasing its capacity of health care providing individuals to make the easy and quick delivery of services. It also has compelled the doctors to return back to their districts to serve in the government hospitals for at least two years. However, the implementation part seems very weak. Some often, the family planning methods and devices as well as some other medicines do not reach to the said locations. In many district hospitals and health care centers doctors and the health personal are unavailable and many people who seek remedy to their illness have to return back with out getting treatment.

4.4 Step 3: Capacity for Implementation

(In this section, the researcher explores the capacity of the government to the implementation of the policy. Therefore, this section basically tries to inculcate the three aspects of capacity viz., financial capacity, social capacity and political capacity.)

4.4.1 Describing the capacity for implementing the policy

4.4.2 Availability of financial resources for the implementation of the policy

Especially the government of Nepal is responsible to manage the health budget which is passed on annual budget of the Nation. However, there are several INGOs/NGOs/bilateral organizations to act over the matters relating to family planning services. Hence, the total health budget of Nepal is around 5 billion Nepalese Rupees which has managed all the health services in it including service of family planning. During the year 2052-2063 B.S., Nepal was engulfed in the civil war between the Maoist and the state which resulted the severe decrease in the financial regulation in the development sector. The budget then was highly invested in the security sector. Nonetheless, after the Comprehensive Peace Accord 2063, the budget in the health sector is widely increasing. For example, IPPF, DFID, GTZ, UN and other agencies have greatly supported the strengthening of health sector.

Investing over health is quiet challenging because the priorities in each geographical regions and development region varies as some regions have the problem of severe uterine prolapse where as other have inadequacy of family planning services while the other have the problem of HIV and AIDS. However we can realize that the government of Nepal has specification budget allocations. To count more, the budget allocation is made as per the primary, secondary and tertiary health care demand. Due to several emerging obstacles in health care delivery the goods, facilities and services are moderately functioning. Some time the lack of trained health personals are absent from the service area and some often the people in health need can not reach to hospitals due to lack of money or due to establishment of such institution in inaccessible locations. To conclude we can say that they are moderately functioning.

4.4.3 Available human resources for the implementation of the policy

In all the cases, Ministry of Health (MoH) is highly responsible to execute the efficient delivery of health services. To add more, the DG of Family Health Division (FHD) is responsible under which the medical counselor, Head of District Health Office (DPHO), Doctors, Nurses in the tertiary level are responsible and Health Assistant (HA), Village Health Worker (VHW), Maternal Child Health Volunteer (MCHW) are responsible to implement the policy and programmes at the primary level. In terms of existence the health care institutions following professionals are present in terms of location level and background:

Locations/Level and Background:

National Hospitals: Doctors with MD degree and Nurses with Intermediate/Bachelor in Nursing

Regional Hospitals: Doctors with MD degree and Nurses with Intermediate/Bachelor in Nursing

District Hospitals: Doctors MD/MBBS degree and Nurses with Intermediate/Bachelor in Nursing

Health Care Centers: Doctors with MBBS degree and Nurses with Intermediate in nursing

Health Post: Doctor with MBBS degree and ANM, HA with three years basic health training

Sub-health Post: HA, ANM, VHW, FCHV etc. with basic three years basic health care training

(Source: Ministry of Health)

The staffs are distributed as per the national health strategy paper. However, it can be realized that the presence of these staffs at all levels is negligible in remote hilly areas of Nepal. Regarding the issue related to distribution of family planning services, the district level government especially the DPHO, Health Care Centers, Health Posts and Sub-health Posts are directly responsible to regulate for the implementation of the policy.

4.4.4 Factors limiting or expanding the implementation capacity

To much extent, many people of Nepal are illiterate and even do not possess primary or basic level education. The Muslims due to their strict religious values do not use any methods of contraception. In other community some religious values prevent the people to use these preventive methods. Due to which many people do not use family planning devices. Topography and environment may limit the influence the implementation of the policy. Other factors are found to be quiet negligible. Nepalese government is in the state of progressive realization which implies in making the service delivery to most of its population by making free health services in the government health care providing institutions. For example: from 2008, the government of Nepal has made the basic health care free to its people. In Regional and National hospitals the government provides 44 different facilities and services for free and in district the number is 32 and in health post level, it is 24. Hence, one can conclude that to some extent it implies in Nepalese context because the state is in the process of reform after a long arm conflict between Maoists and the then government. The Ministry of Health lacks the adequate fund to have this programme run appropriately. However, it is trying to improve the situations. There are no conflicting interests involved. But the health priorities are set.

To a lager extent we can say that the government of Nepal has shown the political will to implement the policy as family planning services are free for example: condoms and other contraception are distributed for free. Currently the government of Nepal is in the phase of constitution preparation and has included health as the fundamental rights of its citizen. DFID, UN and line agencies, German Development Cooperation (GTZ), World Bank etc. are supporting the government to expand the capacity of implementation. These agencies have shown a greater interest to improve the health situation of Nepal. They have always supported to expand the health services in nooks and corners of Nepal. It is inevitable for the international institutions working in the areas of health to support the government because there has been a massive investment to upgrade the peoples' health especially by providing the family planning and reducing the Crude Birth Rate (CBR), Total Fertility Rate (TFR).

Many bi-lateral and multilateral agencies also particularly influence the government. For example DFID supports in some prioritized areas such as maternal health, UN for AIDS and other basic health care, GTZ for health sector support etc. Many of these institutions work for the betterment of health facilities and services of Nepal. However, International Planned Parenthood Federation (IPPF) has great investment in family planning and is continuously supporting several agencies of Nepal.

4.4.5 Conclusion of step 3

The government of Nepal has its yearly health budget and there are several other national and international agencies which influence the government to promote and prioritize the health needs of the people. The government programmes have wide and national coverage. In fact, the quality of the services needs to be improved. Transparency and accountability is necessary in the government share. The state of progressive realization can be experienced in the core interest of the government.

4.5 Step 4: The impact of the policy

(This section is basically focused to measure and detect the human rights impact of the policy. In this case, violence against women, time and other socio-economic variables involved are minutely discovered regarding the policy implementation.)

4.5.1 The impact on human rights

4.5.2 Relevancy of timely and appropriate health care

In fact it is a relevant issue. For instance, one out of every three pregnancy of Nepal is unwanted. This is so because many of the women give birth simply in the absence of the family planning resulting the coital into pregnancy. Many women in the rural hills of Nepal do not visit the health care providing institutions. If women are provided with family planning methods and devices, the CBR, TFR as well as early pregnancy can be prevented. In addition to this, the highest maternal mortality is comparatively higher in Nepal than other developing countries which can be reduced. Some significant indicator is already seen in this field such as Contraceptive Prevalence has reached to 48 % among married couples and Maternal Mortality has reached to 281 among 100,000 live births (UNDP, 2009).

4.5.3 Relevancy of underlying determinants of health

In fact, it is relevant. The socio-cultural factors some often limit the access, and use of the contraception or acquire the safe abortion facilities. It is noticed that the medical personal are some time absent in their work places. There is coercion and sexual violence in families. Therefore, the policy under analysis has a greater influence by the underlying determinants for the prevention to reach the desired outcome. The limiting factors are always there to intervening the programmes; however strong follow-up action is required.

4.5.4 Relevancy of participation

Yes it is. The concerned stakeholders along with the civil society organizations should have their acute participation because the government alone may fail to reach the expected outcome. Further, if they do not participate in the policy implementation process, than there may be only the partial fulfillment of desired objective. Further, making all accountable is also necessary for the family planning services delivery else the government may seem poorly accountable towards people. The people including the civil society organizations can positively pressurize the government to implement it and also come under support themselves for the effective implementation of it. The government representatives especially of Ministry of Health (MoH), Department of Health Services, Family Health Division, and the representatives from the National Planning Commission (NPC), including several other civil society organizations have participated in the development of the policy. Further, all the civil society organizations including the government organization are highly responsible for the implementation the policy.

4.5.5 Relevancy of the issue of violence against women

It is very difficult to answer this part as there are several socio-economic ill-practices those have made women forced and limited them with their rights. For example: accusation as witch, accusation of being killer of husband if she is widow, limited within homes and stopping to acquire education. Truly speaking, the policy is not the factor of violence against women. However, many women do not have control over their body and is decided by the male members and other members of the family. Women are forced to

conceive and forced with several dos and dons limiting with their rights. Therefore, this policy somewhere addresses violence against women.

4.5.6 Impact of the policy on the availability of services, goods and facilities

The government of Nepal has legalized the abortion under some critical terms and conditions. It also has improved the family planning services delivery system. Short term family planning camps are also run under government programmes. The women are also provided with the Uterine Prolapse (UP) surgical removal facilities. The health workers distribute the condoms to the rural women. However it seems inadequate in terms of health promotion of the people. Collectively, the policy promotes the availability of family planning goods and services.

4.5.7 The impact on the accessibility of services, goods and facilities

The Muslim women do not use contraceptives. The topography of the Nepal also limits women to access the family planning goods and services. Family structure, in many instances, also forbids women to acquire these services and goods. But the policy alone tries to promote the supply of family planning goods and services and ensure the right to health to women.

4.5.8 The impact on the acceptability of services, goods and facilities

Many health care providing institutions are not providing the constellation of methods and services to choose the goods, services and facilities regarding the family planning, abortion facilities. Many young women and elderly women are at the risk of life due to unwanted pregnancies and bad practice of abortion. But the policy itself does not limit the acceptability of these goods, services and facilities. The only budget constraints and insufficient services provided by the civil society organizations have brought women under trouble.

4.5.9 The impact on the quality of services, goods, and facilities

The quality of available services, goods and facilities is however satisfactory. Hence the policy positively affects the quality of services, goods and facilities.

4.5.10 Discriminatory effects of the policy

The rural women feel more vulnerable themselves than the urban women as because the goods, services and facilities in urban settings are better than the rural areas. If the rural women are provided with some family planning methods, than the unwanted pregnancy, HIV, STI can be ensured. Therefore, women in the rural areas are severely affected than the urban women.

Men compel women for the use of permanent and temporary family planning; a woman is seen negatively if she purchases condoms. All the household chores are maintained by the women. A woman is not allowed to speak about the family planning freely with their husbands. Hence, the policy has some difficulties in implementation. Yes, to some extent it has some discriminatory effects such as right to information of family planning among rural and urban women.

4.5.11 Conclusion of step 4

It is essential to have some kind of review over the policy because the implementation part of this requires strong programmes which really influence both male and female or rural and urban areas. The other part is that the rural setting of Nepal should be viewed as the challenging part of programme implementation. Further, the role of the International Non-governmental Organizations and civil society organizations also should be made more accountable towards peoples' right to information on family planning.

4.6 Step 5: State obligation for the implementation of the policy

(This section gives an overview of the state's obligation for the implementation of the policy as the government of Nepal has made several commitments in different forums and this tries to find out the reality behind the state's obligation to implement the policy.)

4.6.1 State obligations

4.6.2 Who is responsible?

Family is the primary segment which violates the women's rights then the next come the government which has still not sent its health workers in these areas. If sent, the duty by these people is not appropriately fulfilled. Hence, the community, society, local government, including the district, regional, and central government are equally responsible factors those are involved in the violation of rights of women. The women are denied with their rights primarily by the family members. Than it is the society that

discards the women and the third is the government who has noting to say about the human rights violation of women. Hence, social norms, family norms are the basic ones. Under these, the family members are the violators. Then the next is the government. The government has committed to penalize the violators but the measures seem to be inadequate. Some actions are sometime taken against the violators however it is not taken much seriously as other crimes.

The international actors have only programme limited to some certain sectors. They only recommend the government about the issues at the grassroots. The government commits to reduce the violation but the implementation is really a big problem. Especially the violators are left behind with small punishment. But the international actors some often publish the press releases and condemn the incidents and bring it to the national as well as international concern through the media. Simply to understand the violators are not that big penalized vis-à-vis the right violation.

4.6.3 Holding governments accountable for the effects

Complete supply of family planning goods as the unmet demand is around 28% among married couples. Here, a consideration should be made because there are many unmarried couples who wish to use the family planning services. Further to add more, the services and facilities on safe abortion; information, education and communication on family planning have to be made vigorous with the general people's accessibility probably through the local media and national media. Hence, these are some of the core obligation of the government which is yet to be achieved.

After the historic Constituent Election (CA), the government of Nepal is quiet serious about the health of general people. Some of the progressive realization measures adopted by the government of the Nepal are increasing the subsidy in health centers, hospitals and other bodies those supply health services to the people. Some other steps taken by the government are: providing NRs. 500, 1000 and 1500 respectively to women of Terai, Hill, and Mountain; if they deliver their babies in the government hospitals. Legalizing abortion, free health services in the health care centers, coverage of immunization programme etc. are some beautiful steps taken by the government in the recent years to ensure right to health as fundamental rights. To conclude, it seems that the government is

under progressive realization. In the case of Nepal it does not seem the government is in the stage of non-retrogression especially with the concern of health services.

The commitment to core obligations of respect, protect and fulfill of the family planning goods, services and facilities are not genuinely fulfilled. The impact is unwanted pregnancies, unsafe abortion and unsafe sexual behaviour among young people. This has caused unexpected population growth as the Total Fertility Rate (TFR) 3.6 (NDHS-206). The government has done enough in the urban areas but still needs vigorous approach in the rural areas. Therefore, it seems that it is a natural discrimination. The policy itself has a positive impact over the health and well-being of general people.

Partially the women are involved in this process. On the contrary the national decision making body the National Planning Commission does not have any women members for making the policy. But, the some women from civil society organizations have an acute role to suggest the government and monitor evaluate supervise the programme level intervention. CEDAW article 12 sub article numbers 1 and 2 are linked to the effects of the policy.

4.6.4 Government obstacles meeting its obligations

The cause of the weakness is basically due to the lack financial commitments by the government. But mildly political will also sometime plays a crucial role in the government weakness. Further, mild legal mechanism sometimes plays a vital role to implement and the poor penalizing procedure while failing to provide appropriate health care services by the health workers. Yes the government of the Nepal has genuinely tried to attempt to obtain technical and financial assistance. For example, DFID, GTZ, UNFPA, UNICEF, JICA, IPPF, World Bank, Asian Development Bank, International Monitory Fund, embassy of different countries etc have extended their supportive hand to Nepalese government to ensure health of people.

The international donor communities including the External Development Partners (EDPs) have extended the necessary support for example DFID. Especially in relation to this segment, the government of Nepal and the concerned ministries are always in the financial deficit. While speaking about the Ministry of Health (MoH) needs to have

around 8% percent of the total national budget in order to ensure the health of the people. Hence, the government claims that financial constraints for the effective execution of health services to its people.

4.6.5 Conclusion of step 5

Despite the commitments made by the government and the core obligation of respect, protect and fulfill, the other big challenges such as financial deficit, political instability, and the conflict resulted the poor implementation of the policy in the past. However, the government priorities for health care of women at present are largely supported by the international agencies. In the nearest future, the policy is expected to be implemented appropriately because the government of Nepal is going under federal structure through new constitution of Nepal.

Chapter 5

The Summary, Conclusion, Recommendation and Action Plan

(Inculcating the research findings from each of the chapters above, the researcher has tried to summarize and develop some critical areas of intervention through the recommendations and the researcher himself has developed a short-term action plan to start with the right to information on family planning among young girls of Nepal.)

5.1 The summary and conclusion of the research

Following summary can be drawn for the study:

Increase the budget for the improvement of family planning goods, services, and facilities: As per the conclusion drawn during the analysis it is found that the government has increased budget in other development sectors and the budget is declining in health sector hence the government needs to increase the budget for the improvement of family planning goods, services, and facilities.

Develop a mechanism which can regulate the health programmes with appropriate quality: On the other instance, it is also discovered that several health care providing institutions govern by the government have lack of tools, lack of available human resource, as well as proper maintenance of the available tools used for health care delivery hence it is inevitable to develop a mechanism which can regulate the health programmes with appropriate quality.

Provide the safe abortion facilities to the rural women: The research work is also able to find out that the health care providing institutions such as family planning health camps, health posts, hospitals as well as private medical services are highly centralized to urban areas. On the contrary, more than 80 percent of national population resides in rural

areas and the bulk of people are facing several health related hazards. Therefore, it can be concluded that the government should provide the safe abortion facilities to the rural women.

Centralize the programmes to the rural settings as well: As a general trend of investing large part of the budget in urban infrastructure and development, it should be noted that the government should centralize the programmes to the rural settings as well.

Monitor the funds used by other non-governmental organizations whether is used at the appropriate place or not: There are more than 220 International Non-governmental Organizations (INGOs) and more than 26000 Non-governmental Organizations (NGOs) currently active in Nepal. Hence, the government has to monitor the funds used by other non-governmental organizations whether is used at the appropriate place or not.

After all do not forget the commitments and the obligations that were made on behalf of treaties, consensus documents and the declarations: Nepal rely its most of its budget on the foreign aid. Further, the government also makes commitments in various national, regional and international forums, conventions, conferences and United Nations (UN) declarations there the government of Nepal has to remember that after all do not forget the commitments and the obligations that were made on behalf of treaties, consensus documents and the declarations.

It is inevitable to have the effective SRHR programmes in the rural areas as compared to urban areas. The financial expense that takes place on the share of the government is still inadequate. In addition to this the commitments made are crucial to safeguard peoples' right to health. Finally, the researcher is also very keen at the implementation of the designed action plan so the right to information is ensured among young girls.

5.2 Recommendations to the government

Following recommendations can be made for the effective execution of the existing policy on right to information on family planning services:

Design youth friendly Sexual and Reproductive Health Services: Youth of Nepal have poor access to youth friendly services as well as appropriate information on changes during adolescents and other aspects related to youth and development. Further, the women even have worse situations compared to male as they are the victim of unsafe sex and unsafe abortion services and other several socio-economic evils. Therefore, the government of Nepal is recommended to design youth friendly Sexual and Reproductive Health Services as soon as possible.

Penalize the violators of health rights seriously rather leaving them without any punishment: The state of impunity is severely experienced during the transitional phase of the political shift. In the duration, it is felt that the rules and rights violators are given political reservations and protection. This has resulted in the massive violation of human rights. In order to maintain the rule of law the government is recommended to penalize the violators of health rights seriously rather leaving them without any punishment.

Develop the health clinics with safe abortion facilities in the rural areas: It is yet said that the Maternal Mortality Rate (MMR) of Nepal is 281 per 100000 live births therefore it is to be noted that the government should immediately think to develop the health clinics with safe abortion facilities in the rural areas.

Make the availability of family planning services, goods and facilities wide: As a subsidy if the family planning services are provided to the newly married couples, than the health of the young mothers can be protected. They can be protected from STI, HIV, unwanted pregnancy resulting to unsafe abortion and other health hazards. Hence, the government of Nepal including the national and international funding agencies as well as the private sectors should make the availability of family planning services, goods and facilities wide.

Assign health professionals for appropriate counseling on reproductive health: If women are protected than the family can be protected. Making this as the main slogan of health care delivery care system, the health providing personals should be motivated for their services in their respective regions. Therefore, the government of Nepal should

immediately assign health professionals for appropriate counseling on reproductive health.

Effective family programme implementation along with the women empowerment classes, adult education programme, wider publicity and availability of family planning services along with preparation and supply of technical human resources at the remote locations, establishment of infrastructure with adequate equipment in the hospitals, ensuring girl education, nation wide scholarships to girl students, increment of women health workers and practitioners, penalizing the rights violators, strong supervision, monitoring and evaluation of the executed programmes, establishment of strong data base system, commencement of intensive national research on family planning, establishment of Youth Friendly Services (YFS) are the crucial fact for intervention for the betterment of health situation of women. The health sectors function but the staffs need good training, enough equipment and adequate supply family planning materials at all levels should be maintained.

In the case of the researcher, this dissertation document will be submitted to the Ministry of Health (MoH). Further the researcher also tries to remain in close contact with the ministry and the line agencies for the betterment of health services including the safe and appropriate supply of family planning methods and devices. In addition to this the researcher takes the support of some organizations those are active in the areas of Sexual and Reproductive Health and Rights (SRHR) to advance the findings and start lobby and advocacy with the government.

5.3 Action plan in lobbying for improvement of the policy

The Director General (DG) of Family Health Division which is under the Ministry of Health and some of the leaders from the civil society organization are some of the helpful person to the implementation of the recommendations. The researcher is expecting to send this research report to UN, Family Planning Association of Nepal (FPAN), Safe Motherhood Network Federation (SMNF), Maiti Nepal, NAPN, including other line agencies and some bilateral organizations to assess the impact of the policy.

The government's and the concerned stakeholder's SRHR events, meetings, gatherings as well as different national and international events and programmes and functions are appropriate to submit the findings. The researcher may also organize some programmes such as interactions and discussion with the government and other relevant people. It is also within the plan of the researcher to seek some further support from some like-minded organizations to publish the dissertation and stickers, and posters which will be used to promote the people's awareness as a result government feels the pressure is increased. In addition to this the researcher actively participates in different meetings with the government to ensure the right to information on family planning. The other plans are to provide concrete suggestion during the design of other relevant policies and be a part of the policy review team. Bi-monthly, quarterly and annual health reports published by the government and the website of the Health Ministry are some sources that let us know about the action taken by the government on the recommendations made by this report. National Census and Health related indicators let us know that women are enjoying their health rights to a greater extent.

5.4 Awareness-raising activities plan

Sticker campaign and documentary show among the rural people are some programmes to inform the community people. Besides these, the researcher has planned to coordinate with the reputed media homes to deliver the findings of the research for the betterment of the health of the people.

5.5 Necessity to implement the above plans

The researcher requires around three years for the execution of the action plan as awareness type of activities require quiet a lot of time. Besides these facts, the researcher also requires some fund to make the change happen. An approximate amount of 200,000 is needed to implement the planned activities.

Annexure

1. The questionnaire used for the analysis in the research

Step 1: Policy Identification

S1/Q2: Which main policy will be the focus in the HeRWAI analysis? Why has this policy been selected?

S1/Q3: Who is the main actor implementing the policy?

S1/Q4: What does the government aim to achieve with this policy?

S1/Q5: What is the actual effect of the policy on women's health?

S1/Q6: Are there any special programmes to implement the policy? Who is responsible for these programmes?

S1/Q7: Are there protocols and regulations to guide the implementation of the policy? Do they include a description of the exceptions?

S1/Q8: Which groups does the government (or the main actor) intend to reach with the policy?

S1/Q9: Which groups does the policy actually affect (positively or negatively)?

S1/Q10: What are the perceptions of the affected groups regarding the problem and the related policy?

S1/Q11: Which human rights may be affected?

Step 2: Government's Commitments

S2/Q1: Which international treaties has your country ratified? Were any reservations or limitations made?

S2/Q3: Which consensus documents does your government support?

S2/Q4: Is the government bound to other bilateral or multilateral agreements which may influence the policy? Which ones?

S2/Q5: What does the constitution or the other national laws say about the right to health?
S2/Q6: Does the country have a law prohibiting the discrimination of women?
S2/Q7: What does the constitution or other national laws say about other rights which are relevant to the policy?
S2/Q8: Does the country have laws that criminalize medical procedures only needed by women and/or that punishes women who undergo those procedures?
S2/Q9: Do local, customary or religious laws influence the health rights of women in relation to your policy?
S2/Q10: Does the government have a national health strategy?
S2/Q11: Has the government developed indicators and benchmarks to measure its progress?
S2/Q12: Which other national policies are relevant to the policy under analysis?
S2/Q13: What are the official way by which individuals, NGOs, and other civil society groups can influence policy-making and legislation (mechanisms for civil society participation)?
S2/Q14: Where can people go to make a complaint (mechanisms for redress)?

Step 3: Capacity for Implementation of the policy
S3/Q1: What is the budget for the implementation of the policy?
S3/Q2: Is the budget for the implementation of the policy decreasing or increasing?
S3/Q3: Do allocations to specific areas of health indicate where the government sets its priorities?
S3/Q4: Are the public health and health-care facilities, goods, services and programmes functioning properly?
S3/Q5: Which staff is involved in implementing the policy or related programmes?
S3/Q6: How is the staff distributed in terms of location, level, background?
S3/Q7: Which level of the government is directly responsible for the implementation of the policy?
S3/Q8: Which cultural, religious, environmental and other factors influence the implementation of the policy?
S3/Q9: Is the state in a process of reform, structural adjustment or crisis which influences the implementation of the policy?

S3/Q10: Describe conflicting interest or lack of consistency related to the implementation of the policy?
S3/Q11: Does the government show political will to implement the policy?
S3/Q12: To what extent do other governments, international donors and agencies such as the World Bank, IMF, WTO, UNDP, EU, WHO, ILO, UNICEF, UNFPA, expand or limit the implementation capacity of the government?
S3/Q13: Which other international actors influence the government? What are their priorities and interest relating to the policy under analysis?

Step 4: The Impact

S4/Q1: Is timely and appropriate health care a relevant issue for the policy? If yes, explain why and how.
S4/Q2: Are underlying determinants of health a relevant issue for the policy? If yes why and how.
S4/Q3: Is participation a relevant issue? If yes, explain why and how.
S4/Q4: Who participates or participated in the development and implementation of the policy?
S4/Q5: Is violence against women a factor in the policy? If yes, explain why and how.
S4/Q7: Does the policy affect the availability of the relevant services, goods, and facilities for (certain groups of) women and how?
S4/Q8: Does the policy affect the accessibility of the relevant services, goods, and facilities for (certain groups of) women and how?
S4/Q9: Does the policy affect the acceptability of these services, goods, and facilities for women and how?
S4/Q10: Does the policy affect the quality of services, goods and facilities?
S4/Q11: Is the impact of the policy—as analysed in the previous questions—equally felt by all groups, or are some groups affected more than others?
S4/Q12: What is the impact of the policy on stereotypical gender roles?
S4/Q13: Considering the above, does the policy have discriminatory effects?

Step 5: State Obligation

S5/Q1: Who are the main actors involved in the violations which were noted in step 4?

S5/Q2: If actors other than the government are involved, what is the relation between the violators and the government? Has the government taken any measures to regulate the activities of the violators? Are these measures adequate?
S5/Q3: What is the role of the governments of other countries or international actors in relation to the violators?
S5/Q4: Which of the core obligations is relevant for the policy and has not yet been achieved?
S5/Q5: Does the obligation of progressive realization apply?
S5/Q6: Does the non-retrogression apply?
S5/Q7: Which of the effects of the impact is a result of the government's failure to meet its obligations to respect, protect and fulfill health rights?
S5/Q8: Has the government done enough to prevent discrimination in the implementation of the policy itself or in the impact of the policy?
S5/Q9: Does the policy include effective measures to ensure influence and the participation by women?
S5/Q10: Which government commitments are linked to the effects of the policy?
S5/Q11: Is lack of resources (rather than, for example, lack of political will) a major cause of the weakness of the policy and its implementation?
S5/Q12: Did the government attempt to obtain international technical and financial assistance?
S5/Q13: Did other (donor) governments or international institutions extend the necessary assistance?
S5/Q14: Is the government likely to claim that other obstacles caused the weakness in the policy or its implementation?

Step 6: Recommendation and Action Plan

S6/Q1: Make a summary of the information collected in the previous steps.
S6/Q2: For each of the violations and unwanted effects listed in step 5, try to formulate a recommendation to change the policy so that it has a better impact on women's rights.
S6/Q3: If a change in the policy is not the solution, what action should the government take?

S6/Q4: To what extent is your organization or you willing and able to assist the government or other actors in the further development and implementation of the recommendations?
S6/Q5: Which national government department, persons or procedure might be most helpful in achieving implementation of the recommendations and demands?
S6/Q6: Which other governments, funding agencies or other actors do you want to approach, to point out how their funding or actions should/could contribute to the improved impact of the policy?
S6/Q7: What is the most suitable time to present the findings?
S6/Q8: Which options are available to increase pressure on the government (if needed)?
S6/Q9: When and how will you know if the government has taken action corresponding to the recommendations?
S6/Q10: When and how will you check whether the changes have really led to an improvement of women's enjoyment of their right to health?
S6/Q11: How will the community be informed about the findings and recommendations?
S6/Q12: How much time and which resources (financial and in terms of skills) does you/your organization need to implement the action plan? Can these be made available?

2. Questionnaire guideline for the Focused Group Discussion (FGD):

(Manage a tape recorder, a key note taker in every FGDs. Please make sure that no one notices that you are writing the same thing what the FGDs participants saying.)

Introduction and warm up is done so that every body feels comfortable to talk. Brief the participants about the importance and objective of the discussion. Tell them why you are there. Try to make sure that you are in the same line as the FGDs participants. Discuss openly and freely. Do not impose any questions. Make sure that you are not asking 'Why' questions to the participants. Convince the participants about the confidentiality and let every one know that the discussion will remain in the form of general discussion only. Take prior consent to take the photographs and record from the participants. Initiate this session for five to ten minutes and proceed with the questionnaire guideline.

Criteria:

Participants Number: 8 to 10 per FGD

Venue: Usually an open space and make sure that other people are not disturbing of observing your discussion but an enclosed place is also preferred.

FGD with the young girls of Kathmandu:

1. Can any one let us know that where the health centers/institutions are located near by our locality? Can some one explain about the right to health? How family planning are distributed in Nepal?
2. How far are these locations? Is it at accessible place? If no, what obstructs you to reach there? Road, money or other things?
3. Have you ever been to these centers and institutions? Just to know, for what purpose? When and which and how often you have visited there?
4. Could you tell something about the kind of services available there? From what source you came to know this? Are there any family planning methods distributed?
5. Are these services affordable? Do you think that these services are acceptable to you and your family? How do you think so? Are the services applicable to you and your family?
6. Can any one remember the free services available there? Have we ever utilized these free services? What are those services you have utilized for free? Could you tell about the Family planning, counseling, maternity service, and other services that benefited you?
7. Did any one directly got benefit of these services? If yes/no, how?
8. What is the quality of the services that you have acquired? What suggestions do you want to give for the improvement of these services?
9. What is your role for the improvement in the service delivery of these institutions?
10. Please give your final remarks.

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