

ADOLESCENT AND YOUTH REPRODUCTIVE HEALTH IN NEPAL

Status, Issues, Policies, and Programs

Ajit Pradhan

Senior Demographer, Family Health Division, Ministry of Health

Molly Strachan

Senior Research Specialist, Futures Group

January 2003

POLICY Project

TABLE OF CONTENTS

Acknowledgments	ii
Abbreviations	iii
1. Introduction	1
ARH indicators in Nepal	3
2. Social context of ARH.....	4
Gender socialization	4
Education	5
Employment	5
Marriage and social expectations for fertility	5
3. ARH issues	7
Sexual behavior	7
Contraception	7
Early pregnancy	7
Unwanted pregnancy and abortion	8
STIs and HIV/AIDS	9
4. Legal and policy issues related to ARH.....	10
Overview	10
Legal barriers	10
Existing ARH policies	10
5. ARH programs	13
6. Operational barriers to ARH.....	15
7. Recommendations	16
Appendix 1. Data for Figures 1 through 4.....	17
References.....	18

ACKNOWLEDGMENTS

This report was prepared by the POLICY Project as part of a 13-country study of adolescent reproductive health issues, policies, and programs on behalf of the Asia/Near East Bureau of USAID. Dr. Karen Hardee, Director of Research for the POLICY Project oversaw the study.

The authors would also like to thank the following people for their support of this study: Lily Kak, Gary Cook, and Elizabeth Schoenecker at USAID; and Ed Abel, Karen Hardee, Pam Pine, Lauren Taggart Wasson, Katie Abel, Nancy McGirr, and Koki Agarwal of the Futures Group. The views expressed in this report do not necessarily reflect those of USAID.

POLICY is by the U.S. Agency for International Development under Contract No. HRN-C-00-00-0006-00, beginning July 7, 2000. The project is implemented by the Futures Group International in collaboration with Research Triangle Institute (RTI) and the Center for Development and Population Activities (CEDPA).

ABBREVIATIONS

AIDS	Acquired immune deficiency syndrome
AMK	Ama Milan Kendra
ANM	Auxillary nurse midwife
ARH	Adolescent reproductive health
ASFR	Age-specific fertility rate
BEOC	Basic essential obstetric care
CBO	Community-based organization
CEDPA	Centre for Development and Population Activities
CEOC	Comprehensive essential obstetric care
CPR	Contraceptive prevalence rate
CREHPA	Center for Research on Environmental Health and Population Activities
DOHS	Department of Health Services
EC	European Commission
EOC	Essential obstetric care
FCHV	Female community health volunteers
FHS	Family Health Survey
FP	Family planning
FPAN	Family Planning Association of Nepal
HIV	Human immuno-deficiency virus
HMG/N	His Majesty's Government of Nepal
HP	Health post
ICPD-POA	International Conference on Population and Development <i>Programme of Action</i>
IEC	Information, education, and communication
IPPF	International Planned Parenthood Federation
MCHW	Maternal child health worker
MOH	Ministry of Health
MOPE	Ministry of Population and Environment
MOWCSW	Ministry of Women, Children, and Social Welfare
NCASC	National Center for AIDS and STD Control
NDHS	Nepal Demographic and Health Survey
NGO	Nongovernmental organization
NHEICC	National Health Education Information and Communication Center
PAC	Postabortion care
PHCC	Primary health care center
PHECT	Public Health Concern Trust
PID	Pelvic inflammatory disease
RH	Reproductive health
RTI	Research Triangle Institute
SCL	School Leaving Certificate
SHP	Sub-health post
STD	Sexually transmitted disease
STI	Sexually transmitted infection
TFR	Total fertility rate
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund

USAID
VDC
WHO

United States Agency for International Development
Village development committee
World Health Organization

1 INTRODUCTION

This assessment of adolescent reproductive health (ARH) in Nepal is part of a series of assessments in 13 countries in Asia and the Near East.¹ The purpose of the assessment is to highlight the reproductive health status of adolescents in each country, within the context of the lives of adolescent boys and girls. The report begins with social context and gender socialization that sets girls and boys on separate lifetime paths in terms of life expectations, educational attainment, job prospects, labor force participation, reproduction, and duties in the household. The report also outlines laws and policies that pertain to ARH and discusses information and service delivery programs that provide reproductive health information and services to adolescents. The report identifies operational barriers to ARH and ends with recommendations for action to improve ARH in Nepal.

As a signatory to the 1994 International Conference on Population and Development *Programme of Action* (ICPD-POA), His Majesty's Government of Nepal (HMG/N) is committed to providing a package of reproductive health services to its population, including ARH services. This is a considerable challenge because Nepal's population is characterized by a young age structure. Nepal's adolescent population (ages 10–19) constitutes more than one-fifth (22 percent) of the total population. The population of adolescents ages 15–24 will grow from 4.8 million in 2000 to an estimated 6.9 million in 2020—an increase of 30 percent in just 20 years (Figure 1). Educational attainment is low but on the rise, and the gender differential is shrinking. Ten years ago, in 1991, 23.4 percent of males and 64.7 percent of females had no formal education. In 2001, these figures had decreased to 14.6 percent of males with no formal education compared with 45.9 percent of females (Figure 2). For girls this represents a significant change of 18.8 percentage points. Over one-half of boys ages 15–24 had some secondary or higher education while only one-third of girls were educated at this level. The labor force participation among boys ages 10–14 is 26 percent compared with 40 percent among females in the same age group. Labor force participation is lower for young men because a relatively large percentage of men in these age groups are still studying. Labor force participation increases for both sexes with age; 58 percent of young men and 67 percent of young women ages 15–19 participate in the labor force.²

Six percent of male and 16 percent of female adolescents ages 10–19 are married.³ Approximately one-fifth of married women younger than 20 enter into motherhood.⁴ The more than 396,000 births to teenagers (ages 15–24) in 2000 will increase to an estimated 589,000 by 2020 (Figure 3). Approximately 35 percent of youth (ages 15–24) have an unmet need for family planning (Figure 4). Experts posit that sexual activity among the adolescent population is increasing, yet this increase is not accompanied by an increase in knowledge of sexuality and reproductive health. Few adolescents have information about family planning, and access to contraceptives has been restricted to married women and men. Older generations are reluctant to give adolescents access to family planning education and services out of fear that sexual activity would increase.

There is growing political commitment to ARH issues in Nepal. HMG/N, by signing the 1994 ICPD-POA, has displayed a strong commitment to reproductive health issues, of which ARH is one of the key components. In 1998, the Ministry of Health (MOH), which holds primary responsibility for the health of Nepalese, adopted the *National Reproductive Health Strategy*. This strategy identifies ARH as a key

¹ The countries included in the analysis are Bangladesh, Cambodia, Egypt, India, Indonesia, Jordan, Morocco, Nepal, Philippines, Sri Lanka, Pakistan, Vietnam, and Yemen.

² Central Bureau of Statistics, 1999.

³ Central Bureau of Statistics, 2002.

⁴ Ministry of Health [Nepal], New ERA, and ORC Macro, 2002.

component of integrated reproductive health services. In line with the *National Reproductive Health Strategy*, the *National Adolescent Health and Development Strategy* was developed and adopted by HMG/N in 2000. The Department of Health Services (DOHS) is in the process of developing several initiatives to address the goals of the *National Adolescent Health and Development Strategy*. In addition to the DOHS, various nongovernmental organizations (NGOs) are engaged in information, education, and communication (IEC), advocacy, and service provision for adolescents throughout the country.

Two initiatives stand to significantly impact ARH in Nepal. First, the National Reproductive Health Program Steering Committee recently endorsed a policy stating that adolescents should not be denied family planning services, irrespective of their marital status. Second, in March 2002, the House of Representatives passed the 11th amendment of the country's civil code, which will enable women to legally terminate unwanted pregnancies under certain circumstances (see section on the 11th amendment later in this report). The bill will become an act after royal assent.

It is clear that meeting the reproductive health needs of Nepalese youth will remain a significant challenge in the future. Funding remains a major barrier to implementing ARH programs. Government funding for such programs is scarce, and currently, the majority of funds for ARH is available from external support. While ARH programs are slowly emerging, efforts need to be scaled up rapidly in order to meet the extreme lack of information and services available to youth as well as the lack of knowledge among youth. Moreover, the low status of women poses an obstacle to improving reproductive health status in Nepal.

ARH indicators in Nepal

Figure 1. Total Adolescent Population (Ages 15-24)

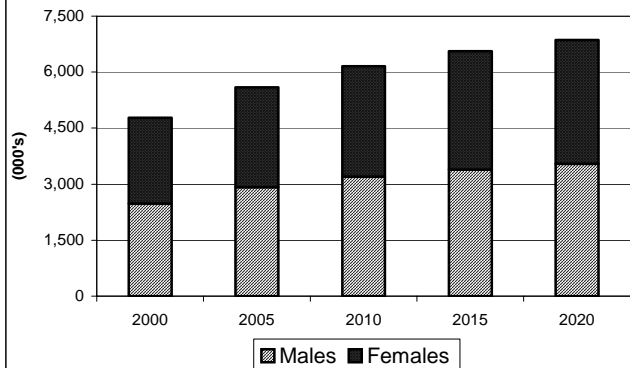


Figure 2. Years of Education Completed (Ages 15-24)

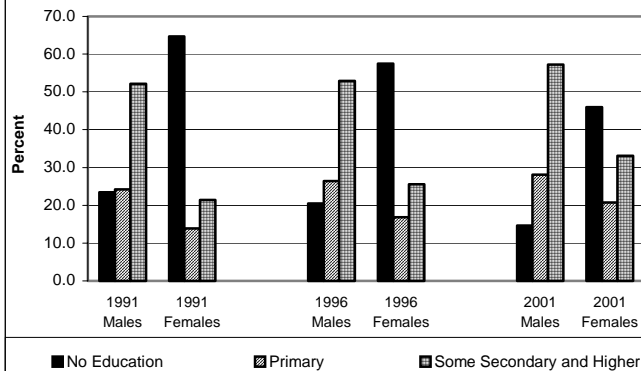


Figure 3. Annual Pregnancies and Outcomes (Ages 15-24)

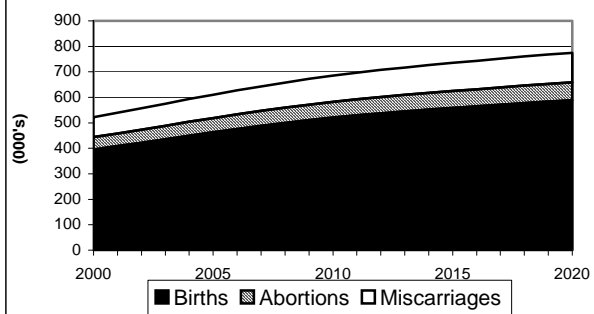
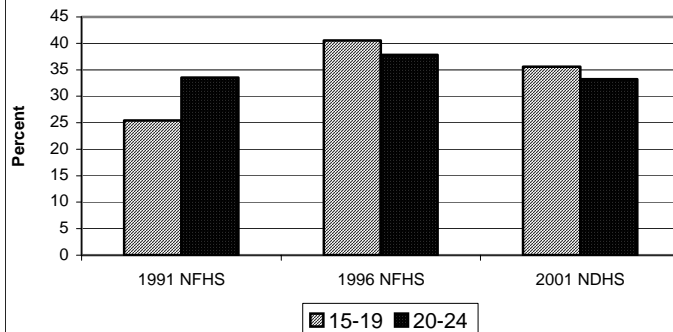


Figure 4. Total Unmet Need for FP (Ages 15-24)



Note: See Appendix 1 for the data for Figures 1 through 4

2 SOCIAL CONTEXT OF ARH

Adolescence is a distinct phase of development in the life cycle of an individual. The World Health Organization (WHO) defines adolescence as the period between 10 and 19 years of age, which generally encompasses the time from the onset of puberty to the legal age of majority. It is a period of transition from childhood to adulthood that is characterized by physical, mental, emotional, and social development. The onset and experience of adolescence is both a socio-cultural and physiological phenomenon. During adolescence, influences outside the family take on a greater significance, and adolescents face new opportunities and are eager to take on new responsibilities. Because of physical and hormonal changes, adolescence is also a formative stage in terms of sexual and reproductive maturity. Decisions made during adolescence can affect reproductive health and well being throughout life.

Gender socialization

In Nepal, as it is elsewhere, adolescence is associated with a number of social changes. Research findings indicate that these changes include personality changes, interest in new activities, increasing interest in peer networks, and development of romantic relationships.⁵ In the same study, findings indicate that female adolescents experience greater character or personality change during adolescence than do their male counterparts. Urban males place more emphasis on appearance, maturity, and responsibility. Furthermore, the study's findings reveal that the degree of interaction with peers is associated with gender. For boys, on the one hand, adolescence marks a period of increased mobility, reduced supervision, growing interest in fashion, and increased participation in youth clubs. The majority of boys and young men are unemployed and idle. Study participants also exhibited a high prevalence of drugs, alcohol, and tobacco abuse and other unhealthy behavior, among urban men in particular. For girls, on the other hand, adolescence is marked by decreased social mobility. Within the household, girls are expected to do more housework than their brothers and, consequently, have no time for leisure.

The status of women in Nepal is low, and the differentiation of gender roles and the power imbalance are reinforced throughout adolescence. Findings of the Nepal Demographic and Health Survey (NDHS) 2001 revealed that only 25 percent of adolescent women (ages 15–19) who received cash earnings were able to decide for themselves how their earnings were used. Decisions on earnings usage were made jointly by 18 percent of respondents and by someone else for 56 percent of the respondents. Few adolescent women ages 15–19 participated in household decision making. For example, only 7 percent had self or joint decision-making power regarding their own health; 8 percent had the final say in making large household purchases; 11 percent had the final say in daily purchases; 10 percent had the final say in visiting family or relatives; and 51 percent had self or joint decision-making power in what food to cook daily.⁶ Adolescent women (ages 15–19) are also less likely to be portrayed in or have access to the mass media than are men in the same age group.

Gender discrimination may also result in adverse health conditions among women, such as anemia. Studies indicate that the major cause of child malnutrition, which is markedly higher in South Asia than anywhere else in the world, is the poor care that is afforded to girls and women by elders and husbands because of the lower value society places on women.⁷ Women in Nepal generally have a larger work

⁵ Thapa et al., 2001.

⁶ Ministry of Health [Nepal], New ERA, and ORC Macro, 2002.

⁷ UNICEF, 1996.

burden compared with men, and women of all ages perform the majority of domestic work. Furthermore, women generally work longer hours than men both within and outside the house.

Education

In 1990, HMG/N adopted the policy of free education for all children through the seventh grade. The government also places special emphasis on the need to educate girls. Access to education has increased significantly over the years; however, a large majority of children who start primary education do not complete it, and there is a significant gap between educational attainment of boys and girls. Enrollment rates for girls are considerably lower than those for boys in Nepal. The NDHS 2001 revealed that 52 percent of young women ages 15–19 had no education compared with only 14 percent of men in the same age group. Forty-seven percent of young women (ages 15–19) are illiterate compared with 17 percent of young men.

Employment

The legal age of employment in Nepal is not explicitly stated but in the public and private sector (particularly with government ownership),⁸ a certificate of citizenship, which can only be obtained after reaching 16 years of age, is a requirement for employment. According to the 2001 NDHS, in the last twelve months, 71 percent of 15–19 and 74 percent of 20–24 year-old women were employed, compared with 89 percent of 15–19 and 96 percent of 20–24 year-old males. Of employed young adults (ages 15–19), 54 percent of men and 94 percent of women worked in the agricultural sector.⁹ In the age group 20–24, 59 percent of men and 90 percent of women worked in agriculture.¹⁰ A focus group study of youth and young adults (ages 10–24) conducted in 11 urban and rural districts indicates that unemployment and lack of work were significant problems in the community.¹¹ Estimates of youth employment in this study ranged from 25 to 95 percent.

Marriage and social expectations for fertility

In Nepal, the legal age at marriage with parental consent is 18 for males and 16 for females. Without parental consent, men can marry at age 21 and women at age 18. The NDHS 2001 revealed that 40 percent of young women ages 15–19 are currently married compared with 11 percent of young men in the same age group. About 2 percent of young women (ages 15–19) are in polygynous relationships.¹² Child marriages are still prevalent in selected communities in Nepal, particularly in rural areas. Consummation of marriage (*guana*, or living together after marriage), however, takes place mostly after the woman's menarche.

The NDHS 2001 revealed that the median age at marriage for women ages 20–24 is 16.8 years and for men ages 20–24 it is 18.7 years.¹³ The median age at first intercourse for women ages 20–24 is 16.9 years and for men ages 20–24 it is 17.8 years. This indicates that among men, first sexual intercourse begins outside marriage.

⁸ This implies that private sector businesses can be owned by the government.

⁹ NDHS, 2001.

¹⁰ NDHS, 2001.

¹¹ Thapa et al., 2001.

¹² Polygynous relationships involve one husband with multiple wives.

¹³ NDHS did not provide statistics for the age group 15–19 when less than 50 percent of respondents are married or had had sexual intercourse.

The NDHS 2001 also provided information on recent sexual activity among young, married adolescent men and women (ages 15–19). Among this age group of married youth, 68 percent of women and 95 percent of men had experienced sexual intercourse within the last four weeks. Women in Nepal generally have the first birth within at least three years of the first marriage.¹⁴ Culturally, it is expected that a couple give birth to at least one male child.

The proportion of never-married men and women ages 15–19 is steadily increasing.¹⁵ This exposes more unmarried adolescents, particularly young men, to becoming sexually active outside marriage.

While the extent to which unmarried adolescents enter into motherhood is not known, given its taboo nature, the consequences of pregnancy outside marriage among adolescents range from socioeconomic difficulty due to isolation from the community to suicide.

¹⁴ Ministry of Health [Nepal], New ERA, and ORC Macro, 2002.

¹⁵ Ministry of Health [Nepal], New ERA, and ORC Macro, 2002.

3 ARH ISSUES

Sexual behavior

Adolescents' sexual and reproductive health is a function of hormone-induced biological change as well as behavior that is conditioned, in part, by social and gender norms. While sexual activity among married 15–19 year-olds is common and expected (see NDHS 2001:108; mentioned on previous page), premarital sexual activity is also taking place. A study conducted in Makwanpur district revealed information about sexual behavior among adolescents: 10 percent of unmarried adolescent boys (ages 15–19) were sexually active.¹⁶ A study on sexually transmitted infections (STIs) and HIV/AIDS revealed that 19 percent of adolescent boys and girls had some type of sexual experience before marriage.¹⁷

Contraception

In 2000, current use of modern contraception among married women ages 15–49 was 35.4 percent and among men ages 15–59 it was 43.6 percent. The NDHS 2001 provides information based on the question asked to currently and ever-married women ages 15–49 and therefore does not provide information on use of contraception among unmarried adolescents. Current use of modern contraception among married adolescent women (ages 15–19) was 9.3 percent, virtually all of whom used temporary methods. An additional 3 percent of married adolescent women (ages 15–19) were currently using traditional methods of contraception, including periodic abstinence, withdrawal, and folk methods involving plants and herbs.¹⁸

Early pregnancy

Pregnancy outside of marriage is culturally inadmissible and thus rare in Nepal. However, due to early marriage, adolescent motherhood is common. As age at marriage is increasing, adolescent pregnancy and motherhood among women ages 15–19 is declining. In 1996, 24 percent of women ages 15–19 were either mothers or pregnant with their first child;¹⁹ by 2000, this had decreased to 21 percent.²⁰ The adolescent fertility decrease is more prominent among adolescent women in urban areas or in the Terai and among women with a secondary or higher education.

Adolescent pregnancies are accompanied by higher risk of obstetric complications, such as obstructed labor, hypertensive disease, anemia, and low birth weight.²¹ The risks are greatest among women younger than 17. The median age at first birth for women ages 25–49 was 20. Obstetric complications are also more common with inadequate birth spacing. The median number of months between births (excluding the first birth) was about 22 months for adolescent women (ages 15–19).

¹⁶ Plan International, 1996.

¹⁷ Subedi and Gurubacharya, 1992.

¹⁸ Ministry of Health [Nepal], New ERA, and ORC Macro, 2002.

¹⁹ Pradhan et al., 1997.

²⁰ Ministry of Health [Nepal], New ERA, and ORC Macro, 2002.

²¹ WHO, 1989.

Table 1. Teen Pregnancy and Motherhood: Percentage of all women age 15–19 who are mothers or pregnant with their first child, by background characteristics, Nepal 2001

Background Characteristics	Percentage who are:		Percentage who have begun childbearing	Number of women
	Mothers	Pregnant with first child		
Age				
15	0.5	1.0	1.5	361
16	3.9	5.4	9.3	451
17	12.6	4.9	17.5	571
18	25.3	8.8	34.0	510
19	35.9	4.6	40.5	441
Residence				
Urban	10.1	2.5	12.6	249
Rural	17.0	5.5	22.5	2,087
Education				
No education	24.9	6.6	31.5	842
Primary	14.3	5.3	19.6	662
Some secondary	9.7	3.6	13.2	706
School Leaving Certificate (SLC) and above	4.3	4.0	8.3	138
Total	16.2	5.2	21.4	2,335

Source: NDHS, 2001.

Unwanted pregnancy and abortion

A total of 36 percent of adolescent women (ages 15–19) have an unmet need for family planning (33% unmet need for spacing and 2% for limiting). The mean ideal number of children for women ages 15–19 was 2.4 and for men of the same age it was 2.6.²² Overall, the difference between the total fertility rate (TFR) (4.1) and the total wanted fertility rate (2.5) is about two (1.6) children. This means that both adolescent females and males (ages 15–19) want 1.6 children fewer than they would have given the current TFR.²³

The NDHS 2001 also revealed that 5 percent of ever-married women younger than 20 experienced spontaneous abortions and 0.3 percent reported induced abortions. It should be noted that the estimates of induced and spontaneous abortions are likely to be underestimated. However, more accurate data are not available; apart from the NDHS 2001, no other population representative study has been conducted in Nepal.

Unmarried adolescents who become pregnant are not likely to seek maternal health services. Instead, they resort to induced abortion performed primarily by unskilled persons, which too often results in hemorrhage, sepsis, and death. This typically occurs at first pregnancy.²⁴ Among women who survive unsafe abortion there is a high prevalence of pelvic inflammatory disease (PID) and secondary infertility.

²² Ministry of Health [Nepal], New ERA, and ORC Macro, 2002.

²³ Ministry of Health [Nepal], New ERA, and ORC Macro, 2002.

²⁴ Tamang, 1996.

Women with higher levels of education are the most likely to receive “safe abortions” (i.e., from trained personnel).²⁵

Some women are imprisoned for having an induced abortion. A study conducted by the Center for Research on Environment Health and Population Activities (CREHPA) on women in prison in Nepal reveals that 15 percent of 14–19 year-old female prison inmates were imprisoned for abortion/infanticide.^{26,27}

Recently, postabortion care (PAC) services have been initiated in 29 facilities in 21 districts in Nepal. These services were created to deal with complications of spontaneous abortions, but women who come into the health facilities with complications of induced abortions will also be treated.

STIs and HIV/AIDS

AIDS was first detected in Nepal in 1988. At 0.29 percent, the HIV prevalence in Nepal is second highest to India (0.7 percent) in South Asia.²⁸ HIV seroprevalence among young people is about 0.02 percent. As of August 2002, a total of 2,440 HIV-positive cases (1,767 males and 673 females) were reported to the National Center for AIDS and STD Control (NCASC) in Nepal.²⁹ About 92 percent of HIV infections occur among commercial sex workers, their clients, and injecting drug users.³⁰ Of the total HIV cases, 11 percent were among youth younger than 19. About 10 percent of these cases were due to perinatal transmission.

The NDHS 2001 revealed that 52 percent of adolescent women (ages 15–19), and 86 percent of adolescent men (ages 15–19) have heard about AIDS. Forty-two percent of adolescent women and 81 percent of adolescent men believe that there is a way to avoid HIV/AIDS. Among the adolescent women who knew specific ways to avoid HIV/AIDS, 38 percent cited condom use and 41 percent cited limiting the number of sexual partners as ways to avoid contracting HIV/AIDS. In comparison, 79 percent of adolescent men cited condom use and 57 percent cited limiting sexual partners.

²⁵ Tamang, 1996.

²⁶ Tamang et al., 2000.

²⁷ Thirty-one percent of the 14–19 year-old women were imprisoned for prostitution, 15 percent for abortion or infanticide, 11 percent for drug trafficking, 7 percent for murder, 4 percent for girl trafficking, and the rest for other reasons.

²⁸ UNAIDS and UNICEF, 2001.

²⁹ NCASC, 2002.

³⁰ NCASC, 2002.

4

LEGAL AND POLICY ISSUES RELATED TO ARH

Overview

At the highest level, the National Planning Commission chaired by the Prime Minister formulates and monitors all development programs, including the reproductive health program. In 1995, the Ministry of Population and Environment (MOPE) and the Ministry of Women, Children, and Social Welfare (MOWCSW) were created. The MOPE is responsible for developing population policies and coordinating activities linked to population while the MOWCSW is responsible for promoting and protecting issues related to women's development. The Family Health Division of the MOH is responsible for implementing the *National Reproductive Health Strategy*, and the *Adolescent Health and Development Strategy*. Reproductive health services are delivered through health service delivery points, including sub-health posts (SHPs), health posts (HPs), primary health care centers (PHCCs), district hospitals, and tertiary hospitals.

Legal barriers

A safe and supportive legal and policy environment is necessary for undertaking ARH initiatives. Existing legal barriers impede the protection of adolescents' rights. For example, until recently, the de facto family planning policy prohibited unmarried adolescents from receiving family planning services. Recently, the National Reproductive Health Program Steering Committee³¹—a policy-level body—passed a policy stating that adolescents, irrespective of their marital status should not be denied family planning services. This means that service providers are not required to ascertain whether a client is married or not while providing family planning services.

Existing ARH policies

Population policy: The existing population policy articulates the need to alleviate poverty and accelerate economic development. In addition, the policy focuses on areas such as gender equity, population management through good governance, decentralization, and public private partnership. The policy also emphasizes the need to address demand for family planning among couples. The *Ninth Development Plan (1996–2001)* aimed to reduce the TFR to 4.1 and increase the contraceptive prevalence rate (CPR) to 39 percent—goals that were met. The long-term goal is to achieve replacement level fertility by 2016. It is worth noting that the population policy is a part of the development plan. The previous long-term plan explicitly related population and development by articulating the need to balance rapid population growth and economic development whereas in the ninth plan (1996–2001), the emphasis was not as subtle as in the past—the ninth plan emphasized poverty alleviation.

³¹ The Secretary, Ministry of Health is the Chairman. Other members are the Secretary of Ministry of Law and Justice; Secretary of MOWCSW; Secretary of Ministry of Education and Culture; Secretary of Ministry of Population and Environment; representatives of USAID, UNICEF, UNFPA, WHO, GTZ, Family Planning Association of Nepal (an NGO), and other program divisions, such as the National Center for AIDS/HIV and STD Control.

The MOPE has identified the importance of addressing critical issues related to the youth population, such as:

- Ensuring the compliance of the existing legal age at marriage;
- Providing opportunities for youth in education, skill development, and employment;
- Encouraging youth to develop skills in literature, arts, and science and technology through information and counseling; and
- Providing information/counseling services for youth in a variety of settings, such as health institutions, secondary and higher secondary educational institutions, local NGOs, sports organizations, youth clubs, and industries.

National Reproductive Health Strategy: The *National Reproductive Health Strategy* was adopted by the MOH in 1998. This strategy identifies ARH as a key component of integrated reproductive health services. Additionally, the strategy recognizes that Nepalese women have the right to access health care services to ensure safe pregnancy and childbirth, thus providing couples with the best chance of having a healthy infant.³²

The National Adolescent Health and Development Strategy: HMG/N adopted the *National Adolescent Health and Development Strategy* in 2000. The goal of the strategy is to improve the health and socioeconomic status of adolescents. Its main objectives are to increase the availability of and access to information on adolescent health and development; provide opportunities to build skills among adolescents, service providers, and educators; increase accessibility and utilization of health and counseling services among adolescents; and promote a safe and supportive environment for adolescents to improve their legal, social, and economic status.³³ The strategy also identifies critical interventions, such as information campaigns, for increasing knowledge about reproductive health issues and services availability.

The Adolescent Health and Development Strategy emphasizes the need for a safe and supportive environment through advocacy and a legal framework. It recognizes the importance of NGOs and the private sector in supplementing and complementing government efforts to provide accessible and appropriate services to adolescents. NGOs and community-based organizations (CBOs) work synergistically with the government to create a safe and supportive environment for ARH and to sensitize parents, teachers, and social workers/leaders on needs and issues related to ARH through IEC and interpersonal communication. The strategy also recognizes the need to establish linkages among health facilities, schools, clubs, and workplace and vocational technical institutes. Furthermore, the strategy emphasizes the promotion of partnerships among youth clubs, CBOs, and village development committees (VDCs) to utilize local resources for ARH more effectively.

The strategy has yet to be operationalized. Whatever services are provided are currently provided by NGOs through clinics in selected VDCs in selected districts. Through the government sector, adolescent clinics are being established in a few government hospitals to cater to adolescents' needs.

National Safe Motherhood Plan: 2002–2017: The *National Safe Motherhood Plan: 2002–2017* emphasizes improved access to and utilization of services among women during pregnancy, childbirth, and postpartum to prevent maternal death.³⁴ To this end, the plan aims to gradually establish at least one comprehensive essential obstetric care (CEOC) facility in each of the 75 districts of Nepal and basic essential obstetric care (BEOC) facilities in 137 PHCCs throughout the country. Community-level

³² Family Health Division, 1997.

³³ Family Health Division, 2000.

³⁴ Family Health Division, 2002.

activities should operate synergistically with health facilities in order to increase utilization of these services. Peripheral health workers such as auxiliary nurse midwives (ANMs) and maternal child health workers (MCHWs) are being provided with EOC³⁵ first aid kits so they can manage and refer women with obstetric complications such as postpartum hemorrhage, pre/eclampsia, and sepsis. Community-level activities are also emphasized to promote health care throughout pregnancy and organize transportation arrangements in emergency situations.

The National Reproductive Health/Family Planning (RH/FP) IEC Strategy for Nepal: 1997–2001: The National Health Education Information Communication Center (NHEICC) in the MOH adopted the national IEC strategy for the reproductive health program in 1997.³⁶ It should be noted that the *National Reproductive Health Strategy* was developed in 1998 and the *National Adolescent Health and Development Strategy* was developed much later in 2000. Therefore, the reproductive health IEC strategy was not clear with regard to issues related to ARH although the group is mentioned as a target audience that would be a focus. However, the NHEICC plans to revise the national reproductive health IEC policy strategy document in the near future, with the support from UNFPA.

11th Amendment Bill on Abortion: Induced abortion is currently illegal in Nepal; nevertheless, it is still prevalent. In March 2002, the House of Representatives passed the 11th amendment of the country's civil code, which will give more latitude to women to terminate unwanted pregnancies. With royal assent, the bill will become an act. It will allow abortion in the following circumstances:

- Up to 12 weeks gestation for any woman;
- Up to 18 weeks gestation if the pregnancy results from rape or incest; and
- Any time during pregnancy, with the recommendation of an authorized medical practitioner, if the life of the mother is at risk, if her physical or mental health is at risk, or if the fetus is deformed.

However, abortion will be punishable by law if it is practiced for sex selection or if it is performed without the pregnant woman's consent.

Legal age at marriage: Men can legally marry without parental consent at age 21 and women at age 18. With parental consent, the age drops to 18 for boys and 16 for girls. In practice, age at marriage laws are not enforced. In some parts of Nepal, child marriage is still common.

School health: Currently, there is no policy to address the health needs of students in school. Furthermore, while first aid is available in some schools, there are no health clinics in schools. Some private schools provide hepatitis B vaccines for students; however, these are independent initiatives and students are charged the cost.

³⁵ This care is neither basic nor comprehensive, because the MCHWs with the EOC first aid kit cannot provide the BEOC signal functions, not to speak of CEOC. The aim is to stabilize the women with complications and refer to a BEOC or CEOC where the woman can be provided with appropriate treatment.)

³⁶ NHEICC, 1996.

5 ARH PROGRAMS

Government sector: Despite the *National Adolescent Health and Development Strategy*, information, education, and reproductive health services for adolescents in Nepal are severely limited. Since the 1994 ICPD-POA and the formulation of the *National Adolescent Health and Development Strategy*, programs have begun to emerge to address ARH needs. Recently, the National Reproductive Health Program Steering Committee passed a policy stating that unmarried adolescents can obtain family planning services. Prior to this decision, family planning services were available to only married men or women.

The Family Health Division, Department of Health Services, MOH is in the process of forging partnerships with other sectoral ministries, such as the Ministry of Education and Culture, the Ministry of Local Development, the MOPE, the Ministry of Labor, and the MOWCSW for advocacy and improving the status of the women. The partnerships are for all reproductive health, including ARH. More importantly, the MOH's ARH program aims to orient parliamentarians on the policy and legislative needs and issues related to adolescent health and developments in ensuring enforcement of legal age at marriage, legal age for employment, and compulsory education as stipulated by the law.

IEC program for adolescents: The MOH's NHEICC adopted the *National RH/FP IEC Strategy for Nepal* in 1996. The strategy includes an adolescent component as well. Following the RH/FP IEC strategy, the NHEICC launched an adolescent-focused IEC program in 55 districts through its health post staff to address ARH issues among school students. In addition, brochures and posters targeting adolescents have been printed and distributed. A radio program "Jana Swasthya Karyakram" (Public Health Program), which airs four times a week, also occasionally covers ARH issues.

FM radio and television programs: An FM radio station aired the program "Teen Plus" three years ago. This program mainly covered the Kathmandu valley adolescent population and focused on ARH issues. The program was cancelled due to lack of effectiveness. Another radio program currently airs that responds to adolescents' questions regarding life skills development. This program, which is technically and financially supported by UNICEF, is drawing considerable attention from adolescents in Nepal. More than 2,000 letters are received from adolescents every month. A UNICEF-supported television program on life skills development for teenagers is also currently transmitted on national television.

Population education program: HMG/N initiated the population education program through the Ministry of Education and Culture. This program incorporates population and health topics into lower and secondary level (levels six through 10) school curricula. The curricula include topics such as family life education, quality of life, safe motherhood, and community health. Emphasis is placed on health, population, and environment because this is one of the compulsory courses in schools. The population education program is supported by UNFPA.

NGO sector: NGOs are mainly engaged in ARH initiatives at the grassroots level. The Family Planning Association of Nepal (FPAN), one of the largest NGOs in Nepal, is engaged in advocacy, IEC, and service activities for adolescents in 34 districts of Nepal. The FPAN service area covers 472 VDCs. ARH services are integrated with other reproductive health services and are provided through FPAN clinics. FPAN activities are funded by the International Planned Parenthood Federation (IPPF), the European Commission (EC), Vision 2000, World Neighbors, and the Finnish Government.

Other NGOs are also active in ARH activities in Nepal. The Ama Milan Kendra (AMK), an NGO working with female community health volunteers (FCHVs) and mothers' groups, focuses on issues such

as male involvement and working with adolescent girls to make informed decisions regarding social, economic, and health needs and rights. PHECT-Nepal provides safe motherhood, family planning, and STI services to adolescents in one municipality. Sunaulo Pariwar Nepal, a local NGO affiliated with Marie Stopes International, provides youth-friendly services through one of its clinics in the far western region of Nepal and is in the process of extending similar services through its clinics in other parts of the country.

6

OPERATIONAL BARRIERS TO ARH

Gender considerations: Adolescent girls are in need of special protection and an enabling environment in terms of realization of human rights and empowerment. Adolescent boys should be made aware of the inequities between the sexes—Nepal’s gender norms favor males over females. Socialization of boys and girls needs to be examined to promote equity between girls and boys with regard to both education and life expectations.

Lack of information: Information on ARH in Nepal is virtually nonexistent. At the same time, cultural taboos prohibit discussion of adolescent sexuality and prohibit adolescents from talking and learning about sexuality. There is little understanding that sex education could lead to an increase in the adoption of safer sexual practices rather than increasing sexual activity among unmarried adolescents.

Lack of knowledge: There is a general lack of knowledge among both married and unmarried adolescents on topics that include sexuality, reproductive functions, contraceptives, and safe sex.

Lack of services: Until recently, family planning services were limited to married couples. The recent decision by the National Reproductive Health Program Steering Committee to permit the provision of family planning services to unmarried adolescents is not yet fully operational. Services targeted to ARH needs are currently non-existent.

Lack of research on adolescents: Few studies have addressed adolescent sexuality and reproductive health. This lack of information on adolescents’ knowledge, behavior, needs, and problems poses serious problems in the formulation of appropriate reproductive health program activities for Nepalese adolescents.

7

RECOMMENDATIONS

Implement the *National Adolescent Health and Development Strategy*. In line with the *National Adolescent Health and Development Strategy*, a holistic approach to adolescent needs to be pursued to promote ARH issues in addition to issues such as laws that ensure a safe and supportive environment, increased status, and safeguarded adolescent rights. Strong intersectoral coordination and collaboration is imperative to adequately address the health and development issues of adolescents.

Organize and expand information for adolescents. Although sporadic ARH programs have been implemented, access to information remains limited. Information campaigns addressing behavior change and life skills should be scaled-up and disseminated through electronic/print media, school-based information programs, youth clubs, and peer education/counseling. Furthermore, in view of young age at marriage and substantial teenage pregnancy rates (within marriage), counseling and education should be provided so that parents can educate their children about safe motherhood and family planning.

Provide services for adolescents. Until recently, reproductive health services, particularly family planning services, were not accessible to young adults. However, the public sector is not yet fully geared to providing a wide array of reproductive services to adolescents through regular outlets. All public sector outlets should be preparing to provide services for adolescents.

Involve NGOs and the private sector. Public–private partnerships should be encouraged and strengthened given the present involvement of NGOs and the private sector in providing information, counseling, and services to adolescents.

Undertake research to understand ARH and development issues. Nepalese adolescent health and development issues are poorly understood because few studies on the subject have been conducted. This body of research is especially inadequate because the attitudes and behaviors of adolescents are not necessarily consistent among different groups of adolescents. Research is needed in order to better understand the various adolescent health and development issues and to then design appropriate programs for different adolescent audiences. The research agenda should be prioritized to address the most urgent information gaps first.

Promote activities to raise the status of women/address gender issues. In order to address the unfavorable status of women and gender discrimination that prevail in Nepal, existing laws that ensure female schooling need to be enforced. There should be incentive schemes for families that send a girl child to school. In addition, existing laws need to be changed so that females and males are equally entitled to parental property. The persisting gender discrimination in Nepalese culture also needs to be addressed through widespread behavior change communication (BCC) activities.

APPENDIX 1. Data for Figures 1 through 4

1. Adolescent Population (15–24) (000's)						
	2000	2005	2010	2015	2020	
Males	2,484	2,921	3,200	3,394	3,541	
Females	2,292	2,665	2,956	3,166	3,313	
2. Level of Education (%)						
	1991 Males	1991 Females	1996 Males	1996 Females	2001 Males	2001 Females
No Education	23.4	64.7	20.5	57.5	14.6	45.9
Primary	24.2	13.9	26.4	16.8	28.1	20.8
Some Secondary and Higher	52.2	21.4	52.9	25.5	57.2	33.1
3. Pregnancy Outcomes (000's)						
	2000	2005	2010	2015	2020	
Total Pregnancies	522	611	686	735	775	
Births	396	463	521	559	589	
Abortions	48	56	62	66	70	
Miscarriages	78	92	103	110	116	
4. Unmet Need (%)						
	1991	1996	2001			
Total Unmet Need (15–19)	25.4	40.5	35.6			
Total Unmet Need (20–24)	33.5	37.8	33.2			

Assumptions and Sources:

Figure 1. Adolescent Population Projections were made by entering the base year population estimates from the UN medium population projection, *World Population Prospects, The 2000 Revision*, into the POLICY Project's SPECTRUM Model and projecting the population to 2020.

Figure 2. Level of education for 1991 and 1996 was taken from the Nepal Family Health Survey (FHS) reports, and for 2001 was taken from the 2001 NDHS report. The figures cited are a weighted average of household educational attainment statistics for 15–19 and 20–24 year olds.

Figure 3. Births, abortions, and miscarriages were calculated by multiplying the appropriate age-specific rates (i.e., TFR, abortion, and miscarriages) by the estimated number of adolescent females (single-age population estimates were calculated using the SPECTRUM Model). Total pregnancies were calculated by summing the total number of births, abortions, and miscarriages. TFR and age-specific fertility rate (ASFR) for the base year were taken from the NDHS 2001 report. TFR assumptions for future years were derived from the World Population Prospects data. Mortality and migration rates were derived from World Population Prospects data. The abortion rate was assumed to be 21 per 1,000 (Profiles estimate). Since no age-specific rates were given for adolescents, the overall abortion rate for women was used. The miscarriage rate was assumed to be 15 percent (Guttenmacher Institute estimate). Since no age-specific rates were given for adolescents, the overall miscarriage rate for women was used.

Figure 4. Levels of unmet need were taken from the 1991 and 1996 Nepal FHS reports, and 2001 NDHS report.

REFERENCES

- Central Bureau of Statistics. 1999. *Nepal Labour Force Survey 1998/99*. Kathmandu, Nepal: National Planning Commission Secretariat.
- Central Bureau of Statistics. 2002. *National Population Census 2001 Nepal (CD-ROM)*. Kathmandu, Nepal: National Planning Commission Secretariat.
- Family Health Division. 1997. *National Reproductive Health Strategy*. Kathmandu, Nepal: Department of Health Services, Ministry of Health.
- Family Health Division. 2000. *National Adolescent Health and Development Strategy*. Kathmandu, Nepal: Department of Health Services, Ministry of Health.
- Family Health Division. 2002. *National Safe Motherhood Plan: 2002–2017*. Kathmandu, Nepal: Department of Health Services, Ministry of Health.
- Ministry of Health [Nepal], New ERA, and ORC Macro. 2002. *Nepal Demographic and Health Survey 2001*. Kathmandu, Nepal and Calverton, Maryland: Family Health Division, MOH [Nepal], New ERA, and ORC Macro.
- National Centre for AIDS and STD Control (NCASC). 2002. *Cumulative HIV/AIDS Situation in Nepal*. Kathmandu, Nepal: NCASC.
- National Health Education, Information, and Communication Centre (NHEICC). 1996. *The National RH/FP IEC Strategy for Nepal: 1997–2001*. Kathmandu, Nepal: Ministry of Health.
- Pradhan, Ajit, Ram Hari Aryal, Gokarna Regmi, Bharat Ban, and Pavallavalli Govindasamy. 1997. *Nepal Family Health Survey 1996*. Kathmandu, Nepal and Calverton, Maryland: Family Health Division, MOH [Nepal], New ERA, and Macro International, Inc.
- Subedi, B.K. and V. L. Gurubacharya. 1992. “Sexual Behaviour Pattern in Nepal.” *Journal of Institute of Medicine* 30(103).
- Tamang, Anand, Mahesh Puri, Binod Nepal, and Mani Dahal. 2000. *Women in Prison in Nepal for Abortion, A Study on Implication of Restrictive Abortion Laws on Women’s Social Status and Health*. Kathmandu, Nepal: CREHPA.
- Tamang, Anand. 1996. “Induced Abortion and Subsequent Reproductive Behaviour among Women in Urban Areas of Nepal.” *Social Change* 26(3–4).
- Thapa, Shyam, Jessica Davey, Cynthia Wasak, and Rajendra Bhadra. 2001. *Reproductive Health Needs of Adolescents and Youth in Nepal: Insights from a Focus Group Study*. Kathmandu, Nepal: Family Health International, Population and Reproductive Health.
- UNAIDS and UNICEF. 2001. *A Survey of Teenagers of Nepal: For Life Skill Development and HIV/AIDS Prevention*. Nepal: UNICEF.