

Family Planning Association of Nepal

Overall Annual Program Summary 2009

A. Country in the Process of Writing New Constitution

The fresh election held in April 2008 formed an inclusive 601 member Constituent Assembly with sizeable representation of ethnic minorities, Dalit and Madheshi people and other 25 political parties. The function of the Constituent Assembly is to draft and implement a new constitution, which ensures the realization of the demands voiced by the people of Nepal, such as rule of law, proportional representation, equal rights to all, political freedom and guarantee of human rights. While the new constitution is being drafted the Constituent Assembly will also act as an interim legislature, until a new government is elected through general elections under the new constitution.

There are 11 Thematic Sub-committees and main Constitutional Committee in the Assembly. The thematic committees will submit their report to Constitutional Committee and it will compile all reports and prepare a draft constitution and present in the full Assembly for discussion and approval. However, the constitution writing is in limbo due to ideological differences among political parties particularly in state re-structuring, modality of governance, whether presidential or prime-ministerial system, and judiciary system. The thematic sub-committees could not reach in a consensus on disputed issues and submit their report to main committee. Therefore, the promulgation of new constitution in pre set deadline of May 2010 is questionable.

Promulgation of new constitution is further complicated to accomplish all procedures. The procedures set by the Assembly for promulgation of new constitution are: the draft constitution will be tabled before the Constituent Assembly, from the preamble to each Article, shall be voted and formally adopted; for the constitutional bill to be passed, a minimum of two thirds of the effective members of the Constituent Assembly must be present and adopt the bill unanimously. If such unanimity cannot be reached regarding the preamble or any other Articles of the constitutional bill, the parliamentary leaders of political parties represented in the Constituent Assembly shall hold consultations among themselves to reach a consensus on the issue. After the consultation is over, the Preamble or the concerned Article of the bill shall be put before the Assembly for re-voting. If unanimity can not be reached even after re-voting, the bill may be passed by a majority of two-thirds of the votes at a meeting attended by a minimum of two-thirds of the effective strength of the Constituent Assembly and in course of voting, if no members cast his/her vote against the motion, it shall be deemed as passed unanimously. The Assembly even has no simple majority of any political parties. It is a hang Assembly with representation of 25 political parties and promulgation of new constitution is not possible unless major political parties reach in a consensus. Consensus building among major political parties has been a tough job in recent months. Rival political parties are advocating on their own agenda and it is uncertain when the political parties will reach in a consensus and new constitution will be promulgated. It has increased political instability in the country which has multiplier effects in maintaining peace and security and socio-political and economic development of the country.

B. Political Transformation

Nepal was ruled by absolute monarchy from 1768 to 1946. Nepal was under the sway of heredity Chief Ministers known as oligarchy Rana regime between 1946-1950. In this period, the power of the monarchy was seized by Rana Chief Minister and Nepal was cut off from outside world to sustain the power for Rana heir. In 1950, anti Rana democratic forces with an alliance of the King overthrown the Rana regime and restored the power of Monarchy. Multiparty parliamentary democratic system was practiced between 1950-1960. The Monarchy again seized all state power dissolving the parliament in 1996. Since then, unilateral (Party less system called Panchayat) political system with little political freedom to people was practiced till 1990. Pro-democracy movement 1990 restored multiparty democracy bringing the monarchy under constitution. In 1996, Maoist started arms struggle and conflict was widespread between the Maoist and security personnel. The King again took absolute power in February 2005 to suppress the Maoist but failed to achieve and intended objective. In November 2005, mainstream political parties and the Maoist agreed to restore multiparty democracy. 19 days long protest across the country was launched by political parties in April 2006

which ended direct rule of the King and restored multiparty democracy. Maoist and the government signed a peace accord in November 2006 which ended a decade long conflict in Nepal. Since then Maoist army personnel are kept in 27 cantonments under the UN supervision. Interim constitution was promulgated in 2007 in consensus of all political parties including the Maoist urging to draft new constitution through constituent assembly. The election for the Constituent Assembly was held successfully in April 2008. First meeting of the Constituent assembly held in May 2008 abolished monarchy from Nepal and declared Nepal as a federal republican state.

Politically Nepal is at the crossroad of transformation from constitutional monarchy and parliamentary democracy to a federal, inclusive, secular and democratic republication country through new constitution. The comprehensive peace accord (CPA) between Maoist and seven party alliance (SPA) envisages an inclusive, democratic and progressive state restructuring that eliminate the centralized and unitary character of the state in order to address the concern of the women, Dalits, indigenous nationalities, Madhesis and the oppressed and neglected people¹. Drafting of new Constitution is underway and it is expected to bring transformation from monarchy to republic that guarantee wide spectrum of freedom, from authoritarianism to a conception of democracy that respect Universal Declaration of Human Right 1948, from hegemonic to participatory governance and from centralized unitary system to decentralized system at sub-national levels.

C. Economic Transformation

Nepal is one of the poorest and least developed countries in the world where 31 percent of the population live below the absolute poverty line. Nepal is ranked 145 out of a total of 179 countries in the Human Development Index (HDI) with a GDP per capita (PPP US\$) 990 in 2006². Overall life expectancy at birth (60.7 years for female and 60 years for male), adult literacy rate, 15 years above (55.6), gross enrolment of children in primary, secondary and tertiary level and GNP per capita are low compared with neighbouring countries in South Asia Region.

Overall GDP increased marginally from negative growth of 0.3 percent in 2001 to 2.0 percent in 2005³ and 4.7 percent in 2008/09⁴. Ministry of Finance estimated that the per capita income increased from US\$ 276 in 2004 to 300 in 2005 and 322 in 2006. Such an increase was contributed by appreciation of Nepalese currency against US\$ and increasing volume of remittance from Gulf countries by labour migrants. National living standard survey 2004 estimated that the share of remittance in per capita income increased from 16 percent in 1996 to 25 percent in 2004. Nearly one third of households (32%) received remittance within and outside the country⁵. Majority of households (67%) who have no off-farm source of income including remittance have borrowed loan from financial institutions, moneylenders and relatives to maintain the household economy.

The labour force participation rate (15 years and above) is 83 percent in Nepal. Out of this active labour force, only 17 percent is employed in formal sector and 83 percent is self employed in informal sector. Nearly three fourth (74 percent) employment is in farm sector and rest one fourth (26 percent) is in off-farm sector⁶. Farm sector alone consume largest share of the active labour force but this sector contributes only 33 percent in GDP⁷. The ever increasing demand for investment in infrastructures and social development will be largely insufficient through current level of GDP growth and economic opportunities to people. Therefore, main development agenda of Nepal after 2006 people's movement and comprehensive peace accord is economic transformation from agrarian structure to industrialize economy. Therefore, the development practitioners are advocating for pro-poor, pro-women, pro-excluded and pro-environment economic policies that contribute to rapid economic transformation in Nepal.

D. Social Transformation

Nepal is a multi-lingual and multi-ethnic country. Nepal began to generate demographic information on caste and ethnicity since 1991 after restoration of multiparty democracy in 1990. The 2001 population census listed

¹ UNDP, 2009, Nepal Human Development Report 2009, Kathmandu, Nepal

² United Nations Development Program, 2008, World Human Development Report 2008/09, New York, USA

³ Ministry of Finance (MoF), 2006, Economic Survey of Nepal, 2005/06, Kathmandu, Nepal

⁴ MoF, 2009, Economic Survey of Nepal, 2008/09, Kathmandu, Nepal

⁵ CBS, 2004, Living Standard Survey Report, 2004, Kathmandu, Nepal

⁶ CBS, 2008, Second Labor Force Survey of Nepal, Kathmandu, Nepal

⁷ MoF, 2009, Ibid Economic Survey 2008/09

103 social groups but no single group is found pre-dominant in population. These social groups can be categorised into five broad cultural groups, including Brahmin/ Chhetri (B/C), Terai middle castes, Dalits, Janajatis, Muslim and others. The Brahmin/Chhetri constitute 32.8 percent population, Terai middle castes 12.9 percent, Dalits 11.8 percent, Janajatis 37.2 percent, Muslim 4.3 percent and other 1 percent^{8 and 9}. Wider inequality is prevalent among these social groups¹⁰. The Human Development Index (HDI) 2006 by major caste and ethnic groups resembles such inequality. The HDI of Newar was 0.61, it was 0.552 among Brahmin/Chhetri 0.49 among Janajati excluding Newar, 0.42 among Dalit and 0.40 among Muslim. Such inequality was contributed by unequal gender relations, caste differentials due to social stratification by the Muluki Ain 1854 (the National Civil Code), caste and ethnicity differences resulting from the norms and socially defined practices of dominant caste groups, linguistic discrimination, religious differences, spatial exclusion and geo-political discrimination¹¹. Such elements resulted unequal citizens and develop human poverty in Nepal. Therefore, social transformation from discrimination and exclusion to social harmonization and inclusion are at the forefront in all development endeavours.

The issue of social inclusion gained momentum in public discourse after the social inclusion was first incorporated as one of the four pillars of the 2003 Poverty Reduction Strategic Paper (PRSP), which was also Nepal's 10th Development Plan. There is now greater understanding that a social exclusion is a structural problem and the state is moving from a welfare state to right based state¹². Manifestation of such policy shift for social transformation is apparent in policy instruments. The Interim Constitution of Nepal prohibits any forms of discrimination and social exclusion based on caste, race, ethnicity and geographic origin of people. Nepal ratified the Convention on Elimination of All Forms of Discrimination against Women (CEDAW) 1979. Similarly, Nepal set up a Women Commission in 2002 to eliminate gender based discrimination to women, National Dalit Commission in 2002 to eliminate caste based discrimination, and Nepal Federation of Indigenous Nationalities (NEFIN) to eliminate ethnicity based discrimination. Despite such efforts there are still cultural, caste, gender, ethnic based discrimination in practice and Nepal is waiting to their end through social transformation and increased state intervention.

E. Topography and its implication in national development

Nepal is a mountainous land locked country situated between two rapidly changing economies, China in the North and India in other sides. Nepal has total land area of 147,181 sq. km. and estimated population density is 183 persons per sq. km. in 2009. The altitude of Nepal ranges from 60 meter as low in the south to 8,848 meter as high in the north from the sea level within 150 km width from south to north. Geographically the country is divided into three ecological zones. High Mountain in the north extends from east to west comprising 36 percent of the total land area, 7.29 percent population and 19 administrative districts (out of 75 districts in Nepal) of Nepal. The Mid-hill region lies between northern High Mountain and southern Gangetic plain locally known as Terai. This region comprises 42 percent of the total land area, 44.28 percent of total population and 36 districts of Nepal. The southern Terai consists of 23 percent land, 48.53 percent population and 20 administrative districts. Livelihood in High Mountain and Mid-hill regions is extremely difficult owing to rugged topography, little connection by roads and scarcity of other livelihood options. Nepal's topography is widely acknowledged as a significant constraint to sustained progress towards social development. Weak transport and communication systems that impact on sustainable livelihoods and poor access to services such as health and education pose severe handicaps to improve social development indicators.

F. Population and Fertility

Nepal's population increased from 8 million in 1952-54 to 23 million in 2001. Inter census (1991-2001) population growth rate was 2.25 with 33 CBR/1000 and 10 CDR/1000. Present level of population growth is relatively high for Nepal considering the available resources within the country and current level of GDP growth to absorb the growing labour force per annum. Total population projected with an assumption of medium fertility decline for 2009 is 27 millions, 28.5 millions for 2011, 31 millions for 2016 and 34 millions for

⁸ CBS, 2001, Population Census Report 2001

⁹ CBS, 2003b, Population Monograph Volume I and II, Kathmandu, Nepal

¹⁰ DFID and World bank, 2006, Unequal Citizens: Gender, Caste and Ethnic Exclusion in Nepal

¹¹ UNDP, 2009, Ibid

¹² DFID and World Bank, 2006 Ibid

2021¹³. Such growth demand huge investment in social and human capital which is beyond the capacity of national government. However, the total fertility rate declined slightly from 6.3 per woman in 1976 to 6.0 in 1986, 5.1 in 1991, 4.6 in 1996, 4.1 in 2001 and 3.1 in 2006¹⁴. There is still rural urban disparity in fertility decline. TFR in urban area is close to replacement level where as it is still high in rural area. Therefore, more investment is required in rural area to bring down the fertility at replacement level.

G. Poverty and Consumption Gaps

The estimated number of people living below the absolute poverty line (earning less than US\$ 1 per day) was 42 percent in 1996, which declined to 38 percent in 2000¹⁵ and further down to 31 percent in 2005¹⁶. There is wide variation in poverty incidence between rural and urban area. It is estimated that 44 percent of the rural households and 23 percent of the urban households lie below the poverty line indicating that the poverty is more severe in rural area in Nepal where 84 percent of the total population live in rural area¹⁷. There is also a caste-based inequality in poverty in Nepal. Indigenous ethnic groups (*Janajati*) and minority ethnic caste group (*Dalits*) make up 37 and 12 percent, respectively, of the total population of Nepal. Poverty is the highest among these groups ranging from 45 to 59 percent among *Janajatis* and 65-68 percent among *Dalits*. The Millennium Development Goal of Nepal aims to halve the proportion of people living below the absolute poverty line to 21 percent by 2015¹⁸. However, the achievement to date deem blink picture because there is no adequate funding mechanism for poverty reduction in rural area. It is estimated that the incidence of poverty in rural area is increasing in recent years due to conflict and displacement of people from their home.

Employment generation within the country is virtually low due to political instability. However, the tourism sector is getting better after peace agreement with Maoist. Under employment of active labour force is recorded as high as 32 percent. Hence out migration of young people in search of employment opportunity to India and Gulf countries is increasing gradually over the year. The estimated number of young out migrants in search job is estimated 1.5 million in East Asian and Gulf countries and 0.5 million in India. Annual income to the nation from remittance is about Rs 4 trillion which is nearly double of the national budget.¹⁹ There is a wide consumption gap between high and low-income population. In 2003/4, the bottom 20 percent of the population accounts for a mere 6 percent of total consumption while the richest 20 percent of the population consume 53 percent. The large gap in consumption share across population groups has become worse during last decade²⁰. This indicates that the poorer people are becoming more vulnerable to diseases and hunger.

H. Interim National Development Plan and Investment Priority

National Planning Commission of Nepal developed Interim National Development Plan (2008-2010) in 2007 for transitional period where the country was governed by caretaker government of seven parties' coalition. National development and investment priorities are given for peace and reconstruction. First priority is given to reconstruction of physical infrastructures, rehabilitation of internally displaced people and their social integration. Second priority is given to social inclusion of women and marginalized groups in development mainstream and attain equitable development in the country with social justice. Third priority is given to develop an enabling environment for sustainable peace. Fourth priority is given to increase investment in tourism, agriculture and industrial infrastructures for making a dynamic economy and last priority is given in increasing national investment in education and health for skilled human resources development required for national development²¹. Overall the social sector like health and education is not given top priority in transitional period. The poor and marginalized people are likely to face many problems in health and education sectors because the private sector is booming significantly making a clear distinction between have got and have not.

¹³ CBS, 2003, Population Projections for Nepal 2001-2021, Kathmandu, Nepal

¹⁴ NDHS, 1976, 1981, 1986, 1991, 1996, 2001, 2006

¹⁵ National Planning Commission of Nepal, 2002, 10th Five Year Periodic Development Plan of Nepal

¹⁶ HMG/N, 2005, MDG + 5 Review Progress Report of Nepal

¹⁷ National Planning Commission of Nepal, 2001, Poverty Reduction Strategy Paper of Nepal

¹⁸ UN Country Team Nepal, 2002, Progress Report of the MGDs

¹⁹ Ministry of Finance Government of Nepal 2008, Economic Survey

²⁰ National Planning Commission of Nepal, 2004, Nepal Living Standard Survey

²¹ National Planning Commission of Nepal, 2007, Base Paper for Interim National Development Plan

I. Three Year Interim Health Development Plan (2008-2010)

The Interim Health Development Plan of Nepal recognizes access to health care as a fundamental right of people for the first time in Nepal in official document. It has also given due emphasis to implement preventive, promotive and curative health services and achieve the targets set in Millennium Development Goals. Besides, due attention is given to strengthen health management system, integrated district level health management system through decentralization, health research and emergency health care system; promote public private partnership; supply quality drugs with appropriate price; expand homeopathic medicine; and link population management with poverty reduction²². Investment targets set in the interim plan is to increase per capita government expenditure from US\$ 5 to 9. However, the interim health development plan has no adequate attention on adolescent sexuality and reproductive health, behaviour change in utilization of existing health services, demand generation for SRH services, gender equity in health sector, HIV/AIDS prevention and management and regulation of booming private sector in capital city Kathmandu and other regional towns.

J. Free Health Care Policy of the Government and Its Implications to FPAN

The Free Health Care Policy of the government targets poorer, marginalized, and destitute populations in order to increase their utilization of curative care. The main features of this policy are as follows²³:

- The policy provides free health care to the poor (Those whose income is enough to feed their families for less than six months), the destitute, the elderly, the disabled and Female Community Health Volunteers (FCHVs).
- A provision has also been made to reduce by fifty percent fees for inpatient and emergency services for those whose income is enough to feed their families for six to twelve months.
- The Free Health Care Policy covers consultation and treatment, minor surgeries, obstetric emergencies, both CEOC, and BEOC (where available), x-rays and laboratory services, essential drugs (for a week), and logistics.
- The services have been made effective since December 2006 at hospitals and PHCCs in those districts where hospital development committees have been established.
- Free health care services are provided in district hospitals (with up to 25 beds) and PHCs.
- Free health Care Services are planned to gradually phase in to better address deficiencies, problems, and issues as they became apparent.

Free out patient service is also announced for Karnali Zone and the Far Western Development Region, including 35 districts under the poverty alleviation program²⁴. Such free service policy in district hospital and other health facilities below the district hospital will affect FPAN's service fee policy. Service fee is the main source of local income for sustainability of the program which at risk due to this policy. Besides, the government pressed FPAN to provide all family planning services free of cost to all people irrespective of their income. Such move ultimately leads FPAN towards the donor dependency.

The estimated additional cost for free health care up to district hospitals for MOHP is US\$ 18 to 21 million per year²⁵. MoHP is requesting with other development partners for financial assistance to implement this plan effectively. FPAN has no alternative funding, which poses a challenge in 2010.

K. National Health Account and National Financing in Health Sector

National expenditure in health is relatively low in Nepal. Per capita public health expenditure is only US\$5²⁶ which is significantly low compare with internationally agreed standard of US\$ 34 for developing countries.

²² Ministry of Health and Population (MOHP), 2007, Interim Health Development Plan (Draft Copy)

²³ MoHP, 2007, Implications of the Government of Nepal's Free Health Care Policy, HSRSP Report no 2.2-06-07, RTI Kathmandu, Nepal

²⁴ NPC, 2007, Three Year Interim Plan of Nepal, Kathmandu Nepal

²⁵ MoHP, 2008, Minutes of the Seventh Joint Program Review Meeting, MoHP, Unpublished Report

²⁶ Ibid MOHP, 2007

General government expenditure on health as percentage of total government expenditure (1998-2002) was only 7.5 percent^{27/28}. It was further down to six percent in 2006/07²⁹ and 7.2 percent in 2007/08. However, the resource flow from centre to district is relatively low. Most of the expenditure is made at central level. Only 13 percent of the total budget (amounting Rs 1.21 billion) allocated for health sector was allocated for the district in 2006-7, while it was increased to 21 percent (2.52 billion) in 2007-8. There was a substantial growth in 2007-8 compared with previous year though the amount allocated for districts was relatively low. This can not cover all costs required for implementation of Free Health Care Policy of the Government.³⁰

National Health Account (2001-2003) reveals only 17 percent of the total health expenditure is met by the government, 20 percent by external development partners and 63 percent is met by household out of pocket money³¹. Besides, more than nine tenth (92%) of treatment cost is paid privately by individuals and overall national financing in health sector is focused on curative health. Preventive service through out reach education is minimal in Nepal as result utilization of existing health services is also low. National health account 2002/03 reveals more than two fifth (43%) of total health expenditure was in medicine, 19 percent in inpatient care, 12 percent in health management functions, 16 percent in preventive health care and 10 percent in other miscellaneous health related functions³². Health insurance and other security systems are virtually non-existence in Nepal. This clearly indicates that the funding on health at private and public sector is relatively low compared with other countries in SAR region. Resource flow in the country is gradually diverted towards restoring the peace, security and reconstruction of the infrastructures destroyed during the conflict. As a result the government has no adequate funding for health and other social sectors. The poor and marginalized people are the main sufferer due to low funding in public sector and soaring price of medicine and other health care cost in private sector.

Even the budget absorption capacity within the Ministry of Health and Population is weak. The ministry spends close to 70 percent of the annual allocated budget, of which utilization of capital budget is only 45 percent. Budget expenditures in each of the first trimesters of the fiscal years are below 18 percent of the annual budget.³³ Increase budget allocation alone is not sufficient to increase financing in health sector. Increasing decision making capacity and timely disbursement of budget is necessary through series of capacity building programs.

L. Education and Literacy

Overall the literacy rate (6 years and above) is growing gradually in Nepal. The literacy rate grew from 39 percent in 1991 to 54 percent in 2001³⁴. However, there is wider gender gap in literacy rate. Male literacy rate is 65 percent where as the female literacy rate in only 43 percent. Besides, there is a wider gap in literacy among ethnic majority and minority people. The national average literacy rate of *Dalit* ethnic minority for 6 years and above is only 23 percent consisting of 33 percent male and 12 percent female. Similarly, there is wider gender gap in adult literacy (15 years and above) rate in Nepal. Male adult literacy rate is significantly high (47 percent) compared with (14 percent) female counterparts³⁵. Overall the female literacy rate is very low in Nepal, which has direct bearing in health seeking behaviour, early marriage, teen-age pregnancy, childcare, nutrition, unsafe abortion, use of family planning methods and fertility. Similarly gender gap is visible in school enrolment of children. There are 3 million children in primary school going age (6-10 years) in Nepal. Out of them 0.9 million do not go to school. Net primary school enrolment ratio of male and female is 79 and 64 respectively. Out of them, only 54 percent complete primary school education. Overall 30 percent of Nepali children, mostly from poor households and disadvantaged groups, have no access to primary education³⁶. Even the physical infrastructures in school are not good. The students are taught in crowded rooms. Average student/teacher ratio is 49:1 in primary schools, 60:1 in lower secondary schools and 36:1 in

²⁷ UNICEF, 2005, The State of the World Children, New York, USA

²⁸ WHO 2005, The World Health Report 2005, Geneva, Switzerland

²⁹ Ministry of Finance National Budget Allocation for 2006/2007

³⁰ MoHP 2007, Budget Analysis 2007-08, HSRSP and RTI, HSRSP Report No. 2.4-08

³¹ MOHP, 2006, National Health Account 2001-2003, Kathmandu, Nepal

³² Ibid MoHP, 2006

³³ MoHP, 2008, Bottleneck Study for Timely Disbursement of Funds, HSRSP, MOHP, Kathmandu, Nepal

³⁴ Central Bureau of Statistics, 2001, Population Census Report 2001

³⁵ UNICEF South Asia Regional Office, 2005, The State of South Asia's Children, Katmandu, Nepal

³⁶ Ibid UNICEF, 2005

secondary schools³⁷. This indicates relatively poor quality of education because one teacher can not take care of such large number of students.

M. Millennium Development Goals

The Millennium Development Goals are an ambitious agenda for reducing poverty and improving lives that world leaders agreed on at the Millennium Summit in September 2000. For each goal one or more targets have been set, most for 2015, using 1990 as a benchmark. Nepal joined its hand with international community to achieve Millennium Development Goals by 2015. Nepal has established 17 targets (2 -each in goal 1, 6 and 7, one each in goal 2,3, 4 and 5 and 7 in goal 8) and 37 indicators (6 in goal 1 and 3, 3 each in goal 2, 4 and 5, 9 in goal 6 and 7 in goal 7) to monitor the progress³⁸. MDG + 5 review (2005) reveals slow progress in achieving the millennium development goals and Nepal has to go long way to achieve the set targets. Some indicators reviewed in 2005 reveals slight improvement indicating that the percentage of people below the poverty line reduced 42 percent to 31 in 2005; percentage of people below the minimum level of dietary energy consumption decreased from 49 percent in 2000 to 47 in 2005; percentage of under weight under 5 children reduced from 57 percent to 48 percent; net enrolment rate in primary education increased from 72 to 84; under 5 mortality rate reduced from 92 to 64 and percentage of deliveries assisted by health care providers increased from 11 percent to 18 percent³⁹. Yet Nepal needs additional efforts and ensuring adequate funding mechanism to achieve the millennium development especially to achieve goal 5 reducing maternal mortality and goal 6 reversing the spread of HIV/AIDS by 2015.

N. Challenges in Adolescent, Abortion, HIV/AIDS and Access

i. Adolescent

The Ministry of Health and Population of Nepal defined adolescent to individuals between ages of 10-19 years and the term youth to individuals between the ages of 15-24 years, while young people cover the entire age range from 10 to 24 years⁴⁰. While the Ministry of Youth and Sport of Nepal defined youth to individuals between ages of 15-29 years⁴¹. However, the definition used by the Ministry of Health and Population is used in this entire document for analysis and planning. Nepal's population is dominated by young people. Adolescent alone comprises 19.34 percent of the total population in Nepal. Adolescent and youth combinedly constitute one third (32.49 percent) of the total population in Nepal⁴². However, there are wide disparities between male and female young people. Literacy rate among young people is growing gradually. More than four fifth (82 percent) of young male are literate where as it is just 65 percent among their female counterparts. Mean age at marriage for male increase gradually from 19.5 years in 1961 to 22.9 years in 2001 while it increased marginally from 15.4 years in 1961 to 19.5 years in 2001⁴³. Still early marriage of young girls is widespread in Nepal. More than one fourth (34 percent) of young female are married compared with 16 percent of their male counterparts⁴⁴. Contraceptives, prevalence rate among adolescent is very low. It grew marginally from 6 in 1996 to 16 in 2006.

Adolescent and youth are facing many problems to get access to reproductive health care services. Young women are facing more problems as the socio-cultural factors such as early marriage and pregnancy, poor maternal nutrition, high fertility, low literacy, and low status of women further undermine women's health and well-being, contributing to Nepal's reproductive health indicators being among the poorest in the SAARC region. About two fifth of adolescent mother do not receive antenatal care and majority of them (85.9%) of adolescent mothers deliver their babies at home. These facts indicate poor health of young women in Nepal.

³⁷ Ministry of Education and Sports Department of Education, 2006, School Level Educational Statistics of Nepal Consolidated Report 2005

³⁸ HMG/N and UNDP, 2005, Nepal Millennium Development Goals, Progress Report 2005

³⁹ Ibid

⁴⁰ FHD (Family Health Division), 2007, Implementation Guide on Adolescent Sexual and Reproductive Health, Kathmandu, Nepal

⁴¹ NPC (National Planning Commission), 2007, Three Year Interim Development Plan of Nepal

⁴² CBS, 2003, Ibid

⁴³ MoHP, DoH, 2005, Adolescent Health and Development in Nepal: Status, Issues, Program and Challenges, A Country Profile, Kathmandu, Nepal

⁴⁴ CBS, 2003, Ibid

Poverty, labour migration, gender inequalities, girl trafficking, harmful socio-cultural practices and displacement from home due to conflict have made young population at high risk of having unwanted pregnancy and STI/HIV infection. This vulnerability is also a reflection due to limited access to youth friendly sexual and reproductive health information and services. Some factors that discourage young people from using health services include lack of privacy and confidentiality in service centres, insensitive service providers, non-conducive environments and inability to pay for SRH services. Young population aged 10-24 years, which comprises one third of population, thus needed to enhance with complete knowledge on human sexuality, preventing unwanted birth and STI/HIV not only to improve their SRH but also to control unwanted birth and HIV prevalence in the country. Young people and their needs are frequently not involved when strategies on SRH are drafted, policies made and budgets allocated. Very little systematic research or evaluation exists to indicate that youth participation results in measurable changes in reproductive health knowledge attitudes and behaviours. In this context, increasing access to youth friendly SRH services and creating a favourable environment to utilize SRH services by adolescent and young people remain a real challenge in Nepal.

ii. Abortion

Access of safe abortion services is an important issue in Nepal. The number of certified clinics for safe abortion services increased impressively from a dozen in 2004, 163 in 2006, 167 in 2007, 206 in 2008 and 245 as of July 2009⁴⁵. Despite such impressive growth in number of CAC centres, availability of services is still challenge in rural area of Nepal due to transfer of trained personnel, absentees of service providers in service centre outside the capital city Kathmandu and regional towns and location CAC centre in urban and per-urban area. At present all 75 districts in Nepal has at least one CAC centre and 610 medical doctors and 94 nurses are already trained as service providers. This is expected that the number of service providers will grow gradually and more women will have access to terminate their unwanted pregnancy. Besides, the manual vacuum aspiration (MVA) method, government of Nepal introduced medical method of abortion (MMA) since 2009 to increase choice of abortion methods and access to safe abortion services. However, the supply of medicine and training to service providers is still a challenge in Nepal.

Community attitude towards abortion in the context of religion showed prohibition. The religious context of Nepal in regard to abortion is linked with Hindu sculptures. Hinduism places a high value on female fertility and at the same time seeks to rigidly control female sexuality, which shows strict prohibitions against abortion⁴⁶. Hindu sculptures including the Rigveda, the Athruaveda, and the Manu Smriti (which are major sources of Hindu law) deem abortion to be unacceptable on all social, moral and ethical grounds. According to Hindu religion a women who intentionally terminates her pregnancy is denied traditional funeral rites and is doomed to be punished in hell. Other family and community members are required to treat her as a social outcaste. A husband who helps his wife to terminate a pregnancy is also considered to have committed a sin; a husband who was involved in helping his wife to terminate her pregnancy is required to abandon her. Hinduism's censure of abortion extends to miscarriages as well. A woman who miscarriage is considered ritually polluted after miscarriage for a period of time equal to the length of pregnancy⁴⁷.

There are many variations in decision-making behaviour of Nepalese women to go for induced abortion depending upon community, locality, family consultation, and educational and socio-economic level. Decision making behaviour is characterized by a complex pattern of delay. The process of making a decision to seek safe abortion began with individual woman's own personal interpretation of the gravity of her situation and needs which has been shaped in turn by information to her, including community beliefs and perceptions. Ability of woman to share what is happening to her by unwanted pregnancy with other people is affected by issues of shame, embarrassment and fear⁴⁸.

Culture of salience on reproductive health matters is another issue of Nepalese women to have better access of safe abortion services. Many factors combine to create such cultural salience, and thus an information vacuum related to reproductive processes and health. Widespread cultural beliefs about the need for female

⁴⁵ MoHP/DoS, 2009, Unpublished List of CAC Service Sites and CAC Providers in Nepal

⁴⁶ Sturley, 1998, Perception of Contraception in Rural Nepal, Ph.D. Dissertation University of Hawaii

⁴⁷ FWLD, 2003, Struggle to Liberalize Abortion in Nepal, Challenges Ahead, Kathmandu, Nepal

⁴⁸ Manandhar, 2000 Ethnographic Perspective on Obstetric Health Issues in Nepal

sexual puberty and strict control of woman's sexuality both inside and outside of marriage contribute to such culture⁴⁹. Information about and discussion of reproductive processes, or anything related to sex and sexuality is denied to girls and women because the culture believed that it might ruin their characters or signify loose character⁵⁰. In addition to illiteracy, poverty, lack of free time due heavy work loads, and restrictions on mobility all serve to limit women's access to variety information resources. Thus, they need adequate information and counselling in their community in order to enable them for timely decision to terminate their unwanted pregnancy safely in appropriate place. These issues will be addressed through community education and awareness programs.

Husbands' opposition is also a problem to practice safe abortion by Nepalese women. A study conducted on male attitudes after liberalization of abortion indicated that more than one third of hills male and two fifths of *Tarai* males would convince their wives not to abort if she wanted to terminate a pregnancy⁵¹. Same study has indicated that about one third of hill men and one fourth of *Tarai* men felt that a woman's consent is not required to obtain abortion if they like to abort pregnancy of their wife. Such attitude of male people creates problems to women to get access of safe abortion and exercising their reproductive rights despite the legal provision of safe abortion without spouse consent up to 12 weeks pregnancy. Male people need to be educated on unsafe and safe abortion and reproductive rights of women through outreach programs to create an enabling environment for women.

iii. HIV and AIDS

AIDS epidemic is moving from concentrated epidemic to general epidemic in Nepal because new infections are growing among monogamous housewives in recent years. HIV prevalence among most at risk populations is high in Nepal. The prevalence rate in 2006-07 was 1.4 among female sex workers, 1 among clients of FSW, 2.9 among MSW, 34.7 among IDU and 1.9 among labour migrants⁵². Still the reach with most at risk population with HIV prevention programs is relatively low in Nepal. Estimated reach for HIV prevention to FSW is 38.6 percent, MSW 55.56 percent, IDU 78.33 percent, MSM 46.75 percent, clients of FSW 48.5 percent and migrants 13.9 percent⁵³. The Global Fund round 7th HIV/AIDS component is expected to increase coverage for HIV prevention among migrant, MSM and IDU.

There is wide gap between estimated number of HIV case and self reported case tested in VCCT centres. As of 2007, national estimate indicates that about approximately 70,000 adults and children living with HIV in Nepal, with an estimated prevalence of about 0.49 percent in the adult population, 15-49 years old⁵⁴. Where as the total number of reported case in VCCT centres as of 15th December 2009 is recorded 15,043. Out of them 2,729 (18 %) are AIDS cases⁵⁵. Percentage share of reported HIV+ case levels 6 percent FSW, 17 IDU, 1 percent MSM, 44 percent clients of sex workers, 25 percent housewives and rest 7 percent others like blood or human organ recipients, male partners and children. The share of housewives in total HIV + case is increasing gradually over the years which need serious consideration in HIV prevention. Key factors contributing to spread of HIV are population mobility and migration, extreme vulnerability of women, trafficking of young women and girls, gender based violence to women, stigma and discrimination surrounding to HIV and AIDS, sex workers, MSM and IDU, inadequate national financing in HIV and low coverage of HIV prevention program in rural set up. Estimated budget for HIV and AIDS response for three years (2009-2011) is US\$ 128 millions but the committed amount is just 57.9 millions which show net resource gaps of US\$ 70 millions⁵⁶. As of July 2009 there were around 200 VCT centres, 23 ART sites in the country and 3,226 PLHIV were receiving ART from these centres⁵⁷. Considering the vulnerability of high risk groups, there is still need to expand VCT sites in mountain and hill districts particularly in mid-west and far-western development regions of the country.

⁴⁹ PATH, 2004, Factors Affecting Access to Safe Abortion in Nepal, A Literature Review

⁵⁰ Kaufman, 2001, Enhanced Monitoring of Mobile Outreach Serialization Services in Nepal

⁵¹ CREHPA, 2003, Exposure of Unwanted Pregnancy and Attitude towards and Practices of Abortion among Married Women Residing in Small Towns in Nepal

⁵² HSCB and NCASC, 2008, UNGASS Country Report of Nepal

⁵³ Ibid

⁵⁴ Ibid

⁵⁵ NCASC, 2009, Unpublished Cumulative HIV/AIDS Data , December 15 2009

⁵⁶ Government of Nepal and HSCB, 2009, National HIV/AIDS Action Plan

⁵⁷ Pathak, 2009, Overview of HIV/AIDS Control Program in Nepal: Epidemics, Responses and Challenges, Unpublished Paper Presented in Second National AIDS Council, 26 August 2009

iv. Access

There are only 93 public, NGO and private hospitals, 210 Primary Health Care Centres, 676 Health Posts and 3,134 Sub-health Posts in the country⁵⁸. The ratio of doctors to population is approximately 5 per 100,000 and a nurse to population is about 22 per 100,000. In addition to the insufficiency of trained personnel, health facilities suffer chronic difficulties in delivering services due to absenteeism and to lack of other resources such as basic medicine, water and electricity. Under funding is also a serious problem as the national resources are gradually diverting to peace building, reconstruction of infrastructures destroyed during conflict (1996-2006), rehabilitation of internally displaced people and security. Still 25 percent women have unmet need of family, BCG vaccination coverage is 87.5 percent, DPT 82 percent, OPV3 81 percent, measles 79 percent, growth monitoring of children 57 percent, coverage of iron distribution to pregnant women is 74 percent, institutional delivery 15 percent, delivery assisted by SBA at home and health facilities 31 percent, antenatal first visits 68 percent and post natal first visit 38 percent in 2008⁵⁹. The government of Nepal aims to establish at least one health facility within 30 minutes walking distance to all people. However, the vital health service statistics reveal inadequate access to basic health services to people on the one side and the people have no good practice to visit health facilities for basic health services on the other. These phenomena combinedly affected health of women and children in Nepal.

O. Partnership with Stakeholders

Gender discrimination in social, economic, political and cultural structure of society has direct impact on women's and has resulted into violence since long ago in Nepal. In 2009 a "Women Rights Monitoring National Network" was formed with the main objective of monitoring efforts of GO, NGO and civil society for developing gender equality and reporting and informing women rights status, making concerned authority more responsible and establishing women rights as human rights in the existing societal structure. Altogether, 23 government and non-government organizations working in the field of women rights came together and establish this network. FPAN is an active member of this network and it also worked in partnership and collaboration with other network members on gender based violence, human trafficking and other women issues in 2009.

Within the "Women Rights Monitoring National Network" a seven member working committee was formed in 2009, where National Women Commission (NWC) of Nepal is working as a secretariat of the network and the other member organizations are Family Planning Association of Nepal (FPAN), Forum for Women Law and Development (FWLD), SAATHI, Institute of Human Rights Communication Nepal (IHRICON), Feminist Dalit Organization (FEDO) and Jagaran Nepal. Initially this network has been extended in twenty districts of Nepal covering all five development regions. This Working Committee is doing regular supervision, monitoring and documenting district status on women rights issues to establish a data base system at National Women Commission of Nepal. Five FPAN branches were selected as local level leader for such supervision and monitoring work.

Besides, the Government of Nepal established an Inter-Ministerial Committee comprising Chief Secretary, Secretary Ministry of Women, Children and Social Welfare, Secretary Ministry of Finance, Secretary Ministry of Home Affairs, Secretary Ministry of Local Development, Secretary Ministry of Health and Population, Secretary Ministry of Education and Secretary Council of Ministries at Prime Minister Office to monitor women discrimination issues separately with an objective to eliminate all kinds of discriminations against women in Nepal. This Committee prepared a national plan and extended partnership with NGO, civil society and other external development partners. FPAN also worked in close coordination with this Committee and other partners involved in women issues in 2009.

FPAN worked in partnership with District Development Committees and Village Development Committees in Dang, Makwanpur, Sindhupalanchok and Nuwakot districts for combating girl/women trafficking. Respective VDC in project area supported remuneration of one community counselor to work with FPAN's Girl Trafficking Project. Similarly, FPAN provided capacity building training to community counselors supported by the VDC.

⁵⁸ DoH, 2009, Annual Report 2007/08, Kathmandu, Nepal

⁵⁹ Ibid

Now the Community Counselors supported by VDC and Girl Trafficking Project are working together in rural area to educate young girls and women against trafficking.

FPAN worked in partnership with Tribhuvan University, civil society, school teacher, youth organizations and other right based organizations for SRHR advocacy especially to introduce Comprehensive Sexuality Education (CSE) in secondary school in 2009 at central level. A concern group was formed in 2008 under the Non-governmental Organization Coordination Council (NGOCC) for advocacy on this issue in the Ministry of Education, Health and Population, National Planning Commission and other line ministries. FPAN worked actively with this group in 2009 and organized different advocacy programs on CSE in collaboration and partnership with its member organizations. Besides, FPAN worked with local level youth groups, youth forums, municipalities and village level women and youth groups.

FPAN is advocating for introducing comprehensive sexuality education in school curriculum. FPAN worked jointly with National Curriculum Development Centre and National Teacher Training Centres under the Ministry of Education, Tribhuvan University, Education Journalist Group, Teacher and Students Associations, Youth Clubs and other interest groups for the promotion of Comprehensive Sexuality Education in schools. A reference manual on comprehensive sexuality education to school teacher is drafted and it is expected to finalize in 2010 in partnership and collaboration with these agencies.

In HIV/AIDS response, FPAN worked with "National Association Positive Network (NAP+N) in HIV/AIDS prevention and management in 2009. Coordination with PLHIV groups at local level was strengthened in 2009 in 22 districts where FPAN has VCT services. Besides, Partnership was strengthened with relevant government agencies like National Centre for AIDS and STD Control (NCASC), HIV/AIDS and STI Control Board (HSCB) at national level and District AIDS Coordination Committees (DACC) at district level. FPAN received HIV test kits and STI drugs from NCASC and respective DHO.

FPAN was selected one of the Principal Recipient (PR) along with UNDP and Save the Children US by HIV/AIDS National Coordination Mechanism (CCM) in 2008 for implementation of HIV/AIDS component funded by GFATM in 7th round. FPAN selected 20 sub-recipients (SRs) for implementation of this HIV/AIDS component. Partnership with all SRs was strengthened in 2009 for implementation of this project. FPAN also worked with The Global Fund (TGF) Program Coordination Committee, including FPAN, Save the Children, UNDP and NCASC in 2009. Besides, FPAN worked with USAID funded Global Management Solution (GMS) for FPAN's capacity building for The Global Fund program.

FPAN also has technical partnership with WHO, UNAIDS, UNICEF, UNODC and INGOs like FHI, Save the Children and other technical partner like Grant Management Solution (GMS), HIV/AIDS alliance (India), back up initiatives of GTZ. As PR FPAN is working in good coordination with Local Fund Agent (LFA), Global Fund secretariat and submit progress updates and other required reports. FPAN represent civil society in CCM meeting and other CCM procedures and send progress updates and reports to CCM. CCM is providing oversight role for TGF grant management.

In abortion area, partnership was strengthened with Nepal Chemists and Druggists Association (NCDA). FPAN provided training on referral services, IEC/BCC materials and service site information sheet to NCDA and they referred the women seeking safe abortion services to FPAN clinics. The NCDA also distributed IEC/BCC materials to the women in their shop/clinic. Besides, partnership was also strengthened with other agencies including local governments, community based organizations, women and youth groups for referrals services.

Ministry of Health and Population is the key SRH service provider in Nepal. FPAN represented in number of SRH committees formed under the ministry including Family Planning Sub-Committee; Safe Motherhood Committee, Adolescent and Youth Sub-Committee, National RH Commodity Security Working Group, National AIDS Council, National Population Committee, HIV/AIDS National Coordination Mechanism, RH Coordination Committee formed at national and local level and working group on Gender based Violence under Family Health Division. FPAN worked in close coordination with central and local level health facilities. FPAN received selected IEC/BCC materials, contraceptives to some extent and HIV test kits from the Ministry of Health and Population in 2009 for program implementation. Besides, special attention was also given to strengthen partnership with Logistic Management and Family Health Divisions of the Ministry of Health and Population to receive contraceptives free of cost to FPAN.

FPAN worked in partnership with 300 NGO and CBO at grassroots level for program implementation (under IPPF core and TGF program). FPAN district branches provided technical back up including training and logistic support to these NGO and CBOs for program implementation. Collaboration and partnership with these organizations contributed to increase access of SRH information and services to the poor, marginalized and socially excluded people. New partnership was also developed with youth groups, clubs and users groups like Forest User Groups, Livestock Development Groups, Dairy Groups, Mother Groups, Water User Groups, Saving and Credit Groups formed and promoted by other agencies for expanding family planning services among these groups.

Partnership was re-established with USAID funded Nepal Family Health Program in 2009 after withdrawal of the Global Gag Rule by new US President. USAID begin to support FPAN for expanding access to family planning services in 5 districts. Similarly, partnership and collaboration was strengthened with PSI Nepal for expanding access to long acting family planning methods especially IUCD in 15 lowland districts in Nepal.

There are number of GOs and I/NGOs involved in sexual and reproductive health education and services in Nepal. Ministry of Education is the main agency involved in SRH teaching in school. Nepal has a compulsory Environment, Population and Health Curriculum from grade 6 to 10. However, the school teachers are not teaching properly the SRH section in school curriculum due to unavailability of training and reference materials on SRH teaching. Family Planning Association of Nepal worked together with school authority in 2009 in its operational area and provided SRH training to school teachers for improving teaching of this subject to school teachers.

P. Overall Program Summary

FPAN developed five-year Strategic Plan (2005-2009) based on IPPF's Strategic Framework. FPAN implemented its program activities in 2009 following its five-year Strategic Plan. FPAN programs were focused on five different thematic areas including Adolescents, HIV/AIDS, Abortion, Access and Advocacy. In addition to IPPF core program on 5 As, FPAN implemented several other innovative projects including, Advocacy on Introducing Comprehensive Sexuality Education in School Curriculum Project, Improving SRH Status of Adolescent Girls and Young Women Project, Improving Access of Safe Abortion Services to Marginalized People Project, and Network for Addressing SRH Right of Nepalese Women Project, Guaranteeing Sexual Rights of Out of School Youth Project. Improving Access to long acting FP method project and USAID supported strengthening family planning program. FPAN gained new experiences in these areas during 2009. Besides, FPAN was selected Principal Recipient to Manage Global Fund 7th round HIV/AIDS component for STI and HIV prevention among labour migrant and MSM. This component has been implemented in 25 districts through 20 sub-recipients. The assessment of the progress made by FPAN in major programmatic areas is highlighted in following section :

1. Advocacy

Key advocacy activities implemented in 2009 were as follows:

i. Advocacy with parliamentarians on ICPD + 15

On 15th July 2009, a workshop for parliamentarians was organized by the Family Planning Association of Nepal (FPAN) in Hotel Everest, Kathmandu on ICPD + 15. This particular workshop aimed not only to inform the parliamentarians on SRH issues or bear witness while FPAN renewed its commitment to work more for the cause of SRH, but it also aimed to more concretely involve the parliamentarians as a part of a team involved in designing SRH policies and again as a team, entrusting to advocate to work towards fulfilling the commitments Nepal has made in international forums, as a signatory to ICPD and MDG. Present in the occasion were more than two dozen parliamentarians, representatives from the government sector, youth and journalists. Besides, the parliamentarians also expressed their commitment toward ICPD PoA.

During the workshop, the parliamentarians were divided into three groups for the group work. Each group was required to work on two common queries, put forward to parliamentarians across the globe in ICPD seminars held to revive the commitments and determination of the signatories, in their respective countries. On behalf

of SRH advocates and FPAN in this particular context, CA member Hon. Dr. Arzu Rana Deuba, facilitator for the Group Work session, said it becomes important to identify our champions and our target audience and to identify the key people who can lobby for the cause we work for.

The groups work came up with the following commitments:

Group 1 agreed to create work groups, carry out regular monitoring of the work implementation and lobby to allocate high amount of budget for SRH.

Group 2 aspired to make a women caucus, to put experts in the caucus, who would not only solve women's issues but also health issues related to the youth.

Group 3 asserted to set a believable target for fund allocation (10%) from the national budget to SRH sector. They would properly manage the allocated budget. They would ensure that the concerned line agencies shall keep proper track of the work being done. They would conduct social audit from time to time in the lead of the communities and beneficiaries. To abide by these commitments, the group felt a need to set a timeline for all activities.

ii. Advocacy on Comprehensive Sexuality Education

The education system can play a crucial role to ensure reproductive well being of countless young people by imparting comprehensive sexuality education (CSE). In Nepal there are two National curriculums such as Health and Physical Education (optional) and Health, Population and Environment (HPE) (compulsory) taught in the lower secondary and secondary schools in Nepal. It has briefly introduced sex education and has incorporated components of sexuality such as, changes during adolescents and problems of adolescents. SRH issues for instance reproductive system, pregnancy and birth, sexually transmitted diseases, STI, HIV and safe motherhood. This curriculum has started to develop a platform where young people get opportunity to know about their body and SRH issues.

However, the content on sexuality education including SRH issues under the existing school curriculum are not sufficiently addressed the concerns of young people. The curriculum has heavily focused on bio-medical perspective of SRH without considering the impact of social norms on individual SRH. It is essential not only to review content but also to reflect on the way such education is delivered in classrooms. FPAN interactions with teachers have shown that the teachers who are teaching Health, Population and Environment curriculum in school are not able to teach SRH and they need training and appropriate reference materials to facilitate such topic. Even though the students were eager to learn but the teachers were hesitant to teach this subject.

FPAN advocated directly on the need for CSE with senior level policy makers in the Ministry of Education, Health and Population and universities in Nepal. FPAN worked in partnership with CSE stakeholders in Nepal. A coalition of I/NGOs and universities is formed at the national level for CSE advocacy. An eight-member committee, called the Concerned Group for National Curriculum Structure, was formed for joint advocacy to sustain the Health Population and Environment Curriculum as a compulsory subject in school curriculum.

Members of the Concerned Group prepared a memorandum and then read and handed over to Ms. Renu Kumari Yadav, Ministry of Education to sustain HPE in National Curriculum. The Minister supported that the HPE curriculum is important and serious discussion is needed before finalizing the new National Curriculum Structure. She directed the Director of Curriculum Development Centre, Mr. Haribol Khanal (who was present in this meeting) to discuss in detail about this issue before finalizing the NCS. A press conference from this group was held to sensitize the journalist on CSE and to give information about the meeting with the Minister of Education (MoE).

Advocacy through media is an ongoing activity of this project. Massive media coverage regarding CSE took place. Approximately 37 articles and news coverage on sexuality education in newspapers and magazines has taken place since the initiation of the project. CSE Project in partnership with one of the most popular media station is broadcasting CSE issues once a week for the remainder of the project period. Six youths are actively involved to discuss on CSE issues with experts and the discussion is aired once a week.

Advocacy on CSE was conducted in many occasions such as on the occasion of International Youth Day. On this day, rally started from Basantapur to workshop place at Rastriya Nach Ghar. Signature campaign with the

message "make CSE accessible to all" was done before the rally started. Conference started after the rally was over in an auditorium of Nach Ghar. At the opening ceremony 20 minute drama related to the need of CSE was shown by youth. Over 16,000 signatures to reinstate HPE curriculum was handed over to joint secretary of the Ministry of Education. Guests gave speech on different topic related CSE. Powerful speech was given by Young Parliamentarian, Mr. Gagan Thapa, on the role of parliamentarian to promote CSE to sensitize the participants of the gathering. Also spokespersons were from the Ministry of Health & Population and Ministry of Education. Cultural program by youth was shown. More than 400 people were sensitized on the issues related to CSE and on the need for SRH education. Youth, teachers, representative of INGOs/NGOs, government people and staff of FPAN actively participated in this program. Likewise, advocacy on CSE issues was done while celebrating International Women's Day, 20th International World Population Day, World HIV Day celebration etc.

Reference Manual and the Training Manual on CSE is developed in partnership with related government bodies, professors, and other organizations- As an outcome of these advocacy efforts, a high level Steering Committee was formed to prepare Reference Manual on Comprehensive Sexuality Education and Teacher Training Manual on 22nd Feb 2009 to school teacher comprising Director of National Curriculum Development Centre and Director of National Centre for Education Development under Ministry of Education (MoE), Director of IEC/BCC Centre Ministry of Health and Population (MoHP), University Professor, Representative of civil society, teacher and FPAN. A separate Technical Committee was formed on 13th March 2009 to draft the CSE reference manual and teacher training manual comprising representatives from MoE, MoHP, university, civil society, school teacher and FPAN. The technical committee prepared draft manuals in 2009 and then a content finalization committee was formed including university professors, MoE, civil society and FPAN. The manuals are waiting for printing. The manuals will be circulated to all secondary schools in Nepal in 2010. FPAN targeted senior level policy makers, university professors, civil society and school teachers and young people to take forward the CSE agenda at national level to bring these manuals.

iii. Advocacy on implementation of Domestic Violence Control Act 2009

A national level advocacy workshop on implementation of GBV Zero tolerance policy was organized with parliamentarians, lawyers, government officials, stakeholders and media people on the occasion of International Women's Day on 8th March 2009. GBV Zero tolerance policy and facts and figures on the status of Domestic Violence in Nepal was shared among 54 participants. Challenges in the implementation of recently passed Domestic Violence Control Act were also discussed among parliamentarians. The workshop participants also urged for increased budget allocation for implementation of Domestic Violence Control Act in the country.

2. Adolescent and Youth SRH Counselling

Adolescent and youth focused SRH programs were implemented to empower them on informed choice and decision making regarding their sexual and reproductive health in all branches/projects in 2009. The most effective means of communicating with adolescents & youth were Youth Information Centres, Youth Friendly Service Centres, Youth Forums and mobilization of peer's groups. Empowerment of adolescent girls involved in Multipurpose Resource Centre and Youth Forum under Finnish Project and Comprehensive Sexuality Project was significant. The shy and innocent adolescent girls are empowered significantly and now they can speak openly on their sexuality and SRH problems of their own and their colleagues without hesitation. The projects provided scholarship to selected marginalized girls to continue school level education and micro-credit support to start income generating activity. A team of consultant hired by IPPF central office visited youth activities around youth managed Multipurpose Resource Centre in Bardiya district, another group of consultant hired by IPPF/SARO visited youth programs in 7 districts and IPPF central office Organizational Learning team reviewed the CSE Project and youth involvement in the project in 2009. All of these reports revealed significant change in SRH behaviours among young people in program area. Achievements in provision of adolescent sexual and reproductive health counselling and services were as follows in 2009:

Adolescent and youth SRH

Type of Services	Achievement
Counseling on SRH	45291
Counseling on SRH life skills	16664
Counseling on sexuality	15663
Counseling MCH and personal hygiene,GBV and trafficking	41150
Hotline counseling	6522
Total	125290

3. STI, HIV and AIDS

STI and HIV prevention information and counselling are intergraded in all SRH services in FPAN's service delivery network. Besides, FPAN's institutional capacity was enhanced to work with key population in 2009. Information and education for STI and HIV prevention was provided through all branches and projects in 2009. STI services were provided through all FPAN clinics in 2009 where as the HIV VCT services were provided to most at risk population through 20 centres under IPPF core program and 26 centres under the Global Fund Program.

STI and HIV counseling and services

Type of Services	Achievement
HIV/AIDS	
Sero status lab test (Rapid test)	35112
HIV/AIDS prevention counseling	108397
HIV/AIDS consultation & referral for (ARV)	434
HIV/AIDS consultation & referral for treatment (OI)	1011
HIV/AIDS psycho social support	363
HIV/AIDS pre counseling	47184
HIV/AIDS post counseling	37968
HIV/AIDS other counseling	11750
PMTCT counseling and referral	0
Care and support to PLHIV	23
Subtotal	242242
STI/RTI	
STI/RTI prevention/post test counseling	197927
STI/RTI treatment syndromic diagnosis	51185
STI/RTI treatment etiological diagnosis	2508
STI/RTI treatment Hepatitis B vaccination	15
STI/RTI consultation follow up & other	6295
STI/RTI lab test	3702
Subtotal	261632
All Total	503874

Overall achievement in HIV prevention program was 510 percent in 2009. Similarly achievement in VCT test was significantly high (35,112 persons against the projection of 2335 persons) in 2009. Besides, the HIV consultation and referral for treatment (ARV) and opportunistic infection (OI) were also significantly high compared with annual projection for 2009.

Overall achievement in 2009 in STI counselling and service delivery was impressive. A total of 197,927 STI related counselling and services were provided through all FPAN and partner clinics which is 389 percent

compared with annual target of 50,905. Similarly, STI diagnosis and treatment services were provided to 51185 persons against the annual projection of 16398 which is 312 percent compared with annual projection for 2009. Besides, STI consultation and follow up services were provided to 6295 persons in 2009.

Overall high achievement in STI and HIV counselling and service was contributed by following factors:

- Implementation of Global Fund 7th Round HIV program through 20 sub-recipients with accelerated implementation plan to meet the pre set target for 2009
- Increased out reach program through peer educators and outreach workers in Global Fund Program
- Increase number of VCT centres from 20 in 2008 to 46 in 2009
- Increase supply of HIV test kits, condom and lubricant by the Global Fund through UNDP
- 20 VCT centres, 26 associated clinics, 541 CBD and 541 community groups were added under the Global Fund Program which contributed significantly to increase STI and HIV prevention, STI diagnosis and treatment, and VCT services in 2009 compared with 2008
- Arrangement for various capacity building training in 2009 to counsellors, lab technicians, peer educators and outreach workers by Global Fund Program

4. Safe Abortion

Information and education on safe abortion to women and young girls were provided in all 32 program districts. While safe abortion services were provided through 20 comprehensive reproductive health clinics in 2009. Besides, the clinical infrastructures in existing clinics were upgraded based on recommendations of facility survey conducted by FPAN in 2008 to improve the quality of services particularly in Jhapa, Dhanusha, Itahari, Makwanpur, Kavre, Rupandehi, Dang and Nawalparasi clinics.

Safe abortion counselling and services

Safe abortion services	Achievement
Abortion counseling	99851
Abortion Induced (MVA)	12386
Abortion Induced (Medical)	261
Post abortion counseling	57710
Post abortion follow up	6994
Incomplete abortion referred by other agencies	28
Total	177230

Medical method of abortion was also introduced in FPAN clinics in 2009 after the government formally introduced MMA on pilot basis. A total of 261 MMA cases were performed by FPAN clinics in 2009.

5. Access of SRH Information and Services to Marginalized and Disadvantaged Groups

FPAN aimed at providing quality family planning and other reproductive health services to couples and individuals especially for marginalized and underserved groups based on informed choice by increasing the accessibility and availability of RH/FP information and services in meeting the unmet needs through right based approach. SRH information and services provided by FPAN through following service delivery points managed by of its own or in partnership with other agencies.

Types of clinics

	Urban	Peri-urban	Rural	Total
Static clinics	41	45	43	129
Mobile clinic	-	9	107	116
Associated clinic (Partnership with local CBO)	31	20	136	187
CBD	-	-	1439	1439
Social marketing agent	-	-	1	1
Other agencies (Global Fund Supported SDPs)	47	60	439	546
Total	119	134	2165	2418

Overall the number of service delivery points increased by two folds from 834 (114 static, 52 mobile, 155 associated, 495 CBD, 12 social marketing, 3 government and 3 other agencies) in 2008 to 2418 in 2009.

Major services provided through these service delivery points were as follows:

i. Family Planning Services

Overall achievement in family planning service delivery was satisfactory compared with the annual projection for 2009. Overall achievement against the projection was 99 percent.

Family planning services projected and actual

Methods	Achievement
Oral pills	72873
IUCD	11470
Male condom	93227
Female condom	357
Injectable	90290
Implant	11313
M. Sterilization *	25899
F. sterilization *	2617
Total	308,046

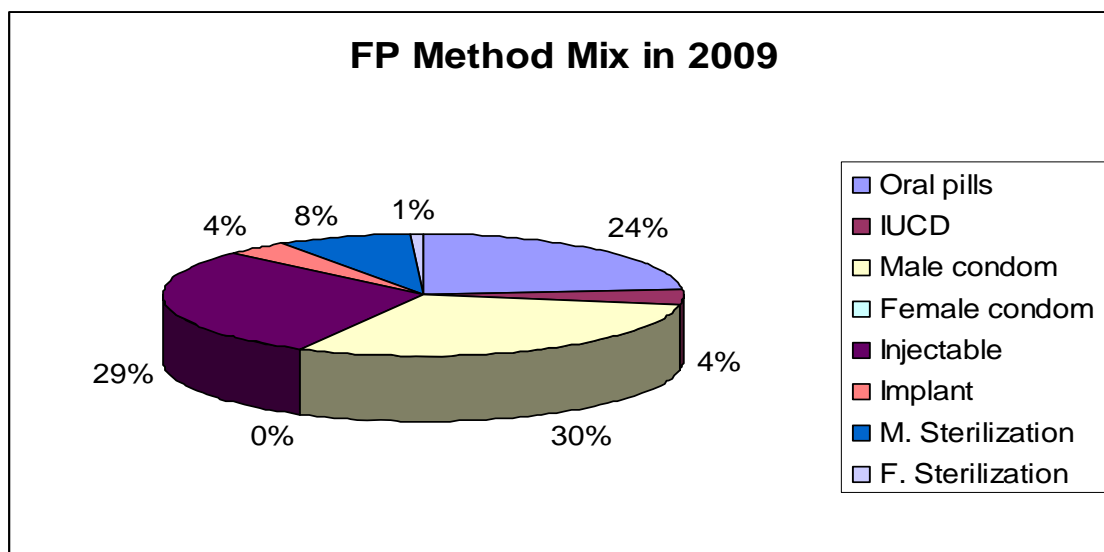
Overall recruitment of family planning clients was 56 percent high in 2009 compared with 2008. Total number of family planning users increased from 197,179 in 2008 to 308,046 in 2009. Similarly, recruitment in new FP users increased by 10 percent in 2009 compared with 2008.

Significant increase in family planning clients in 2009 compared with 2008 was contributed by following factors:

- Withdrawal of service fee for contraceptives following the free health care policy of the government
- Free supply of contraceptives from District Public Health Office to FPAN's branches in respective program districts
- Implementation of four new projects supported by PSI Nepal, USAID (NHFP), Ford Foundation through IPPF, and DFID Civil Society Challenge Fund
- Increase in IEC/BCC outreach programs
- Expanded 15 static clinics under PSI and DFID supported project
- Additional 64 mobile team were mobilized for IUCD
- 944 CBD were added in 2009 under PSI, USAID and TGF projects
- District branches established partnership with 543 new groups in the community like women and youth groups for distribution of condom and oral pills
- Consolidation of supervision and monitoring system and capacity building of the field staff through in-house on the job training.

Method mix

The method mix of family planning methods reveals higher preference for male condom (30%), followed injectable (29%), oral pills (24%), male sterilization (8%), implant and IUCD each (4%), female sterilization (1%). Majority of FP clients in FPAN's branch and outreach clinics are using spacing methods as the programmatic focus is on birth spacing among young people.



Age profile of family planning users

Out of 122,838 new FP users recruited by FPAN in 2009, adolescent (10-19) comprises 6 percent, youth (20-24 years) comprises one fourth (23%) and young adult (25 and above) comprises more than half (71 %). Similarly, the share of adolescent in total family planning users was 7 percent, youth 29 percent and adult 64 percent in 2009. Overall, use of family planning services in FPAN clinics by young people was more than one third and it is expected to grow in future through enhanced peer education.

Age profile of family planning users

Methods	Total number of users	Adolescent (10-19)	% Share in total	Youth (20-24)	% Share in total	Adult (>25)	% Share in total
Condom	93227	9818	11.0	27094	29.0	56315	60.0
Pill	72873	4697	6.0	20780	29.0	47396	65.0
Injectable	90290	5424	6.0	25855	29.0	59011	65.0
IUCD	11470	363	3.0	2449	21.0	8658	75.0
Implant	11313	194	2.0	1581	14.0	9538	84.0
M. Str.	25899	46	0.18	12017	46.0	13836	53.00
F. Str.	2617	11	0.42	674	26.0	1932	74.0
F. Condom	357	58	16.0	122	34.0	177	50.0
Total	308046	20611	7.00	90572	29.00	196863	64.0

ii. CYP achieved

Total CYP in 2009 calculated based on IPPF conversion factors was 139,774. Where as it were 172,960 based on conversion factors of the Ministry of Health and Population. Major contribution in CYP was made by IUCD, Implant and Depo-Provera (Injectable) followed by condom, pills, sterilization and other clinical methods. Overall, the CYP grew by 61 percent in 2009 compared with 86,464 in 2008 (according to IPPF Conversion factors). Similarly the CYP according to MoHP conversion factors increased from 91852 in 2008 to 172960 in 2009. The growth rate was 88 percent in 2009 compared with 2008.

iii. No of gynaecological and obstetric counselling and services

A total of 613,788 gynaecological and obstetric education, counselling and services, including 206,852 gynaecological and 406,936 obstetrics services were provided to the clients through 2418 service delivery points during the program year 2009 as follows:

Types of gynecological and obstetric services provided by FPAN clinics in 2009

A. Gynecological and obstetric services	Achievement
Gynecological diagnostic services (Lab test)	19630
Gynecological diagnostic and treatment (imaging)	12829
Gynecological exam (vaginal) pap smear	46
Gynecological exam (manual) breast cancer	3356
Gynecological exam (other) health check up	163691
Gynecological counseling	7300
Subtotal	206852
Obstetric services	
Obstetrics prenatal care	88489
Obstetrics-prenatal counseling- pre natal care information (ANC, TT etc)	76225
Obstetrics-prenatal counseling- unplanned pregnancy	34398
Obstetrics- pregnancy test (lab test)	11634
Obstetrics- post natal care	980
Obstetrics- post natal care consultation including uterine evolution monitoring	16480
Obstetrics- post natal counseling breast feeding advice	65853
Obstetrics- post natal counseling other	111372
Obstetrics- surgery other	8
Obstetrics - surgery - child birth, vaginal delivery (safe delivery)	1497
Subtotal	406936
Total	613788

iv. Counselling on sub-fertility, re-canalization and other reproductive health services

Overall achievement in sub-fertility counselling and services was 193 percent in 2009 compared with annual projected figure. Overall these services were 8 percent high in 2009 compared with 2008. Counselling on sub-fertility was provided to women and men who visited FPAN clinics for SRH education, counselling and services in 2009. A total of 31,939 men and women who expressed their problem on fertility were provided counselling and treatment services in the clinics. The counselling service was 5 percent high in 2009 compared with 2008. Similarly, 2253 persons receive treatment on sub-fertility in 2009 which is 152 percent high compared with 893 persons in 2008. Whereas the laboratory tests declined by 40 percent in 2009 compared with 2008.

Sub-fertility counselling and services

Type of Services	Achievement
Infertility/sub-fertility counseling	31939
Infertility - treatment	2253
Re-canalization	52
Infertility - laboratory tests	413
Total	34657

FPAN is a sole provider of re-canalization services in Nepal. Achievement in re-canalization services was 88 percent compared with projected figure in 2009. However, the number of case increased by one third in 2009 compared with 2008.

Increase in sub-fertility counselling and treatment services in 2009 was contributed by recruitment of medial doctors in branch clinics and enhanced referral system from community to FPAN clinics.

v. Gender based violence (GBV) screening and counselling

Combating gender based violence is one of the most important programs implemented by FPAN. Achievement in GBV screening was 67 percent low compared with projected figure for 2009. However, achievement in GBV counselling was 177 percent compared with projected figure for 2009. Unlike GBV screening overall achievement in GBV counselling was five percent low in 2009 compared with 2008. However, micro-credit support to GBV survivors, trafficked returnees, and other marginalized women was encouraging in 2009 compared with 2008.

GBV services	
Type of Services	Achievement
GBV screening	2528
GBV counseling	26249
Micro credit support	900
Total	29677

Overall GBV services declined by 17 percent in 2009 compared with 2008. Such decline was contributed by phase out of GBV project, over engagement of counsellors in safe abortion and VCT counselling, turnover of trained counsellors on GBV screening, unavailability new GBV screening training in 2009, and relatively weak supervision and monitoring from relevant division and section from FPAN head quarters to district branches.

vi. Other non-SRH medical services

Achievement in other SRH medical services like laboratory services including urine, blood and stools tests were more than expected in 2009. Overall achievement in these services was 117 percent in 2009 compared with expected services. These services were 65 percent high in 2009 compared with 2008.

Other SRH Medical Services	
Type of Services	Achievement
Other SRH Medical Services - Diagnostic Test (Lab services)	21113
Other SRH Medical Services (complication management, eye and dental check up)	5264
Other SRH Medical Services - Therapy / Treatment (parasite control)	200
Total	26577

vii. Other non-SRH paediatric services

Achievements in other non-SRH paediatric services like immunization were more than expected in 2009. Achievement in immunization services were 17 percent high in 2009 compared with 2008.

Non-SRH Paediatric Services

Non SRH Pediatrics services	Achievment
Pediatrics - Therapy / Treatment (Immunization services)	54480
Pediatrics - Consultation (Infant health check up)	8136
Total	62616

Similarly, achievement in infant health check up services was more than expected in 2009. These services increased significantly in 2009 compared with 2008. Overall achievement in non-SRH paediatric services was 33 percent high in 2009 compared with 2008. Increase in such services was contributed by recruitment of medical doctors in some branch clinics in 2009.

T. Capacity Building of the Association

Clinical Management and organizational development trainings were in high priority in 2009. Large number of service providers and field staff including service providers, accountants, branch managers, supervisors, community counsellors and program staff working in district branches were trained on various issues. Major clinical trainings organized in 2009 were as follows:

- Comprehensive Training Skills (CTS) training to 12 medical doctors and staff nurse
- Comprehensive abortion care training to 10 medical doctors
- Medical Method of Abortion training to 4 medical doctors
- IUCD insertion and withdrawal training to 67 medical doctors, ANM and staff nurse
- Implant insertion and withdrawal training to 9 paramedics
- Comprehensive counselling and family planning training to 62 paramedics
- Basic VCT counselling training to 5 counsellors
- VCT counselling refresher training to 6 counsellors
- VCT test laboratory training to 23 lab assistants
- Pre and post abortion counselling training to 6 counsellors
- Youth friendly SRH service training to 30 paramedics
- PMTCT counselling training to 16 paramedics
- Vasectomy training to 5 medical doctors
- Minilap training to 4 medical doctors
- Quality care training to 22 paramedics
- Infection prevention training to 28 paramedics and medical doctors
- Trauma and guilt counselling training to 20 counsellors/staff nurse
- Value clarification training to 15 medical doctors and service providers

Besides above mentioned medical trainings, branch managers, accountant, peer educators, community counsellors, youth volunteers were trained on following issues:

- Social audit training to 30 branch managers and project coordinators
- Comprehensive sexuality education (CSE) training to 30 branch managers and project coordinators
- TOT on Comprehensive Sexuality Education (CSE) to 51 youth
- TOT on Comprehensive Sexuality Education (CSE) to 20 community counsellors
- MIS and account keeping training to 60 branch managers, project coordinators and accountants
- MIS training to 681 supervisors, community workers, community counsellors and service providers
- Nutrition training to 30 youth volunteers working in MPRC
- Organization development training to 21 MPRC youth volunteers
- Comprehensive sexuality education (CSE) training to 172 youth working in branches/projects
- Candle making training to 26 youth
- Idol making training to 13 youth
- Explore research training to 20 youth

- Social mobilization training 24 project staff
- Trafficking and gender based violence training to 209 peer educators and community counsellors
- SRH counselling training to 396 peer educators and community counsellors
- STI and HIV prevention counselling training to 667 peer educators and outreach workers
- TOT on sexuality to 36 peer educators
- Stigma reduction training to 23 youth

Besides, FPAN also trained volunteers and staff of the partners on abortion counselling, advocacy and referral as follows:

- Abortion counselling, advocacy and referral training to 800 Female Community Health Volunteers of the Ministry of Health and Population
- Abortion counselling, advocacy and referral training to 500 school teachers
- Abortion counselling, advocacy and referral training to 950 private chemists and druggists

Similarly selected poor and marginalized women in project area were trained on various income generating activities as follows:

- Skill development training on poultry, livestock raising, handicraft making, beauty parlour, tailoring, embroidery etc to 254 women
- Micro-credit training to 189 women

Besides above mentioned trainings, large number of FPAN's staff and volunteers were trained outside the country on organizational development, quality of care and clinical services as mentioned at the end of this report.

Q. Association Finance (overall)

FPAN received Rs 304.12 million cash and commodity grant from various donors, including internal income in 2009. The share of cash and commodity income from various donors was 38.94 percent from IPPF core grant, 51.77 percent from other donors and 9.29 percent internal income. Overall income to FPAN was 24.88 percent high in 2009 compared with 2008.

FPAN received a total amount of Rs 117.30 millions as regular cash grant from IPPF for the budgeted activities against the expected grant income of Rs 114.44 millions. FPAN received 1.90 percent (Rs. 3.17 million) high than expected amount for budgeted activities in 2009. Besides, FPAN received Rs. 72.10 million for non-budgeted activities like Global Fund, DFID (GTP), PSI, Salin etc. Total amount received from IPPF for budgeted and non-budgeted activities was Rs. 117.30 millions. Overall financial support from IPPF for budgeted and non-budgeted activities was 8.44 percent high in 2009 compared with 2008.

Cash grant received from restricted donors in 2009 was Rs. 66.73 millions against the budgeted amount of Rs. 65.70 millions. FPAN received 1.58 percent high amount from restricted donors against the budgeted amount. Overall cash and commodity received from restricted donors was 45.31 percent high in 2009 compared with 2008.

FPAN generated a total amount of Rs 28.26 million as compared to forecasted amount of Rs. 27.28 millions in 2009. Overall internal income decreased by 2.15 percent in 2009 compared with 2008. Such decline in internal income was an effect of free health care policy of the government because FPAN was instructed to drop out service fee in contraceptives. Besides above mentioned cash grants from IPPF, other donors and internal income, FPAN received small amount of contraceptives, HIV/AIDS test kits, lubricants and medicine from Nepal Government, PSI Nepal and the Global Fund through UNDP equivalent to Rs. 33.65 millions.

Overall expenditure of the Association was 290.94 million against the forecasted expenditure of Rs. 191.74 millions. There was net over expenditure of Rs. 99.20 million against the budgeted amount in APB 2009. This happened because the Global Fund Program, PSI, USAID, UNFPA supported projects and SLINE fund were approved after preparation of APB 2009.

R. Success

Besides, overall achievement in implementation of the programs during the program year 2009 was successful except in some programs. Achievements in STI counselling and services, HIV prevention and care, safe abortion counselling and services, family planning services, recruitment of new family planning users, couple year of protection, sub-fertility counselling and treatment services, other non-SRH medical services and other non-SRH pedantic services were satisfactory. Overall achievement was significantly high compared with projected figures for 2009.

Success in major program interventions

SN	Type of services	Achievement
1	Adolescent SRH counselling	125290
2	STI counselling and services	261632
3	HIV prevention and care	242242
4	Safe abortion counselling services	177230
5	Family planning	308046
6	Recruitment in new FP users	122838
7	CYP	139774
8	Gynaecological and obstetric counselling and services	613788
9	Sub-fertility counselling and services	34657
10	GBV screening, counselling and support services	29677
11	Other non-SRH medical services	26577
12	Other non-SRH obstetric services	62616

S. Outside Assistance

During the program year 2009 FPAN received financial and technical assistance from different organizations. Global Management Solution (GMS) provided technical assistance to strengthen institutional capacity for implementation of The Global Fund Program.

HIV/AIDS test kits were received free of cost from National Centre for STI and STD Control. FPAN received technical support and expertise for undertaking training program for service providers from IPPF/SARO, government, teaching hospitals and partner organizations. Similarly, contraceptives were received from government of Nepal. IEC/BCC materials, training manuals, service delivery guidelines and human resources to organize mobile camps in under served area were received from government and partner agencies.

Besides, National Training Centre of the government provided technical assistance to re-activate FPAN's central clinic as one of the national training centre in family planning and Chitwan and Itahari clinics as regional family planning training centres.

Many NGO working in concern group joined hand with FPAN for CSE advocacy at national level. Similarly, community people provided construction materials, cash and labour for renovation/construction of community clinics.

T. In-kind Contribution

The in-kind contribution mobilized by the Association during the program year included free accommodations provided by the community for static and outreach mobile clinics and service centres. Besides, FPAN received contraceptives, HIV test kits and lubricants free of cost from Ministry of Health and Population, Global Fund through UNDP and PSI Nepal equivalent to US\$ 442,125.0 in 2009 as follows:

Contraceptives, HIV test kits and lubricants received from the government, Global Fund through UNDP and PSI free of cost in 2009

Items received	Quantity	Unit cost	Total cost in US\$
Condom	4439654* Pcs	US\$ 3.74 per gross	115,307.0
Pills	236027** Cycles	US\$ 0.32 per cycle	75,529.0
Injectable	141679** Vials	US\$ 1.08 per vial	153,013.0
IUCD	8274** * Pcs	US\$ 0.47 per piece	3,922.0
Jaddle	1817** Set	US\$ 23.52 per set	42,735.0
Determine	37600 *** * Pcs	US\$ 0.72 per piece	27,072.0
Unigold	770*** * Pcs	US\$ 1.9 per piece	1,463.0
SD Bioline	730*** * Pcs	US\$ 0.8 per piece	584.0
Lubricant	500000***** Sachet	0.045 per sachet	22,500.0
Total	-	-	442,125.0

Note:

* Condom: 3539654 pieces from government and 900000 pcs from TGF through UNDP

** Pills: from government

*** IUCD: 5934 pieces from PSI and 2340 pieces from government

**** Determine: 5600 pcs from government and 32000 pcs from TGF through UNDP

**** Unigold: 520 pcs from government and 250 pcs from TGF through UNDP

**** SD Bioline: 480 pcs from government and 250 from TGF through UNDP

***** Lubricant: From TGF through UNDP

Besides, FPAN received significant contribution in, land, cash, commodity and free labour for renovation and construction of 64 community clinics in 2009. In Jhapa district a business couple, Mr. Jagat Man Shrestha and his wife Bijaya Shrestha constructed a community clinic worth of Rs 1.5 millions and handed over the ownership of the building to FPAN in 2009. FPAN honoured Mr. Shrestha with honorary membership of the Association.

