

## **FAMILY PLANNING ASSOCIATION OF NEPAL (FPAN)**

### **ANNUAL WORK PROGRAM BUDGET 2010- OVERALL PROGRAM SUMMARY**

#### **A. Geography**

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 influence sustainable livelihoods and poor access to services such as health and education pose severe handicaps to improve social development indicators.

#### **B. 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 2021<sup>1</sup>. Such growth demand huge investment is 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 2006<sup>2</sup>. 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.

#### **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 2006<sup>3</sup>. 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 2005<sup>4</sup> and 4.7 percent in 2008/09<sup>5</sup>. 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 country<sup>6</sup>. 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

---

<sup>1</sup> CBS, 2003, Population Projections for Nepal 2001-2021, Kathmandu, Nepal

<sup>2</sup> NDHS, 1976, 1981, 1986, 1991, 1996, 2001, 2006

<sup>3</sup> United Nations Development Program, 2008, World Human Development Report 2008/09, New York, USA

<sup>4</sup> Ministry of Finance (MoF), 2006, Economic Survey of Nepal, 2005/06, Kathmandu, Nepal

<sup>5</sup> MoF, 2009, Economic Survey of Nepal, 2008/09, Kathmandu, Nepal

<sup>6</sup> CBS, 2004, Living Standard Survey Report, 2004, Kathmandu, Nepal

percent) employment is in farm sector and rest one fourth (26 percent) is in off-farm sector<sup>7</sup>. Farm sector alone consume largest share of the active labour force but this sector contributes only 33 percent in GDP<sup>8</sup>. 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. 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. Drafting new constitution is now underway.

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, Madhesi and the oppressed and neglected people<sup>9</sup>. Drafting of new Constitution is underway and expected date of its completion is May 2010. New constitution 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.

#### **E. 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 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<sup>10 and 11</sup>. Wider inequality is prevalent among these social groups<sup>12</sup>. 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

---

<sup>7</sup> CBS, 2008, Second Labor Force Survey of Nepal, Kathmandu, Nepal

<sup>8</sup> MoF, 2009, Ibid Economic Survey 2008/09

<sup>9</sup> UNDP, 2009, Nepal Human Development Report 2009, Kathmandu, Nepal

<sup>10</sup> CBS, 2001, Population Census Report 2001

<sup>11</sup> CBS, 2003b, Population Monograph Volume I and II, Kathmandu, Nepal

<sup>12</sup> DFID and World bank, 2006, Unequal Citizens: Gender, Caste and Ethnic Exclusion in Nepal

exclusion and geo-political discrimination<sup>13</sup>. 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 is 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 state<sup>14</sup>. 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.

#### **F. 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 2000<sup>15</sup> and further down to 31 percent in 2005<sup>16</sup>. 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 area<sup>17</sup>. 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 2015<sup>18</sup>. 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.<sup>19</sup>

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 decade<sup>20</sup>. This indicates that the poorer people are becoming more vulnerable to diseases and hunger.

#### **G. 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

---

<sup>13</sup> UNDP, 2009, Ibid

<sup>14</sup> DFID and World Bank, 2006 Ibid

<sup>15</sup> National Planning Commission of Nepal, 2002, 10th Five Year Periodic Development Plan of Nepal

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

<sup>17</sup> National Planning Commission of Nepal, 2001, Poverty Reduction Strategy Paper of Nepal

<sup>18</sup> UN Country Team Nepal, 2002, Progress Report of the MGDs

<sup>19</sup> Ministry of Finance Government of Nepal 2008, Economic Survey

<sup>20</sup> National Planning Commission of Nepal, 2004, Nepal Living Standard Survey

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 development<sup>21</sup>. 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.

#### **H. 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 reduction<sup>22</sup>. 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.

#### **I. 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 follows<sup>23</sup>:

- 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 impatient 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 program<sup>24</sup>. 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 year<sup>25</sup>. 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.

#### **J. 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\$5<sup>26</sup> which is significantly low compare with internationally agreed standard of US\$ 34 for developing countries. General

---

<sup>21</sup> National Planning Commission of Nepal, 2007, Base Paper for Interim National Development Plan

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

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

<sup>24</sup> NPC, 2007, Three Year Interim Plan of Nepal, Kathmandu Nepal

<sup>25</sup> MoHP, 2008, Minutes of the Seventh Joint Program Review Meeting, MoHP, Unpublished Report

government expenditure on health as percentage of total government expenditure (1998-2002) was only 7.5 percent<sup>27/28</sup>. It was further down to six percent in 2006/07<sup>29</sup> 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.<sup>30</sup>

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 money<sup>31</sup>. 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 functions<sup>32</sup>. 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.<sup>33</sup> 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.

#### K. 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 2001<sup>34</sup>. However, there is wider gender gap in literacy rate. Male literacy rate is 65 percent where as the female literacy rate is 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 counterparts<sup>35</sup>. 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 education<sup>36</sup>. 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 secondary

---

<sup>26</sup> Ibid MOHP, 2007

<sup>27</sup> UNICEF, 2005, The State of the World Children, New York, USA

<sup>28</sup> WHO 2005, The World Health Report 2005, Geneva, Switzerland

<sup>29</sup> Ministry of Finance National Budget Allocation for 2006/2007

<sup>30</sup> MoHP 2007, Budget Analysis 2007-08, HSRSP and RTI, HSRSP Report No. 2.4-08

<sup>31</sup> MOHP, 2006, National Health Account 2001-2003, Kathmandu, Nepal

<sup>32</sup> Ibid MoHP, 2006

<sup>33</sup> MoHP, 2008, Bottleneck Study for Timely Disbursement of Funds, HSRSP, MOHP, Kathmandu, Nepal

<sup>34</sup> Central Bureau of Statistics, 2001, Population Census Report 2001

<sup>35</sup> UNICEF South Asia Regional Office, 2005, The State of South Asia's Children, Kathmandu, Nepal

<sup>36</sup> Ibid UNICEF, 2005

schools<sup>37</sup>. This indicates relatively poor quality of education because one teacher can not take care of such large number of students.

#### **L. 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 progress<sup>38</sup>. 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 percent<sup>39</sup>. Yet Nepal needs additional efforts and ensuring adequate funding mechanism to achieve the millennium development especially to achieve goal 5 and 6 set for 2015.

#### **M 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 years<sup>40</sup>. While the Ministry of Youth and Sport of Nepal defined youth to individuals between ages of 15-29 years<sup>41</sup>. 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 Nepal<sup>42</sup>. 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 2001<sup>43</sup>. 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 counterparts<sup>44</sup>. 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.

---

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

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

<sup>39</sup> Ibid

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

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

<sup>42</sup> CBS, 2003, Ibid

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

<sup>44</sup> 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 2009<sup>45</sup>. 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, absences 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.

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 abortion<sup>46</sup>. Hindu sculptures including the Rigveda, the Athuruaveda, 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 pregnancy<sup>47</sup>.

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 fear<sup>48</sup>.

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 sexual puberty and strict control of woman's sexuality both inside and outside of marriage contribute to such culture<sup>49</sup>. 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 character<sup>50</sup>. 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.

---

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

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

<sup>47</sup> FWLD, 2003, Struggle to Liberalize Abortion in Nepal, Challenges Ahead, Kathmandu, Nepal

<sup>48</sup> Manandhar, 2000 Ethnographic Perspective on Obstetric Health Issues in Nepal

<sup>49</sup> PATH, 2004, Factors Affecting Access to Safe Abortion in Nepal, A Literature Review

<sup>50</sup> Kaufman, 2001, Enhanced Monitoring of Mobile Outreach Serialization Services in Nepal

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 pregnancy<sup>51</sup>. 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 migrants<sup>52</sup>. 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 percent<sup>53</sup>. The Global Fund round 7<sup>th</sup> 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 old<sup>54</sup>. Where as the total number of reported case in VCCT centres as of 15th July 2009 is recorded 14,320. Out of them 2,493 (17 %) already dead<sup>55</sup>. Percentage share of reported HIV+ case reveals 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 millions<sup>56</sup>. 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 centres<sup>57</sup>. 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.

### 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 country<sup>58</sup>. 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 2008<sup>59</sup>. The government of Nepal aims to establish at least one health facility within 30 minutes walking distance to all people. However, the vital

---

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

<sup>52</sup> HSCB and NCASC, 2008, UNGASS Country Report of Nepal

<sup>53</sup> Ibid

<sup>54</sup> Ibid

<sup>55</sup> NCASC, 2009, Unpublished Cumulative HIV/AIDS Data

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

<sup>57</sup> 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

<sup>58</sup> DoH, 2009, Annual Report 2007/08, Kathmandu, Nepal

<sup>59</sup> Ibid

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.

#### **N. Partnership with Stakeholders**

In HIV/AIDS response, FPAN will work with "National Association Positive Network (NAP+N) in HIV/AIDS prevention and management in 2010. A MoU has been signed with this organization to organize joint programs to advocate for and to increase access of support and care services to PLHIV. Linkages and coordination will be strengthened gradually with PLHIV (people living with HIV) groups in district branches to implement HIV prevention programs. Coordination with such groups will be strengthened in 2010 in 22 districts where FPAN has VCT services. Besides, Partnership will be 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. An effort will be made to receive HIV test kits and STI drugs from NCASC and respective DHO.

FPAN is selected one of the Principal Recipient (PR) along with UNDP Nepal and Save the Children US by HIV/AIDS National Coordination Mechanism (CCM) 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 will be strengthened in 2010 for implementation of this project.

In abortion area, partnership will be strengthened with Nepal Chemists and Druggists Association (NCDA) on safe abortion services. FPAN already signed a MoU with NCDA in 2006 and new partnership programs were implemented in 2007, 2008 and 2009 at national and district levels. FPAN will provide training on referral services, IEC/BCC materials and service site information sheet to NCDA and they will refer the women seeking safe abortion services to FPAN clinics. The NCDA will also distribute IEC/BCC materials to the women in their shop/clinic. Besides, FPAN will continue branding to some private chemists and druggists in close collaboration with NCDA so that the women will know those branded shops are good centre for information on safe abortion. FPAN will also strengthen partnership with other agencies including local governments, community based organizations, women and youth groups for referrals services.

FPAN will work for revival of National Coalition on Gender Violence formed in 2006 through FPAN's initiatives. Altogether there are 34 organizations including Ministry of Women, Children and Social Welfare, UN agencies, external development partners, NGOs and INGOs. FPAN will work as a secretariat of the coalition and coordinated all activities of the coalition. Advocacy works against GBV, trafficking and women empowerment will be strengthened through this coalition in 2010.

Ministry of Health and Population is the key SRH service provider in Nepal. FPAN represents 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, 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 will work in close coordination with central and local level health facilities. FPAN will also receive selected IEC/BCC materials, contraceptives to some extent and from the Ministry of Health and Population in 2010 for program implementation. Besides, special attention will be 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 is working in partnership with 278 community-based organizations at grassroots level. FPAN district branches will provide technical back up services including training and logistic support to some extent to these CBOs for implementation of SRH programs. Collaboration and partnership with these local level organizations will continue in 2010 for increasing access to SRH information and services to the poor, marginalized and socially excluded people. New partnership will be 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.

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 will work together with school authority in its operational area and provide SRH training to school teachers to empower them with SRH knowledge.

Besides, FPAN is advocating for introducing comprehensive sexuality education in school curriculum. FPAN will work 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 will be published and distributed to all subject teacher teaching Environment, Health and Population curriculum in school through Curriculum Development Centre. Similarly, selected trainers involved in teachers' training will be trained in close partnership with National Teacher Training Centre.

FPAN is chairing the Non-governmental Organizations Coordination Council (NGOCC) since 1990. Altogether there are 34<sup>60</sup> organizations including 12 INGOs, two bilateral agencies, three UN agencies, and 17 NGOs. Experience and lessons learnt while working in SRH field are shared in this forum for focused SRH programs in Nepal. Experience sharing in this Forum will be continued as before in 2010. A CSE concern group has been formed within this Council to take forward the CSE advocacy among policy makers and stakeholders in Nepal. Partnership and coordination within this concern group will further strengthen in 2010.

To intensify the SRHR advocacy, FPAN will work with media partners in 2010 including the "Association of Community Radio Broadcasters Nepal" (ACRB), Sarbanam (street theatre group), Health Journalist Association of Nepal (HJAN) and Education Journalist Association of Nepal for advocacy in order to increase access of SRH services to underserved and marginalized people. MoUs are signed with ACRB and Sarbanam. FPAN youth were trained on radio journalist in collaboration and partnership with ACRB in 2007 and 2008. Trained youth volunteers working in the field will collect real stories and testimonies of women, men and young people on how they are deprived from basic RH services. Then they will send to local FM for dissemination. The community radio (local FM) will broadcast the information collected by FPAN youth volunteers for wider masses. Street theatre programs will be organized in partnership with Sarbanam for awareness rising among community people. Similarly, selected research findings and policy analysis completed by FPAN will be published through HJAN and Education Journalist network in 2010. District branches will also work in partnership with local journalists associated with national and local newspapers. District branches will invite local journalists to visit FPAN service sites and out reach programs to collect first hand experience on SRH situation of poor and marginalized people. Then the journalists will be encouraged to advocate on various SRH issues of the poor, marginalized and socially excluded people to sensitize local level planners and policy makers.

Besides, FPAN will further strengthen its partnership with other right based organizations like Lawyer's Association, human right groups, women's groups for the promotion of IPPF deceleration on sexuality in 2010.

## **O. Overall Program Summary**

All programs/projects pertaining in APB 2010 are prepared in logical framework based on IPPF/SARO guidelines. The monitoring and evaluation plan is inbuilt in all programs and projects. Altogether there are 10 projects under IPPF core program, including five thematic areas (adolescent, abortion, AIDS, access and advocacy), four supporting strategy (Governance and accreditation, capacity building, resource mobilization and knowledge management and M & E) and special project on improving performance indicators. Similarly, there are nine restricted projects, including four projects in adolescent (Improving the Sexual and Reproductive Health Status of Young Women (Micro-credit) Project, MPRC Initiatives- Improving SRHR of Young Women Project, Comprehensive Sexuality Education Project, and Guarantying SRHR of out of School Young People Project), two projects in abortion (Networking for Addressing Women's Reproductive Rights Project and Global Comprehensive Abortion Care Project), one project in HIV/AIDS (Global Fund Supported HIV Prevention among Labor Migrants and MSM) and two projects in access (Improving the Sexual and Reproductive Health Rights and Economic Opportunities of Nepali Women and Girls Project and Increasing Access of Long Acting Family Planning Methods to Marginalized Population Project). All together there will be 19 projects under IPPF core programs and supported by other restricted donors. Besides, two more projects: Strengthening FP Services and Improving SRH of Young People are expected to be funded by USAID and UNFPA in 2010. Almost all projects have two focus areas including increasing access of SRH information, education and services in underserved rural area with special focus to the poor and marginalized people and advocacy for SRHR among policy makers, program implementators, religious and community leaders at national and local levels.

## **Adolescent Programs**

Adolescent programs under IPPF support have given emphasis on extensive mobilization of peer groups to reach with in and out of school adolescent and youth. Equal importance is given to increase access of youth friendly SRH information, education and services to young people particularly in rural area in FPAN's district branches and projects.

---

<sup>60</sup> NGOCC, 2004, NGOCC Secretariat, Kathmandu Nepal

Peer approach is adopted to reach with out of school adolescent and young people and empowerment of school teacher to teach SRH curricula to in-school young people. Development of favorable environment and positive support from government and communities to exercise SRH rights by adolescent and youth is another priority area. The outreach programs will give emphasis on early prevention of STI, HIV, unwanted pregnancy and other sexual and reproductive health problems. The peer educators, peer members, Community Counselors and other youth club members will also educate young women on safe and unsafe abortion, legal aspect of safe abortion, service site information, service fee etc. They will also refer the adolescent and young women who seek safe abortion services in FPAN clinics. Similarly, the community level advocacy program will give focus to develop appropriate support system and favorable environment to address SRH needs of adolescent and young people in Nepal.

The Comprehensive Sexuality Education Project is focused on development of CSE reference manual to school teachers, endorse it from Ministry of Education and distribute one copy to each school teacher assigned to teach Environment, Population and Health curriculum in secondary school. Besides, it also aims to train the selected trainer involved in regular teachers' training program under the Ministry of Education; develop a sustainable network of right based organizations for CSE advocacy; and empower young people to speak on their sexuality.

The MPRC Initiative Project supported by Finland Government through Vaestolitto emphasizes on life skill development of young people. Provision of SRH information, education and services are entry point of the project. The poor and marginalized young girls and women are supported through skill building training and micro-credit to start entrepreneurship for income generation and small scale scholarship program to continue school level education. Besides, prevention of gender based violence, human trafficking and care and support to GBV survivors and trafficked returnees are other key program interventions in this project.

Improving the Sexual and Reproductive Health Status of Young Women (Micro-credit) Project supported by Louis and Harold Price Foundation has laid emphasis on improving economic status of poor and marginalized young girls and women through micro-credit support. Adequate emphasis is given to develop cooperative society of the poor and marginalized women for saving credit and their livelihood improvement.

The Guaranteeing SRHR of out of School Young People Project has given emphasis on empowering out of school young people to initiate public discourse on their own sexuality and educating young people on sexuality.

#### **Abortion Programs**

Abortion programs under IPPF support have given emphasis to expand CAC services in four branch clinics (Dhankuta, Doti, Baglung and Kavre) in 2010. Similarly, emphasis is given to consolidate the safe abortion clinics for quality of care and increasing access of safe abortion services through referral services; enhance pre and post abortion counseling skills of the counselors; strengthen post abortion follow up services, integration of sterilization services with safe abortion services in CAC centers; improve infrastructures in Itahari CAC training centre and organize CAC training to FPAN and government medical doctors. The IEC/BCC outreach programs will focus to minimize the myths and misconceptions surrounding abortion; strengthen referral services from various groups and individuals like FCHV, private chemists and druggists, mother groups, women group and saving credit groups to CAC centers; and enhance FPAN's sphere of influence in safe abortion. Besides, the FPAN's service providers and outreach workers will be trained to implement IEC/BCC programs with community people surrounding to their clinics to minimize the myths and misconceptions surrounding abortion in Nepal.

Abortion programs under GCACP will focus to strengthen the IEC/BCC outreach programs in collaboration and partnership with local government and community people, to educate community people on safe and unsafe abortion, to minimize the myths and misconceptions surrounding to abortion, educating people on impact of unsafe abortion on women's health and to strengthen the referral services from community to project clinics. The program also aims to initiate public discourse among planners and policy makers on health and economic impact of unsafe abortion on women through discussion and publication of position paper. Improving quality of care will be in top priority. The service providers and counselors will be trained value clarification, attitude reconstruction for increasing access of safe abortion services to the poor and marginalized women, pre and post abortion counseling. Equal emphasis is given to strengthen post abortion follow up services; integration of sterilization services with safe abortion services and post abortion contraceptive use.

Programs under Networking for Addressing Women's Reproductive Rights Project will give emphasis on organizing refresher training to community based service providers for referral services and strengthening capacity of service providers for quality services.

#### **HIV/AIDS Programs**

Family Planning Association of Nepal (FPAN)  
Phone No- 977 1 5010240, 5010104  
Fax – 977 15010151, 5010248  
E-mail- fpandg@fpan.org.np

Major focus in HIV/AIDS under IPPF core program is given to strengthen HIV continuum of care, including HIV prevention among key populations (including IDU, sex workers and their clients, labor migrant, prisoners, lesbian, gay, transgender, inter-sexual, GBV survivors, trafficked returnees and the poor in urban slums), condom distribution for HIV prevention, positive prevention, voluntary confidential counseling and testing (VCCT), prevention of mother to child transmission (PMCT), community care and support to PLHIV, their children and family members, opportunistic infection prevention and treatment and meaningful involvement of PLHIV in program planning and implementation. Besides, capacity building of staff members and volunteers is given high priority to implement HIV continuum of care in FPAN's outreach programs and service delivery points. Similarly, attention will be given to strengthen partnership and collaboration with line agencies of the government, PLHIV and community based organizations.

HIV/AIDS programs under Global Fund 7th Round will focus on reaching to labor migrants and MSM in 25 districts (out of 75 districts) for STI and HIV prevention, STI diagnosis and treatment and voluntary counseling and testing services through partnering NGOs (sub-recipients).

### **Access**

Access programs under IPPF support have given emphasis to increase contraceptives choice in underserved rural areas, increasing access of SRH services through mobile clinics to the poor and marginalized people, improving quality of care in rural outreach clinics established for the poor and marginalized people and community sensitization for increased utilization of available SRH information and services. Emphasis will also be given to strengthen long acting family planning methods like sterilization, IUCD and Implant in comprehensive branch clinics and selected birthing centers. Infrastructures, equipment and human resources will also strengthen in three family planning training centers (Itahari, Chitwan and Central clinics) managed by FPAN under government authorization to produce skills human resources for FPAN to provide long acting family planning methods from its clinics. Accordingly various training on family planning COF and counseling, IUCD and Implant insertion and withdrawal, vasectomy, miinilap, STI case management, infection prevention and gender, sexuality and right will be organized to service providers.

FPAN will also publish various IEC/BCC materials for distribution to community people aiming to educate people in underserved area on family planning, gynecological and obstetric care, gender based violence, trafficking, male involvement in improving women's health and STI and HIV prevention. Scaling up of GBV screening and support to GBV survivors is another focus area under access. GBV screening will be scaled up to all comprehensive SRH clinics in 2010.

Improving the Sexual and Reproductive Health Rights and Economic Opportunities of Nepali Women and Girls Project is focused to educate young girls and women at risk of trafficking, help poor young girls to complete school level education and identify trafficked returnees, provide psycho-social counseling, enhance their self esteem, organize skill development training, provide micro-credit support and reintegrate them in family and community.

Increasing Access of Long Acting Family Planning Methods to Marginalized Population Project is focused on promoting the long acting family planning methods, particularly IUCD in 15 districts of Nepal. Besides, it also emphasizes on prevention of post partum hemorrhage and educating community people on gynecological and obstetric care and medical method of abortion.

### **Advocacy**

Advocacy programs in 2010 will give focus to review discriminatory national laws that discriminate women in state affairs, in the community and within the household and publish such discriminatory laws for reform. Similarly, interaction with media people to integrate sexuality education in school curriculum, advocacy on implementation of domestic violence and human trafficking control acts, interaction with policy makers on sexual rights of men, women and young people and advocacy to protect the human rights of PLHIV will be given high priority.

### **Supporting Strategies**

#### **Governance, Accreditation and Management**

This program will focus on improving FPAN's financial management and internal control systems as well as the role and function of internal audit section, strengthen decision making capacity of senior management team, periodic review of management and program, and overall strengthening the governance and management through implementation of recommendations given by IPPF, restricted donors and external auditors.

#### **Capacity Building**

Family Planning Association of Nepal (FPAN)  
Phone No- 977 1 5010240, 5010104  
Fax – 977 15010151, 5010248  
E-mail- fpandg@fpan.org.np

Capacity building programs will focus on preparation of an inventory of expertise (Staff and volunteers) within FPAN, training need identification of all types of staff, develop human resource development policy, training on MIS, documentation of best practices, paper writing for publication, monitoring and evaluation, financial management, web page design to relevant staff members and volunteers.

Improving performance indicators program will focus for increasing better understanding about key populations by branch managers and services providers, advocate with donor and government to galvanize SRHR funding, training to service providers on GBV screening for scaling up of this activity in all comprehensive SRH clinics and training to volunteers working in governance on accreditation and resource mobilization.

#### Resource Mobilization

Resource mobilization programs will focus on increasing interactions with existing and new donors for more resources; intensify contract and correspondence with non-residence Nepalese to explore the possibility of funding support to FPAN; organize donors visit programs to FPAN's program sites; meeting and interaction with high level officials of the line ministries for collaboration and partnership; organize resource mobilization training to branch managers for resource mobilization at local level.

#### Knowledge Management and M & E

Knowledge management and M & E programs will give priority on installation of revised financial and data recording computer software in FPAN central office and district branches; extend branding practices to district branches, upgrade IT infrastructures; publish best practices; strengthen integrated supervision and monitoring to district branches and projects; performance evaluation of individual staff and organize review meetings.

#### Integration of Sexual Rights: an IPPF Deceleration

Sexual Rights: an IPPF Declaration will be integrated in all 5 thematic areas and four supporting strategies. One session will be integrated on this subject in all outreach programs and trainings for mainstreaming in all FPAN's programs.

#### Clinical and Non-Clinical Services

Major clinical and non-clinical SRH education, counseling and services under different thematic areas discussed above will be provided through 1270 SDPs (344 clinical SDPs and 926 non-clinical SDPs) as follows:

##### i. Family planning counseling and services

	Family planning counseling services (methods)	378,822	
	Counseling on emergency contraceptives	27,382	
	<b>Sub-total</b>		<b>406,208</b>
	<b>Family planning services (spacing and permanent) (no of persons)</b>		<b>Oral pills</b>
		72,492	
	IUCD		4,061
	Male condom		81,593
	Injectable		94,359
	Implant	3,338	
	Male sterilization	1,380	
	Female sterilization	2,315	
	Emergency contraceptives	4,625	
	Referral for sterilization	540	
<b>total</b>	<b>Family planning all total</b>	<b>264,703</b>	<b>Sub-</b>
		<b>670,911</b>	

##### ii. Gynecological and obstetric care (no of services)

	check up	312,818	PNC check up	ANC
		213,107		
	Other RH check up including general health check up	205,880		
	Immunization		56,242	
	Safe delivery		2,110	

	Gynecological services		2,750		
	<b>Sub-total</b>				<b>792,907</b>
<b>iii. Gynecological and obstetric counseling (no of services)</b>					
	Gynecological counseling/consultation	693,698			
	Breast feeding counseling		51,509		
	Obstetric nutrition counseling		223,750		
	<b>Sub-total</b>				<b>968,957</b>
<b>iv. Sub-fertility services (no of services)</b>					
	Counseling on sub-fertility		36048		
	Recannalization		50		
	<b>Sub-total</b>				<b>36,098</b>
<b>v. Gender based violence (no of services)</b>					
	GBV screening		9,537		
	Identification of GBV survivors		1,947		
	GBV counseling		43,001		
	Care and support to GBV survivors		250		
	Micro-credit support to GBV survivors	750			
	<b>Sub-total</b>				<b>55,485</b>
<b>vi. Safe Abortion</b>					
<b>Counseling (no of services)</b>					
	Pre-abortion counseling		88,203		
	Post abortion counseling		18,179		
	<b>Sub-total</b>				<b>106,382</b>
<b>Abortion and post abortion services (no of services)</b>					
	Safe abortion MVA method		18,577		
	Safe abortion drug (MM) methods		250		
	Post abortion follow up services		1,475		
	Post abortion contraceptives		5,050		
	Post abortion EC		1,525		
	<b>Sub-total</b>				<b>26,877</b>
<b>vii. STI counseling and services (no of services)</b>					
	STI prevention counseling		83,956		
	STI/RTI diagnosis and treatment		38,773		
	STI/RTI follow up services		2,000		
	STI/TRI hepatitis A and B		1,269		
	<b>Sub-total</b>				<b>125,998</b>
<b>viii. HIV/AIDS Continuum of Care (no of services)</b>					
<b>a. HIV prevention education/counseling to key populations</b>					
	Sex workers		500		
	Client of sex workers		2,000		
	Labor migrants		145,500		
	MSM		15,850		
	IDUs		1,000		
	Prisoners	300			
	GBV survivors	1,947			
	Trafficked returnees		500		
	General population including adolescent and youth	169,263			
	<b>Sub-total</b>				<b>336,860</b>
	b. Positive prevention education to PLHIV		400		
	c. Voluntary counseling and testing (VCT) services	33,907		d. ARV	
referral		250			
	e. CD4 count referral		25		

f.	PMTCT	1000	
g.	Opportunistic infection prevention and treatment services	90	h.
	Care and support to PLHIV	40	
i.	Stigma reduction education	1400	
	<b>Sub-total</b>		<b>37,112</b>
	<b>HIV all total</b>		<b>373,972</b>

#### ix. Adolescent SRH counseling

	Life skills counseling		38,959
	Sexuality education		39,865
	Hotline counseling	49,621	
	SRH counseling	148,741	
	<b>Sub-total</b>		<b>277,186</b>

#### x. Anti Trafficking Education and Services (No of persons)

	Anti-trafficking education to young girls and women	12,000	
	Health check up services	5,000	
	SRH services		2,500
	Family planning services	1,100	
	Identification of new survivors	200	
	Psycho-social counseling to trafficked returnees	500	
	Emergency support to trafficked returnees	25	
	Legal counseling to trafficked returnees	300	
	Scholarship to the poor and marginalized girls	120	
	Micro-credit support to trafficked returnees	500	
	<b>Sub-total</b>		<b>22,245</b>

#### P. Budget and Finance of the Association

Total budget of the Association will be Rs 324.64 millions in 2010. Percentage share of IPPF core grant in total budget is 37.80 percent, funding from other donors (non-IPPF) will be 53.25 percent and internal income will contribute 8.95 percent in total budget.

Allocation of budget in different thematic area is made based on program priority. Allocation of IPPF core grant in different thematic area is as below:

Thematic area	Budget allocation	%share
Adolescent	Rs. 23,790,529.00	19.39
Abortion	Rs. 30,859,213.00	25.15
HIV/AIDS	Rs. 22,741,915.00	18.53
Access	Rs. 23,222,070.00	18.92
Advocacy	Rs. 6,590,750.00	05.37
Governance and accreditation	Rs. 6,964,600.00	05.68
Capacity building	Rs. 1,673,030.00	01.36
Resource mobilization	Rs. 1,379,800.00	01.12
Knowledge management and M & E	Rs. 3,750,500.00	03.06
Improving Performance indicators	Rs. 1,737,100.00	01.42
<b>Total</b>	<b>Rs. 122,709,507.00</b>	<b>100.00</b>

An effort has been made to allocate more resources for program activities. Allocation of IPPF core grant in program, program overhead, personnel and contraceptives is as below:

Expenditure head	Budget allocation	%share
Program cost	Rs. 48,092,390.00	39.19
Program overhead cost	Rs. 12,625,033.00	10.29
Personnel cost	Rs. 60,197,054.00	49.06

Contraceptives cost	Rs.	1,795,030.00	01.46
<b>Total</b>	<b>Rs.</b>	<b>122,709,507.00</b>	<b>100.00</b>

Overall allocation of FPAN budget including IPPF core grant, non-IPPF sources including the Global Fund support and internal income in different thematic areas in 2010 will be as below:

<b>Thematic area</b>		<b>Budget allocation</b>	<b>%share</b>
Adolescent		Rs. 49,112,798.00	15.12
Abortion	Rs.	58,975,909.00	18.16
HIV/AIDS	Rs.	147,766,306.00	45.50
Access		Rs. 46,147,768.00	14.22
Advocacy	Rs.	7,130,779.00	02.20
Governance and accreditation	Rs.	6,964,600.00	02.15
Capacity building	Rs.	1,673,030.00	00.52
Resource mobilization	Rs.	1,379,800.00	00.43
Knowledge management and M & E	Rs.	3,750,500.00	01.16
Improving performance indicators	Rs.	1,737,100.00	00.54
<b>Total</b>	<b>Rs.</b>	<b>324,638,590.00</b>	<b>100.00</b>

Overall allocation of financial resources including IPPF core grant, funds available from other non-IPPF sources and internal income in program, program overhead, personnel and contraceptives will be as below:

<b>Expenditure head</b>		<b>Budget allocation</b>	<b>%share</b>
Program cost		Rs. 138,618,687.00	42.70
Program overhead cost	Rs.	34,012,755.00	10.48
Personnel cost	Rs.	152,007,148.00	46.82
<b>Total</b>	<b>Rs.</b>	<b>324,638,590.00</b>	<b>100.00</b>

