



Family Planning Association of Nepal



Strategic Plan 2005-2009



Message from the President



Nepal is experiencing socio-economic disparities across the geographical regions and ethnic groups since long ago. Various forms of discriminatory practices between men and women in utilization of sexual and reproductive health services reinforce and intensify further marginalization of people. The poor, socially marginalized and internally displaced people, refugees and young people continue to face difficulty in getting access to SRH information and services which contributed to high maternal mortality and morbidity rates in Nepal compared with other neighboring countries in South Asia region.

This Strategic Plan is a guiding document to tap market opportunities and counteract the challenges that appear at internal and international level based on FPAN niche in the field of sexual and reproductive health. FPAN has gradually been shifting, its emphasis from mere family planning to comprehensive sexual and reproductive health program. In the coming years, FPAN will concentrate on five major thematic areas of sexual and reproductive health including Adolescent, HIV/AIDS, Abortion, Access, and Advocacy.

FPAN envisages a world in future where every woman, man and young person has the right and access to sexuality and reproductive health information and services, in which SRH choices are fully respected; stigma and discrimination have no place; and all have a better quality of life. It is with these concerns that the strategies and directions in this document have been developed. We believe that with collective vision and commitment for the future, it is possible to create conditions for better quality SRH in Nepal, for which FPAN is thriving.

FPAN is committed to achieve the goal and targets pertaining in this document through concerted and continuous effort of its own and joining had for partnership with other national and international players in SRHR.

I expect many people from all walks of life will contribute to materialize this strategic plan. FPAN acknowledges and thanks to all contributors and hopes that the support from various individuals and organizations will continue further in future.

A handwritten signature in black ink, which appears to read 'Chhatra Bahadur Giri'.

Chhatra Bahadur Giri
President
FPAN

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Country Situation

DEMOGRAPHIC

Nepal is a landlocked country situated between India and China. It has a total population of 23.15 million in an area of 147,181 square kilometres with a density of 157 persons per square kilometre.

According to Population Census 2001, the annual growth rate was 2.25% between 1991 and 2001. Almost equal number of males and females is recorded in the census with a sex ratio of 99.8. Population growth continues to be very high on account of the large size of female population in the reproductive age group (49.2%) and high fertility rate (4.1 children per woman) due to high-unmet demand for contraception (27.8%) and early marriage of girls before the age of eighteen years.

Adolescents and youth constituted the largest segment of the population (32.48%) in Nepal. Adolescents aged between 10-19 years constituted 22.3% in 1991 and 23.61%. This is indicative of an increasing entry of young people into Nepal's overall population.

The country is divided into three ecological zones: mountain, hill and terai (plains) and is inhabited by more than 100 caste and ethnic groups. About 80% of Nepalese people are dependent on agriculture for their livelihood. However, the agricultural sector contributes only about 40% of the GDP. The GDP per capita remains very low at US\$ 236. Inequality in the means of subsistence and incomes are widespread. Acute underemployment is considered to be the principal cause of large-scale poverty. Economic growth of the country has not improved markedly over the years to outstrip population growth rate.

The topography of the country is another challenge. Hills and mountain areas are not linked with national highways. Village and market centers are widely scattered and often remote and inaccessible so that in it often takes sometimes more than 24 hours to reach the service centre.

Facts

According to Population Census 2001, the annual growth rate was 2.25% between 1991 and 2001.



Nepal adopted the policy of incorporating population issues into the development process since the first plan in 1956. Population issues are being given priority by the government in periodic plans as an endeavour towards sustainable development.

ADOLESCENTS

According to DHS Report 2001, approximately 21% of adolescent women of age group 15-19 were already mothers or pregnant with their first child. The same survey also indicates that almost one in five were already mothers or pregnant with their first child. The contraceptive prevalence rate (CPR) according to same report was reported to be merely 12% amongst adolescents of age group 15-19 and 23.4% amongst the 20-24 age group, whereas in 1996 it stood at 6.7% for adolescents and 15.8% respectively for the 20-24 age group. This indicates

that the use of contraceptives by these age groups is yet quite low as compared to other countries in the region.

The 2001 DHS also revealed that 40.7% of adolescent mothers do not receive antenatal care and the majority (85.9%) of them deliver babies at home. A trained health worker assists only 13% of these deliveries. There is higher incidence of anaemia, hypertensive disorders, abnormal and premature deliveries and greater fetal demise amongst adolescent mothers compared to older mothers. DHS 2001 reports that a significant proportion of maternal deaths (28.5%) occur in the adolescent age group.

Adolescents and youth are scattered in the community as they are also mobile. Their risk taking behaviour and long absence away from home in search of economic opportuni-

ties makes them susceptible to STI/HIV/AIDS. The age wise data of HIV/AIDS infection is 9% in the age cohort of 14-19; 53% in 20-29 age groups. The HIV scenario in Nepal reveals that 62% of HIV/AIDS infected people consist of adolescents and youth (NCASC 2003).

Moreover, 66% adolescent girls in the age group of 10-19 are illiterate whereas the figure is only 24% among adolescent boys. SRH education and services are critical for these groups. Particular emphasis needs to be given to adolescent girls in order to bridge the gender gap, government and NGOs are required to play a lead role in providing SRH information and services to these groups.

This situation calls for special interventions to address the needs and concerns of adolescents and youth. Some causes of lag-behind have been due to the lack of clear cut effective policies and programs and failure to involve young people in existing promotional activities; insensitivity among educators, providers of health and social services, religious and youth leaders and parents about special problems of young people; absence of young people's involvement in

educational programs or services; unavailability of trained manpower for provision of special services and resource constraints.

HIV/AIDS

Although the HIV/AIDS epidemic is a relatively new phenomenon in Nepal, it is transforming from 'low' to almost becoming a 'concentrated' epidemic. The first case was identified in Nepal in 1988 (NCASC, 2002). As of 31st March 2004, a total of 3,529 HIV infected cases were reported in government facilities. Of this number 715 were infected by AIDS of which 191 had already died (NCASC, 2004). Actual HIV/AIDS infection in Nepal is feared to be many times higher than the recorded cases. The number of adults and children living with HIV/AIDS until December 2002 was 60,000 (estimated) and AIDS related deaths were 2958 (UNAIDS, 2002). Current estimated HIV infection rate of 0.5% pervades the adult population between the age cohorts of 15-49. Of the total reported HIV/AIDS infections, males comprise 73% and females 27% (NCASC, 2003). Young people (20-29 aged) comprise the highest group suffering from HIV/AIDS.

“Although the HIV/AIDS epidemic is a relatively new phenomenon in Nepal, it is transforming from 'low' to almost becoming a 'concentrated' epidemic.”

Sexually transmitted infections are proven co-factors that increase the risk of HIV transmission. Their appropriate diagnosis and treatment are critical. It is estimated that about 200,000 new STI episodes take place in Nepal every year. STI prevalence rate among women is estimated at 4.7% (MOH, 2002).

The migrant population is one group that is most vulnerable to STI/HIV infection in Nepal. Independent estimates reveal that the number of periodic migrants is higher than is recorded in official statistics. About 8,00,000 people cross the southern border as seasonal migrant labourers to India every year and approximately 3,50,000 labourers migrate from one part of the country to another for wage earnings (MEH and REGHED, 2000).

Most of these migrants do not have access to information, condoms, and supportive services to enable them to have safer sex. They are likely to take the virus back to their wives and partners who are also most likely to transmit it to their babies. This category of the population also becomes major transmitters of HIV/AIDS in Nepal's population. Moreover, female sex workers (FSWs) and their cli-

ents are also another vulnerable group for HIV infection in Nepal. It is estimated that about 5000-7000 rural women, mostly girls, are trafficked to India annually across the open border. Altogether, there are more than 2,00,000 Nepalese women currently engaged in the flesh trade in India (CWIN, 2002).

Injecting/Intravenous Drug Users (IDUs) with high-risk behaviour are also most vulnerable to HIV/AIDS epidemic in Nepal. There are about 2,00,000 drug addicts in Nepal (CWIN, 2002), of whom 30,000 are injecting drug users. Of these, again approximately 40% are HIV infected (MoH, 2002).

Mobile transport workers, factory employees and people living in slum areas are other vulnerable groups of people. Altogether, there are 1,35,000 transport workers, 1,30,000 male and 5,000 female and 500,000 factory employees in Nepal (CBS, 1999).

ABORTION

There are many challenges in Nepal in the area of abortion which relate mostly to socio-economic problems, lack of access to quality abortion services, lack of skilled/trained

Facts

STI prevalence rate among women is estimated at 4.7% (MOH, 2002).



service providers and advocacy work, especially in rural areas of the country.

Nepal is a Hindu kingdom and about 79% of its population are Hindus who have their own religious norms and concepts and one of them is son preference. According to religious norms, a son particularly during the death of a parent is expected to light the funeral pyre and perform the last rights. This ensures him a place in heaven. Daughters are prohibited from undertaking this ceremony. Sex selection for son is another challenge in abortion services.

The total wanted fertility is only 2.5, which clearly shows that large proportions of pregnancies are unwanted (DHS 2001). Women with unwanted pregnancy are more likely to

seek abortion and are at more risk. In Nepal, abortions are performed in unsafe, unhygienic conditions by untrained personnel. Complications during abortion are one of the important causes of maternal mortality and morbidity in Nepal.

Most unwanted or unintended pregnancies especially in rural areas are directly related to unsafe abortion. Despite overall preference amongst women for fewer children and birth spacing, the unavailability of modern family planning methods in rural areas remains a national problem. Many women do not want the burden of many children and therefore want to space births but modern family planning methods are not easily accessible in rural areas of the country.

The Demographic Survey of 2001 shows that about 8% of pregnancies are terminated as abortion, of which, 2% are terminated as stillbirths and the rest 6% as spontaneous or induced abortions. There are limited service facilities in selected urban areas as well for safe abortion. And despite huge demand for safe abortion services in rural areas, the institutional capacity of GOs and NGOs is limited in fulfilling unmet needs of safe abortion services.

“Most teenage mothers die due to complication during of childbirth (Morbidity Study, 1998).”

ACCESS

The maternal mortality rate is 515 deaths per 1,00,000 live births (CBS 2001). Significant proportion (18.9%) of maternal deaths occurs amongst the adolescent age groups and there is also high prevalence of chronic energy deficiency among adolescent girls. Most teenage mothers die due to complication during of childbirth (Morbidity Study, 1998).

In Nepal, about 89% of all women deliver babies at home. Only about 10.9% births are attended by a nurse and a doctor attends only 10.9%. The childbearing age (15-49 years) constitutes 23% of the total population (DHS 2001).

The total fertility rate for Nepalese women aged 15-49 is high (4.1 births per woman). There is a large difference in fertility in urban (2.1) and rural areas (4.4). There are also differences in fertility by region, e.g. mountains (4.8) and other ecological regions (Terai-4.1 and Hills-4). There is a strong association between fertility and education in Nepal. The TFR of women with no education (4.8) is more than double that of women with at least School Leaving Certificate (SLC), i.e. high school. Chances of Nepalese women suffering from pregnancy complications are very high and consequently this risk increases as women undergo multiple pregnancies during their reproductive years (DHS, 2001).

The knowledge of at least one modern method of family planning is nearly 100%. The total demand for family planning is 67%, of which 39% currently married women indicate satisfaction. The remaining 28% women still remain unserved by family planning services. Unmet need is twice as high among women in rural areas (29%) than among women in urban areas (15.8%) (DHS, 2001).

Anaemia is a serious problem throughout a person's life-

cle in Nepal. More than 78% of preschool children, 75% of pregnant women and 68% of non-pregnant women suffer from anaemia in rural areas (Hellen Keller International, various reports-1998).

Doctors, nurses/paramedics are not easily available even in district level government hospitals. Most hospitals are without required doctors and staff nurses. This is further aggravated by the fact that doctors and nurses are unwilling to serve in remote districts. Rather, they are mostly concentrated in urban areas. This makes it difficult to recruit trained service providers in rural areas to provide RH, including abortion services. Another major concern is the behaviour and attitude of service providers which remains an obstacle in communication and care provision.

GENDER

About 90% of the economically active female population in Nepal is engaged in agriculture and related activities, while less than 1% work as professionals and technicians. Those employed in non-agricultural sectors are generally found in lower levels and in low paid jobs. Women are generally involved in household work and though women form a large portion of the agricultural labour force, their contributions in agriculture, livestock and forestry management is considered to be unproductive work.

The incidence of violence against women is on the rise. Each year, 5000-7000 girls between the ages of 12-20 are trafficked out of Nepal. Altogether, there are more than 2,00,000 Nepalese women



currently engaged in the flesh trade in India (CWIN, 2002). Domestic violence is rampant but is widely unreported. Women have practically no right over their own pregnancy. Marital rape is considered a normal phenomenon, although the court has recently given a verdict that even husbands can be punished for coerced sex with their wives. Husbands and in-laws usually decide about when a woman should become pregnant and how many children she should have. Usually they also make decisions on whether or not to seek medical assistance during pregnancy, delivery and post delivery. Women are victims of rape, sexual harassment and incest. High preference for son puts extra pressure on women, and giving birth to daughters only increases chances of

husbands seeking the company of other women or bringing another wife.

According to an NGO Saathi, in a study done in 2001, the existence of mental and emotional torture was reported by 93% of women, and beating was identified as the most common form of physical violence against women and girls (82%), followed by rape (30%), and forced prostitution (28%).

Among 59 prisons in the country, 20% of all women imprisoned (460), were accused of abortion and infanticide. All of them were illiterate and from low-income families. 26% of them were unmarried, 12% were widows and 65% of them were not engaged in any kind of income generating activities (CREHPA in 1997).



Poor, marginalized and Internally Displaced People (IDPs), refugees and youth continue to face discrimination in access to SRH services, contributing to higher maternal mortality and morbidity rates in these communities.

Various socio-economic, cultural and political barriers to access, including gender discrimination and anti choice groups are also remain high in Nepal.

Government Policy, Plan & Priority

HMG/N policy and plans have given increasing emphasis on fostering partnership programs with NGOs and private and health sector development partners for STI/HIV/AIDS prevention, control and management. The policy, plan and priority areas of HMG/N are reviewed briefly below.

LONG-TERM HEALTH PLAN OF NEPAL (1997-2017)

His Majesty's Government of Nepal (HMG/N) formulated the second long-term National Health Plan (1997-2017) in 1997, aiming to create a socio-economic environment for enabling Nepalese citizens to lead a healthy life through preventive and curative health

services. Importantly, the plan focuses on preventive aspects of all reproductive health services in a package. It places greater emphasis on community involvement, increasing access to PHC outreach, sub-health posts, health posts, PHCC and district hospitals as well as establishing functional referral linkages at all levels. The following targets are identified in the National Health Plan to be attained by the end of the Tenth Five-Year Plan and by the end of a 20 year period.

Health Indicators

Infant Mortality Rate/1000

Child Mortality Rate/1000

Total Fertility Rate

Life expectancy

Maternal Mortality Rate/100000

Contraceptive Prevalence Rate

Delivery by Trained Health worker

Crude Birth Rate/1000

Crude Birth Rate/1000

Life expectancy at birth (year)



STI/HIV/AIDS prevention and control program is placed under the reproductive health package, which includes family planning, safe motherhood, child health, prevention and management of abortion complications, human sexuality, sub-fertility management, adolescent reproductive health and life cycle issues as well as problems of elderly people. However, the plan does not pay much attention to the alarmingly growing epidemic of HIV/AIDS. Program activities for HIV/AIDS prevention and control are loosely integrated with the reproductive health package. The growing expansion of the HIV/AIDS epidemic was not visualised during the plan formulation period.

However, the long-term plan of the government has emphasized community participation, equitable access and inter-sectoral collaboration in all aspects of the reproductive health package. In order to ensure supplementary and complementary roles of the NGOs and private sector in the implementation of the reproductive health package in a sustainable way and to expand coverage and quality of services, the plan has identified the need for strengthening NGO/private sector partnership with HMG/N.

The following strategies adopted by the plan for an

Situation (1997-1998)	Situation at the end of 9 th Plan (2002)	Targets of the 10 th Plan (2002-2007)	20 Year Targets
74.7	64	45.0	34.4
118.0	91	86.8	62.5
4.58	4.1	3.5	3.05
56.1	57.6	62.0	68.7
475	439	300	250
30.1	39.0	47.0	58.2
11.5	13%	18.0	95.0
34.5	-	30.4	26.6
-	10	7	6
	61.9	64	-

Source: Ministry of Health 1997, Ministry of Health and New Era, 2001, NPC, 2002



effective and efficient provision of quality RH services have given enough scope for NGOs and private sector to supplement and complement the national RH program including STI/HIV/AIDS prevention and control. Some of these are :

- Implement Integrated Reproductive Health Package at Hospital, Primary health care centre, health post, sub-health post and primary health care outreach, TBA, FCHVs, mother's group and other community and family level activities based on standard clinical protocols and operational guidelines.
- Encourage non-governmental organizations and associations to provide health services under the prescribed policies of HMG/N.
- Encourage private parties interested to extend health services through the establishment of hospitals and health units without any financial liability to HMG/N to open and operate such health facilities based on prescribed standards.
- Encourage the establishment of an alternative health fund in the non-governmental sector to increase the per capita health expenditure from Rs. 538 in 1997.
- Decentralize the planning and program formulation system (from the centralized departmental decision making to the lower tier of health facilities).
- Ensure effective management systems by strengthening and revitalizing the existing committees working at various levels.

- Develop a national RH research strategy, which outlines research priorities and work plans based on the information requirement of policy makers, planners, managers and service providers.
- Construct/upgrade appropriate service delivery and training facilities at the national, regional, district and health post levels.
- Review and update the existing training health curricula to include missing RH components.
- Enhance the functional integration of RH activities carried out by different divisions within the Ministry of Health.
- Emphasize advocacy of RH concepts including the creation of an environment conducive to inter and intra-sectoral collaboration.
- Review and develop IEC/BCC materials to support all levels of intervention including rumour-countering messages.
- Develop appropriate RH programs for adolescents.
- Support national experts and consultants and
- Promote inter-sectoral and multi-sectoral coordination.

NATIONAL REPRODUCTIVE HEALTH STRATEGY 1998

Following the long-term Health Plan (1997-2017), the National Reproductive Health Strategy formulated in 1998 emphasized the prevention and management of STI/HIV/AIDS and other reproductive health issues through the integrated reproductive health package introduced at hospitals, primary health centres (PHC), health posts, sub-health posts, outreach clinics, TBAs and FCHVs. The National Reproductive Health Strategy has no clear-cut policy, strategy or activities for HIV/AIDS prevention and control. It is loosely integrated with the reproductive health package. However, it lays stress on some preventive aspects and syndromic treatment of STI/HIV/AIDS at various levels as follows:

- Awareness about STI/HIV/AIDS and the distribution of condoms at family level.
- Promotion of sex education, counselling and condom promotion/ distribution at community level.
- Identification, treatment and referral for vaginal discharge, lower abdominal

“The National Reproductive Health Strategy formulated in 1998 emphasized the prevention and management of STI/HIV/AIDS and other reproductive health issues.”

pain, genital ulcers in women and urethral discharge, swelling in the scrotum or groin in men along with condom promotion and distribution and implementation of IEC activities for preventive aspects at health post and sub-health post levels.

- Treatment and management of STIs based on syndromic approach (if diagnosis facilities are not available), condom promotion and distribution at primary health centre level, and
- Clinical diagnosis laboratory diagnosis and treatment of STI and condom promotion and distribution along with implementation of IEC/BCC activities for HIV/AIDS prevention at district and hospital levels.

The strategy is relatively progressive compared to the long-term national health plan in addressing the STI/HIV/AIDS epidemic in Nepal. However, it does not clearly spell out any intervention approach or programs required to fight the high risk or to safeguard vulnerable groups of people.

NATIONAL ADOLESCENT HEALTH AND DEVELOPMENT STRATEGY 2000

Specific health services of adolescents were virtually non-existent in Nepal prior to the International Conference on Population and Development (ICPD) 1994. However, selected programs focusing on drug abuse and HIV/AIDS prevention and control were implemented by a few NGOs. Following a number of international, regional and national meetings such as ICPD Program of Action (1994); the Fourth International Conference on Women in Beijing (1995); WHO/South East Asia Regional Strategy for Adolescent Health and Development (1996); and the Second Long Term Health Plan (1997-2017) of Nepal as well as the National Reproductive Health Strategy of Nepal (1998) HMG/N formulated a National Adolescent Health and Development Strategy in 2000. As in the National Reproductive Health Strategy, STI/HIV/AIDS prevention and control among adolescents is only loosely integrated with the reproductive health package.

Facts

The HIV scenario in Nepal reveals that 62% of HIV/AIDS infected people consist of adolescents and youth (NCASC 2003).



The strategy aims to increase access to and utilization of friendly health care services in order to reduce the incidence of STI/HIV/AIDS among adolescents through integration of adolescent health services into existing health care delivery system. It also seeks to involve and establish links with youth clubs, NGOs and the private sector to expand and improve STI/HIV/AIDS education and services.

Major activities proposed in the document are to provide adolescent friendly health services through existing static and outreach service outlets to initiate peer counselling program in schools/clubs and workplaces to increase knowledge of STI/HIV/AIDS, to increase communication between parents and adolescents on STI/HIV/AIDS education, to increase STI/HIV/AIDS knowledge in adolescents (married 15-19) from 24.3% in 2000 to 50% in 2006 and 75% in 2011.

NATIONAL HIV/AIDS STRATEGY 2002-2006

In the past, sexually transmitted diseases were diagnosed and treated by the department of venereal diseases in all major hospitals. With increase in STD in the country, a STD control committee was formed by HMG/N in 1986. The committee was later upgraded to a semi-autonomous organization of National Centre for STDs and AIDS Control (NCASC). HMG/N formulated a short-term AIDS control plan in 1988 and a medium-term plan (1990-1992).

In 1992, a National AIDS Coordination Committee, chaired by the Minister for Health, was established bringing government and non-governmental organizations for STDs and AIDS prevention and control together. Reviewing the experience of both the short-term and medium-term plans, HMG/N formulated a second

long-term (1993-1997) plan. The NCASC launched the HIV/AIDS control strategic plan (1997-2001) in 1997.

However, these short and medium term plans and strategic plans had no clear-cut objectives and programs for HIV/AIDS control at national level. In 2000 NCASC had a meagre budget of 1.04 million indicating weak commitment for government (MEH and REGHED, 2000). To make up for the shortfalls of past plans and strategies, HMG/N formulated a comprehensive National HIV/AIDS strategy in 2002, to bring all sectors into the mainstream and constituted the National AIDS Council chaired by the Prime Minister, to proclaim political commitment.

Overall, the national HIV/AIDS Strategy intends to expand the number of partners in the national response of controlling the HIV/AIDS epidemic and to increase the effectiveness of the response by focusing on priority areas. Due emphasis is given to the need for care and support for people already infected and affected by HIV/AIDS. Similarly, commitment is sought not only from the Ministry of Health but also from all concerned agencies within and outside the government and better-coordinated

support is solicited from external development partners.

Decentralization of HIV/AIDS programs and activities at local level is given enough emphasis. In response, local government bodies at local level, e.g. District Development Committees (DDCs) and Municipalities are expected to include program activities in their own local development plans. INGOs, NGOs, CBOs, civil society as well as the private sector and external development partners are invited openly to supplement and complement the national HIV/AIDS control program.

The strategy seeks multi-sectoral involvement for building an adequate response to the HIV/AIDS epidemic with primary focus on prevention. Rights based response is advocated with a specific focus on the rights of people infected and affected by HIV/AIDS, in particular the rights to confidentiality. Resource allocation will be made for defined priorities based on the vulnerability of various affected groups and communities.

People and communities are to empower to protect themselves from HIV infection within a supportive environment. Equal access to basic care

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and services is emphasized for all persons infected and affected by HIV/AIDS. Similarly, gender has been considered central to the development of program interventions, and due consideration is given to universal precautions to counteract the possibility of HIV transmission through medical interventions.

Voluntary HIV testing is encouraged with guaranteed confidentiality and adequate pre and post-test counselling both in the public sector and the private sector. Emphasis is given to the participation of people living with HIV/AIDS in programs including formulation of policies, strategies, programs and projects. The major strategies of the government for STI/HIV/AIDS

prevention, control and management are as follows:

- Prevention and control of STIs and HIV infection among vulnerable people including female sex workers (FSWs) and their clients, injecting drug users (IDUs), mobile populations, (especially migrants to India) and men who have sex with men and prisoners.
- Prevention of new infection among young people
- Ensuring the availability and accessibility of care and support services for all people infected and affected by HIV/AIDS.
- Expansion of the monitoring and evaluation framework through evidence based effective surveillance and research, and



- Establishment of an effective and efficient management system for an expanded response.

ABORTION POLICY

The Safe Abortion policy 2002 was developed in the context of 11th Amendment of the Muluki Ain 2020 B.S. (The Law of the Land 1959), the basic code for the kingdom of Nepal. This amendment reformed the restrictive abortion framework, which prohibited abortion and characterized it as an offence against life.

His Majesty Government of Nepal amended the Nepal Abortion Bill in March 2002 and Royal Assent was given to the Bill on 26th September 2002.

The Eleventh Amendment provides provision for safe abortion upon voluntary consent of the woman on the following grounds:

- Within first twelve weeks of pregnancy
- Pregnancy due to rape or incest within first 18 weeks of pregnancy
- Or when a woman's pregnancy poses danger to her life or to her physical and mental health, abortion can be performed with the advice of a medical practitioner at anytime during pregnancy
- Abortion can also be performed if, in the view of the medical practitioner, the pregnancy would lead to the birth of a disabled child at any time during pregnancy, with recommendation of a medical practitioner.



Introduction to FPAN

The Family Planning Association of Nepal (FPAN) founded in 1959 became an Associate Member of the Planned Parenthood Federation (IPPF) in 1960 and full-fledged member in 1969. Prior to the establishment of the association, the concept of family planning was quite new and went against religious/traditional beliefs and social values in Nepal. FPAN, in consonance with the social system, focused on information and education as a means of advocating a small family as norm among the rural masses. Family planning programs in the government sector gained momentum after the establishment of the Maternal and Child Health Division at the Ministry of Health in 1965 and the launching of the National Family Planning and Maternal and Child Health Project in 1969. It was after this that FPAN started complementing and supplementing the national program.

Family planning services in 1960s were limited to distribution of condoms, pills and insertion of loops. All activi-

ties were implemented by volunteers because there were no staff members to assist their work. The association resorted to meetings and print media to educate people during the time. Since the only electronic media reaching the general public was radio, FPAN initiated a weekly radio program on family planning in 1968.

FPAN increased the number of target-oriented and focused programs in the 1970s. A Family Planning Welfare Project was implemented in ten wards, i.e. (administrative unit at local level) of Kathmandu valley in 1972, which started providing sterilization services on request and through assistance of USAID. Since these projects required fulltime workers, staff and volunteers were recruited to provide the services. Publishing family planning magazines and other IEC materials for the target population in the 1970s was an important function FPAN. Similarly, FPAN programs were expanded from 3 districts in the 1960s to 15 districts in the 1970s and 32 districts in 2004.

Facts

FPAN contributes 25-30% to the national family planning programs.



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The program focus of FPAN has been changing gradually to adjust its program thrust and activities with contemporary demand for FP services by the people. In the 1960s and 1970s, it adopted an integrated approach of amalgamating community development and family planning programs. Consequently, emphasis was given to disseminating FP messages and delivering services to needy people in the 1990s in compliance with changes in behaviour and attitudes of the people. In this endeavour, it has laid greater emphasis on service delivery since 1992 to meet the unmet demand for family planning and reproductive health services. Community development programs were curtailed substantially and new programs, including STI/HIV/AIDS, counselling and services, sexual and reproductive health education and services to adolescents and youth, maternity services and strong advocacy for safe abortion, were added in the 1990s.

FPAN contributes 25-30% to the national family planning programs and its program activities are ever expanding, to meet the unmet needs of family planning, including STI/HIV/AIDS prevention and management.

ORGANIZATIONAL SWOT

STRENGTHS

- Recognized by both government and NGOs as a leading national NGO specialized in the field of reproductive health service delivery
- Good public rapport
- Large network covering 32 districts with good physical infrastructure up to lowest administrative unit (VDC level)
- Good reputation with national and international funding agencies
- Effective coordination among GOs, INGOs and NGOs
- High level of technical capacity to provide

comprehensive reproductive health services

- Long term vision to implement SRH program in the country
- Larger population of volunteers including youth for community mobilization
- Well structured management system to run the association
- Optimum utilization of available limited resources

WEAKNESS

- Heavily dependent on external funding
- High turnover of experienced technical staff
- Inadequate bottom up approach
- Inadequate and under utilization of information and database
- Limited decentralization of authority among middle-level managers
- No clear cut exit (phase out) plan
- Lack of expertise on some SRH issues.
- Inadequate RH programs for marginalized and underserved population

OPPORTUNITIES

- Initiate service fee for specialized services for cost recovery and sustainability
- Support from the government for program implementation

- Network and partnership with GOs/NGOs and CBOs
- Membership of IPPF and long working relationship with other donors
- Attract international agencies for contraceptive supply through local government to meet high unmet needs on FP

THREATS/CHALLENGES

- Low economic status of beneficiaries, high illiteracy among rural people, political instability in the country and rugged topography, a challenge for program implementation and sustainability
- Retaining competent volunteers and staff
- Weak technical capacities for some specialized RH services

FPAN'S PROGRAMMATIC THRUST

In consonance with the newly changed context at national and international level in the field of reproductive health, FPAN has gradually been shifting its emphasis from mere family planning to comprehensive sexual and reproductive health programs. Accordingly, the major program thrust of FPAN will henceforth concentrate on five

major areas (Advocacy, Adolescents, AIDS including HIV, Access to marginalized and under-served groups and Abortion).

Some examples of how this will be reflected are through:

- To enlist public, political and financial support in the field of reproductive health, various seminars, workshops and orientation programs to address four major issues (SRH rights of men, women and young people; resource mobilization; accessibility of SRH services to the marginalized and removal of socio-cultural barriers).
- Providing information, education and services to adolescents and youth on issues covering early marriage, gender-based discrimination and violence, unwanted pregnancy, unsafe abortion, STI/HIV/AIDS and sexual abuse will be an important area of work.
- Providing easy access to STI services, to ultimately contribute reduce the incidence of HIV/AIDS in FPAN operational areas.
- Providing safe abortion services to women within the context of universal rights of women.

- Strengthening sexual and reproductive health services and education, including family planning to marginalized and internally displaced people in rural areas are where FPAN is active.

FPAN VISION

FPAN envisages a world in future where every woman, man and young person has the right and access to sexuality and reproductive health information and services, in which SRH choices are fully respected; stigma and discrimination have no place; and all have a better quality of life.

FPAN MISSION

FPAN is committed to improve the quality of life of individuals through SRH information and services especially for the poor, marginalized and vulnerable people in underserved areas. It defends the rights of all young people to enjoy their sexual lives free from ill health; unwanted pregnancy; violence and discrimination; to empower women to exercise their SRH rights to terminate unwanted pregnancies legally and safely at affordable cost; and to eliminate STIs and to eradicate HIV/AIDS.

Goal of Advocacy

To increase public, political and financial support for sexual and reproductive health and rights in Nepal.



ADVOCACY

STRATEGIC DIRECTION

To promote basic human rights of women, men and young people regarding their own sexual and reproductive health by involving policy makers and communities

GOAL

To increase public, political and financial support for sexual and reproductive health and rights in Nepal

OBJECTIVE

To strengthen the recognition of SRH rights in all sectors, including policy and legislation

ACTIVITIES

- Conduct dissemination workshops for policy makers, stakeholders and media about information collected from survey/studies relating to sexual and reproductive health and rights in order to familiarize them with the actual situation prevailing in the country

- Build capacity of FPAN volunteers and managerial staff for effective advocating on SRH issues at various levels
- Establish cordial relationship with other organizations to work jointly in advocating for sexual and reproductive health and rights of women, men and young people
- Establish linkages for advocacy amongst policy makers, parliamentarians, government officials for resource generation
- Organize meetings/workshops/seminars with responsible government officials to advocate and raise awareness about the central need for SRH information, education and services amongst rural women.
- Organize meetings/workshops/seminars/orientation among influential persons within the community to advocate for removal of socio-economic barriers on sexual and reproductive health issues.

- Produce evidence-based advocacy packages and learning tools that illustrate how the inclusion of SRHR approaches are critical to the achievement of the National Development Goals
- Undertake opinion polls and KABPs to assess changes in understanding and commitments of policy makers and communities to SRHR issues
- Review existing religious texts, which encourage violence of sexual and reproductive rights of women.
- Collect, document and publicize major court decisions made in favour of SRH rights of women.
- Review existing laws and bylaws which contradict international treaties signed by HMG/N with regard to sexual and reproductive rights of women and men including rights relating to gender equity and equality.

OUTCOME

- Enhanced understanding and favourable environment within partner agencies (government and non-government) for the promotion of SRHR

- Rural women in FPAN's operational areas are able to exercise their SRHR

INDICATORS OF SUCCESS

- Results of surveys
- Increased partnership and networking with other organizations
- Increased budgetary allocation for promotion of SRH
- Developed SRH policy in favour of poor, marginalized and underserved people

ADOLESCENTS AND YOUTH

STRATEGIC DIRECTION

Access to SRH information, education and services to adolescents and youth in marginalized, underserved and resource poor settings of FPAN's operational areas through gender and right based approaches.

GOAL

Empower young people within society to make informed choices to improve their sexual and reproductive health.

OBJECTIVES

- To increase access to a broad range of youth and gender friendly sexual and

reproductive health education and services.

- To strengthen commitment to and support for the sexual reproductive rights of young people.

ACTIVITIES TO ACHIEVE OBJECTIVE-1

To increase access to a broad range of youth and gender friendly sexual and reproductive health education and services.

- Conduct baseline surveys to create a database on adolescent and youth issues within gender and right based approach.
- Conduct pilot testing on the use of service delivery guidelines, protocols and manuals
- Review and update existing guidelines and manuals with youth and gender friendly SRH components
- Produce BCC materials for utilization on SRH information and services

- Provide knowledge and skill for young girls and boys to help/support in exercising their SRH rights
- Enhance knowledge and skills of service providers for youth friendly SRH education and services
- Establish youth and gender friendly service outlets
- Establish partnership with other organizations working in the field of adolescent reproductive health at various levels
- Develop monitoring check-lists.
- Undertake surveys/research to document lessons learnt

ACTIVITIES TO ACHIEVE OBJECTIVE-2

To strengthen commitment to and support for sexual reproductive rights of young people

- Review existing laws and policies that affects the SRH

Goal of Adolescents & Youth

Empower young people within society to make informed choices to improve their sexual and reproductive health.



of adolescent and young people

- Develop advocacy tools for aimed at parents, community leaders, teachers, religious leaders on SRH problems of adolescent and youth.
- Conduct workshops/seminars for local policy makers to create supportive environment for the promotion of SRH rights of adolescent and young people
- Conduct community sensitisation programs to disseminate information about the national laws and policies which affect the SRH of adolescents and young people
- Produce documentation of activities to share with other stakeholders
- Expand adolescent and youth programs
- Conduct joint programs with other line agencies

working for the promotion of sexual and reproductive rights of adolescents and young people

- Involve young people at various levels of management and governance
- Conduct workshops and press meetings for both national and local media.

EXPECTED OUTCOME

- Increased accessibility and availability of youth and gender friendly SRH education and services
- Created positive social and policy environment for sexual reproductive rights and needs of adolescents and young people.

INDICATORS OF SUCCESS

- Favourable policies and laws on sexual and reproductive health of adolescents and youth formulated.



- Increased awareness among adolescents and young people on SRH
- Attitudinal changes among service providers towards working with young people
- Improved positive behavioural changes among adolescents and youth regarding their sexual and reproductive health
- Increased utilization of SRH services among adolescents and youth

HIV/AIDS

STRATEGIC DIRECTION

Reduce HIV incidence by strengthening STI services and improving sexual and reproductive health in FPAN operational areas

GOAL

Contribute towards reduced incidence of HIV/AIDS in FPAN operational areas

OBJECTIVES

- To increase access of gender sensitive STI services and STI/HIV/AIDS education to vulnerable population
- To reduce HIV/AIDS stigma and discrimination at all level

ACTIVITIES TO ACHIEVE OBJECTIVE 1

To increase access to gender sensitive STI services and STI/

HIV/AIDS education to vulnerable population

- Conduct surveys/studies on STI/HIV/AIDS among vulnerable population
- Develop IEC/BCC materials for vulnerable population
- Develop training curriculum and service delivery guidelines
- Build capacity of service providers to provide STI services and proper knowledge to deal with stigma and discrimination relating to HIV/AIDS
- Provide STI diagnosis and treatment services through selected FPAN's clinics
- Provide care and support services to HIV infected and affected people (on pilot basis in selected area)
- Establish referral linkages within government and NGO facilities at appropriate levels for STI services, confirmatory HIV test and care\support services to people living with HIV/AIDS (PLWHA)
- Document implementation processes and success stories.

ACTIVITIES TO ACHIEVE OBJECTIVE 2

To reduce HIV/AIDS stigma and discrimination on HIV/AIDS at all level

- Review and update existing service delivery guidelines

Goal of HIV/AIDS

Contribute towards reduced incidence of HIV/AIDS in FPAN operational areas.

- Conduct workshops/seminars among health planners, policy makers, implementers and media persons to generate awareness about the non-discriminatory policy and implementation to protect the rights of HIV infected and affected people.

INDICATORS OF SUCCESS

- Improved positive attitude of policy makers, planners and service providers towards HIV infected and affected people
- Improved behaviour among vulnerable population on STI/HIV transmission and means of prevention
- Increased utilization of STI services among vulnerable population.

ABORTION

STRATEGIC DIRECTION

Increase access to gender sensitive Comprehensive Abortion Care (CAC) services and education by lobbying and advocating for the universal rights of women to live healthy and safe lives and

Goal of Abortion

Recognize of the universal rights of women to choose and have access to safe abortion services to reduce the incidence of unsafe abortion in FPAN operational areas.

EXPECTED OUTCOME

- Supportive environment developed to reduce stigma and discrimination among vulnerable population
- Increased awareness among vulnerable population on STI/HIV prevention
- Increased access to STI diagnosis and treatment services for vulnerable population in FPAN's operational area





thereby reduce socio-economic barriers in FPAN operational areas.

GOAL

Recognize of the universal rights of women to choose and have access to safe abortion services to reduce the incidence of unsafe abortion in FPAN operational areas.

OBJECTIVES

- To increase access to safe abortion services, post abortion care and other abortion related services and education
- To reduce socio economic barriers (e.g. son preference, low priority to women) that infringe on women's right to safe abortion services

ACTIVITIES TO ACHIEVE OBJECTIVE -1

To increase access to safe abortion services, post abortion care and other abortion related services and education.

- Conduct base line survey on socio cultural norms and

impact of abortion at household level.

- Conduct feasibility study for cost recovery and fee charging scheme.
- Establish and maintain a national database on abortion related information by the association
- Advocate policy makers for expansion of service outlets.
- Identify stakeholders working in abortion activities e.g. Govt/I/NGO (Marie Stopes, CREPHA, FWLD at national level and many others at district level) and private sector (nursing homes, private practitioners, national society of gynaecologists)
- Build capacity of service providers to ensure quality safe abortion including PAC focusing on sensitisation of clients' rights and gender issues
- Upgrade existing clinical infrastructure and establish new service delivery centres
- Develop monitoring indicators and checklists for quality services

Goal of Access

Enable people in general, particularly the poor, marginalized, the socially-excluded and ensure that the underserved are able to exercise their rights.

- Integrate and expand abortion related services into existing FPAN service outlets
- Establish/develop model clinics for gender and youth sensitive quality abortion services
- Provide proper counselling on safe abortion services and post abortion care in selected clinics
- Provide post abortion contraceptives (unconditional) from FPAN service outlets
- Provide FP services, including emergency contraception to reduce unplanned/unintended pregnancies
- Establish partnership and referral linkage with relevant CBOs and primary health care institutions for access and advocacy
- Document the process of implementation, lessons learnt and best practices
- Develop gender focused advocacy package and BCC materials based on the information collected from base line surveys
- Sensitise communities against stigmatisation about abortion through gender based approach
- Undertake public awareness and community based education programs about stigmatisation and dangers of unsafe abortion
- Advocate for access to CAC services to rural women
- Document advocacy efforts in Nepal, including role of FPAN for liberalization of abortion law.

EXPECTED OUTCOME

- Increased access to gender sensitive safe abortion services
- Reduced socio-cultural barriers hindering safe abortion.

ACTIVITIES TO ACHIEVE OBJECTIVE -2

To reduce socio economic barriers (son preference, low priority to women's reproductive rights) for safe abortion services.

- Disseminate information on actual problems among various groups (gynaecologists, social workers, women groups, lawyers, media persons) on safe abortion services

INDICATORS OF SUCCESS

- Results of baseline survey
- Increased referral linkages with stakeholders
- Increased skills and knowledge of service providers
- Increased service outlets
- Tools/checklist developed for monitoring quality of abortion services (client based satisfaction)
- Increased clients for safe abortion services
- Increased media support

ACCESS

STRATEGIC DIRECTION

Increase access to right based quality SRH services focusing on poor, marginalized and Internally Displaced People-refugees, youth, women, etc by expanding gender sensitive service facilities in rural settings

GOAL

Enable people in general, particularly the poor, marginalized, the socially-excluded and ensure that the underserved are able to exercise their rights to make free and informed choices about sexual and reproductive health, and access SRH information, sexuality education and high quality services, including family planning.

OBJECTIVES

- To increase availability of gender sensitive SRH information and services including family planning in rural setting of FPAN's operational areas.

ACTIVITIES

- Conduct baseline survey to maintain database on SRH related issues
- Conduct workshops/seminars with different stakeholders to disseminate information relating to SRH issues
- Organize campaigns in support of sexual and reproductive health and rights of marginalized, disadvantaged and Internally Displaced People(IDPs)
- Develop IEC materials relating to SRH issues targeting



the poor, marginalized, the socially-excluded and underserved community

- Conduct orientation programmes at community level on various aspects of SRH including men's roles and responsibilities in relation to women's SRH rights
- Provide necessary skills to service providers for ensuring quality services
- Establish service delivery points in rural areas served by of FPAN to provide SRH services including family planning focusing on poor, marginalized and Internally Displaced People (refugees, youth, women, etc)
- Establish working relationship with other agencies to provide SRH services
- Conduct various income generating activities and small scale programs to uplift the socio-economic status of poor, marginalized and Internally Displaced People with particularly focus on women.
- Review FPAN structure from a genderperspective-to institutionalize gender sensitivity within the organization.
- Document processes of successful implementation of programmes

- Undertake end line surveys/studies to measure impact of the programmes

EXPECTED OUTCOME

- Increased utilization of SRH including family planning services amongst the underserved and marginalized in FPAN's operational areas
- Increased awareness on SRH among the poor and marginalized.

INDICATORS OF SUCCESS

- Profile of clients (age, sex, income etc) served by FPAN
- Results of survey
- Findings of periodic assessment and monitoring.

GOVERNANCE AND LEADERSHIP

Family planning movement was initiated by social workers and volunteers in Nepal with establishment of the Family Planning Association of Nepal in 1959, before the government incorporated population activities in its programs in late 1960s. The strength of FPAN lies in its vision, dedication and contribution of its volunteers who provide leadership and demonstrate good governance. Besides, volunteers play an

important role in advocacy for policy change, resource generation and in enlisting community support for program intervention. They have thus made enormous contribution to meet the unmet SRH needs of people over the past years.

However, improvements are needed in recruitment and retention of professional volunteers, equitable participation of women in governance at all levels and in attracting of young volunteers. Similarly, growing numbers of CBOs and NGOs involved in SRHR in the country have increased competition for resources on the one hand and on the other hand, the national budget allocation priority is shifting gradually from social sector to security. These emerging shifts pose a serious challenge to FPAN in its attempt mobilize required amounts of financial and material resources to meet growing SRH needs of people in its operational areas. This calls for serious efforts for strong leadership, good governance and effective advocacy for resource generation.

STRATEGIC DIRECTION

Build professional capacity of volunteers for commitment to advocacy for resources, pro-

motion of sexual reproductive health and rights in the country and good governance within FPAN.

GOAL

Increase competency of voluntary leadership and governance to increase public, political and financial support for SRHR

OBJECTIVE

To develop professionalism among volunteers for effective advocacy, resource mobilization and image building of FPAN at national and international level

ACTIVITIES

- Recruit new and energetic professional young volunteers representing all sectors of the society including marginalized, socially disadvantaged and ethnic minorities
- Revise constitution, laws and bylaws of FPAN to ensure 50% representation of women in governance at all levels
- Provide leadership, governance, advocacy and program related training to volunteers for capacity building
- Organize consultation meetings between FPAN volunteers and HMG/N policy makers and plan-

Goal of Governance & Leadership

Enable people in general, particularly the poor, marginalized, the socially-excluded and ensure that the underserved are able to exercise their rights.



ners, donor agencies, I/NGO, journalists, professional groups, corporate sector and the community for resource mobilization and partnership programs

- Enhance knowledge and skill of volunteers on dissemination of successful SRHR strategies, success stories and lessons learned among stakeholders and donors.

EXPECTED OUTCOMES

- Recognize FPAN as a leading national NGO in the field of SRHR at national and international level
- Increase participation of women, young professionals and marginalized people in FPAN governance
- Increase percentage share of non-IPPF funding in FPAN program
- Increase partnership programs with GOs and I/NGOs

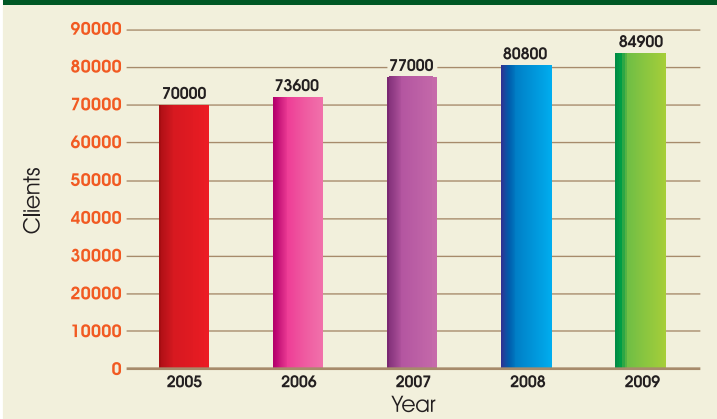
- Increase the number of positive outcomes in SRHR policies

INDICATORS

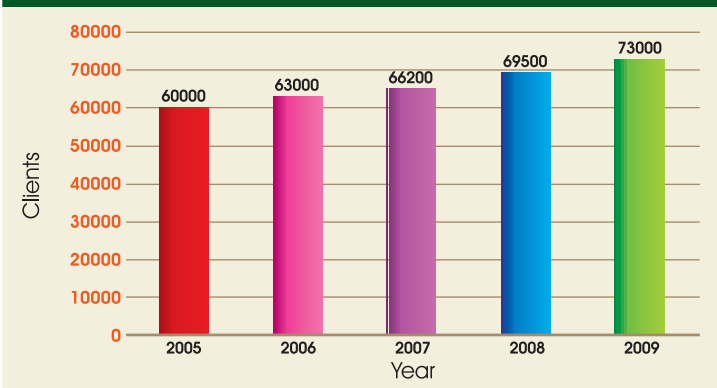
- Involvement of FPAN in key SRH committees formed by GO and NGOs
- Increased and effective participation of FPAN volunteers and staff in national and international SRH forums and meetings
- Increased share of women, marginalized people and ethnic minorities in governance
- Greater share of young volunteers in governance and in total volunteer numbers
- Increased share of non-IPPF funding in total FPAN cost
- Increased number of partnership programs implemented
- Amendment on SRHR for positive impact.

EXPECTED FP CLIENTS (2005-2009)

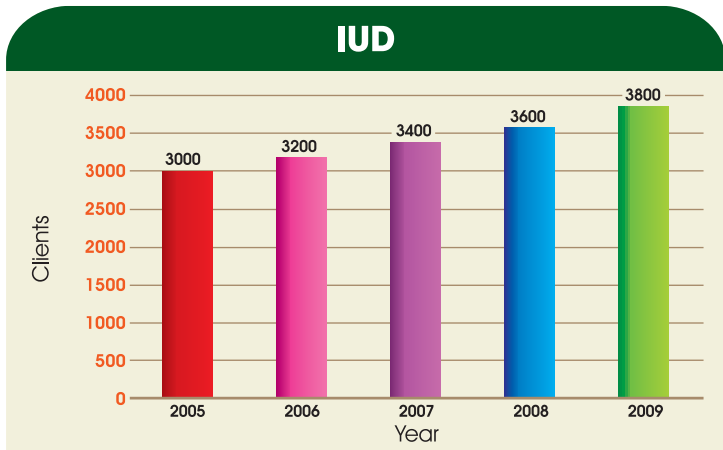
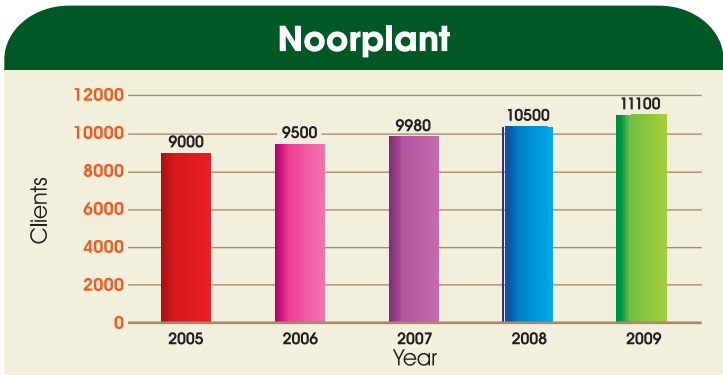
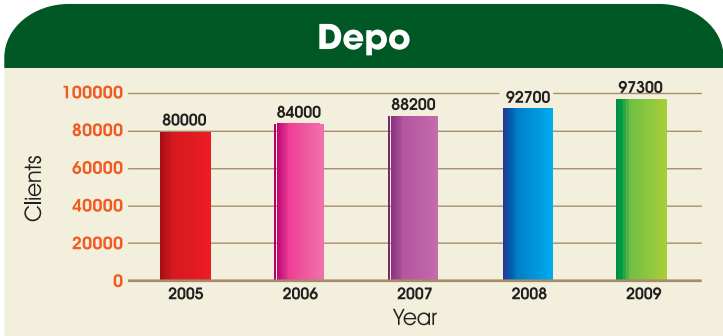
Condoms



Pills

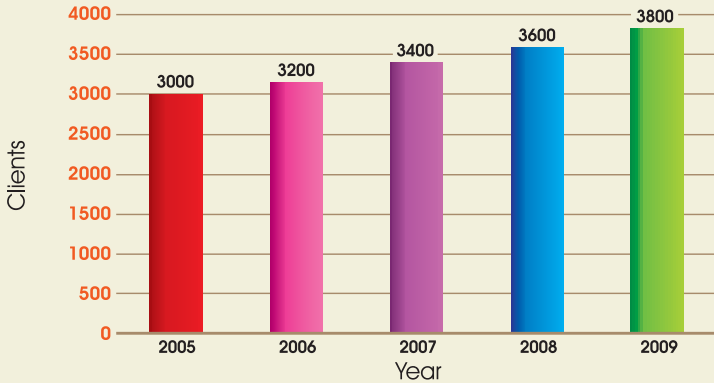


EXPECTED FP CLIENTS (2005-2009)

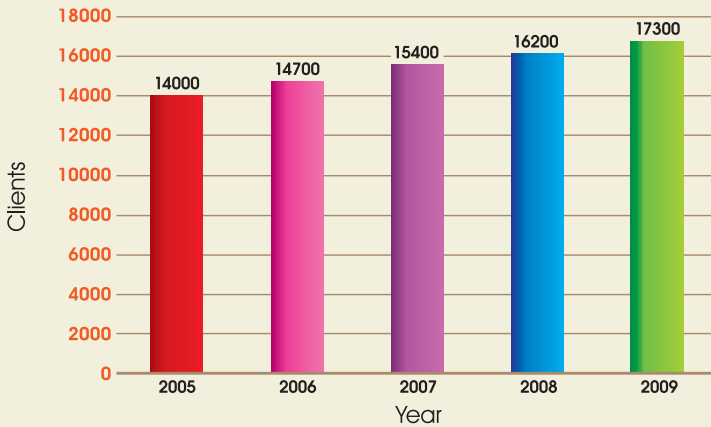


EXPECTED FP CLIENTS (2005-2009)

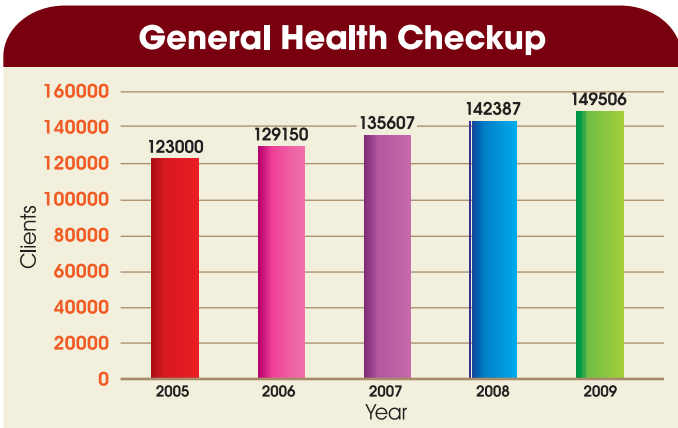
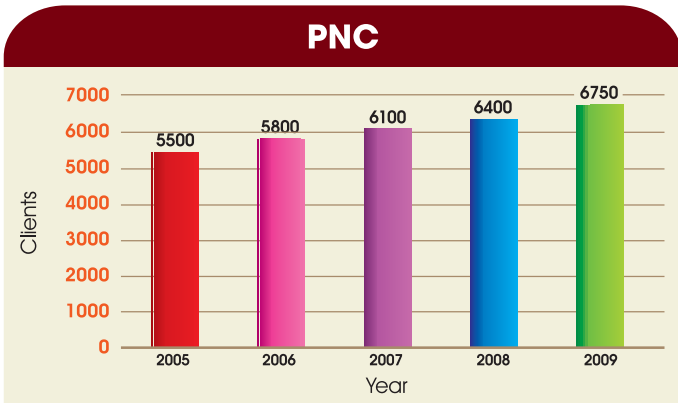
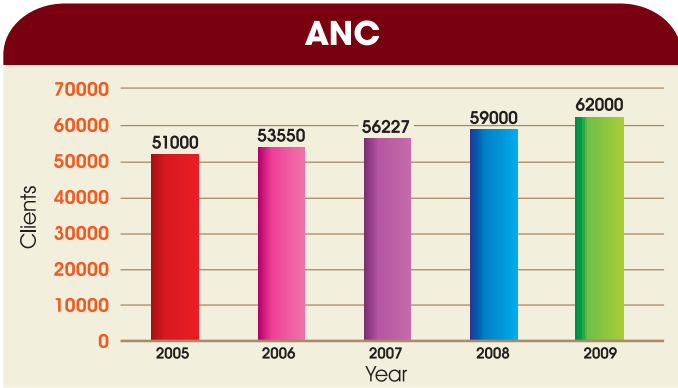
Female Sterilization



Male Sterilization

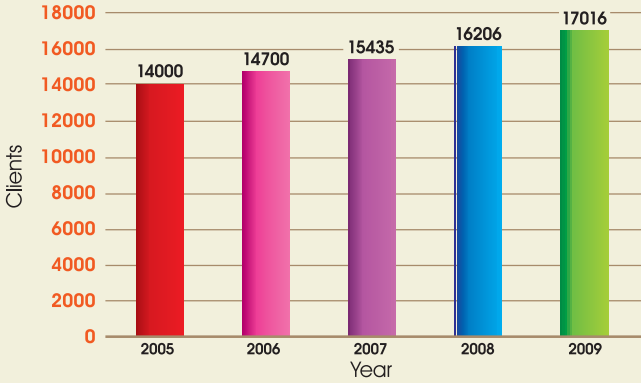


SERVICES (2005-2009)

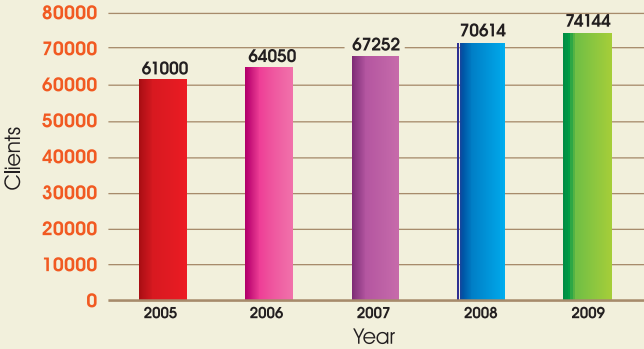


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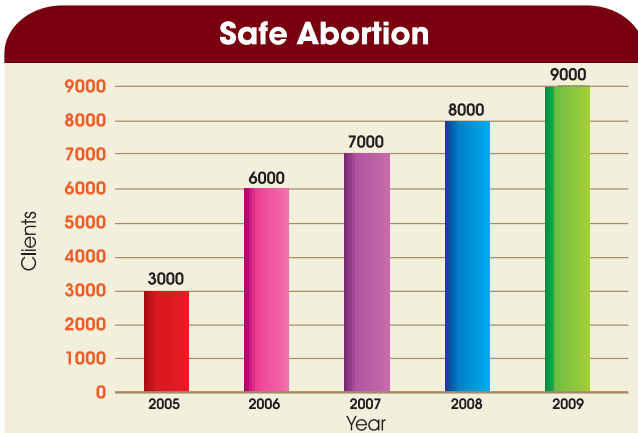
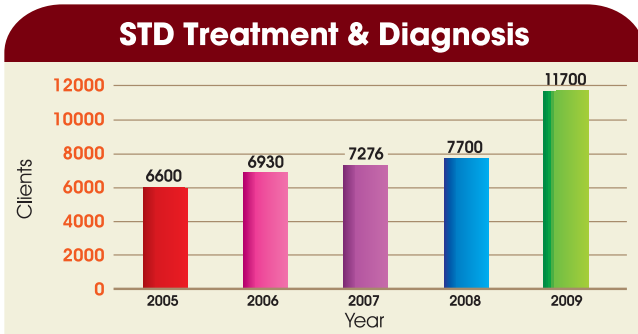
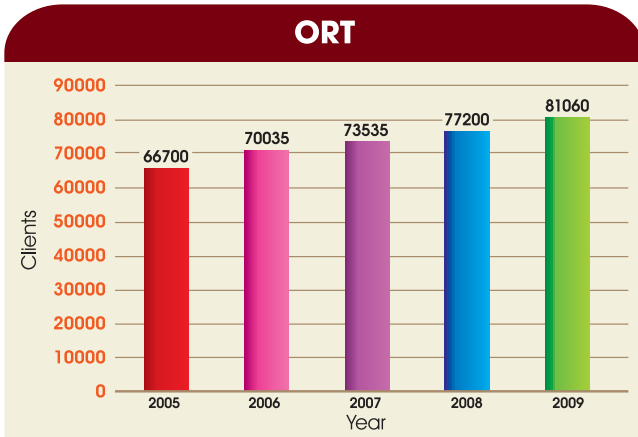
Nutrition



Breast Feeding

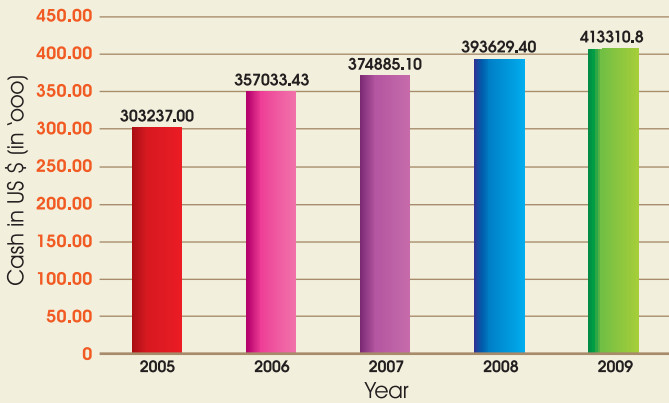


SERVICES (2005-2009)

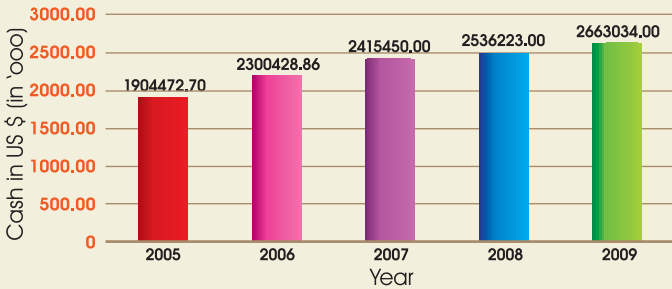


FPAN (2005-2009)

Contraceptives

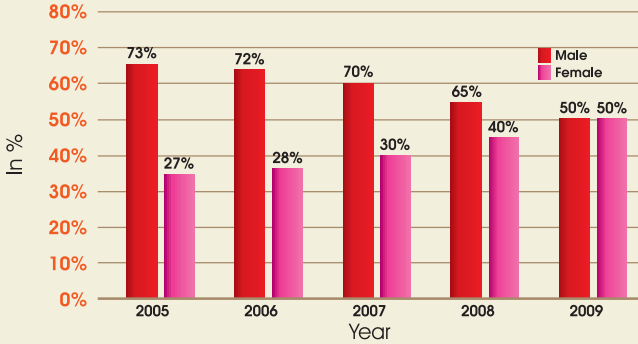


Cash in US \$

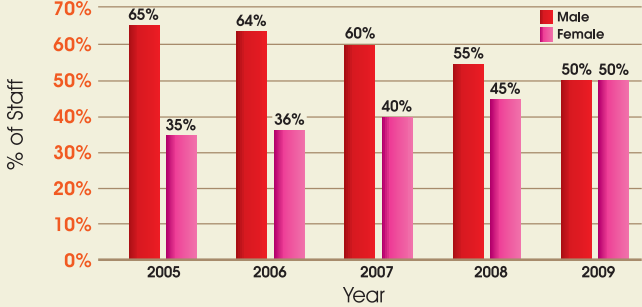


FPAN (2005-2009)

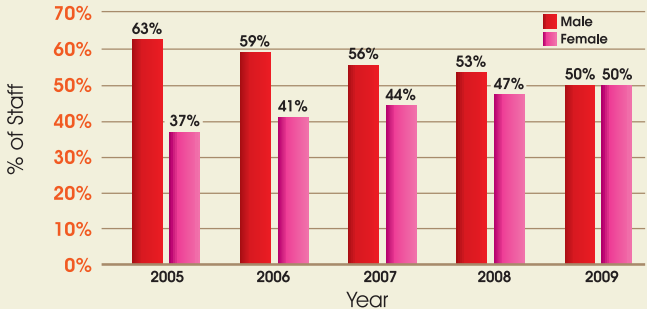
Sexwise Central & Branch Executive Members



Sexwise Officer Level Staff of FPAN



Sexwise Non-officer Level Staff of FPAN



Acronyms

AIDS	- Acquired Immune Deficiency Syndrome
BCC	- Behavior Change Communication
CAC	- Comprehensive Abortion Care
CBO	- Community Based Organization
CBS	- Central Bureau of Statistics
CPR	- Contraceptive Prevalence Rate
CREPHA	- Center for Research on Environmental Health and Population Activities
CWIN	- Child Workers in Nepal Concerned Center
DDCs	- District Development Committees
DHS	- Demographic Health Survey
FCHVs	- Female Community Health Volunteers
FPAN	- Family Planning Association of Nepal
FSWs	- Female Sex Workers
FWLD	- Form for Women Law and Development
GDP	- Gross Domestic Product
HIV	- Human Immune Deficiency Virus
HMG/N	- His Majesty's Government of Nepal
ICPD	- International Conference on Population and Development
IDPs	- Internally Displaced People
IDUs	- Injecting/Intravenous Drug Users
IEC	- Information Education & Communication
INGO	- International Non-governmental Organization
IPPF	- International Planned Parenthood Federation
KABP	- Knowledge Attitude Behavior and Practice
MEH	- Multi Engineering and Health Consultant Pvt. Ltd
MoH	- Ministry of Health
NCASC	- National Center for AIDS & STD Control
NGO	- Non-Governmental Organization
PAC	- Post Abortion Care
PHC	- Primary Health Center
PLWHA	- People Living with HIV/AIDS
REGHED	- Research Group for Health Economics and Development
RH	- Reproductive Health
SRH	- Sexual and Reproductive Health
STI	- Sexually Transmitted Disease
TBA	- Trained Birth Attendance
TFR	- Total Fertility Rate
USAIDS	- United Nations Acquired Immune Deficiency Syndrome
VDC	- Village Development Committee
WHO	- World Health Organization



Program Support Section

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