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ADOLESCENTS REPRODUCTIVE HEALTH IN NEPAL

1.1 Introduction

In 1996, young people aged 15-19 was estimated at 519 million, with 83% living in developing countries. By the next century over half of the world's population will live in urban areas where young people are estimated to have poverty and stressful loss of family ties. In developing countries, four out of five of world's young people live and where more than half of population is under the age of 25.

With 28% of the world's population on between the ages of 10 and 24, 1.5 billion people growing up today will be the leaders, citizens and partners in the future. Hence, young men and women will become parents of the next generation. In South-East Asia region, (Bangladesh, India, Maldives, Nepal, Pakistan and Sri Lanka), more than 30% of the total population is between the ages of 10-24, of which about 40% are growing into adolescence below the age of 15. Many adolescents have already married and started own families, but without information and services which are known to promote healthy and responsible sexual and reproductive behaviors. More and more young people are suffering from STDs including HIV, seeking unsafe abortion, resulting into the consequences of early, close and frequent pregnancies and social problems.

1.2 Adolescents Population in Nepal

The total population of Nepal was 18.5 million in 1991 against 11.5 million in 1971. The share of adolescent population in the age group of 10-14 was 11.22% in 1971, which increased to 11.36% in 1981 and 12.58% in 1991. The younger male adolescent group i.e. 10-14 age group increased by 31% (1971-1981) and 32% (1981-91) while the corresponding figures for the female were 33% and 42% during the same period. Similarly the older adolescent male population i.e. 15-19 age group increased by 27% (1971-1981) and 27% (1981-1991) while the increase for female are relatively higher, indicating rapid growth of adolescent population in Nepal.

1.3 Mean Age at Marriage & Marital Status

Age at marriage is one of the most important proximate determinants of aggregate level of fertility (Bongaarts and Potter, 1993) and it is also an important indicator of women's status. The mean age at marriage for female is comparatively lower in Nepal as compared to other SAARC countries. However, there has been gradual change in the mean age at marriage during inter census period 1961-1991.

The mean at marriage for women increased from 15 years in 1961 to 18 years in 1991. The change is more pronounced among young girls between 10-14 years. In case of young girls between 10-14 years, 25% were already married in 1961 but it changed over time and as a result 8% (82,000 children at the age of 15 in

the marriage category) of such girls were in married category in 1991. This indicates that over the 30years, girl child marriage in the 10-14 years group has been reduced by more than two-thirds.

1.4 Adolescents Fertility

During the most recent period (1991-1996), fertility among 15-19 and 20-24 is 1.31 and 2.71 respectively. Fertility rates, despite some visible indication of decline, are still high in Nepal. The total fertility rate per women was 6.33 in 1976, which declined to 4.6 in 1996. The decline in TFR is largely attributed to the use of family planning services. Fertility was observed to be highest among women 20-24 years (266/1000 women) in 1996.

1.5 Adolescent Child-Bearing

Problems of adolescent reproductive health are those resulting from traditionally early marriage of girls that still prevail in many developing countries, including Nepal. Twenty-five percent of 14 years old girls in Bangladesh and 34 percent of girls of 15 years in Nepal were married, although legal minimum age for marriage is 16 in both the countries. Moreover, 44% of 15-19 age are married according to the 1996 health survey report.

In South Asia, women under 20 years are married. Highest percentage of young men aged 15-19 who are married is 12 percent in India, and in most developed countries it is around 2% or 3%. Children born to adolescent mothers are about 40% more likely to die during their first year of life than those born to women in their twenties. Forty-percent adolescent childbearing takes place before 18 in African and Latin America, against 31% in Asia.

1.6 Knowledge of FP Methods among Adolescents

There has been sharp increase in the knowledge of family planning methods in Nepal over the years. The share of currently married women who know about modern methods was 21% in 1976 which jumped to 98% in 1996.

1.7 Use of Contraceptive among Adolescents

The trend of modern contraceptive use in Nepal has risen steadily over the last two decades. Current use of modern contraceptives among currently married non-pregnant women has increased from 3% in 1976 to 29% in 1996. The survey indicates that the share of temporary methods has risen from 14% in 1986 to 33% in 1996.

1.8 Adolescents Pregnancy and Abortions

Abortion is an illegal phenomenon in Nepal. Anybody, seeking an abortion, practicing it or willing to be accomplished to such is punishable in accordance with prevailing laws. There are limited exceptions where the induction of abortion is permissible after a medical practitioner certifies it on medical background.

Nepalese women seek access to abortion for various reasons. The unmarried woman who finds herself pregnant has the choice of either getting married rather quickly or terminating the pregnancy at every risk. Any women either widow or unmarried who became pregnant due to relationships with persons other than their husband utterly seek abortion to escape from strong social pressure and abuse.

1.9 Adolescents & Knowledge of STDS, HIV/AIDS

The incidence of RTIs and STDs among adolescents has increased markedly world-wide for the past 2 decades. Gonorrhea, chlamydia, syphilis, herpes, genital warts and HIV are the most prevalent RTIs/STDs among the teens. One-fifth of people world wide with AIDS are within their twenties.

More than 50% of the female STD patients in Nepal were found to be involved in commercial sex trade and casual or professional CSWs were identified as the source of STDs in more than 86% of patients.

2. National Reproductive Health Strategy for Nepal

2.1 In Nepal, reproductive health is not a new program, rather a new approach which seeks to strengthen the existing safe motherhood, family planning HIV/AIDS, STDs, child survival and nutrition programs with a holistic life cycle approach. This calls for strengthening inter-divisional linkages with the Department of Health services as well as between other sectors, e.g., education, women's development, and the legal/justice system. Gender perspectives and empowerment of women will be built into all relevant program areas.

2.2 The new strategy is consistent with the 1991 Health Policy and 1997-2017 Second long-term Health Plan. The integrated RH package in Nepal will be delivered through the existing primary health care system. A substantive gender perspective, community participation, equitable access and inter-sector collaboration will be emphasized in all aspects of package.

2.4 The strategy encompasses interventions at various levels. The first level includes family / decision makers, community / mother's groups, FCHVs / TBAs, PHC outreach/EPI outreach clinic, the second level includes SHP/HP, the third level includes PHCC, and the fourth level includes the district. These levels broadly envisage information counseling, contraceptive supply and services/referrals.

1. RESPONSIBLE SEXUAL & REPRODUCTIVE HEALTH BEHAVIOR AMONG ADOLESCENTS

1.1 Adolescents in the South Asia Region

In 1996, young people aged 15-19 was estimated at 519 million, with 83% living in developing countries. By the next century over half of the world's population will live in urban areas where young people are estimated to have poverty and stressful loss of family ties. In developing countries, four out of five of world's young people live and where more than half of population is under the age of 25.

With 28% of the world's population on between the ages of 10 and 24, 1.5 billion people growing up today will be the leaders, citizens and partners in the future. Hence, young men and women will become parents of the next generation. In South-East Asia region, (Bangladesh, India, Maldives, Nepal, Pakistan and Sri Lanka), more than 30% of the total population is between the ages of 10-24, of which about 40% are growing into adolescence below the age of 15. Many adolescents have already married and started own families, but without information and services which are known to promote healthy and responsible sexual and reproductive behaviors. More and more young people are suffering from STDs including HIV, seeking unsafe abortion, resulting into the consequences of early, close and frequent pregnancies and social problems.

Table-1
Basic Key Indicators of Adolescents Youth in South Asia, 1996

Indicators	Bangla desh	Bhutan	India	Nepal	Maldives	Pakistan	Sri Lanka
Total Popn (million) 1997	122.2	NA	969.7	22.6	0.3	137.8	18.7
Teen Popn ages 15-19 (millions)	13.9	0.2	92.7	2.4	NA	14.3	1.9
Average Age At First Marriage							
Male	23.9	-	23.4	21.5	22.1	24.9	27.9
Female	16.7	-	18.7	17.9	17.9	17.6	24.4
Total Fertility Rate	3.4	6.2	3.4	4.6	6.2	5.6	2.3
% of TFR contributed by ages 15-19	15.0	5.0	9.0	10.0	NA	5.0	7.0
% of Currently Married Females (15-19)	48	-	38	50	NA	24	7
% Birth of Teenagers	13.0	-	9.0	9.0	NA	6.0	4.0
% Using Contraception (15-19)	19	-	19.0	2.5	NA	3.4	20
% Using Contraception (15-49)	40	-	45	28.9	NA	17.8	66

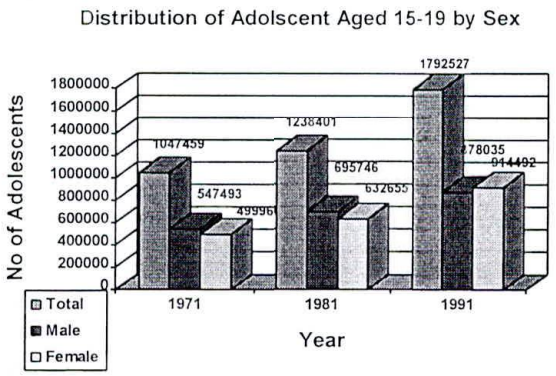
Sources: - The World's Youth, 1996, Population Reference Bureau, Inc., Washington, DC, USA
- State of World's Population, 1996, UNFPA

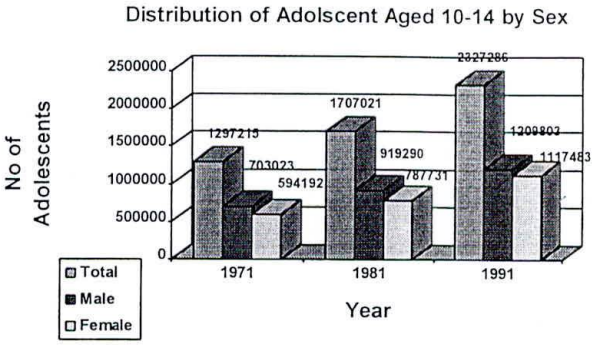
1.2 Adolescents Population in Nepal

1.2.1 Adolescents Distribution By Age and Sex

The total population of Nepal was 18.5 million in 1991 against 11.5 million in 1971. The share of adolescent population in the age group of 10-14 was 11.22% in 1971, which increased to 11.36% in 1981 and 12.58% in 1991. The younger male adolescent group i.e. 10-14 age group increased by 31% (1971-1981) and 32% (1981-91) while the corresponding figures for the female were 33% and 42% during the same period. Similarly the older adolescent male population i.e. 15-19 age group increased by 27% (1971-1981) and 27% (1981-1991) while the increase for female are relatively higher, indicating rapid growth of adolescent population in Nepal.(Figure-1).

Figure-1

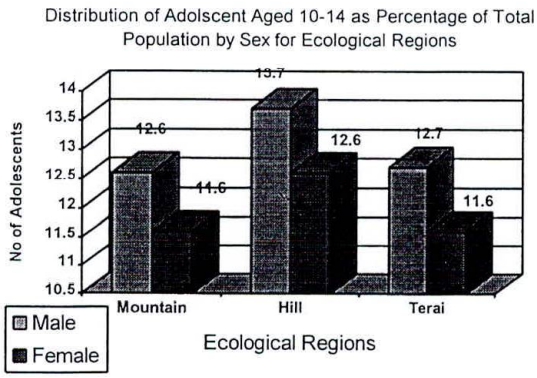


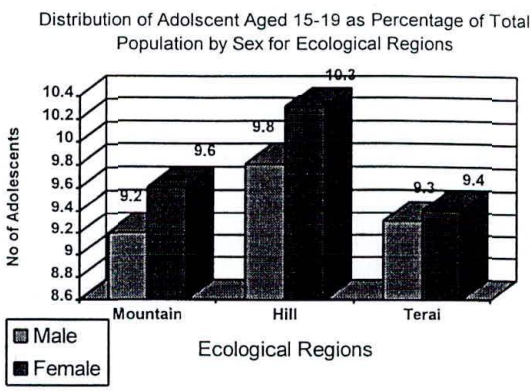


Sources : - Population Monograph of Nepal,1995
- Statistical Year Book, CBS, HMG, Nepal, 1991

The distribution of adolescent population shows that the percentage decreases more or less with increasing age in the hills and mountains. The percentage of both adolescent boys and girls is higher in the hill in comparison to other ecological regions. The percentage of adolescent boys and girls in the age group 10-14 is also highest among other age groups among ecological all the regions (Figure-2).

Figure-2



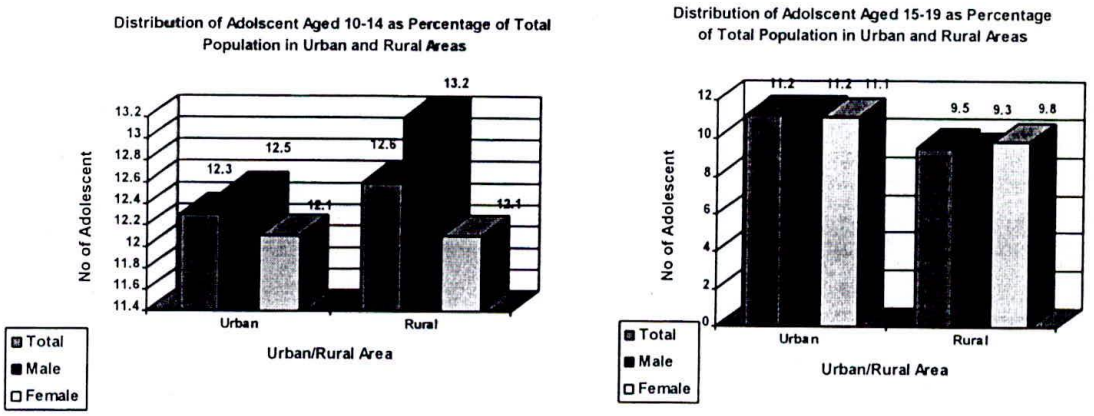


Source: Population Monograph of Nepal 1995

1.2.2 Urban/Rural Situation

The percentage of population in both the areas are greater in the age group 10-14 compared to 15-19. The proportion of adolescent population (10-14) in the urban areas is 34.4 percent in urban areas, which is slightly higher compared to 30.4 percent in rural areas. Similarly the percentage of male and female population is also slightly higher in urban areas in comparison to rural areas except for female in the age group 10-14 (Figure-3)

Figure-3

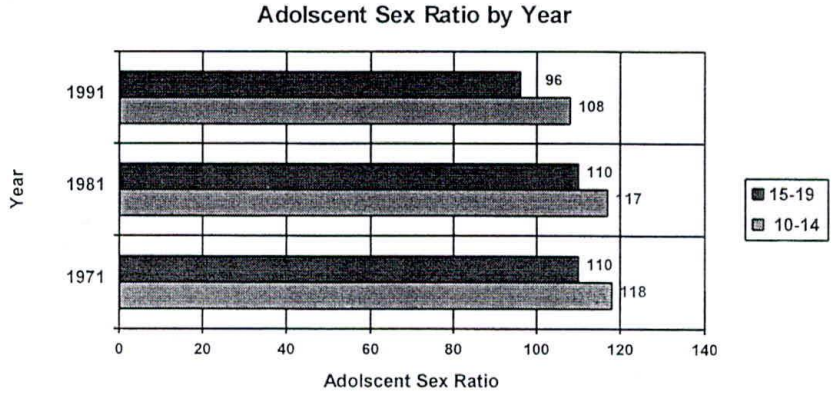


Source: Population Monograph of Nepal 1995

1.2.3 Adolescent Sex Ratios

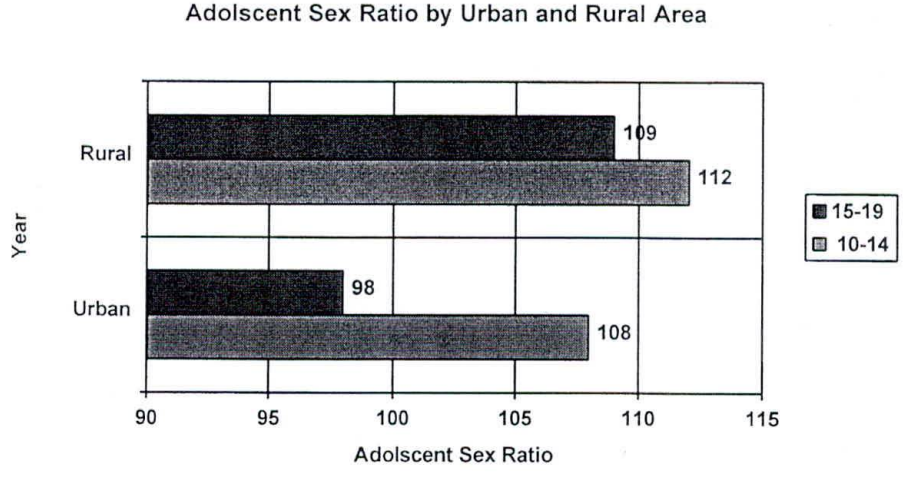
Sex ratio, measured as number of men per 100 women, is one of the most important indicators of women's status. Generally, more boys are born than girls, but more women survive to old age than men. A preponderance of men over women in the overall population indicates social discrimination against women, as well as male in-migration. (Meena Acharya). The following Figure-4 shows that the sex ratio which was 118 in 1971 decreases to 108 in the age group 10-14 in 1991 and the ratio also decreased in the older adolescent group which was less than the national average. . Similarly the Figure-4 also shows that the sex ratio is higher in the younger adolescent 10-14 age group than the older adolescent group 15-19.

Figure-4
Source: population Monograph, 1995 CBS, HMG/Nepal



The age specific sex ratios are greater than one hundred in urban areas and are greater than those in rural areas. The urban sex ratios are particularly higher in working age group. This could be mainly due to the male selective out-migration from rural areas. Among those at age 15-19, most of them might have gone outside the country for work or study, indicating decreasing trend of sex ratios among the rural people (Figure-5).

Figure-5



Source: Population Monograph of Nepal, 1995, CBS, HMG/Nepal

1.3 Mean Age at Marriage & Marital Status

Age at marriage is one of the most important proximate determinants of aggregate level of fertility (Bongaarts and Potter, 1993) and it is also an important indicator of women's status. The mean age at marriage for female is comparatively lower in Nepal as compared to other SAARC countries. However, there has been gradual change in the mean age at marriage during inter census period 1961-1991. The mean age of marriage is found to have been increasing steadily in Nepal since 1961. This is an encouraging trend. (Table-2).

Table-2
Trends of Mean Age at Marriage

Category/Year	1961	1971	1981	1991
Mean Age at Marriage	15	17	17	18
Married among 10-14 Age (%)	25	13	14	8

Source: CBS, 1995, pp. 173-190

The mean at marriage for women increased from 15 years in 1961 to 18 years in 1991. The change is more pronounced among young girls between 10-14 years. In case of young girls between 10-14 years, 25% were already married in 1961 but it changed over time and as a result 8% (82,000 children at the age of 15 in the marriage category) of such girls were in married category in 1991. This indicates that over the 30years, girl child marriage in the 10-14 years group has been reduced by more than two-thirds. Whereas in 1961, nearly three-fourth of the females in the age group of 15-19 were married, it declined to just below 50% in 1991. Moreover, Family Health Survey 1996, (MOH) suggests that 47% of the females are married by age 17, percentage married increases rapidly between 15 and 16 years.

There exists an inequality by sex in the mean age at marriage. Most of the women are compelled to get married by their parents even in utter disregard to their interest. The cultural heritage and religious norms of Nepal still insist the girls to be married before their first menstruation whereas for male there is no such socio-cultural interference to get married at the early age. The legal age at marriage is 16 years for female and 18 for male (with consent of guardian) and 18 years for female and 21 years for male (without consent of guardian). However, most of the women in the hinterland are married before 15 years. Immediate after the marriage most of the women enter into sexual union and become mother earlier than their legal age at marriage. Before 20, they have either two or three children in general which have weakened their health status as well in Nepal (Gender Equality and Empowerment of Women, Dr Mina Acharya, 1997).

1.4 Marital Status in Rural/Urban Residence

According to the 1991 census report, the proportion of the currently married persons in urban areas has decreased in 1991 compared with the proportion in 1981. The proportion of currently married females has decreased significantly compared to the male counterparts. Table-3 below shows that urban areas (as compared to rural areas) are characterized by higher proportion of single, lower proportion of

married, lower proportion of widowed and lower proportion of divorced/ separated, for both men and women.

Similarly in urban areas the proportion of single adolescent girls (31%) is lower than male counterparts (42%) while in rural areas it is 35% in adolescent boys and 35% in adolescents girls. This is due to the early marriage in rural areas (Table-3).

Table-3
Marital Status among Adolescents in Rural/Urban Residence
(Percentage)

	Single		Married	
Rural	Male	Female	Male	Female
All Ages	35	25	61	66
10-14	96	92	4	7
15-19	78	51	21	47
Urban				
All Ages	42	31	56	61
10-14	97	95	3	5
15-19	88	66	11	32

Sources: Population Monograph of Nepal 1995

1.5 Age At Marriage and Age at Menarche

Many countries have raised the legal age for marriage but with little impact, especially in traditional societies, where the earlier the women start having children, the more they will be valued in societies. Those who start having children early generally have more children at shorter intervals than those who embark on parenthood later.

In Nepal, data on adolescent females show that the proportions of females are getting married at an early age, showing a decreasing trend over the years. In 1971 and 1981, the proportion of ever married females aged 10-14 was between 13 percent and 14 percent respectively but this has decreased to 8 percent in 1991. Similarly the proportions of females aged 15-19 getting married has declined from 61 percent in 1971 to 47 percent in 1991. (CBS, HMG/Nepal, 1987 & 1995)

Child marriage exists widely in Nepal although it is illegal. According to a survey conducted by UNICEF in 1996, about 40% of marriages take place before the girl reaches her legal age. Likewise, polygamy is also a criminal offence, yet it exists and is traditionally approved in many parts of Nepal. Since the penalties for polygamy and child marriages are not very severe, the number of child marriages and polygamy are increasing in Nepal.

Increasing level of nutrition, in general, lowers age at menarche. In Nepal where marriage is early the gap between age at menarche and age at first marriage is not big. However in the absence of national level data this situation cannot be examined. A recent study reveals that in rural areas of Nepal the age at marriage is lower than the age at menarche. Only among the women completing 6-years of schooling or more the mean age at marriage is higher than the mean age at menarche.

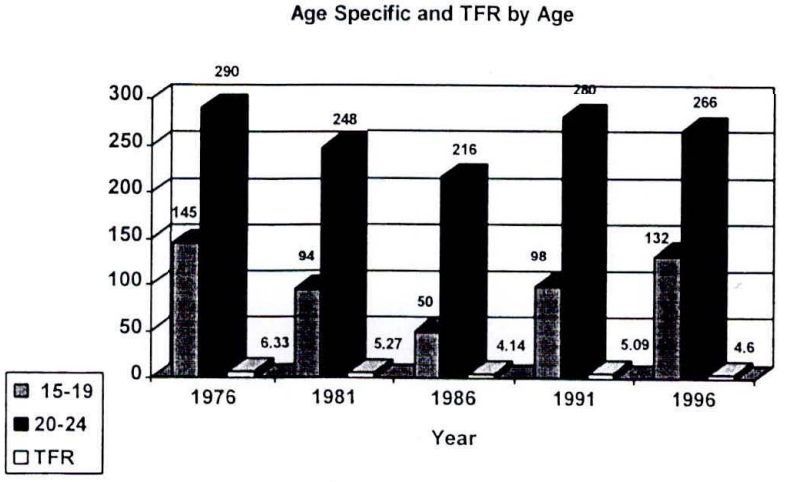
The educated adolescent and youth female populations of Nepal, as in other developing countries, are therefore, experiencing increasing gap between sexual and social adulthood as indicated by the declining age at menarche and the rising age at marriage. This gap represents the non-marital fecundity. During this period, adolescents and youths are exposed to the risks of unwanted, premarital pregnancy for more years than previous generations.(Survey Report of Vision 2000, 1998).

1.6 Adolescents Fertility

There is higher adolescent fertility in developing countries than in the developed countries. There are 171 live births per 1000 woman in Bangladesh, 32 in Sri Lanka while only 4 in Japan. However, fertility rates for women under 20 are declining, while number of births to adolescents are increasing. The number of children born to women under 20 is 4 per 1000 in Japan, while 200 per 1000 in Bangladesh.

During the most recent period (1991-1996), fertility among 15-19 and 20-24 is 1.31 and 2.71 respectively. Fertility rates, despite some visible indication of decline, are still high in Nepal. The total fertility rate per women was 6.33 in 1976, which declined to 4.6 in 1996. The decline in TFR is largely attributed to the use of family planning services. Fertility was observed to be highest among women 20-24 years (266/1000 women) in 1996 .The annual rate of births per 1000 women in 20-24 years showed a declining trend for the past two decades (Figure-6). Cross-country comparison shows that percentage of TFR contributed by ages 15 is 10 as against 15 in Bangladesh, 9 in India and 7 in Sri Lanka. (Table-1)

Figure-6



Source: NFHS, 1996 (PP 39)

The TFR estimated for 1985-86 seemed to be very low. This could not be accepted as a real picture because this may be due to data quality problem in the 1986 survey rather than of a true drop in fertility at that time. The pattern of age-specific fertility rates before 1981 indicates that women in Nepal had high fertility at 20-34 years of age with a peak at ages 25-29. From 1986 onwards an earlier peak in fertility at 20-24 years has emerged. The decline in fertility after age 34 is quite marked between 1986 and 1996, which indicates some fertility-limiting behavior among Nepalese women. Fertility trends have to be interpreted within the context of data quality and sample size. (Family Health Survey, 1996, HMG, Nepal.)

1.7 Adolescent Sexual Attitude and Behaviour

Depending on cultural and social values, there is a variation in the age at which young men and women begin sexual relations. According to the Family Health Survey, 1996, among the currently married women aged 15-19, some 63 percent were sexually active in the last four weeks compared to 67 percent aged 20-24. Marital sexual activity was reported to be the highest (73%) among women aged 25-34. Similarly, 3 of 4 women were sexually active in urban areas compared with 2 of 3 rural women.

According to a study on Reproductive Care, Knowledge, Attitude and Practice Among Adolescents sponsored by PLAN International in Makwanpur district, there is a high level of ignorance among adolescent girls about genital hygiene or safe sanitation practices during menstruation, over two thirds of the adolescent girls faced some menstruation related health problems immediately before or at the end of menstrual period. A large majority of adolescent girls mentioned that they were experiencing some symptoms of urinary tract infection (UTI). One in four adolescent girls complained about burning with urination, one in eight experienced foul smelling discharge, and one in 20 complained about sore or ulcer around genital area.

Unmarried adolescents are becoming more sexually active. One in ten unmarried adolescent boys of age between 15-19 years are sexually active. More than half of them (54%) had multiple sex partners. Interestingly, close to half of the sexually active adolescent boys did not feel themselves to be at risk of contracting STD and HIV/AIDS and only one fourth (27%) perceived to e at risk of contracting such diseases.

Similarly, a study conducted by CREHPA among men in five border towns of Nepal showed that 41% of unmarried adolescent aged 18-19 were sexually active. Moreover, among the sexually active unmarried men, a large majority (77%) had their first sexual contact while they were 19 years or below. The mean age of first sexual contact was 17.9 years. The first sex partner of these unmarried men were also adolescents, either younger to their age (42%) or the same age (35%). The first sex partner for one in ten was a commercial sex worker. One in five men of age 18-19 have had a non-regular sex partner in the last 12 months preceding the study.

The sexual activity rate is highest in the hill (69%) as compared to other regions. The activity rate in the mountain region was 67 followed by 67% in terai region. Sexual activity varies positively with education and ranges from as high of 76%

among women with a S.L.C to a low of 68% among women with primary education or no education. (Source: Population monograph, 1995)

Young people's premarital sexual encounters are generally unplanned, infrequent and sporadic. Data on premarital sexual activity is not available in Nepal, However recent studies revealed that adolescents are engaged in premarital sex. According to the survey findings conducted in three districts (Kathmandu, Makwanpur & Chitwan), it is reveals that premarital sex in Nepal is 19% and 16.2% have extra-marital sex. (Sexual Behavior Pattern In Nepal, Dr.B.L. Gurbacharya and B.K. Subedi, 1992) Similarly according to Macfarlane (A study of Gurungs of Nepal, Cambridge, London, 1976) Gurungs enter into sexual union for two to three years before marriage. Among the high caste Hindus there is a high value placed on virginity before marriage but for the other ethnic group there is no particular concern that the bride be a virgin.

1.8 Adolescent Child-Bearing

Problems of adolescent reproductive health are those resulting from traditionally early marriage of girls that still prevail in many developing countries, including Nepal. Twenty-five percent of 14 years old girls in Bangladesh and 34 percent of girls of 15 years in Nepal were married, although legal minimum age for marriage is 16 in both the countries. Moreover, 44% of 15-19 age are married according to the 1996 health survey report.

There is the end of schooling for girls and young women when they have child bearing in most of developing countries. Early pregnancies have a tendency to lead to large families with serious consequences for their health and well being. Child-bearing before girls' bodies are fully mature carries risks to both mother and baby as does going on to have a large number of children-more likely when girls marry young.

Pregnant adolescents do not get early and adequate prenatal care, which leads to higher mortality and morbidity. The lower the age of mother, the greater the risk associated with pregnancy and childbirth. Maternal mortality rate in developing countries average about 450 per 100,000 live births, compared to 30 per 100,000 live birth in developed countries. Research findings reveal that pregnancy related deaths are the main cause of death for 15-19 year old women worldwide. Both infant and child mortality are higher for children of mothers aged under 18 years; and babies are more likely to be born prematurely and have low birth weight. Traditionally, teenage childbearing has been common in many parts of the developing countries.

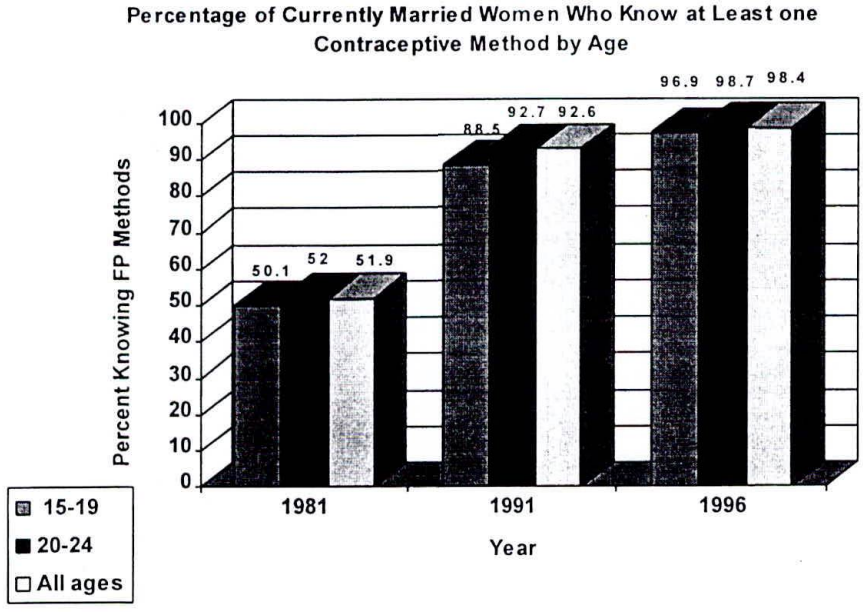
In South Asia, women under 20 years are married. Highest percentage of young men aged 15-19 who are married is 12 percent in India, and in most developed countries it is around 2% or 3%. Children born to adolescent mothers are about 40% more likely to die during their first year of life than those born to women in their twenties. Forty-percent adolescent childbearing takes place before 18 in African and Latin America, against 31% in Asia. (Present Status and Needs of Adolescent Reproductive Health in Nepal, Role of NGOs, H. Khanal, WHO Workshop, Kathmandu). Of all adolescent married females aged 15-19 about 24 per

cent bear children. The practice of early marriage is a major factor responsible for relatively high proportion of teenage child bearing in Nepal.

1.9 Knowledge of FP Methods Among Adolescents

There has been sharp increase in the knowledge of family planning methods in Nepal over the years. The share of currently married women who know about modern methods was 21% in 1976, which jumped to 98% in 1996 (Figure-7). The level of knowledge is so high in Nepal, and there is little difference by age groups. The high level of knowledge is a result of the successful dissemination of FP messages through the mass media.

Figure-7



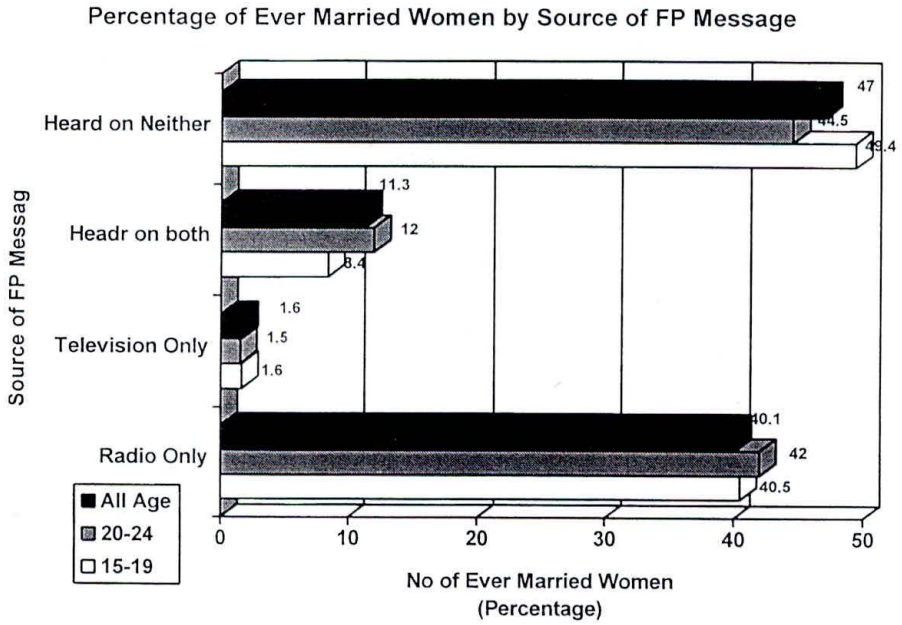
Source: 1.NFHS, 1996 (PP 51)
2.FFPHS, 1991(PP 102)
3.CPSR, 1981(PP 83)

The share of adolescents who have ever heard of family planning is about the same as those of women of reproductive age. The sources of FP knowledge for all adolescents as in the case of women of reproductive age consists largely of mass media (Radio, Television) and print media (Newspapers, Posters, Booklets, Pamphlets etc)

The family planning program in Nepal has been using the electronic media to promote contraceptives. The Fertility, Family Planning and Health Survey (FFHS), 1991 reveals that about 35% of the currently married women has been found to be using the electronic mass media (radio and television) for family planning message.

According to the Family Health Survey, 1996, 11% of ever married women revealed that they had heard family planning messages on radio or television. However, radio is more effective media than television in Nepal because television services are mostly limited to urban areas. Percentage distribution of ever-married women by age-group whether they have heard a radio and/or television message about FP according to selected background characteristics, Nepal 1996 could be seen by the following (Figure-8).

Figure-8



Source: NFHS 1996 (PP69)

More than 40 percent ever married women at age of 15-24 years had heard family planning messages only on radio, which was slightly, more than overall percentage of radio. The percentage under the television who had heard family planning messages remained same compared to overall age group.

There has been significant percentage of ever-married women who were exposed to family planning messages through the print media according to the background characteristics. The NFHS Report, 1996 indicated that 23% of women reported that they had seen a message about family planning in any type of print media, while 22% saw a message in a poster. This indicated that posters play an important role in transmitting family planning information/messages in Nepal. Younger women (less

than 35 years) are more likely to be exposed to print media than older women (40 years or older). Younger women (20-24 years) received messages about family planning through newspaper/magazine which is highest (12 percentage) than other age groups. Similarly, the highest percentage of receiving family planning messages through poster and leaflet/brochure are 27% and 9% under the age group of 20-24 years (Table-4).

Table-4
Percentage of Knowledge through print media among ever-married Adolescent, Nepal 1996.

Age	Any source	Newspaper/Magazine	Poster	Leaflet/brochure
15-19	24	8	21	6
20-24	29	12	27	9
All Ages	23	8	22	6

Source: NFHS 1996 (PP73)

1.10 Use of Contraceptive Among Adolescents

The trend of modern contraceptive use in Nepal has risen steadily over the last two decades. Current use of modern contraceptives among currently married non-pregnant women has increased from 3% in 1976 to 29% in 1996. The survey indicates that the share of temporary methods has risen 14% in 1986 to 33% in 1996. This is because the more women are now using contraception to space rather than limit births (Table-5).

Overall 25% of current married women were using a modern FP method in 1991, of which, about 24% of currently married, non pregnant women, were using a modern FP method while only one percent of the women were using the traditional methods (withdrawal and abstinence). About 29% of currently married women in Nepal are now using modern FP methods, of which 26 % are using modern methods and only 3% are using traditional methods. Thus it is cleared that the increase in overall percentage of currently married women using FP methods led to increase the percentage of both methods (modern and traditional) over the period of 1991 to 1996.

Among individual methods, female sterilization has gained tremendous popularity over the years. Only 0.1 percent of currently married, non pregnant women were reported to have been sterilized in 1976 and this increased to 13 percent in 1996. Likewise the male sterilization recorded as 2 percent in 1976 and this increased to 6 percent in 1996, a three times increase in 20 years period (Table-5).

Table-5
Percentage of Currently Married Non-Pregnant Women Currently Using Contraceptive Method

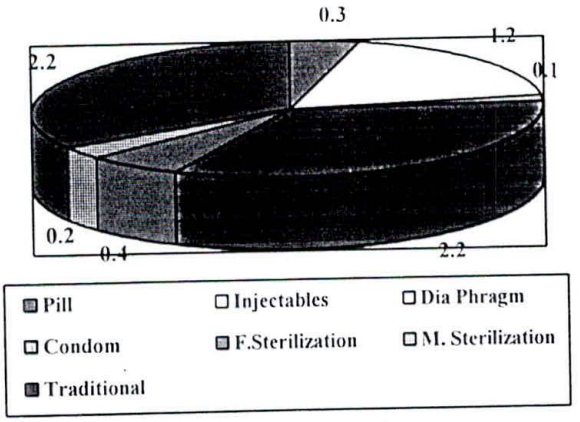
Method	NFS 1976	NCPS 1981	NFFS 1986	NFHS 1991	NFHS 1996
Any modern method	2.9	7.6	15.1	24.1	28.8
Female Sterilization	0.1	2.6	6.8	12.1	13.3
Male Sterilization	1.9	3.2	6.2	7.5	6.0

Source: 1. Nepal Family Health Survey, 1996 (pp 55)
2. Fertility, Family Planning & Health Survey, 1991 (pp 108-111)

Injectables & pills were the most commonly used methods among adolescent and youth in 1991 whereas in 1996 it was condom and withdrawal. It is therefore clear that most of the women at age 15-19 switched FP method to condom and withdrawal from injectables and pills, it was just reverese compared to the practice in all other age groups. The main reason behind this is the shift FP methods on condom and withdrawal were lack of proper specific methods among adolescents. This reflects the fact that the adolescents in Nepal are in dire need of counseling on family planning methods. Figure 9 below gives the method-wise use of contraceptives among currently married non-pregnant women in 1996.

Figure-9

Method Mix of Contraceptives used by Married Women of Age 15-19 (1996)



1.11 Need for FP Services

Although, the knowledge of FP among adolescents is found to be as equal as that among women of reproductive age, yet the use of contraceptives by this age group (15-19) has been significantly low. The use of FP among adolescents of 15-19 age group was 2.5 per cent in 1991 which increased to 6.7 in 1996 (NFHS, 1996). The pattern of current use by age shows a peak at age 35-39 in both in 1991 and 1996 period. While at age 15-19 and 20-24 falls lowest percent in the year 1991 and 1996.Current use also varies markedly by the level of education. Women who have never been to school are less likely to use than the women who have been to school. Use of contraceptives is more prevalent among women than among men and there are more urban women acceptors than rural women acceptors.

The following Table-6 reveals that in 1991 the unmet nee of FP among the 15-19 age group was 25% which increased to 41%in 1996, while the contraceptive use was 2% which increased to 7% during the same period. Likewise, under the age of 15-19 among currently married women 47 percent expressed demand for FP in 1996 whereas in 1991 it was 28 percent. However, only 8 per cent of women 15-19 years are currently using contraceptives were satisfied in 1991which increased to 14 per cent in 1996. All this is indicative of the fact that counseling and provision of FP services are required more than what is actually available at present for adolescents in Nepal.

Table-6
Percentage of Currently Married Women with an Unmet Need/Met Need for FP and the Total Demand for FP Services

		1991		1996	
		15-19	All Ages	15-19	All Ages
Unmet Need for FP	For Spacing	24	12	39	14
	All Methods	25	28	41	31
Met Need for FP	For Spacing	2	1	5	3
	All Methods	2	23	7	29
Total Demand for FP	For Spacing	26	14	44	17
	All Methods	28	51	47	60
Percentage of Demand Satisfied		8	45	14	48

Source: 1. FFPHS 1991 (PP 83)
2. NFHS 1996 (PP 94,95).

1.12 Adolescents Pregnancy and Abortions

WHO has estimated that there are 20 million illegal and 30 million legal abortion every year worldwide. In South Asia (mainly India), South East Asia and Latin America, there are 4 to 7 million abortions annually.

Abortion mortality is estimated to be about 70,000 women globally per year. The data on abortion among adolescents are scarce at cross-country levels. In a study conducted in the Mohammedpur Fertility Centre in Bangladesh, persons aged between 15 and 24 years constituted more than 30 percent of the total menstrual regulation clients.(Adolescence, The Critical Phase, The Challenges and the Potential, WHO, 1997)

Research studies around the world indicate that poorly-timed pregnancies have serious bearing on the health of both mother and child. Pregnancies occurring at too young an age (younger than 20) or too old an age (40 and above) are risky for both the child and the mother and the infant mortality rates are much higher than when the mother is 20 to 39 years old. Today, in Nepal about 5% of all births occur to mothers younger than 20 or older than 40 (Population and Development in Nepal, March 1995).

Although, the legal age at marriage in Nepal is 18, about 60 percent of marriages take place below 18 (Ministry of Health, HMG, Nepal, 1993). A girl in Nepal may bear her first child when she is 14 or 15, while the years between 20-30 is considered to be the safest period for childbearing.

Abortion is an illegal phenomenon in Nepal. Anybody, seeking an abortion, practicing it or willing to be accomplished to such is punishable in accordance with prevailing laws. There are limited exceptions where the induction of abortion is permissible after a medical practitioner certifies it on medical background.

Nepalese women seek access to abortion for various reasons. The unmarried woman who finds herself pregnant has the choice of either getting married rather quickly or terminating the pregnancy at every risk. Any women either widow or unmarried who became pregnant due to relationships with persons other than their husband utterly seek abortion to escape from strong social pressure and abuse.

Although abortion is legally restricted in Nepal, yet there have been sufficient practices of abortion at the backdoor. Unqualified persons perform most of the induced abortion cases with crude and primitive methods. However, the adequate data and information are not available on the types, specific age group reasons for abortion and use of contraception, post abortion health complications etc. The IIDS (Research Institution in Nepal) conducted a study on abortion through interviewing 1241 women at hospitals or private clinics in Kathmandu Valley. The study revealed that 65% of the abortion cases were spontaneous because of overwork inside and out side homes; 7.2 percent induced abortion as a result of the women working as paramedics without any formal training using traditional herbs domestically; 11.2 percent induced abortion in higher income groups through registered private nursing home; 11.1 percent induced abortions performed by untrained paramedics and TBAs outside their homes.

The study being confined only to the hospitals and private clinics in Kathmandu valley does not represent the real picture portraying abortion in the country. There might be tremendous cases of unsafe abortion in Nepal.

Another hospital-based Abortion Study conducted in Nepal, during one year period of 1984-85 reported 124 cases as induced abortion, of which, 41 cases were possibly induced cases. The survey also revealed, the higher proportion of all cases of induced abortion was 30-34 age groups, and the smallest in less than 20 years age group. The age specific data according to the Survey indicated that the percentage of abortion cases was 6.7% in less than 20 years, and 20% in 20-34 years.

An Article on a study of Abortion Practices in Rural Nepal published in Journal of Nepal Medical Association in 1994, interviewed 13,229 women in reproductive age group (15-49). Out of the total pregnancies, 22 were terminated through induced abortion during six months study period. Asides from these 22 cases, 87 percent abortions were reported to have taken place some times in two years preceding the survey. The survey identified a total of 109 induced abortion cases for a period of approximately 30 months from among the 13,229 women of reproductive age. Of the 22 prospectively identified cases in the six months surveillance period, 50 percent were in the age group 25-29.

The most frequently cited reasons for undergoing abortion was economic burden due to large family size (68%). Desire for spacing for the next birth was the reason for 8% of the women. 10% gave poor health as the primary reason and 9% did not

want to continue the pregnancies because of being unmarried or widowed. The remaining 5% cited miscellaneous reasons for terminating.

In Nepal, legislators have declared induced abortion a criminal act under all circumstances, punishable by imprisonment of both the women undergoing abortion and the abortion service provider. Because of this restrictive legal status, only a few Nepalese women can obtain medically safe abortion services provided covertly in various medical clinics in urban areas or provided legally in neighboring India. Understandably, majority of the women have to resort to clandestine abortion services available through folk practitioners.

1.12.1 Children Born To Adolescents

The NFHS Report, 1996 reveals that one teenage among five women has at least one child. About 15 percent have one child and 4 percent have two or more child. The proportion of teenage women who have two or more child is negligible until age 18 and then increases substantially to 12 percent among women age 19. (Table-7)

Table-7

Percent Distribution of Women 15-19 Number of Children Ever Born (CEB), Nepal, 1996

	Number of Children Ever Born			
Age	0	1	2+	Total
15	98.9	1.1	0.0	100
16	93.6	5.3	1.1	100
17	85.0	13.3	1.8	100
18	68.8	26.5	4.7	100
19	55.9	31.7	12.4	100
All ages	81.3	14.9	3.7	100

Source: NFHS, 1996 (PP 47)

Adolescent fertility is a major social and health concern. Teenage mothers are more likely to suffer from severe complications during pregnancy and childbirth, which can be detrimental to the health and survival of both mother and child. The Table-8 below presents the percentage of women aged 15-19 who are mothers or who are pregnant with their first child by selected background characteristics. Overall, 24% of adolescent women age 15-19 are already mothers or are pregnant with their first child. The practice of early marriage (almost 44 percent of women age 15-19 are already married) is the major factor accounting for the relatively high proportion of teenagers who have begun childbearing, particularly in their late teens. The low level of early teenage childbearing is largely due to the proportion of young teenagers who are currently married and partly due to adolescent subfecundity.

Table-8

Percentage of Women 15-19 who are mothers or pregnant with their first child, by selected background characteristics, Nepal, 1996

Age	Percentage who are		Percentage who have begun child bearing
	Mothers	Pregnant with 1st child	
15	1	2	3
16	6	5	12
17	15	8	23
18	31	5	36
19	44	7	51

Source: NFHS, 1996, p.47.

1.12.2 Maternal Mortality and Nutrition

NFHS report 1996 reveals that there is strong relationship between certain characteristics associated with fertility behavior and children's survival chances. The probability of dying in infancy is much greater for children born to mothers who are younger than 18 years or too old (over 34 years) at the time of delivery. If they are born after a short birth interval (less than 24 months after the previous births), or if they are born to mothers with high parity the probability of dying in infancy is much greater for children born to mothers.

Maternal mortality in Nepal is one of the highest in the world. The maternal mortality rate, which is the annual number of maternal deaths per 1000 women age 15-49 for the period 1990 - 1996, is 0.875. Similarly the maternal mortality rate in annual number of maternal deaths per 1000 women age 20-24 and 15-19 for the period 1990-1996 is 0.952 and 0.864 respectively which is higher than other age groups. The maternal deaths accounted for 27% of all deaths to women age 15-49 years. The maternal mortality ratio for Nepal for 1990-1996 is 539 deaths per 100,000 live births or 5 deaths per 1000 live births. It is not surprising that women in Nepal have lower life expectancy than men. The main reasons are early marriage, do not get early and adequate prenatal care and unwanted pregnancies especially among adolescent. (Table 9)

Table-9

Direct estimates of maternal mortality for the period 0-6 years prior to the NFHS, 1996, Nepal

Age	Mortality Rates	Proportion of maternal deaths to female deaths %
15-19	0.864	30
20-24	0.952	42
15-49	0.875	27

Source: NFHS, 1996 (PP 157)

The nutritional status of most rural Nepali women of childbearing age is extremely low. While in some communities, pregnant women are known to consume special foods especially if their families are relatively wealthy, in general women are not acknowledged to have special dietary needs during pregnancy.

Micro-level studies have shown that rural Nepali women work an average of 14 to 16 hours per day, and the work load remains relatively the same even during the pregnancy. Nutritional anaemia is one of major contributors to the high maternal mortality rate in Nepal.

The adolescent girls have tremendous nutritional deficiencies, which may affect their children, resulting in infant's low-weight birth, disabilities or death. As they grow older, repeated pregnancies, anemia, continued malnutrition and excessive workload can result in early death, and Nepal is one of the few countries in which women's life span is shorter than men's (Situation Analysis of Women and Children in Nepal, UNICEF, 1996

Nepalese society has been tremendously influenced by son preference. Son has been regarded as economic insurance against the insecurities of old age, while daughters have been treated as all-time liability to the parents as they are to be given away in marriage. Although receiving the same care and nutrition as boys when infants, older girls often receive less health care and less food, resulting in their higher mortality and morbidity rates than boys. In middle and late childhood, they assume a large share of domestic responsibilities, including sibling care, often to the detriment of their education and social participation.

1.13 Adolescents & Knowledge of STDS, HIV/AIDS

The incidence of RTIs and STDs among adolescents has increased markedly world-wide for the past 2 decades. Gonorrhea, chlamydia, syphilis, herpes, genital warts and HIV are the most prevalent RTIs/STDs among the teens. One-fifth of people world wide with AIDS are within their twenties.

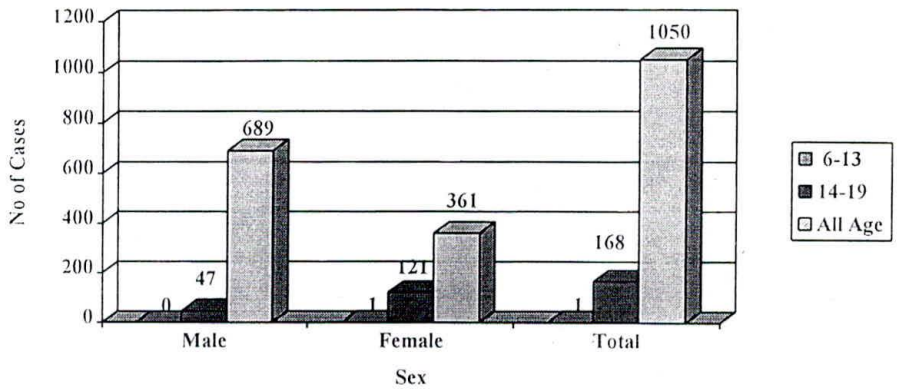
More than 50% of the female STD patients in Nepal were found to be involved in commercial sex trade and casual or professional CSWs were identified as the source of STDs in more than 86% of patients.

A large number of young girls are trafficked out of the country to different brothels in India and other South East Asian countries. They return home after they are found to have RTI/STD or AIDS. Moreover, many young girls and boys have migrated frc rural areas for better livelihood in garment and carpet industries, where they are exposed to infection of RTI/STD and HIV.

As of April 1998, the total number of HIV/AIDS cases accounted for 1050 in Nepal, of which 34.4% female had HIV positive and AIDS. The highest percentage of HIV positive and AIDS were recorded on 20-29 age groups (58.6%) in both sexes followed by 30-39 age (20.4%) and 14-19 (16%) age groups However, the possibility of HIV Positive and AIDS under the adolescent of youth groups is higher due to girls trafficking and premarital sex (Figure-10).

Figure-10

HIV/AIDS Situation of Nepal by Age and Sex
April 30,1998

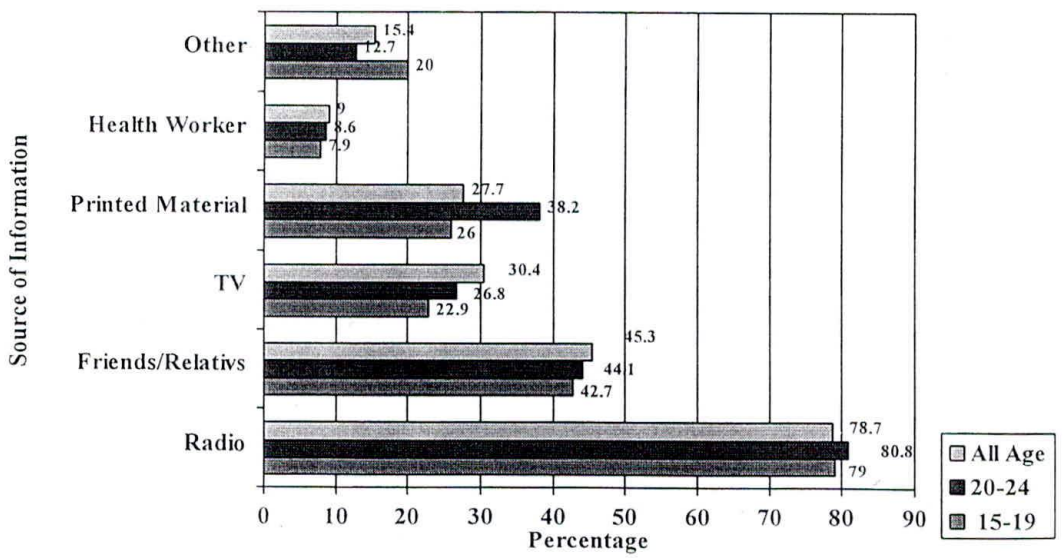


Source: National Center for AIDS and STD Control, Kathmandu, Nepal

The adolescents receive knowledge about HIV/AIDS largely through mass and print media. Accordingly, 27% of ever-married women have heard of AIDS. Women in the younger age group (15-19) are more likely to have heard about AIDS than woman in the older age group. Urban women and women with some education are three times more likely to have heard of AIDS than rural women who have never been to school. Knowledge of AIDS is very high among women who have completed secondary school. The most common source of information is the radio reported by 79% (Figure-11).

Figure-11

Source of Knowledge about HIV and AIDS



Source: NFHS, 1996 (PP 161)

1.14 Exploitation among Adolescents

1.14.1 Adolescents and Prostitution

Nepal has a culture of traditional prostitution like *Deuki & Badini*. In the culture of some of the ethnic groups, the parents or rich people offer young girls to the temples. These girls (*deuki*), are deprived of their rights to marry as they are not accepted by the communities for this purpose and they eventually become prostitutes.

South Asian cultural practices unfortunately support sexual abuse and commercial sex particularly among adolescent girls as young as ten years or so. These are common in Badi and a few other communities in Nepal. In India, child sex is a rapidly growing business where nearly 500,000 children are prostitutes before they are 15 years old. Ironically, the scare of killer AIDS virus has given rise to an increase in demand for supposedly "uninfected" children. Most of these children belong to the schedule castes. Most come from the southern states of India and West Bengal. Less than three percent are from Nepal and Bangladesh (Alyar, S.A., Child Prostitution: A symptom of our sick society, The Times of India, April 16,1997).

Girl trafficking is one of the major forms of sexual exploitation in Nepal. Every year, a large number of girls of Nepalese origin are trafficked to India and other parts of the world for prostitution. The Nepalese girls working as commercial sex workers in India are estimated at 200,000. (Durga Ghimere, Red Light Traffic, Trade of Nepali Girls, ABC, Nepal, 1994).

Factors responsible for girls trafficking include poverty and hardship, lowest status of girl child, lack of employment opportunities, tradition and culture, modernization and development process, highly lucrative business and open border.

Parents are reported to be involved in the trade of their daughters, teenage girls from poor and disadvantages communities of certain areas are vulnerable targets. It is reported that these girls are sold in Indian brothels upto Rs.70,000. According to same reports, some ethinic groups as Tamang & Rai are particularly at risk. 40% of the girls sold in the Indian brothels are under the age group of 18 years. (Madhavi Singh, *cheli beti ko bartaman abastha).*

There are also a lot of women working as commercial sex workers in Kathmandu and other major towns of Nepal. According to a Article published in Journal of Medical Association of Nepal, 1994 (Shyam Thapa & Puspa Bhatta), the average age of CSWs working in the Kathmandu Valley is 21 years, about 42% are in the age group of 15-19 and 39% are in the 20-24 age groups, indicating that majority of the CSWs belongs to unmarried groups.

According to another study on Commercial Sex Workers in Kathmandu Valley: Their Profile and Health Status, Valley Research Group, Kathmandu Nepal, 1993, over 60 percent of commercial sex workers working in Kathmandu valley were unmarried and nearly 45 percent were below 20 years of age. For 95 per cent of

those CSWs, the age at first sexual union was below 19 years. For most CSWs the main reason for entering into commercial sex trade was economic deprivation.

Government has initiated certain measures against girls trafficking in Nepal. Most of the programs under government agencies on trafficking are preventive in nature, while non-governmental organizations involved in prevention inter-section and rehabilitation. The government has adopted certain policy instruments against trafficking and commercial sex exploitation of children:

- Public awareness programs against girl trafficking and the flesh trade will be carried out on a large scale in various districts and villages.
- Equal laws will be established for women removing unequal laws on them.
- Programs to control girl trafficking and prostitution will involve HMG, non-governmental organizations, international organizations and the private sector.
- The Ministry of Women and Social Welfare will be the focal point to carry out programs against girl trafficking.
- By establishing bilateral and multilateral cooperation with other countries. HMG will make efforts to control girl trafficking.
- HMG will adopt different ways to protect human rights and special rights regarding women.
- Necessary programs will be organized to provide payment to children suffering from sexual exploitation. The people responsible for the children's fate will be made to compensate.
- Necessary steps will be adopted to solve problems on girl trafficking, AIDS and other sexual diseases, which are interrelated with each other.
- A coordination committee at the district level will function as a communication center to collect, coordinate and spread news regarding the control on girl trafficking and prostitution.
- HMG will establish coordinating committees at the national, district, and village level to control girl trafficking and prostitution.
- Provisions will be made to carry out formal and vocational education and skill oriented programs to control girl trafficking.

Moreover, Ministry of Women and Social Welfare (MWSW) has entered into an agreement with the ILO- IPEC in November 1997, for a period of two years, with an objective of combating trafficking and sexual exploitation of children. Programme in the agreement include:

- Creating National and District Level Task Forces
- Preparation of a National Plan of Action

- Setting up of a rescue/re-integration fund
- Reviewing the law and its enforcement
- Coordination and networking with GOs, NGOs, donors and regional bodies/governments
- Recommending action programmes through the National Task Force
- Working with GOs and NGOs on Advocacy and awareness creation Prevention, protection, rescue and re-integration.

1.14.2 Violence Against Adolescents

Violence against adolescents here refer violence against women and girls which include all forms of violence which includes domestic violence, sexual slavery, prostitution and international trafficking of women, incest reproductive right, violence, rape, abuse of women with physical and mental disabilities, sexual discrimination etc.

A situation analysis of violence of women and girls in Nepal undertaken in 1997 by SATHI and Asia Foundation at Jhapa, Nuwakot, Banke and Kanchanpur districts and Kathmandu Valley revealed that beating was the most common of physical violence against women and girls in Nepal (82%) followed by rape (30%) and prostitution (28%).

In Nepal, women of all ages, castes, class and ethnic groups are subjected to physical, psychological and sexual violence. Moreover, domestic violence in Nepal are child abuse, wife battering, child marriage, polygamy and physical and mental torture. Since domestic violence is a private affair and unless extremely severe, it is not considered as a cause for concerns.

The study also indicated that psychological violence was most prevalence in urban metropolis of Kathmandu: physical violence was seen to be most prevalent in the hill district of Nuwakot,: traditional forms of violence was most common in mid-western district of Banke. 51 per cent in Banke and 49% in Kanchanpur reported traditional violence against women and girls practice of Deuki & Badi, the tradition of *jari* was also reported by 42% of the respondent of Banke. The highest percentage (17%) of children assaulted were reported to be male children between the age of 11-15 followed by male children between the age of 5-10 (10%) and female children between the age 11-15 (8%). In violence against women and girls, commercial sex workers are the high-risk groups. Violence normally occurred in the night under the cover of darkness and on weekends.

Ministry of Women and Social Worker has initiated certain measures for the cause of women in Nepal, especially after 1994 ICPD. The measures include in establishment of Home for Destitute Women, A Bill on Domestic Violence.

1.14.3 Adolescents and Drugs Dependency

There are about 50,000 drug dependants all over the country, of which 50% are from Kathmandu Valley and the rest were scattered all over the country particularly in Dharan and Pokhara. Among the drug dependence, 75-80 percent were from the age group 20-29, 15% at the age of 20 and 5% after 29 years of age. Similarly, 60-

80% of drug dependence use injection (Tidigesic, Buprenoplint) and
brown sugar injection.

According to a survey of CABP in relation to risk of HIV and HIV prevalence among injecting drug users in Kathmandu, in 1994, the average age of drug dependence was 17 years of age, while the average age at which first injected a drug was 22 years. According to the sources close to the individuals associated with the agencies dealing with drug abuse issues, the tendency of drug dependency of adolescents has been on the increase in the country, and, moreover, if concrete measures are not intensified with the active support of parents/families, communities, educational institutions and private and public, the country has to bear a heavy cost in the future.

1.14.4 Child Labor

According to the 1991 census, the economically active population in the 10-14 age group was 2.4 million in 1991. However, a 1993 estimates that as many as 60% of the child population are engaged in some form of labour, totaling about 5.7 million child laborers in Nepal. Children work in almost all sectors of the rural and urban economy, with approximately 80% employed in agricultural and other allied occupations in the country. There are approximately 200,000 children working in urban areas

Nepal, where 90% of population are rural based, children are generally found to be participating in the family labor force by necessity and domestic child labor is not necessarily exploitative, provided it does not deprive children of their rights to education, etc However. Many children are engaged in labor that is exploitative and injurious to their well-being. Children work as household servants, construction laborers, carpet weavers, restaurant servants, tea pickers and porters.

There exists a system of bonded labor in Nepal, under this system children are forced to work in partial payment of their families' debts to landlords and money lenders. These children are rarely paid, generally receive little or no education or health care and have no right to terminate their employment. The Kamaiya is a type of bonded labor system found in western and far western Nepal. Something around 35,000 are estimated to be working as bonded laborers under the Kamaiya system in Nepal, of which 6000 are bonded child laborers.

A recent study indicates that there are approximately 30,000 street children nationwide, of which 26,000 are children on the street. According to a study undertaken in 13 cities of Nepal, majority of the children are boys; most of the children are between the ages of 9 and 16, majority collect and sell recyclable goods for a living, and no access to education and a high drop-out rate in school are correlated with children living on the street.

2. LITERACY AND EDUCATION STATUS

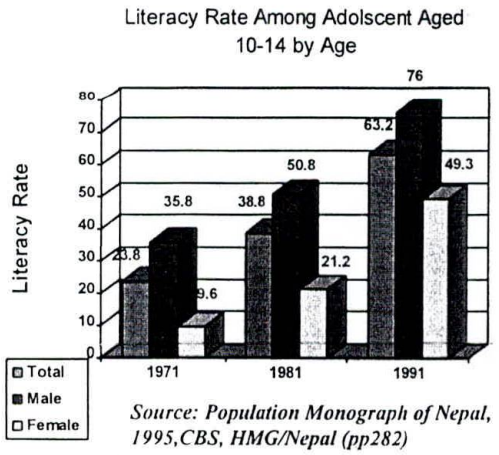
2.1 Formal Education Among Adolescents

2.1.1 There have been tremendous improvements in educational status of both male and female in Nepal for the past 3 decades. However, the status of male literacy is higher than female literacy due to the fact that the growth of male literacy has been greater than female literacy. The overall national literacy rate was 40% in 1991 (Male – 55%, Female - 25%) which was estimated to have increased to 48% (Male – 66%, Female – 30%) in 1996/1997. The acceleration in the growth of literacy is primarily responsible for increasing educational facilities geared towards educating illiterate masses. During 1971-91, the overall literacy has increased three fold (Figures 12, 13 & 14) and (Tables 10 & 11). The increase behind overall literacy in the country could be illustrated by massive education programs of the government through formal and non-formal sectors to provide free education upto secondary level; scholarship programs for girls to raise female literacy rate; launching of "Education for All" campaign by the government.

2.1.2 The urban literacy (all ages) increased from 51% in 1981 to 67% in 1991. The overall male literacy increased by 17% from 61.1 percent in 1981 to 78 percent in 1991, the increase in overall female literacy was also 17% (38.2 percent in 1981 to 55 percent in 1991). The gain in the literacy rate during 1981-1991 was greater for males than females in rural areas while such gender bias was not observed in the urban areas. The higher literacy rate in the urban areas is due to greater necessity of being literate in the urban areas, greater access to educational facilities and tendency of educated rural people to migrate to the towns.

2.1.3 There is an increasing trend of literacy rate of male and females in the age range of 6-11 in both rural and urban areas. After age eleven, the rate shows declining trend. Among the age groups, the highest literacy rate is found in the 10-14 age group. In 1991 the literacy rate in this age group was 61 percent in rural areas against 83 percent in urban areas. (Figure-21). At ages 15-19, the rate in rural areas was 52% and that in urban areas was 79%. Generally there are greater differences in the literacy rate by gender in the rural areas compared to urban areas. For the younger adolescent age group (10-14), the rural literacy rate for male was 74.8 percent and for females the rate was 47 percent, whereas in urban areas the male literacy rate was 88 percent and the female literacy was 78 percent.

Figure-12



Source: Population Monograph of Nepal, 1995,CBS, HMG/Nepal (pp282)

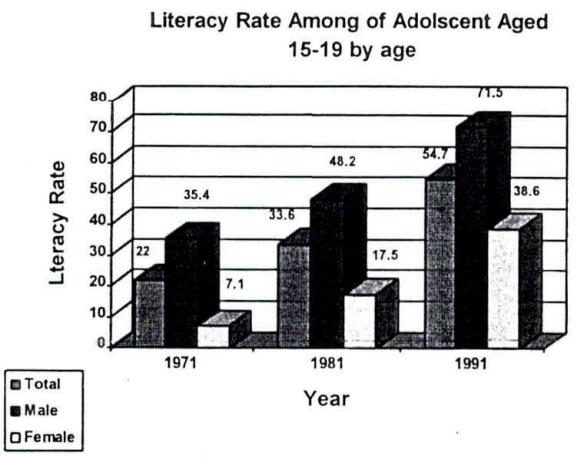
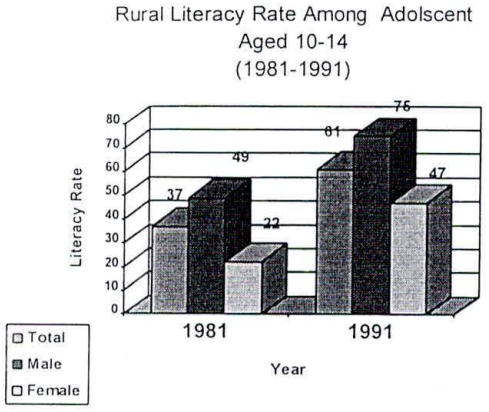


Figure-13



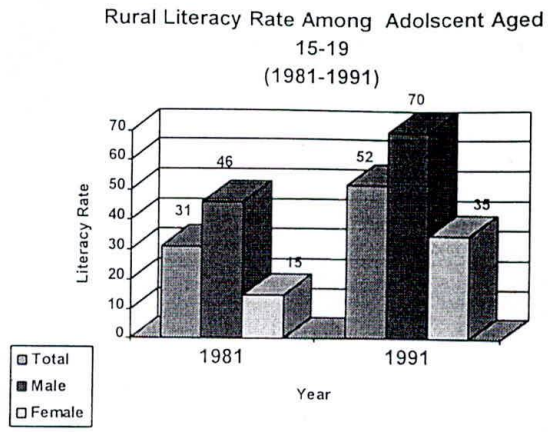
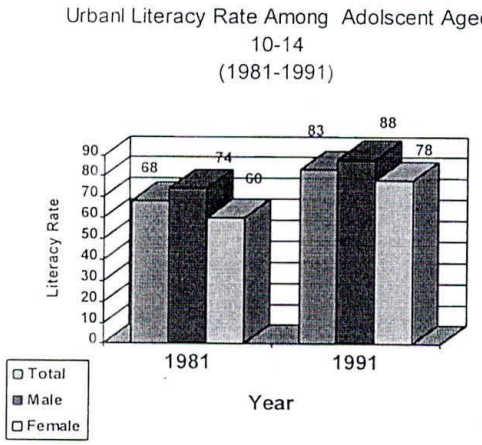
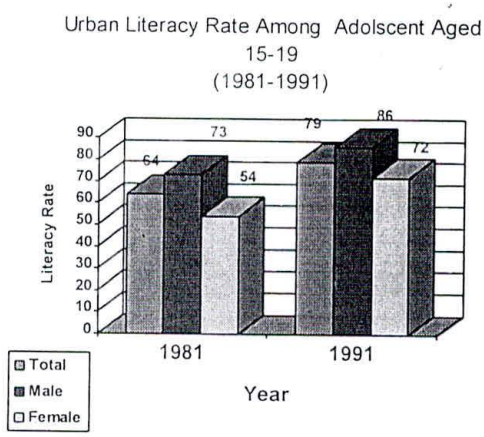


Figure-14





Source: Population Monograph of Nepal, 1995, CBS, HMG/Nepal.

2.1.4 The distribution of adolescent population by level of education and by age and sex indicated that there was an increasing tendency in the proportion of adolescent population who were literate but had no formal education. This revealed that trend of people learning to read and write on their own was on the increase over the past three decades.

2.1.5 Similarly the proportion of adolescent population who had gone through primary, secondary and who had done S.L.C and studied up to Intermediate also shows increasing trend. This is evidently due to the expansion of educational facilities in the country. Graduates and Post-graduate persons constituted a small portion in both the census years. There has been considerable improvement in different level of educational attainment during 1981-1991. In all the age groups the proportion of persons with different educational attainment levels was higher in 1991 compared to 1981. This was true both in male and females. (Table 10)

Table-10

Percent Population by Level of Education Among Adolescents

		1981			1991		
		10-14	15-19	All ages	10-14	15-19	All ages
No Schooling	Total	3.49	4.32	5.50	6.95	7.06	8.98
	Male	4.12	5.32	8.13	7.28	7.33	12.06
	Female	2.76	3.21	2.75	6.59	6.80	5.95
Primary(1-5)	Total	29.37	12.93	11.33	44.24	15.09	16.15
	Male	38.71	18.46	15.65	53.56	19.37	21.18
	Female	18.47	6.85	6.80	34.14	10.99	11.19
Secondary(6-10)	Total	5.87	14.60	4.80	10.34	27.64	8.88
	Male	8.17	22.00	7.55	13.29	38.33	12.85
	Female	3.44	6.45	1.92	7.14	17.38	4.97
SLC/Intermediate	Total	0.12	1.69	1.23	0.02	3.54	2.88
	Male	0.02	2.33	1.98	0.02	4.88	4.48
	Female	0.01	0.98	0.45	0.02	2.26	1.31
Graduate	Total	-	0.07	0.39	-	0.05	0.64
	Male	-	0.10	0.65	-	0.07	1.06
	Female	-	0.05	0.13	-	0.04	0.23
Level Not Stated	Total	-	-	-	1.40	1.06	1.80
	Male	-	-	-	1.63	1.20	2.53
	Female	-	-	-	1.16	0.93	1.09

Sources: Population Monograph , 1995, CBS, HMG/Nepal

2.1.6 The proportion of school attendance for different age group in the rural areas was 53.56 percent for 10-14 years, and 26.18 percent for 15-19 years population. The male attendance rate was also higher than those for females. This is true of all age groups. Similarly, the proportion of different age groups (for both sexes) in the urban areas were 74.6 for the 10-14 years population, 38.04 percent for the 15-19 years population. Highest level of attendance is seen for the 10-14 years population both in male and female population. The proportion attending school among 10-14 and 15-19 years populations were 78.8 and 42.6 percent respectively for males, the corresponding values for females were 69.81 and 33.02 percent. (Table 11)

Table-11

Proportion of Adolescent Population with below SLC level of Education by current status of School Attendance, Sex & Age for Rural/Urban Areas, 1991

		Attending School (%)		Not Attendance School but Attended earlier (%)		Attendance not Stated	
Sex	Age Group	Rural	Urban	Rural	Urban	Rural	Urban
Both Sex	10-14	54	75	3	3	3	3
	15-19	26	38	15	16	7	9
Male	10-14	67	79	4	4	3	4
	15-19	38	43	19	17	8	9
Female	10-14	40	70	3	3	3	3
	15-19	15	33	12	16	6	9

Sources: Population Monograph, 1995, CBS, HMG/Nepal (PP 396,397)

2.1.7 Gender disparity is more evident in secondary than in primary education. Girls comprise only 33% of lower secondary students and 30% of all secondary students. There has been high rate of drop-out in both age groups of male and female students, specially in secondary schools. The drop-out is particularly severe in the case of girl students. The drop-outs are attributed by the following factors:

- The drop-out rate at the primary school level because children are an important workforce in a impoverished rural society.
- Schools, particularly above the primary level are often located far from children's houses, which discourages some from attending school.
- Caste discrimination is a major reason among lower caste groups for staying away from schools or dropping out after a few years.
- Many poor parents are found to have been unable to pay for the costs of uniforms and textbooks.
- There is a tradition in Nepalese society that girl children must look after domestic chores and child care activities.
- Many families hold the traditional view that a girl's education is unnecessary and economically unfeasible as she will be given in marriage, usually at a very young age.

2.2 Non-Formal Education

2.2.1 The execution of non-formal education programs has been stressed in educational and national development policies for the past many years. Literacy is a basic need of the people, it enables people to communicate effectively and raise the productivity of the work they are engaged in. The goal of the non-formal education program of the government are to

- provide basic skills in reading, writing as necessary
- provide information essential to daily life on topics such as agriculture, health population, education, sanitation, forestry, environment
- facilitate on increase in adults' self confidence and awareness
- supplement the formal primary school system to reach primary school age children who cannot utilize the formal system with an emphasis on serving the needs of girls
- strengthen the literacy skills by providing post literacy materials to the literate.

2.2.2 The Ministry of Education (MOE) has been implementing literacy programs for adults (15-49 years) and also of school programs for children who cannot afford to attend the formal schools. The literacy course is of six months duration. Moreover,

population education is included for the general body of the adults as well as workers in organized and semi-organized sectors.

2.2.3 The government of Nepal has adopted several policies and strategies in order to increase the literacy rate, non-formal education schemes, particularly literacy programmes implemented on a national campaign basis. For out-of-school children 6-14 years of age, education will be provided through non-formal approaches such as *'cheli-beti'* and *'sikchha sadan'* programmes.

2.2.4 Non-formal and literacy education aims at providing educational opportunities to the children of 8-14 years of age group who missed primary school. Graduates of these NFE programmes are encouraged to enter into regular primary schools. The adults of 15-45 age group are also taught. In addition, functional knowledge and skills are imparted in order to build self-confidence and raise their standards of living. In these programmes women deserve special priorities.

2.2.5 The neo literates are provided with additional opportunities of learning in order to retain, apply and continue their literacy skill and functional knowledge through post literacy and continuing education progrrammes. A provision is made to link such programmes with development activities operating at the local level.

2.2.6 The implementation strategies of such programmes are based on local participation. Therefore, local communities are involved in collecting base line data, coordinating activities of various agencies and directing their involvement at the implementation level. The literacy campaign as a main strategy, is being implemented gradually in all districts. GOs, NGOs and INGOs have been mobilized to participate in such programmes.

2.2.7 Poverty, children's work obligation and the rigidity of the formal system of conventional education have been identified as reasons for non-enrolment and low retention in primary school. Recognizing these realities, non-formal approaches to education have been introduced to make education available to children, in particular girls, who are unable to attend primary school.

2.2.8 Classes for out-of school children, specifically girls aged 8-14 years, first started through the Seti Education for Rural Development Project, popularly known as the "*cheli beti*" programme. Subsequently the Primary Education Project introduced the "*Siksha Sadan*" functional education programme for both boys and girls. Bal Siksha classes for out-of school children, particularly girls and children of disadvantaged caste and ethnic minorities were introduced in 1989.

2.2.9 The objective of the Bal Shiksha programmes is to provide children an opportunity to join primary schools at the Class Two and Three levels or to complete primary equivalent education if they are unable to attend school. Bal Shiksha coverage expanded from 45,000 in 1992/1993 to over 70,000 in 1994/1995. However, preliminary findings from the 1995 Bal Shiksha Tracer study indicates that only 50 percent of those enrolled in these classes are girls. (Children and Women of Nepal, A Situation Analysis, 1996, HMG/Nepal, UNICEF Nepal. Therefore efforts are being made to increase their enrolment. At least 70 per cent enrolment of girls is desired.

2.2.10 The trend in literacy rates shows that remarkable progress has been made since 1950 when the literacy rate was estimated at 2 percent. However, the national aims to reach all adults in the 15-45 age group by the year 2000. This involve providing education to over eight million illiterates. Of these, nearly 500,000 persons were reached during 1995/1996 through various adult education programmes including those for women. (Women & Children of Nepal: Situational Analysis)

2.2.11 Between 1952 and 1995, the male literacy rate increased from 9.5 to 57 percent, while female literacy rates only increased from 0.7 to 23 per cent. Although the data indicates that significant progress has been made, the fact remains that with the rapid growth of population, the absolute number of illiterate adults, especially women, has increased over the years.

2.2.12 The lack of education for women limits their awareness of the importance of learning for their children. Unless women are educated, efforts to open up learning opportunities to children from poor families are not likely to succeed.

2.2.13 At present, approximately 280 non-governmental organizations, including community based, are coordinated with the Non Formal Education Council Secretariat. In 1991, with the change in political environment, the strategy of the campaign was redirected in order to base literacy centers in schools so that strong linkages are established between the formal and non-formal education systems. (Children and Women of Nepal, A Situation Analysis, NPC, HMG/Nepal, UNICEF, 1996)

2.3 Population/Family Life Education

2.3.1 The evolution of population education is directly related to the rapid growth of population experienced by Nepal. There are several aspects of population situation that are relevant to population education programs. These are the growing rural to urban migration, continuing high fertility rate, relatively low family planning practice, high infant death and low life expectancy level. In Nepal the total population of the country was found to be 18.49 million in 1991 and the compound annual growth rate of population was 2% over the period 1981-91. The population growth rate has come down considerably over the 1981-91 period. Various factors such as wider spread of education, a rise in age at marriage, greater acceptance of family planning as reflected in the increase in contraceptive prevalence rate, greater awareness of population and environmental problems, as well as growing competitiveness in securing jobs may have accounted for this decline.

2.3.2 Population education programs have been implemented in the country since 1980 with the objectives of developing in the students and participants of formal and non-formal education programs an insight into the inter-relationship between population growth and social and economic development, and developing proper attitudes and behavior in the teachers, students and community at large towards population issues, as well as to institutionalize population education in formal and non formal education programs. A number of government agencies and educational organizations have been involved in population education activities for over a decade. The introduction of population education in the education system is more than a response to the population policy. It is also stressed in realization of the need

and role of the education system in contributing to development efforts of the country. It is strongly felt now that education can serve as means of creating awareness of the population issues and modifying social values in regards to family size and other population issues. Hence, Population Education and Environment has been made compulsory subject at lower secondary level.

2.3.3 Under the MOE, office of population education coordinator was established in 1983 in response to the need of coordinating the population education programs of different agencies in the formal education sectors. The long-term objectives briefly are contributing to attainment of population policy goals of the government, to develop awareness and desirable attitude & behavior among students, teachers and community towards population and development issues and to institutionalize population education in the education system.

2.3.4 The government has implemented population education program in all of the 75 districts through both formal and non-formal education schemes. The programs thus seek to provide knowledge about concept of population and designing curriculum required for both school and university level students. Moreover, the government also implemented programs for the promotion of family health and welfare through the involvement of primary school teachers. The project was implemented in 20 Tarai districts for a period of 3 years (1994-1997). The program aimed at creating awareness about the benefits of late marriage, delay of the first pregnancy, use of FP methods, birth spacing and MCH care. Moreover, at the lower secondary level the teaching of health and physical education has been made compulsory, which includes AIDS/STD and reproductive health.

2.3.5 NGOs like FPAN implemented the family life education programs for quite some time. However, these programs sought to impart education through group discussion, lectures and orientation relating to population issues, family planning needs, nutrition, breast feeding, sanitation and environment. The target groups for these programs were mainly women of reproductive age. After the 1994 ICPD conference, FPAN adopted a new strategy and designed programs on reproductive health and sex education. Family life education centers to be established by FPAN aim at providing information and services pertaining to young people's needs to deal with the realities of their lives.

3. STRATEGIES & PROGRAMMES FOR ADOLESCENTS

3.1 ICPD and After

3.1.1 Until quite recently, the health program of the government of Nepal was being implemented in utter disregard to the issues pertaining to the adolescent reproductive health. Despite the fact that adolescent population constitutes a significant fraction of the total population in Nepal, adolescents are found to have been facing serious difficulties relating to early child bearing, unwanted pregnancies, sexually transmitted diseases, social and economic hardships. Adolescents have not been recognized as a priority target group and are not reflected as such in national program.

3.1.2 In relation to the needs of adolescents, the ICPD sought to address adolescent sexual and reproductive health (unwanted pregnancy, unsafe abortion, STDs and HIV/AIDS) through the promotion of responsible and healthy reproductive and sexual behavior and the provision of appropriate services and counselling suitable for that age group.

3.1.3 In line with the overall approach of the ICPD, the government of Nepal recognized the need for improving the reproductive health services in Nepal. As a first step towards this end, a national workshop on reproductive health was organized in March 1996 in Kathmandu. This workshop evolved a strategic framework for reproductive health services to make operational. The workshop identified a reproductive health package, coordination mechanism and indicators for monitoring the reproductive health activities for Nepal. Eventually, the government of Nepal has now been able to formulate a national policy and strategy for reproductive health.

3.2 National Reproductive Health Strategy for Nepal

3.2.1 In Nepal, reproductive health is not a new program, rather a new approach which seeks to strengthen the existing safe motherhood, family planning HIV/AIDS, STDs, child survival and nutrition programs with a holistic life cycle approach. This calls for strengthening inter-divisional linkages with the Department of Health services as well as between other sectors, e.g., education, women's development, and the legal/justice system. Gender perspectives and empowerment of women will be built into all relevant program areas.

3.2.2 The new strategy is consistent with the 1991 Health Policy and 1997-2017 Second long-term Health Plan. The integrated RH package in Nepal will be delivered through the existing primary health care system. A substantive gender perspective, community participation, equitable access and inter-sector collaboration will be emphasized in all aspects of package.

3.2.3 The strategy encompasses interventions at various levels. The first level includes family/decision makers, community/mother's groups, FCHVs/TBAs, PHC outreach/EPI outreach clinic, the second level includes SHP/HP, the third level includes PHCC, and the fourth level includes the district. These levels broadly envisage information counseling, contraceptive supply and services/referrals. The types of program interventions at these levels could broadly be classified as follows:

Family Level

- Condom promotion
- Recognize RTI/STD symptoms and seek care
- Parent-children communication
- Delay the age of marriage
- Families to provide nutritious food for adolescents (in particular to daughters)
- Promote girl child education

Community

- Information on sexuality and gender information

Increasing awareness of family planning methods, availability of contraceptives, awareness of the risks associated with teenage pregnancy.

Sub-Health Post/Health Post

- Free availability of oral pills, condoms
- Antenatal. delivery, post-partum, newborn care services as per Nepal Medical Standard.
- Modification of existing MCH/FP services to make them more accessible to adolescents.
- Conduct family life education clinics
- School Health Programs

PHC Center

FP/HIV/STD/Infertility services modified and delivered as a package e.g. Family Life Education Clinics in selected areas

- Linkage with the school system and indigenous NGOs
- Publicity regarding Family Life Education Clinics in selected areas
- Antenatal care, care during delivery, post-partum and newborn care

District Hospital

FP/HIV/STD/ services modified and delivered as package, e.g., Family Life Education Clinics in selected areas

- Linkages with school system and NGOs
- Publicity regarding Family Life Education Clinics in selected areas
- Maintenance of privacy and confidentiality
- Antenatal care, care during delivery, post-partum and newborn care as per guidelines.
- FP services as per national guidelines

3.3 Program Interventions for Adolescents

3.3.1 National Planning and Policies

In an attempt to promoting young people's health and addressing their health problems, the HMG/N should first of all define priorities, develop common targets and consensus to implement program strategies, as well as establish indicators for monitoring and evaluation of adolescents reproductive health programs. In the planning process, the government needs to get the situation assessment and problems analysis done pertaining to adolescents. Moreover, while initiating for national planning and policies for young people's health and development, the government could strengthen and develop partnerships and in this context various

groups/institutions, including NGOs, could be involved. Further more, the government needs to take necessary steps towards establishing the health coordination center for coordinating the programs and activities undertaken by various groups/institutions and NGOs for meeting the needs of adolescents in the country.

3.3.2 Counselling:

The pregnancies and pregnancy related cases constitute one of the serious problems facing adolescents in Nepal. This problem could be prevented through counseling. Adolescents have a right to complete and detailed knowledge and information relating to their development, health and sensitive sexual issues. Adolescents have higher chances of complications and death. Motherhood in adolescence usually means an end to education, training and economic opportunities for the development of the female adolescent outside home. Counseling contributes to clarifying the feeling and thinking of adolescents and enables them to take more advantageous decisions. Effective counseling may help adolescents to prevent pregnancy through appropriate means such as abstinence and use of contraceptives.

Many adolescents need one to one counseling, especially when they have particular problems. Considering this, HMG Nepal has adopted policies to provide counseling services at different levels (community to district) under the National Reproductive Health Strategy. However, detailed action plans pertaining to providing counseling services have yet to be developed in the public sector. Some of the NGOs are coming forward in this field. FPAN, for example, has strongly felt the need for establishing counseling centers at some selected districts. Towards this end sexual health modules are going to be developed for inclusion within the counseling training curriculum and TOT on counseling will be organized for counselors to be stationed in these centers.

3.3.3 Sex Education

Adolescents needs are not fully met today in Nepal. Education authorities are not prepared to introduce sex education courses for fears parents will disapprove. Hence, formal and non-formal sex education is non-existent in Nepal. Of late, government has adopted a soft attitude that NGOs and private sector could work in the field of sexual and adolescent reproductive health services in Nepal. The family life education program is one of the significant interventions in the field of sex education. The family life education programs should aim at:

- providing family life education, sexual and reproductive health services and other aspects of adolescent development.

- training adolescents/youth to become leaders and volunteers

The sex education could be provided through family life education centers and secondary schools. The sex education should include:

- physical changes at puberty
- psychological changes in adolescence

- male and female reproductive system
- facts about menstruation, virginity, nocturnal emission, masturbation and homosexuality
- evolution, fertilization and conception

For imparting sex education to adolescents through secondary schools, a curriculum on sexual and other adolescent reproductive health education should be developed in collaboration with school- teachers with the consensus of Ministry of Education. For counseling and family life education centers, counselors should be provided with TOT. This TOT should include male and female reproductive system; physical emotional and psychological changes in puberty; the process of conception; STDs, HIV/AIDS and population dynamics.

3.3.4 Information and Supply of Contraceptives

The adolescents have the right to complete and detailed knowledge and information relating to their development, health and sensitive sexual issues. Hence, Adolescents should be provided with information on sexual maturity, sexuality and gender information and these information could be delivered through various outlets, including counselling and family life education centers, health clinics, youth and women clubs/groups, peer groups and so on.

Postponing the first birth or preventing unwanted pregnancies can be done through the use of contraceptives. Some of the contraceptives suitable for young people like condoms, oral pills, injectables, implants, emergency contraception should be available within the reach of adolescents. However, at present unmarried adolescents are either restricted to the free supply of contraceptives of their choice or they are hesitant to seek supplies because of negative attitude of the society. Only condom is freely available for everybody in Nepal because of its promotion for HIV/AIDS prevention, while for the supply of other contraceptive methods meant for adolescents, there is still a long way to go.

3.3.5 Youth-Friendly RH Services

It is evident from the foregoing section of the study that adolescents in Nepal neither have access to, nor use the health services they need. One of the reasons for this is that the young people in Nepal are virtually unaware that they need a service or do not know that the services are available. Young people are likely to use the services that are available if they are youth-friendly i.e. attractive, accessible, affordable, confidential and able to meet a range of health needs.

It is unethical to provide education and counseling along without access to services that will allow young people to take care of their health. Hence, in addition to the supply of contraceptives, some young adolescents need diagnosis and treatment for STDs, emergency post-coital contraception, prenatal care or safe abortion services as far as possible and in this context we have to enlist overwhelming support from the community leaders, parents and teachers. The diagnosis and treatment services of STDs and HIV/AIDS have been provided to adolescents both by government and NGOs and INGOs. However, in most of the cases, these are all too often geared towards adults rather than young people. Moreover, the services are not youth-

friendly, i.e. these services cannot meet the basic needs of accessibility, confidentiality and low cost, and at the same time the services are not closely linked or integrated with the essential health care needs of adolescents and youth.

3.3.6 STDs and HIV/AIDS

A major potential hazard of unprotected sexuality in adolescence is the danger of contracting numerous sexually transmitted diseases. Adolescents are especially vulnerable because of their high-risk behavior and greater biological susceptibility to certain STDs. The younger the girl, the more the risk, especially if she is forced into her first sexual intercourse.

Safer sex is strongly advocated. Safer sex is the term employed to mean any sexual behavior or act which not only prevents pregnancy, but also protects against the transmission of sexually transmitted infections, including HIV/AIDS. His Majesty's Government of Nepal adopted a national policy on AIDS and STD prevention in 1995. This is a major step in offering services to people with HIV/AIDS.. In 1996, the Executive Committee of the National AIDS Prevention program has accepted the guidelines for AIDS and STD prevention in a multi-sectoral basis.

Though certain areas for cooperation and coordination in AIDS and STD prevention activities are weak in effective implementation, an indication of improvement has been noticed. The National AIDS Coordination Committee, which is the highest body to determine the policy on AIDS and STD carries out necessary AIDS and STD prevention activities through National Center for AIDS and STD control.

Although government has been committed to the prevention and control of AIDS/STDs in Nepal with multi-sectoral approach both from the government and non-governmental sectors, yet the programs are limited more to awareness generation and education than towards providing services. The regional and zonal government hospitals in all the regions provide general services, including STDs and HIV cases. The government has no specific programs of its own for the prevention and control of STDs and AIDS.

At the central level government is also engaged in the production of IEC materials and training through the establishment of National AIDS Prevention and Control Center, while UNDP is supporting through technical support in 6 districts with diversed economic and social settings. Moreover, CEC under the University of Hidelburg is engaged in another set of 6 districts in both education and service programs for STDs prevention and control.

There exists a considerable number of NGOs committed to AIDS awareness programs, of which some have been working only occasionally, while 5 or 6 are actively involved in AIDS awareness programs, including AIDSCAP and AmFAR are actively contributing for AIDS prevention programs in Nepal.

3.3.7 Barriers to Adolescents Program Implementation

There have been tremendous problems associated with the implementation of adolescents reproductive health programs in Nepal and these problems mainly relate to the following issues:

- limited access to food and health care for adolescent girls
- unacceptably high maternal mortality rate due to too early and too frequent pregnancies
- high IMR due to low maternal age
- low level of contraceptive prevalence among adolescents age groups
- increasing tendency of STD cases among adolescents (15-19)
- low level of literacy, especially among adolescent girls

Coupled with the above-mentioned problems or constraints, there exists significant barriers to the promotion of adolescent reproductive health programs in Nepal. These barriers could be summarized as follows:

- Lack of effective policies and programs and failure to involve young people in the existing promotional activities

- There does not exist a coherent policy for protection and maintenance of reproductive health in adolescent. Government decision makers are unaware of the need for concerted actions in these field

- Both young people and adults lack understanding of the dangerous of adolescent pregnancies to the health of both mother and child

- Educators, providers of health and social services, religious and youth leaders and parents often lack awareness of, or sensitivity to special problems of young people

- There has been no involvement of young people in any educational programs or services that are provided for their age groups.

- There has a practice among the majority of rural population that young boys are prepared for productive work and decision making while girls are trained to be housewives, mothers and service providers.

3.4 Role of NGOs in Adolescent RH Interventions

3.4.1 Needs Assessment and Situation Analysis

The adolescents reproductive health program is of very recent origin in Nepal. The RH activities addressing the needs of adolescents are mainly undertaken by non-governmental agencies. The bulk of the programs being carried out by government relate to the awareness and prevention of STDs and HIV/AIDS There does not exist any adolescent-specific agency at public, private and NGO sectors. However, some of the national and international level NGOs are fully committed to the cause of women. Their work area varied from providing a safe refuge for a single woman

to income-generating activities for communities. Moreover, there are about 16 other NGOs and INGOs actively involved in reproductive health programs in Nepal. The projects and programs being implemented by these agencies include, among other things, general reproductive care, child survival, safe motherhood, family planning and prevention education of HIV/AIDS and STDs, condom promotion and diagnosis and treatment of STD/STI cases.

There are a few NGOs, which apart from engaging in the field of education and services for the prevention of STDs and HIV/AIDS, are found to have been committed towards addressing the needs of adolescents for the past few years, especially after the 1994 ICPD.

In the process of designing and implementing programs for adolescents, needs assessment surveys, research studies, focus group studies, situation analysis, workshops/seminars, debate/ essay competitions, panel discussions, publications of adolescent-specific literatures and IEC materials are being undertaken by NGOs

In this context it will be pertinent to mention here that FPAN conducted a needs assessment through focus group studies and rapid surveys in urban areas of Kathmandu, Sunsari and Chitwan. The area of study pertained to RH and sexuality needs of adolescents by involving out-of-school and in-school students of secondary level, youths, teenagers, community leaders, family planning acceptors etc. The needs assessment studies and surveys revealed the positive indication about the need for sex education among the adolescents which leads to the growth of responsible parenthood, healthy children, increase in age at marriage.

An Assessment of Sexual Networking in Five Urban Areas in Nepal was undertaken by Valley Research Group in 1994, revealed that there was high prevalence of sexually transmitted diseases among the commercial sex workers and low rates of condom use facilitates HIV transmission. In addition, lack of public awareness resulting from the country's low rates of literacy, a shortage of appropriate AIDS education messages, and strong cultural prohibitions against the public discussion of sex led to further aggravate the problems among commercial sex workers in Kathmandu. Likewise, various institutions and individuals have undertaken similar studies relating to flesh trade and girls trafficking. All of these literatures and research papers deal with the magnitude of problems associated with girls trafficking and recommend various measures for the eradication of problems created by such issues in the country in the future. These studies also recommend that interventions should be made by various levels, including family, community, general public, media, and the government.

Another survey, under the caption Rapid Needs Assessment on Reproductive Health was undertaken by Dr V.L. Gurubacharya in Kathmandu, Chitwan and Makwanpur in 1995. The findings of the study report revealed that the adolescent reproductive health and sexuality has been the need of the time for providing sex education to adolescents in Nepal.

3.4.2 Advocacy Initiatives In Support of Adolescents

In the process of creating environment in favor of addressing the needs of adolescents, various NGOs, especially FPAN, are engaged in organizing workshops/seminars are being organized for parliamentarians, the media, women leaders and social workers on advocating the RH sexuality needs of adolescents. Debate and essay competitions among secondary level school students on the needs of adolescents have been an on-going process of FPAN. It published and distributed reproductive health and teenager booklets meant for providing information to adolescents. A radio program was also organized by it through BBC Nepali program on Be Wise Sex Wise. This program resulted in a great interest/curiosity among the Nepalese teenagers and adolescents.

Soon after the Cairo Conference in 1994, FPAN organized workshops in all the developments with the involvement of local government authorities and social workers. The workshops strongly recommended for the need of introducing sex education at district levels.

Prevention of unwanted pregnancy through counseling, emergency contraception and use of family planning services is the key to preventing abortion. In the wake of forestalling the consequences of unwanted pregnancies, various NGO and private sectors have organized advocacy programs. In this context, FPAN has been playing a significant role towards creating pressure groups in the parliament, in the media forum and in the society to influence the government, policy makers and political leaders to bring favorable policy changes. As continuing efforts, workshops on FP/RH as basic human right, the need for introduction of sexual education and favorable policies on abortion are being organized on various occasions. The workshops recommended that while unrestricted abortion is neither desirable nor right for Nepal, abortion of first trimester of pregnancy should be made legal if performed by registered and trained medical professionals, and if the pregnancy is unwanted. The recommendation also included the legalization of abortion of more advanced pregnancies, if resulted by rape, incest, contraceptive failure. Eventually, a private bill was tabled by Hon'ble Mr Sunil Bhandari, MP in 1996. The bill seeks to modify the existing abortion laws to give access to safe abortion services under certain conditions affecting the health of women. The bill does not propose to make abortion a method of family planning. The move towards this end is consistent with the action plans of both ICPD 1994 and Beijing conference 1995.

In this context, some of the NGOs and INGOs like ABC Nepal, Asia Foundation, Shtrii Shakti, SHATHI, WOREC and WICOM are all working in advocating for the cause of women, violence against women and girls, girls trafficking, eradicating the social barriers like son preference etc. Mothers Clubs

Marriage in adolescence often leads to early pregnancies. Hence, delaying the age at marriage beyond 20 years through effective advocacy and social and legal action can prevent adolescent pregnancies with associated risks. Although there has been significant progress in delaying the age at marriage in Nepal, yet there is still a long way to way in this regard since bulk of the rural adolescent girls get married in their early years. To do away this problem education, both formal and non-formal is the only way out. However, it is pity to say female literacy is one of the lowest in

the world. Marriage in adolescence often leads to early pregnancies. Hence, delaying the age at marriage beyond 20 years through effective advocacy and social and legal action can prevent adolescent pregnancies with associated risks.

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