UNICEF/NEP/IMAGE 01033/ K PANDAY

CHAPTER 1

The Lifecycle Perspective

This section offers an alternative perspective to the sectoral and more technical chapters that follow. It starts with the birth of a child and follows his/her life to adulthood through the various challenges he/she may meet. While the sectoral chapters provide more detail and analysis, this account can be read as a concise overview of the current situation faced by children and women in Nepal.

THE PREGNANT WOMAN AND HER UNBORN CHILD

The condition and treatment of a pregnant woman influence the survival of her unborn child. Although girls in Nepal are not legally entitled to marry before the age of 18 years, many are married by the age of 14 or 15 years. The median age at first marriage is 16.6 years [1]. Early marriage is most common in rural areas and in the *terai*. Young women usually start to bear children soon after they are married; over 40 per cent of married women aged 19 years are either already mothers or are pregnant with their first child [1]. This means that some mothers are barely more than children themselves and have yet to reach full physical maturity. In addition, many women are smaller than they should be, because they suffered from malnutrition during their own childhood. These conditions are known to increase the risk of complications during delivery, and can result in the deaths of both mothers and children. For older women, repeated pregnancies and closely-spaced births exhaust the body's reserves and increase the likelihood of low-birth-weight babies. The current fertility rate for Nepali women aged 15–49 years is 4.1 [1].

The nutritional status of women is generally poor, with a widespread lack of sufficient protein, vitamin A, iron and iodine in the diets of rural women. Furthermore, pregnant women are generally not acknowledged to have special dietary needs. Anaemia—low iron content in the blood—contributes to the high rates of maternal mortality seen in Nepal. Over three-quarters of pregnant women are anaemic [2]. Only a quarter of women receive some iron–folate supplementation during pregnancy, and extremely few take a complete course [1]. The health status of mothers can also affect the outcome of their pregnancies. Sexually transmitted infections and HIV/AIDS are becoming increasingly common in pregnant Nepali women. Malaria is endemic to Nepal; however only in limited areas.

Rural women in Nepal often have very heavy workloads that include heavy lifting and physical labour in the fields during busy agricultural periods as well as routine household chores. Indications are that women's workloads remain relatively unchanged during pregnancy. The lack of special care afforded to pregnant women is also apparent in the figures for gender-based violence. Almost 25 per cent of maternal deaths occur during pregnancy; many of these are the result of physical violence or a general lack of care [3].

The health-seeking behaviour of a woman during pregnancy is linked to the survival of her child and herself. Regular antenatal care can ensure that the health of a woman is monitored, and that she receives supplements, medication and advice that will improve the chances of a successful outcome to her pregnancy. About half of all pregnant women in Nepal receive some form of antenatal care, although few receive the recommended four visits [1].

THE BIRTH OF A CHILD

The low levels of skilled attendance at childbirth endanger the lives of many Nepali mothers and their newborns. Currently, at least 539 mothers die for every 100,000 live births [1]. This translates to about one woman every two hours. Most women give birth at home, with less than one in 10 births taking place in a health facility [1]. Over three-quarters of women are assisted in labour by relatives and friends or untrained Traditional Birth Attendants. Only about 13 per cent are attended by a doctor, nurse, or someone with appropriate midwifery skills [1]. The remaining one in 10 births are delivered without any assistance. Thus, for most deliveries, there is no one present to safely handle the common complications that can kill the newborn baby. Birth and the first month of life are precarious for the Nepali child. Over four out of 10 children who die before their fifth birthday, die during the first month, the majority of them during the first week [1].

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Birth asphyxia is a common complication of delivery in Nepal; it most often occurs when a delivery is not assisted by a skilled attendant. It accounts for nearly half of newborn deaths in the community and at least a quarter of newborn deaths in hospital [4; 5]. Infection is also a common problem. At least a quarter of newborn deaths in Nepal are the result of infections such as septicaemia, pneumonia, diarrhoea and meningitis [6]. Many infections are contracted from the unhygienic conditions in which birth takes place and from unclean practices associated with delivery by unskilled attendants. Some women are obliged to give birth in outhouses that are little more than cowsheds *(chaupadi)*. Although neonatal tetanus used to be a major problem in Nepal, an extensive vaccination programme targeting pregnant women has reduced its incidence. Breastfeeding strenghtens the baby's immune system and is almost universal in Nepal. However, it is delayed by at least 24 hours for about one in three babies [1].

Nepal has a particularly high incidence of low-birth-weight deliveries, with over a quarter of newborn babies weighing less than 2.5 kg [7]. These newborns are more susceptible to hypothermia and acute respiratory infections. Over three-quarters of newborn deaths in Nepal occur in low-birth-weight babies [6].

Hypothermia is also common, particularly during winter, and contributes to the death of many newborns from infections and other causes. It is a widespread practice to bathe newborns soon after delivery, with over nine in 10 babies being washed in their first hour [8]. In addition, a third

of babies are not quickly wrapped in warm clothing following their birth [8].

About one in 25 children born in Nepal die during the first month of life [1].

THE INFANT

For the child that survives its first month, the following 11 months are likely to offer a number of challenges. Most deaths are the result of diarrhoea and/or acute respiratory infections. These conditions are usually exacerbated by underlying malnutrition, and poor standards of care and environmental hygiene. A little less than a third of deaths among children under five years occur during this period [1].

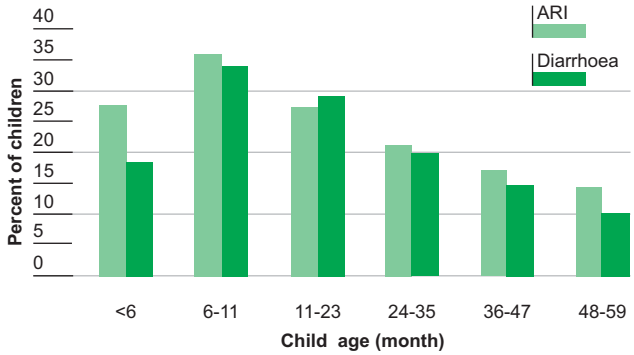
Malnutrition is a serious problem in Nepal, and many children are undernourished from an early age. The early introduction of water and foods increases the risk of infections and thus contributes to malnutrition. By four months of age just over half of Nepali children are exclusively breastfed [1]. By six months of age, one in five children are both too short and thin for their age. The extremely low energy and nutrient content of the typical porridge fed to infants and inadequate frequency of feeding also contribute to malnutrition. By 12 months of age, over half of all children are underweight, and more than one in three is short for their age [1].

Other nutritional problems that affect infants in Nepal include anaemia and vitamin A deficiency. Anaemia (iron deficiency) is by far the most common, impairing the physical and mental development of many children. It affects nine out of 10 children aged 6–11 months [2]. Vitamin A deficiency can make children more susceptible to the effects of diarrhoea, acute respiratory infections and measles. It can also lead to blindness. In 1998, four in 10 children aged 6–11 months suffered from vitamin A deficiency [2]. Nepal has a National Vitamin A Programme that distributes high-dose vitamin A capsules to children aged 6–60 months twice a year.

As infants begin to move around and explore their surroundings, they become more prone

FIGURE 1:

Prevalence of ARI and diarrhoea during the two preceeding weeks



Source: [1]

to infections, and both diarrhoea and acute respiratory infections are more common in children aged 6–11 months than in any other age group (Figure 1). For children who are malnourished and suffering from micronutrient deficiencies, the impact of contracting a common diarrhoeal or respiratory infection can be extremely severe, even fatal, particularly for this age group. The prevalence of diarrhoea is 35 per cent among children aged 6–11 months [1]. However, the increasing coverage of safe drinking water and improved personal hygiene, the availability and proper use of oral rehydration solution, and improved care of children suffering from diarrhoea has reduced its incidence from 3.3 episodes per child per year in 1990 to 1.7 episodes per child per year in 2002 [9]. The incidence of acute respiratory infection is over 36 per cent for children aged 6–11 months [1]. Fatalities are decreasing, as community health personnel in growing numbers are trained to diagnose early pneumonia correctly and treat or refer cases accordingly. The incidence is increasing; however, this may simply mean that reporting is improving.

Another threat faced by children in Nepal comes from vaccine-preventable diseases such as measles, tetanus and polio. Nepal has a strong programme of vaccination, with a full course of routine immunization being offered to all children during their first year. Coverage had risen

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to about 60 per cent by 2001 [1]. National immunization days (NIDs) have been held twice a year since 1996 and have helped maintain polio immunization coverage at over 90 per cent [1].

An important factor in whether common childhood illnesses become life-threatening to the individual child is the family's—and particularly the mother's—knowledge of appropriate care and healthcare-seeking behaviour. Many mothers do not recognize the early danger signs of childhood illnesses. Even if they do recognize such signs, the distance to a point of service, the cost of such a service, and its level of quality also inhibit many families from making use of available healthcare options. Only about one in five children with either diarrhoea or a 'cough/cold' are taken to a healthcare provider [1].

Birth registration is far from universal in Nepal, with only a fifth of children registered before their first birthday [9]. The government guideline is to register all children within 35 days of birth.

About one in 15 children born in Nepal will not survive until his/her first birthday [1].

THE PRESCHOOL CHILD

Common diseases such as diarrhoea and acute respiratory infection also cause death among children aged one to five years. Malnutrition remains a key underlying factor. Other main causes are malaria, *kala azar*, and accidents. Almost one third of deaths among children under five years occur during this period [1].

By their fifth birthday, nearly two-thirds of Nepali children are too short for their age [1]. Anaemia affected about three-quarters of under-fives in 1998 [2]. However, the deworming of preschool children since 1999 is expected to have had a significant impact on these levels. Diarrhoea prevalence falls as children grow older from about 30 per cent for one year olds to 10 per cent for four year olds [1]. However, it still causes a large proportion of deaths in this age group, particularly of malnourished children. Acute respiratory infection is apparent in about 28 per cent of two year olds and about 15 per cent of five years olds [1]. Pneumonia is estimated to cause up to one-third of deaths in children aged less than five years [6]. Worms are also a problem, with about four in 10 under-fives having debilitating infestations [10].

One of the main reasons for the chronic poor health of many children is the harmful sanitary conditions that they encounter in their homes and immediate surroundings. Although the vast majority of households has ready access to a water supply, not all water can be considered safe. Over half of tested water is microbiologically contaminated [11]. In addition, many water sources in the *terai* test positive for arsenic. Furthermore, Dalit households and other disadvantaged groups may face problems with accessing water from a common source due to discrimination.

Open defecation is common in Nepal, often making areas around settlements quite unsanitary. Over the years, Nepal has focused on extending the safe disposal of excreta. By 2002, toilet coverage had risen to 27 per cent [6]. However, most households with toilets are in urban areas. Alongside the provision of adequate water supplies and sanitary toilet facilities, households and communities must engage in proper hygiene practices to protect their health. The use of soap and water to wash hands after defecation and before eating is far from universal, particularly for young children.

The care of young children is considered to be primarily the mother's responsibility, often helped by older siblings. Fathers' involvement in young childcare is very limited. Care during the period between the first and fifth birthday is critical for a child's psycho-social development, such as emotional, cognitive, sensory-motor, linguistic and social developments. This requires that the child feels loved and secure, and receives various kinds of stimulation, response and attention. Awareness about the importance of early child development is very low in Nepal, and opportunities are limited for child caretakers to learn about basic skills for good parenting. There seems to be a general feeling that child development happens on its own, and many preschool children in Nepal, particularly in rural areas, are left alone or in the care of siblings for long periods of time while their mothers work. Parenting orientation classes are run in communities to increase awareness about early childhood development. They also seek to increase fathers' participation in childcare. Community-based child development centres have been established in some areas to provide children with developmentally appropriate stimulation and places to socialize. These centres also give mothers and older siblings greater freedom to pursue activities besides childcare.

Among all children born in Nepal, about one in 11 dies before reaching his/her fifth birthday [1].

THE SCHOOL-AGED CHILD

The government's education policy promotes compulsory, free schooling for children aged from five to nine years. However, at present only about four out of every five primary-school-aged children are enrolled in school [12]. In addition, dropout and repetition rates are high, particularly in Grade 1, with one in three children repeating Grade 1 and 15 per cent dropping out [12].

Even if children complete primary schooling, they have not always mastered the content: the average scores in grade 5 learning achievement tests in 2003 were 33 per cent for Mathematics and 56 per cent for Nepali [12].

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Only half of children complete primary school. Of these, three-quarters go on to secondary school [12]. Enrolment for lower secondary school is about 43 per cent, and 30 per cent for higher secondary school [12]. The literacy rate for children of secondary school age is 79 per cent [13].

Girls and dalits are more likely than other groups to be out of school in Nepal. There are numerous reasons for families not sending their children to school. For girls from some families, education is viewed as a 'poor investment' since daughters leave their family home at marriage and the benefit of their 'learning' is given to someone else. Even if girls are sent to school when they are young, as they grow older marriage can prevent them from being able to complete their education. The poverty of some families means that they are unable to meet the costs of educating their children. If a choice has to be made between sending a boy or a girl to school, the boy will usually be given precedence. In addition, some families cannot afford the opportunity costs of lost income or labour to educate their children. Girls are more likely than boys to have to look after the home while other family members go out to work. For Dalits, caste discrimination can make it difficult to attend school. School can also be too far away from home, and there may be a lack of sufficient places for all children living in the surrounding area.

For children at school, poor-quality facilities and unsuitable teaching methods often result in an environment that is neither child-friendly nor conducive to learning. It is common for

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schools to lack classroom space, and be poorly equipped with no seating, no desks, no blackboard, a lack of adequate lighting, and a roof that leaks when it rains. Many schools lack toilets and a clean water supply. Classroom materials are insufficient and poor quality. Nepali as the language of instruction may present problems for children from non-Nepali-speaking communities. Corporal punishment and verbal abuse are commonplace.

For children who have never been to or dropped out of primary school, the government has an alternative education programme. The Out-of-School Programme aims to provide children with basic literacy and numeric skills, and can also help children to enter the formal schooling system. It is a two-level programme: completion of OSP I is intended to be the equivalent of a Grade 3 education and completion of OSP II is intended to be the equivalent of Grade 5. Availability of the Out-of-School Programme can vary due to quota limitations and not having enough candidates in a settlement to run a class, and many out-of-school children do not receive this second chance.

As children grow older, an increasing proportion either become labourers without entering school or leave school prematurely to find employment. Child labour affects an estimated 2.6 million of the country's 7.9 million children aged 5–14 years [14]. Most of these children, particularly the younger ones, work for their families either in the household or on the farm. However, it is estimated that over 100,000 children work in the worst forms of child labour as domestic workers, porters, bonded labourers, factory workers, rag pickers, and coal miners.

As well as child labourers, children particularly vulnerable to lack of protection in Nepal include those without primary caregivers such as orphans, those in conflict with the law, street children, and institutionalized children. In addition, children can be vulnerable to sexual abuse by relatives, peers, teachers and strangers. In Nepal, where sexual taboos are strong, it is very difficult for any children to talk about sexual experiences, particularly if they are being abused, as children's concerns are rarely listened to and impunity is customary. It is also hard for children who experience violence to find support and justice. Disabled children, children with HIV/AIDS, and children without birth registration are also vulnerable to a lack of protection in Nepal.

The armed conflict has affected children of all ages through its impact on their families. However, it has particularly affected children by disrupting their education and interfering with their access to healthcare. Some children have been removed from school to help at home, as older members of the family have migrated away from their home village to avoid recruitment by the Communist Party of Nepal–Maoist (Maoist) or harassment by the security forces. Children of families displaced by the fighting can expect their schooling to be temporarily suspended or even stopped, their access to healthcare to be made more difficult, and their living and environmental conditions to deteriorate and become less stable. Some children will be pushed into the labour market. Children who become separated from their families or become orphaned are particularly vulnerable to violations of their rights. In a number of cases, children have been killed or injured as a direct result of the conflict, or detained by either the Maoists or the State's security forces.

THE ADOLESCENT CHILD

The status of adolescents is a decidedly grey area in Nepal. In some ways they are still treated as a child and in other ways they are

expected to be an adult. The legal age of majority in Nepal is 18 years. However, society often views children much younger than this as being able to take on responsibilities more closely associated with adulthood than childhood. This is particularly true for many girls and for children from poor households.

The majority of Nepali adolescents are not in school. About a third of children aged 13–16 years are enrolled in secondary school [12]. When adolescent children leave school they usually enter the workforce. Over half of 15–19 year olds claim to be economically active [13]. Children of this age run a high risk of labour exploitation, especially as they are more likely than younger children to leave their family or home to find work. The escalation of the conflict during the past few years has reinforced this trend, as young people leave their homes for security as well as work. Some of the worst forms of exploitation affect adolescents, for instance, over half of trafficked girls were aged 15–18 years when they left their family [15].

Although this is the age that most people in Nepal first become sexually active, adolescent girls and boys have little access to accurate information on sex. Formal sexual education in school is extremely weak. Four out of five adolescents learn about sexual matters from their friends [16]. These limitations mean that young people can be vulnerable to sexually transmitted diseases such as HIV/AIDS, syphilis and gonorrhoea. Although sexual activity in Nepal has traditionally been associated with marriage, a growing number of teenagers consider premarital sex to be acceptable, with one in five unmarried boys and nearly one in 10 unmarried girls claiming to have had a sexual experience [16]. Although HIV/AIDS is currently considered to be concentrated in specific high-risk groups in Nepal, young people are regarded as a potential link for HIV/AIDS to spread into the general population. Most Nepalese teenagers are aware of HIV/AIDS and and its main modes of transmission. Sexual intercourse is better known as a potential risk than sharing of needles for injection. Three in four teenagers can identify using a condom during sex as a means of protection; however, this awareness does not always translate into safe sexual behaviour [16].

UNICEF/NEP/IMAGE 00071/ MANI LAMA

Adolescence can lead directly into marriage and parenthood for children in Nepal, particularly for those in rural areas, and especially for girls. Once married, they are expected to take on the roles demanded of their gender by society. This usually means that girls become mothers and caregivers, and boys become breadwinners for their family. These rigid gender roles handed down from generation to generation remain very strong in Nepal.