ADOPTION EDUCATION, LLC

SPECIAL REGIONAL CONSIDERATIONS

NEPAL

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TO ACCESS THE QUIZ FOR NEPAL:
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INTRODUCTION [1]

Nepal is a landlocked nation in South Asia. It is bordered to the north by the People's Republic of China, and to the south, east, and west by India. Kathmandu, the nation's capital, is its largest city. Nepal is a country of highly diverse geography. The mountainous north contains eight of the world's ten highest mountains, including the highest, Mount Everest. The fertile and humid south is heavily urbanized. Nearly 85% of the people live in villages, in remote and difficult to access terrain. Nepal experiences five seasons: summer, monsoon, autumn, winter and spring.

Nepal is a multi-cultural, multi-linguistic and multi-religious country. Nepal's 2001 census enumerated 103 distinct castes and ethnic groups including an "unidentified group". The major caste/ethnic groups identified by the 2001 census are Chetri (15.8%), Bahun (12.7%)(Both are of the very few Caucasian (indo European Aryan) ethnicity), Magar (7.1%), Tharu (6.8%), Tamang (5.6%), Newar (5.5%), Muslim (4.3%), Kami (3.9%), Rai (2.7%), Gurung (2.5%), and Damai/Dholi (2.4%). The remaining 92 caste/ethnic groups (including the world-famous Sherpa) each constitute less than 2 % of the population.

All the languages spoken in Nepal are national languages. Nepali is the official language of Nepal, with almost 60 percent of the population speaking it. According to the 2001 national census, 92 different living languages are spoken in Nepal (a 93rd category was "unidentified"). Based on estimates from 2007, the major languages of Nepal (percent spoken as mother tongue) are Nepali (57%), Maithili (10%), Bhojpuri (7%), Tharu (4%), Tamang (5%), Newari/Nepal Bhasa (3%), Magar (2%), Awadhi (2%), Rai (2.79%), Limbu (1%), and Bajjika (1%). The remaining 81 languages are each spoken as mother tongue by less than one percent of the population. Nepal's constitution, however, guarantees that, irrespective of what the official language is, all languages spoken in Nepal can be used for official purposes and documentation. Many in government and business also speak English.

Religion is important in Nepal; the Kathmandu Valley alone has more than 2,700 religious shrines. The main religion of Nepal is Hinduism and Shiva, a major Hindu god, is regarded as the guardian deity of the country. Most of the festivals in Nepal are Hindu. The 2001 census identified 80.6% of the population as Hindu and 10.7% as Buddhist (although many people labeled Hindu or Buddhist often practice a syncretic blend of Hinduism, Buddhism or animist traditions). 4.2% of the population is Muslim and 3.6% of the population follows the indigenous Kirant Mundhum religion. Christianity is practiced by less than 0.5% of the population. One of the most important aspects of Nepali culture is the religious harmony and understanding prevailing among the Hindus and Buddhists.

An isolated, agrarian society until the mid-20th century, Nepal entered the modern era in 1951 without schools, hospitals, roads, telecommunications, electric power, industry, or civil service. The country has, however, made progress toward sustainable economic growth since the 1950s. Government priorities over the years have been the development of transportation and communication facilities, agriculture, and industry. Agriculture remains Nepal's principal economic activity, employing 80% of the population and providing 37% of the gross domestic product (GDP). Only about 20% of the total area is cultivable and the main food crops are rice and wheat.

Nepal remains isolated from the world's major land, air and sea transport routes although, within the country, aviation is in a better state, with 48 airports. The hilly and mountainous terrain in the northern two-thirds of the country has made the building of roads and other infrastructure difficult and expensive. There is less than one telephone per 19 people. Landline telephone services are not adequate nationwide but are concentrated in cities and district headquarters.

On May 28, 2008, Nepal was officially declared a federal democratic republic, ending 239 years of royal rule. Historically, the country has been governed as a kingdom under the rule of a monarchy. Today, Nepal one of only three countries that currently have democratically-elected Communist state leaders. The other two countries are Cyprus and Moldova.

Nepal is one of the poorest countries in Asia and the 14th poorest in the world. Poverty is acute; per-capita income is less than US$470. Nearly one-third of the population lives below the national poverty line. The distribution of wealth among the Nepali is consistent with that in many developed and developing countries: the highest 10% of households control 39.1% of the national wealth and the lowest 10% control only 2.6%.

History of International Adoption

Intercountry adoption was formalized in Nepal in 1976 when the National Code of 1964 was amended to enable foreigners to adopt Nepali children. Prior to 1976, only national adoptions were allowed. Childless Nepali couples primarily adopted sons from close relatives to secure the family property and ensure their death rites were taken care of by the adopted son.[2]

In 1964, the Nepal Children's Organization (NCO) was set up to provide food and lodging, education, medical care and vocational training to children, especially to orphans and economically disadvantaged children. Today, in all 75 districts of Nepal, Nepal Children's Organization operates *Bal Mandirs* (children's homes) which provide food, shelter and education to orphans and abandoned children.[3]

From 1976 to 2000 the Nepal Children's Organization was the only entity mandated to conduct adoption in Nepal. In 2000, the Terms and Conditions 2000 opened up intercountry adoption to child centers other than NCO. In 2007, of the 1,048 child centers in Nepal, 47 child centers conducted adoptions. Most of these orphanages are located in the Kathmandu Valley area and a few are located in more remote mountainous areas. The number of adopted children for the period between 2000 and 2007 reached 2161. [2]

Between 2000 and 2007, the number of intercountry adoptions rose every year on average, by 50-100 adoptions. This vast increase in adoptions has led to numerous irregularities, including alleged falsification of documents (children who have parents are declared orphans or abandoned), child centers buying children from biological parents and child centers charging excessive amounts to prospective adoptive parents. [2]

At the initiation of the Government of Nepal and other concerned organizations, an international conference was organized in March 2007 with a view to reform the adoption process. This conference attracted broad public attention and resulted in the adoption of the Kathmandu Declaration. Based on the paramount principle of the best interest of the child, the Kathmandu Declaration reaffirms the commitment to the Convention on the Rights of the Child, recognizes the values of The Hague Convention and expresses deep concern about the inadequacy of the Nepali legal system. Among others, the Declaration appeals to the Government to ratify The Hague Convention and calls for legal reform in accordance with the latter. [2]

Shortly after this international conference, a case arose of a girl, who had been declared an orphan for the purpose of adoption, but who in fact did have parents and did not want to leave Nepal. This triggered the suspension of intercountry adoption in May-June 2007. Over 400 intercountry adoption applications were suspended and no new applications accepted. Under strong pressure from prospective adoptive parents, the Government reviewed the situation and eventually approved the suspended files. [2]

With the endorsement of the new Conditions and Procedures in May 2008, new rules for intercountry adoption have been established replacing the Terms and Conditions 2000. Some changes introduced by the new terms and conditions include: [4]

- The Ministry of Women, Children and Social Welfare ("WCS"), not the orphanages, will be responsible for matching children with adopting parents,
- Documented efforts by the orphanages to find an abandoned child's natural parents will be intensified, as well as efforts to promote domestic adoption of these children by Nepalese families in Nepal as a first preference.

- Adoption agencies must be registered with WCS in order to work in Nepal, and prospective adoptive parents must apply to adopt through these registered agencies.

Most of the children are available for adoption because of poverty and social practices. In general, Nepalese themselves do not usually adopt. Only four out of every hundred adoptions are domestic adoptions.[2] Being very poor, it is difficult for most families to financially support children. In addition, their culture has not yet become accustomed to adopting. Those Nepalese who are unable to have children due to medical reasons will sometimes adopt a relative's child, but even this is considered a rarity.

Shortly after the new rules were established, a two-year study by the United Nations Children's Fund (UNICEF) and the Geneva-based foundation Terre des Homes was released. The report, 'Adopting the Rights of a Child', criticized Nepal's inter-country adoption policies and concluded that it does not always take the best interests of the child into consideration. The study reported major irregularities in the way children were tricked by unscrupulous agents pretending to run 'orphanages' and revealed instances of abduction of children and babies placed for adoption without their parents' consent. They also found that the majority of 'orphans' the researchers talked to should not have been in orphanages because their biological parents and relatives were still living. [2]

ADOPTION FROM NEPAL TO THE UNITED STATES

FY 2008	54
FY 2007	42*
FY 2006	66
FY 2005	62
FY 2004	73
FY 2003	42
FY 2002	12
FY 2001	6
FY 2000	13
FY 1999	3

***** Adoptions by American parents in Nepal were limited in FY2007 due to the Government of Nepal's decision to suspend intercountry adoption.

NOTE: All statistics given correspond with the U.S. Government fiscal year, which begins on October 1 and ends on September 30.
SOURCE: US Department of State, Intercountry Adoption, http://adoption.state.gov/news/total_chart.html

Logistics [5]

January 8, 2009

The U.S. Department of State has released the following announcement: [6]

In an announcement dated January 1, 2009, the Ministry of Women, Children and Social Welfare (MWCSW) established procedures for processing adoptions pursuant to the Government of Nepal's (GON) new Terms and Conditions for adoptions. The initial announcement stated that only 10 applications will be processed from each Embassy, Mission, or enlisted Agency in 2009. We understand these requirements have been provided to all approved agencies. According to Nepali officials, the new requirements will apply to all intercountry adoptions. There is NO provision to permit adoptive families who may have already begun an adoption to continue (be "grandfathered") under the previous regulations.

Prospective adoptive parents should be aware that Nepal suspended intercountry adoptions in 2007 because of serious irregularities as well as credible claims of fraud and possible child-buying. It is not clear that the new adoption procedures will provide sufficient safeguards to ensure that intercountry adoption procedures will be transparent and will adequately protect the rights of children, birth parents, and adoptive parents.

Although the government has announced that the MWCSW is prepared to begin processing intercountry adoptions, adoptive parents considering an intercountry adoption from Nepal should be aware that the current transition period likely will pose considerable delays and challenges as the Government of Nepal seeks to implement its new policies and regulations. The Embassy continues to seek clarification regarding these procedures and will post additional details as they are available.

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U.S. citizens wishing to adopt a child in Nepal must meet both U.S. requirements and the requirements set by the Nepalese Government. Procedures for foreign adoptions in Nepal are unpredictable and the Nepalese Government requirements are not enforced uniformly. The Nepalese Government frequently changes requirements with little notice.

In addition to the U.S. requirements for adoptive parents, Nepal also has the following requirements for adoptive parents:

- **Residency Requirements:** There are no residency requirements for adopting in Nepal.
- **Age Requirements:** The age difference between prospective parents and the adoptive child must be at least 30 years.
- **Marriage Requirements:** The couple must have been married for at least four years prior to filing an adoption application and be "infertile." Single women between the age of 35 and 55 may also adopt. Single men may not adopt.

Nepal has specific requirements that a child must meet in order to be eligible for adoption. You cannot adopt a child in Nepal unless he or she meets these requirements. In addition to these requirements, a child must meet the definition of an orphan under U.S. law for you to bring him or her back to the United States.

Under Nepalese law, single mothers or married mothers who have been left by their husbands must meet stringent requirements regarding the relinquishment of their children for adoption. Fathers have twelve years from the child's birth to claim the child and assert custody rights. Unless a mother identifies the father and he agrees, in writing, to the child's adoption, the child will not be eligible for adoption. This can result in uncertainties as to a whether a child is actually eligible for adoption and may result in further investigations and delays.

Eligibility Requirements:

- **Sibling Requirements**: If the prospective parents already have a child or children, Nepalese Government regulations state they can only adopt a Nepalese child of the opposite sex of their biological child or children. Siblings of the opposite sex can be adopted together if other qualifications are met.

The U.S. Embassy regularly meets with the Nepalese Government, and specifically the Ministry of Women, Children and Social Welfare (WCS), on a variety of adoption issues and to advocate for the general interests of U.S. adopting parents. The U.S. Embassy is not able, however, to intervene on behalf of individual cases or expedite the Nepalese Government adoption process.

The WCS is the Nepalese Government office responsible for adoptions in Nepal. Officially, the Ministry has recognized the Nepal Children's Organization (NCO), also known as Bal Mandir, to process adoptions, although adoptions through other orphanages are possible.

Most adoptive families work with an adoption agency in the U.S. to adopt from an orphanage in Nepal. Some orphanages have established relationships with specific adoption agencies in the U.S. and work only with those agencies. The U.S. Embassy in Kathmandu encourages all parents to work through a U.S. agency, as the adoption process in Nepal is quite complex; furthermore, experienced agencies are able to provide support and counseling services before, during, and after the adoption. The Nepalese Government does not require adoptive parents to work with specific agencies in the U.S. or Nepal. Only designated orphanages in Nepal are approved to process intercountry adoption cases. The U.S. Embassy in Kathmandu does not maintain a list of U.S. agencies or Nepalese orphanages processing intercountry adoption cases in Nepal as these may change frequently.

Adoptive parents in Nepal sign many documents in the process of completing an adoption. Many of these documents are in Nepalese, and English translations are not routinely provided. Parents are encouraged to have documents translated before they are signed. Shree Law Book Management Board is the official Governmental translation office. The office is located in Babar Mahal, Kathmandu. The U.S. Embassy requires both the original and the official translation of all case documents at the time of the immigrant visa interview.

If the prospective adoptive parent is eligible to adopt, and a child is available for intercountry adoption, the central adoption authority in Nepal will provide a child referral. Nepal Children's Organization reviews applications and makes determinations if parents are eligible to adopt. The U.S. Embassy has no authority to challenge or change a decision by NCO to deny an application. Denial by NCO does not mean a definitive end to the process; parents may still be able to proceed with a private agency.

The Nepalese Government requires that all adoptive parents complete and sign a "Guarantee Letter." This letter is part of the dossier that is submitted to the WCS. This letter serves to assure the Nepalese Government that the adoptive parents have been approved by the U.S. Government to be adoptive parents and that, if legally qualified; the child will be eligible to immigrate to the United States. This letter is completed after the child is assigned to the parents

by the Nepalese orphanage or authority. The Guarantee Letter is a requirement of the Nepalese Government, not of the United States Government. The processing of the Guarantee Letter also requires photographs of the child and parents and a letter from the Government of Nepal informing the U.S. Embassy of the details of the match between the child and the adoptive parents, including the child's name and date of birth. The child's photo must be affixed to the letter from the Nepalese orphanage to the U.S. Embassy.

Other required documents include: fingerprint report for the prospective adoptive parents; a favorable recommendation from the District Administrative Officer (Chief District Officer) where the child resides; and a death certificate and/or an affidavit of consent and irrevocable release of the child of biological parents for purposes of emigration and adoption. Additional documents may be requested.

The process from the approval of the I-600A and the issuance of the Guarantee Letter to the approval of the adoption by the Nepalese Government varies in length from six months to two years. The process for adopting children over the age of three years sometimes is completed in a shorter time period. The timing is often uneven and inconsistent; changes in the security situation or the Government may lead to additional delays. Recent changes in adoption regulations may significantly impact adoption processing in Nepal.

Some adoptions in Nepal may be completed with one trip to Nepal; however, many adoptive parents travel to Nepal twice or more. On the first visit, they meet the child and complete initial paperwork required by the Nepalese Government. They then return to Nepal when the adoption is approved by the Nepalese Government to file for the immigrant visa.

The Ministry of Women, Children and Social Welfare charges a fee of $300 for the adoption of an orphan from Nepal. Orphanages and local facilitators in Nepal often charge additional fees to process the adoption and to care for the child once the child has been assigned to adoptive parents but prior to the Nepalese Government approval of the adoption by the Nepalese Government. These fees vary widely. Adoptive parents have reported a wide variance in fees (between $3,000 – $17,000 USD) charged by Nepalese orphanages, which are largely unregulated by the Nepalese Government. Many parents have reported that orphanages have charged them new and unexpected fees once the parents arrive in Nepal. Prospective parents are advised to obtain detailed receipts for all fees and donations paid to orphanages, either by the parents directly or through their U.S. adoption agencies. The U.S. Embassy requires a copy of receipts and information on fees paid in the U.S. and in Nepal at the time of the immigrant visa interview.

IMPORTANT NOTE: Prospective adoptive parents should also be aware that high levels of visa fraud in Nepal include fabricated documents or real documents fraudulently obtained. As a result, the U.S. Embassy in Kathmandu must carefully investigate all orphan visa cases to determine whether the child meets the definition of an orphan under U.S. immigration law. The need for investigations may result in delays in the visa process and issuing the visa. Cases deemed not clearly approvable by the U.S. Embassy in Kathmandu will be referred to the Department of Homeland Security (DHS) for review.

General Health of the Population [7]

Demographic Trends

The population of Nepal increased from 11.6 million people in 1971 to 25.8 million in 2006. As per the Population Census 2001, 39.3 percent of population was below 15 years and 6.5 percent was 60 years and above. About 54.2 percent of population was between 15-59 years.

Life expectancy at birth has been increasing for both males and females in Nepal. It has increased from 42.0 years for males and 40.0 years for females in 1971 to 55.0 years and 53.5 years for males and females, respectively, in 1991. Based on the latest statistics for 2003, life expectancy was 60 years for males and 61 years for females.

Fertility rate is defined as the average number of children that would be born per woman if all women lived to the end of their childbearing years and bore children according to a given fertility rate at each age. This indicator shows the potential for population change in the country. A rate of two children per woman is considered the replacement rate for a population, resulting in relative stability in terms of total numbers. Rates above two children indicate populations growing in size and whose median age is declining. Higher rates may also indicate difficulties for families, in some situations, to feed and educate their children and for women to enter the labor force.[8] According to the Nepal Demographic and Health Survey; the average fertility estimate for 2006 is 3.1. For 2001 it was 4.1 as against 5.1 during 1984-86. There is significant difference in the fertility rate for urban (2.1) and rural (3.3) areas.

Mortality

Remarkable reductions have been seen in child mortality rates in Nepal over the last decades. However, it must be emphasized that in 2005, Nepal's child mortality rate (under 5 years of age) was the fifth highest among all the countries of the WHO South East Asian Region.

From a staggering infant mortality rate of 200 per 1000 live births some 30 years ago, the infant mortality rate in 2006 was 48 per 1000 live births. Trends in infant mortality rate show that it declined from 140 per 1000 live births in 1976 to 103 in 1986. The rate continued its decline to 64 in 2001 and 48 in 2006. It is proposed in the Second Long Term Health Plan (SLTHP) 1997-2017 to reduce the infant mortality rate to 34.4 per thousand live births by 2017.

The most likely causes of the decline in the infant mortality rate are improvements in the management of diarrhea, improved immunization, Vitamin A supplementation, and the improved management of acute respiratory infections, especially pneumonia.

Neonatal mortality is defined as death in the first month of the baby's life. In Nepal the neonatal mortality rate stands at 39 per 1000 live births and accounts for 60 percent of infant deaths. While the overall health of children has improved and as the overall child mortality has declined, the proportion of neonatal deaths has increased from 40 percent of infant deaths in 1987 to 60 percent in 2001. Nepal's newborn mortality is the third highest in the world, as is its percentage of low birth weight babies. Nepal has the fourth lowest percentage of births attended by skilled personnel. According to the Nepal Demographic and Health Survey 2006, of every 1000 newborns, 34 die within the first month of life.

Hospital-based data suggest that the major direct causes of neonatal death in Nepal are infection, birth asphyxia/trauma, prematurity, and hypothermia. Other contributing causes include poor pre-pregnancy health, inadequate care during pregnancy and delivery, low birth weight, and inadequate newborn and post-partum care. The proportion of newborns weighing less than 2,500 grams at birth was 23 percent in 1996/97 and 14.3 percent in 2006.

Fundamental to these is the low status and priority given to women and newborns. Traditional attitudes and practices dominate newborn care and are often hazardous. Appropriate care for the normal newborn is not widely understood or practiced.

There are considerable differences by geographical area. Infants in rural areas are exposed to a risk of death 1.4 times higher than those in urban areas. Similarly, children in the mountain region are twice as likely to die before they reach the age of five as children in the other economic zones.

The mortality rates reflect gender disparities. Girls are nearly 1.5 times more likely to die between their first and fifth birthdays than boys. This most likely reflects gender discrimination in child rearing and health care seeking practices, since biologically, boys are more likely than girls to die in this age group.

According to the Nepal Demographic and Health Survey, 2006, the under-five mortality decreased from 118 per 1000 live births in 1997 to 91 per 1000 live births in 2001. By 2004 it was 76 per thousand live births and continued its decline in 2005 at 61. The main causes of death were neonatal causes, diarrhea diseases and pneumonia.

Nepal's Ministry of Health recognizes that acute respiratory infection (ARI) is one of the major public health problems in Nepal among children under-five years (60 months) of age. The Acute Respiratory Tract Infection Control Program aims at reducing the complication caused by respiratory tract. The program focuses on children under five years because the majority of deaths in this age group are ARI-related. To achieve this objective, there is a regular ARI control program in place which has been implemented in 61 districts as a special program.

In Nepal, the Diarrhoeal Disease Control program was launched in 1984 to reduce the infant and child mortality by promoting oral rehydration therapy. The percentage of children with severe dehydration has decreased from 4 percent in 2000-01 to 3 percent in 2003-04. This improvement is assumed to be due to increased public awareness created by health education programs.

Universal immunization of children under one year of age against the six vaccine preventable diseases (tuberculosis, diphtheria, pertussis, tetanus, poliomyelitis, and measles) is one of the most cost-effective programs in reducing infant and child morbidity and mortality. Since 1988, the Expanded Program of Immunization under the Ministry of Health has covered all 75 districts of the country. Hepatitis B vaccination was added in 2003. Vaccine coverage has been improving during the last three years mainly due to strengthening of program management and monitoring measures at various levels.

The maternal mortality ratio has decreased from 515 per 100,000 live births in 1990 to 475 in 1997. By 2006 the ratio was 281 per 100,000 live births. Government officials attributed the lower maternal mortality ratio figure to under-reporting of deaths in the villages or en route to hospital. At present only 19 percent of all deliveries are attended by a skilled birth attendant and only 18 percent of mothers delivered their babies in the relative safety of institutions, according to UNICEF. Most of the women die as a result of severe bleeding, sepsis, toxemia, obstructed labor and the consequences of abortion. Many of the deaths occur in remote villages, and are due also to the lack of skilled birth attendants. Harsh weather conditions, poor roads and difficult terrain

pose huge challenges in delivering maternal health services in remote areas, especially in far and mid west regions, according to UNICEF. [9]

Cases of heart diseases and cancer are increasing due to extended longevity and changing of life style and dietary patterns. The top ten causes of death for all ages reported in 2002 were: perinatal conditions (10%), lower respiratory infections (10%), ischaemic heart disease (10%), diarrhoeal disease (7%), cerebrovascular disease (5%), chronic obstructive pulmonary disease (3%), hypertensive heart disease (3%), tuberculosis (3%), measles (3%) and road traffic accidents (2%).[10]

The three major causes of death in adult males (15 years and older) were asthma/bronchitis, tuberculosis and cancer. In comparison, the three major causes of death in adult females (15 years and older) were asthma/bronchitis, cancer and complications of pregnancy and delivery.

HIV/AIDS

HIV/AIDS and sexually transmitted diseases (STDs) are emerging as a major threat in the socio-economic and health sectors of Nepal. The first AIDS case in Nepal was detected in 1988. HIV transmission is mainly heterosexual; however, HIV/AIDS is assuming an unprecedented proportion in its prevalence particularly among the injecting drug users. It is estimated that there are 60,000 HIV positive and about 5,000 AIDS cases in Nepal. Among injecting drug users, in 2002, over 68 percent were from the Kathmandu valley and 44 percent of them in the country have been found to be HIV positive.

The estimated prevalence rate of HIV infection is 0.5 percent in the age group 15-49, with a male to female ratio of 3 to 1. Epidemiological data suggests that Nepal has entered the stage of a concentrated epidemic which means that the HIV/AIDS prevalence consistently exceeds 5 percent in some sub-populations such as female sex workers and injecting drug users. A 2003 report by the National Center for AIDS and STD Control and Family Health International (NCASC/FHI) found that among high-risk groups, seasonal labor migrants make up 40 percent of the nation's HIV-infected population, followed by clients of sex workers (18 percent). According to 2002 UNICEF statistics, the number of children orphaned by HIV/AIDS is estimated to be 13,000.

The younger and more educated population is more knowledgeable about HIV /AIDS. In terms of gender differences, men have more knowledge of HIV/AIDS (72 percent) than women (50 percent). However, the percentage of women who have heard of HIV/ AIDS nearly doubled from 27 percent in 1996 to 51 percent in 2001.

There is an acute lack of HIV /AIDS counseling, care, and support. Most of the 62,000 people living with HIV /AIDS are not aware that they are infected and may engage in unsafe sex. Those infected with HIV are subject to stigmatization and exclusion. This could possibly prevent them from taking advantage of the voluntary counseling and testing services provided.

To reduce the transmission of HIV/AIDS/STD, a number of activities have been undertaken over the last decade in Nepal. The National Center of AIDS and STD Control (NCASC) was established in 1993. NCASC is a coordinating body under the Ministry of Health, which looks after the AIDS and STD prevention activities in the country.[11]

Tuberculosis

Tuberculosis is one of Nepal's major public health problems. Tuberculosis generally affects the poor, and the malnourished living in over-crowded spaces, which is particularly common in the context of rapid urbanization.

Tuberculosis contributes to seven percent of the total burden of disease. According to a WHO estimate, about 45% of the population is infected with TB, out of which 60% are in the productive age group. Almost half the 44,000 people suffering from TB have infectious pulmonary disease that can spread unless treated. The use of Directly Observed Treatment Short Course (DOTS) has made remarkable strides in the cure rate of TB. [11] The number of people dying from TB has plummeted from an estimated 15 000-18 000 in 1994 to about 8,000-11, 000 in 2008.[12]

In 1996, DOTS was introduced in Nepal after a joint HMG/WHO review of the National Tuberculosis Program (NTP) revealed that only 30% of TB cases were registered, and of these only 40% were treated successfully. The cure rate in the first cohort of DOTS patients was over 89%. By July 2000 the program had been expanded to 178 treatment centers in 66 districts and covered 75% of the population. The treatment success rate in DOTS centers is now approximately 89%; and, the national treatment success rate has reached nearly 85%. In 2008, over 28,000 TB patients were registered and are being treated under the NTP.[11]

Many hurdles remain before DOTS can be extended nationwide. Much of Nepal is remote, mountain and hilly terrain and many areas are sparsely populated, making drug distribution and treatment supervision extremely difficult. Other concerns include an increase in the number of people co-infected with HIV and TB (currently almost 2% of TB cases) and an increase in the incidence of multidrug-resistant forms of TB (over 1% of TB cases).[12]

Endemic diseases

Nepal is striving to control or eliminate malaria, kala-azar, Japanese encephalitis, leprosy and filariasis, some of the major endemic diseases prevalent in the country. The key strategies that have been adopted to address these diseases include enhanced surveillance, integrated vector control and community-based environmental modifications, early diagnosis and treatment, mass treatment, and protecting those susceptible with inoculations.[13]

Malaria is a vector-borne infectious disease caused by protozoan parasites. In Nepal, malaria is endemic in 65 districts and approximately 74 percent of the total population is at risk. The incidence of malaria cases has gone down from 115 per 100,000 people in 1990 to 65 per 100,000 people in 2000. However, it increased again to 78 per 100,000 people in 2003. The high-risk population in districts covered by preventive measures was 9.75 percent in 1996, before going down to 6.94 percent in 2002, and up again to 11.4 percent in 2003. An analysis of service statistics indicates a resurgence of *P. falciparum* malaria, increasing from six percent in 2000 to 11.75 percent in 2004. Resistance to routine drugs is also on the increase.

Visceral leishmaniasis, also known as kala-azar and black fever, is the second-largest parasitic killer in the world (after malaria). Kala-azar was not a problem in Nepal until 1980. Since then cases of kala-azar have been rising steadily and is now endemic in 12 districts of the Eastern Terai region. Approximately 5.5 million people are at risk from the disease, which is spread by sand flies. The reported cases of kala-azar decreased from 1,290 in 2000-2001 to 829 in 2001-2002. However, in 2003, there were 2,229 cases recorded in the country. There were 32 deaths due to Kala-azar in 2003.

Japanese encephalitis, a vector borne viral disease, has been reported from 14 Terai districts, including some from Kathmandu. From 1978-2003, a total of 26,667 cases and 5,381 deaths have been reported. During the same time period, the case fatality rates ranged from 9.8 percent to 46.3 percent. But in the recent years, the case fatality rate has declined and contained below 20 percent.

Lymphatic filariasis, more commonly known as *elephantiasis,* is caused by thread-like parasitic worms that damage the human lymphatic system and is spread by mosquitoes. The disease is endemic in 60 of the 75 districts in Nepal as reported in 2007. There are 25 million people are at risk.[14]

Nepal is one of the few remaining nations in which leprosy persists in significant numbers and has yet to be eliminated. Leprosy has been recognized as a public health problem since 1950. In Nepal, the prevalence of leprosy has dropped to 2.41 per 10,000 populations in 2004 from 21 per 10,000 population in the 1980s. People showing signs of leprosy have traditionally been shunned, as community members have feared infection or contagion. The situation is much worse for girls and women. They are frequently abandoned by their husbands and male relatives when deformities develop, often caused by a delay in receiving the appropriate leprosy treatment.[15]

Malnutrition

Malnutrition is a major public health problem in Nepal. The most significant nutritional disorders among the Nepalese population are protein energy malnutrition, Vitamin A deficiency, iodine deficiency disorders, and iron deficiency anemia.[11]

Under-nutrition is wide-spread, particularly among children. The Demographic and Health Survey of 2001 reported that about 50.5 percent of children below 5 years were affected by stunting (short of their age), which can be a sign for early chronic under-nutrition. This percentage showed little change five years later when the Demographic and Health Survey of 2006 reported that about 49.3 percent children below 5 years were affected by stunting. The two surveys also found that 48.3 percent in 2001 and 38.6 percent in 2006 of the children were under weight.

Iron deficiency anemia is the most common nutritional problem in Nepal affecting approximately three-quarters of women. Anemia is one of the underlying risk factors in pregnancy. Anemia reduces work capacity of adults by 10-30 percent. Among women, there is distinct variation in the prevalence of anemia according to the region with highest levels in the Terai followed by the mountainous regions. The most common cause of anemia in Nepal is considered to be inadequate intake of iron from food followed by parasitic infection. Seventy-one percent pregnant women are not consuming adequate amount of iron from their daily diets, despite the fact that antenatal iron supplementation has been in place in Nepal since more than two decades. Lack of knowledge about the importance of iron tablets is stated to be the main reason for not taking iron supplementation. However, due to continuous effort by health workers to improve the coverage of iron tablets during pregnancy and postpartum, the coverage of iron tablets reached to 68 percent in the fiscal year 2002-03.

Tobacco, Alcohol and Drug Use

Tobacco smoking is one of the most important risk factors contributing to the high prevalence of lung diseases in Nepal. Nearly three-fourths of men smoke cigarettes, *bidis* or other tobacco, two-thirds consume alcohol; more than one in two both smoke and consume alcohol. Smoking and alcohol consumption is much less common among men in the age group of 15-19. The mean age at first smoking was 16.6 years, 17 years among males and 15.8 years among females.[16] Smoking and alcohol consumption is also less common among divorced, separated, or widowed

men and women living in the Terai ecological zone, western development region, and central Terai sub-region than in other regions.

The 2002 Demographic and Health Survey of Nepal found that 67% of the males between 15 and 60 years of age consumed alcohol. The largest percentage was in the 25-29 year age group (73.3%). In the 15-19 year age group, 47.4% also consumed alcohol. The urban and rural prevalences were 75.0% and 66.7% respectively. [16]

In most parts of the country, liquor is freely available and unlicensed home-brewing accounts for the major production of alcohol. The poor are dependent on home-brewing for their livelihood. Types of traditional and local alcoholic beverages include country liquor (low quality alcohol made from molasses and produced in small distilleries in every district of Nepal), homemade liquor (from grains and sugarcane and often using the powder of dry batteries, ammonium chloride, fertilizer), *Jad* (made of rice), *Chang* (made of rice by a different procedure) and *Raksi* (home-brewed alcohol made out of rice, millet or barley). [16]

In Nepal, many crimes are committed under the influence of alcohol. Much violence both outside and inside the home has taken place under the influence of alcohol, and it has been the root cause or precipitant in many antisocial and criminal acts. Ten percent of violence against women is attributed to alcohol used by the spouse. Alcohol has been the starting drug for many, and it has also been freely available whenever the drug of choice is not available. Excessive use of alcohol is also linked to the economic exploitation in some communities in Nepal. Most of the traditional alcohol user groups have lost their land due to the excessive use of alcohol and the land has been mortgaged by the upper caste people, traditionally non-alcohol user groups.[17]

The Ministry of Health in 1998 estimated that there were more than 50,000 drug users in Nepal, excluding those using cannabis, alcohol and tobacco. The overall prevalence of drugs is 2.7% with 4.6% for men and 0.6% for women. Traditional alcohol non-users are much more likely to use drugs over the traditional alcohol user. The major drugs abused in Nepal, apart from tobacco and alcohol, were cannabis and codeine containing cough syrup, nitrazepam tablets and buprenon-phine injections, glue and opiates. Heroin is the second most prevalent drug in the country and more than 25,000 people depend on it. [18]

Nepal is the biggest producer of cannabis resin in South Asia. Besides the home-grown cannabis, Nepal is also being flooded with low-grade heroin from India and with opium. In 2008, of the 634 people arrested in Nepal for drug smuggling, 72 were foreigners, including 17 women. [19]

Special Considerations for Children Adopted from Nepal

Children Living in Children's Homes [20]

In Nepal, the first children's home was established over 100 years ago. Until 1990, there were very few children's homes. Today there are over 400 children's homes and there numbers continue to increase. A recent survey conducted by the New ERA study team provided information about 335 children's homes and 8,821 children in Nepal. Some of the findings are summarized below. The complete report can be found here: http://www.measuredhs.com/pubs/pdf/OD35/NepalStudyOfChildren.pdf.

The majority of the homes tend to be very small with less than 25 children and run by staff size of less than 10. Very few are larger with more than 100 children. In most case, the caretaker to child ratio is one to nine but can be as high as one to 15.

Children's homes have seen a dramatic increase in the number of children in recent years. Most homes have an admission preference for orphans or children from economically destitute families. Less than a third of the homes give priority to conflict affected children. Conflict related reasons include death of one or both parents, displacement from the family due to high insurgency risk and possibility for children being involved in the insurgency activities.

Over 87 percent of the children were displaced from their communities or admitted in the homes due to non-conflict related reasons: poor economic condition of the family ((81%), natural death of the parents (23%) or remarriage of the child's parent (13%). Only nine percent of the children were displaced due to conflict related reasons. These include adverse effect of conflict on the economic condition of the family, displacement of the family due to high insurgency risk and possibility of the children being involved in insurgency activities. Fifty-six percent of the children were either single orphaned (lost one parent) or double orphaned (lost both parents).

There were a higher percentage of boys (57%) as compared to girls (43%) in the homes surveyed. Most of the children were school aged (six years or above). Most of the children had siblings; nearly two thirds of these children had siblings who remained in their communities while one third had siblings in the same children's home.

Many homes took the initiative to keep children in contact with their families. Seventy percent of the children maintained contact with their families or relatives. Contact was highest among those children with one or both parents still alive. Younger children tended to have less family contact than older children. The policy for most homes was for children to remain in the homes until they completed their secondary education or were capable enough to earn their livelihood.

Over seven percent of the children had some kind of health problems that required ongoing medical care. The top health problems were ENT (21.4%), skin (17.2%), waterborne diseases (11.9%), arthritis (11.8%), mental illness/epilepsy (10.3%), respiratory problem (8.6%), frequent fever (6.4%), malnutrition related problem (5.2%), heart problem (4.0%), HIV/AIDS/STD (3.7%) and cuts, injuries, burns (3.7%). Eight percent of the children were identified as disabled. The types of disabilities included deafness, blindness, physical handicap and mental retardation.

Information on nutritional status was collected for 515 children aged 6-59 months using three indices: weight-for-age (underweight), height-for-age (stunting) and weight-for-height (wasting). The survey found that 41 percent of the children were stunted, 29% were underweight and four

percent were wasted. In comparison to national figures from the 2001 Nepal Demographic and Health Survey, these percentages were 51%, 48% and 10% respectively. These statistics show that the nutritional status of children in the homes were better than the average Nepalese child in the same age group. Most of the homes surveyed with children aged 6-59 months had made some arrangement to provide children with Vitamin A.

Of the total children survey, three percent were found to be suffering from psychological problems noted by the caretakers. These included: homesickness, remaining depressed, keeping quiet all the time, complaining of night suffocation, preferring to stay alone, getting angry all of a sudden, weeping frequently and screaming all of a sudden.

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