

Population Policies and Programme in Nepal

Introduction

RAPID population growth and development are related in what appears to be a vicious circle. Does the slowing of population growth have to wait for 'development' while 'development' is hindered by rapid population growth? On the one hand, if development takes place, the modernization and improved living conditions which are part of it can be expected to bring down the birth rate. On the other hand, development may not be possible as long as the current high rates of population growth continue (United Nations 1975).

Nepal, like many other developing countries, has been trying to combat rapid population growth by introducing family planning programmes. Although family planning programme in general have been criticized for their inability to solve the problem of rapid population growth (Blake 1965; Davis 1967), a report by the Secretary-General of the United Nations presented at the World Population Conference in Bucharest, 1974, states:

Granted that the most favourable context for fertility decline is rapid and widespread development and modernization, there is, however, no reason to reject the common-sense assumption that family planning and educational programs, as integral parts of development policies, may speed up the fall in fertility. Moreover, there are indications that fertility may even decrease in relatively early stages of social and economic development, which suggests that programs designed to reduce fertility need not be postponed until late in the development process (United Nations 1975).

There are several instances where fertility has declined without economic progress. One example is the Peoples' Republic of China. The well-organized Indonesian family planning program, particularly in Bali, has had a significant impact on reducing fertility levels under conditions of slow development (Stratfield 1982). Sri Lanka and Kerala, a state of India, are two other examples where fertility levels have fallen along with substantial mortality reduction and increase in education (Freedman and Berelson 1976). Indeed, these two both signal social change. Hence, it is clear that fertility decline is possible with the implementation of family planning programmes under varying conditions.

Despite a long history of family planning programmes in Nepal, the population

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reached about 17 million in 1985. It has almost doubled within the last 30 years. If the present rate of population growth continues, the population will double in less than 30 years from today. The population density per sq km is more than two and a half times higher than the average for least developed countries. The crude birth rate and crude death rate are still much higher than the average of least developed countries. The prevailing infant mortality rate is one of the highest in the region and per capita GNP is only US \$160, the lowest of all South Asian countries (*Asiaweek* 1989).

The persistent high fertility in Nepal is due to minimal increase in knowledge of and access to contraception, particularly of reversible methods. Despite some progress in urban areas and among some sections of the population, rise in overall contraceptive use and decline in fertility, if any, have been considerably slower than anticipated by both policy-makers and programme implementors. There have been considerable efforts made to find out ways to improve family planning delivery systems and draw more potential family planning users into the programme by conducting various demographic and experimental programme research.

The government's commitment to fulfilling the basic minimum needs of the Nepalese people by 2000 A.D. has turned the attention of policy-makers towards bringing down the current high population growth rate:

"Nepal's demographic situation is serious. However successful efforts to curb fertility during the next decade may prove, the country's population will still reach about 24 million in the year 2000, compared to an estimated 17.5 million today, and will double by the year 2015. This is due to the fact that demographic trends can change only once the momentum effects of past population growth have played themselves out. In Nepal today, there are 4.1 million girls who are approaching fertile age, 50% in excess of the total of all women currently fertile. Although the dynamics of population growth mean that little can be done to change events in this generation, prompt action is nonetheless needed to lessen demographic damage in the next." (World Bank 1988).

Little research has been addressed to the causes for persistent high fertility in Nepal. The study of fertility determinants is very complex. There are many theories or models regarding the dynamics of fertility and at the same time there are numerous controversial issues as to under what conditions transition from high to low fertility will occur. In quest of reasons for persistent high fertility in Nepal, it emerges that there is a lack of mechanisms to raise the age at marriage, create a strong family planning programme and promote an environment for Nepalese women to work outside the home to ensure higher contraceptive use and consequently a decline in fertility (Tuladhar 1989).

A rising age at marriage and increased use of contraception are two important mechanisms through which a decline in fertility occurs. Nag (1985) elaborates that the acceptance of contraception by married couples in Asian countries takes place in two stages. The first is characterized by acceptance of family planning methods primarily by older couples who have attained their desired family size and preferred sex

composition and are seeking to end their child-bearing years. The second—more widespread use of contraception accompanies a change in attitude towards family size and sex preference which is little affected by availability of family planning mechanisms. Its change depends upon the pace of economic development, including institutional changes that reduce the demand for children or the net value of children to their parents.

Persistent high fertility cannot be fully explained by a failure of the national family planning programme to make any considerable impact. Nor can it be fully explained by a lack of socio-economic development and limited mortality decline in the country. It could, therefore, be a lack of popular demand which depends more on the socio-economic and cultural environment. All these three are interlinked. This article aims to address the above issues based on the available literature and knowledge in the country.

Evolution of Population Policies, Strategies and Programmes

In the First and Second Development Plans of the country, there were no specific population policies other than a resettlement policy to absorb the increasing population in the hills. The Third Development Plan (1965-1970) discussed the consequences of population growth on manpower (HMG of Nepal 1965).

The Fourth Development Plan (1970-1975) placed population control as one of the six priorities of the country. The policy envisioned that the family planning programme will help improve the standard of living of the people (HMG of Nepal 1970).

There were two fundamental issues stressed in the Fourth Development Plan to encourage a decline in the birth rate. The first was to bring about changes in the economic and social conditions, cultural patterns and aspirations of the Nepalese people and the second was to create an institution to implement the national family planning programme.

The Fifth Development Plan (1975-1980) clearly envisaged the action needed to raise the standard of living of the Nepalese people. The Plan stated that optimum utilization of manpower, consistent with the aims of broader economic growth and a quicker rise in the standard of living of the masses, demands a pattern of distribution of population in keeping with the present and future geographical distribution of the physical resources endowments of the country (Lohani 1976).

The Sixth Development Plan (1980-1985) discussed the impact of population growth on different sectors, particularly on agriculture, forestry, labour, education, health and urbanization. Its two population objectives were: (1) The annual population growth rate of 2.3 percent per annum will be regulated and pre-requisites to bringing down population growth will be met during the Sixth Plan period; and (2) problems of population distribution and migration will be tackled (HMG of Nepal 1980). The Sixth Plan adopted three specific policies: (1) introduction of a family planning programme with particular emphasis on permanent methods in rural areas of high fertility; (2) intensification of economic activities in the hill areas in an effort to regulate the movement of population; and (3) popularization of the family planning programme among the people at large by adequate provision of publicity and extension of services.

Comprehensive national population policies and strategies have been outlined since the establishment and restructuring of the National Commission on Population (NCP) in 1979. Upon the recommendation of the NCP, HMG adopted a target to reduce the total fertility rate to 2.5 by the year 2000. In January 1983, the NCP made a decision to adopt a number of population strategies giving major thrust to the following issues (NCP, 1983):

1. Accord high priority to the fulfillment of the current substantial unmet demand for family planning services;
2. Integrate population programmes in all projects relating to the environment, forestry, agriculture, and rural development;
3. Emphasize programmes that help increase the status of women, female education and employment.
4. Effect mobilization of local panchayats, class organizations and NGOs, in view of the enormously important role of local communities, in all population and fertility reduction programmes; and
5. Control the steadily increasing immigration into the country.

The NCP's detailed plan of action emphasized that family planning services would be rapidly upgraded and expanded with priority given to areas where population density is high. By the end of the Sixth Development Plan, NCP policy states that family planning services will be made available in all hospitals. While strengthening and expansion of permanent sterilization facilities takes place, the policy calls for the popularization of temporary family planning methods. To best use these available services, a number of measures are proposed. These include indirect incentives to those civil servants and employees of private organizations who undergo sterilization and limit family size to two living children, and direct incentives including a cash incentive in the form of wage compensation to those who undergo sterilization and a non-negotiable development bond to couples with two living children at the time of sterilization. In addition, the NCP recommends free education up to the 8th grade for children of parents who undergo sterilization after having two living children. HMG promotes the involvement of individuals and non-governmental institutions by awarding special awards, medals and certificates to those who have made outstanding contributions to population programmes. Unfortunately, many of the above measures are still to be implemented.

The integration of population and development is viewed as an important step to improving the quality of life and fulfilling the basic minimum needs of the Nepalese people. The policy basically outlines that population education programmes are to be part of the development activities of different Ministeries (Agriculture, Forest, Education, and Local Development) and are to be channelled through: (1) Integrated Rural Development Programmes; (2) Cooperatives and Sajha; (3) Resettlement Programmes; (4) Central Coordination Committee on Skill Development; and (5) Programmes in the corporate sector.

In view of the diverse nature of the Nepalese population in terms of geo-cultural differences, the task of information dissemination is formidable. Population-related Information, Education and Communication (IEC) is aimed to be carefully targeted at specific groups. The IEC component strategy includes compulsory population education in all formal, non-formal and adult education programmes..

The Sixth Development Plan has adopted policies to incorporate a series of programmes which will upgrade the status of women. The long-term plan of HMG has a time-specific target to provide opportunities to enroll 38 percent of girls in primary schools by 1993 and provide free education up to the middle school level to female students. Under the non-formal education programme, functional literacy programmes are to be offered to those disadvantaged girls and women who are unable to attend regular schools. The NCP emphasizes that a communication strategy is essential to inform women about various opportunities available to them through related women's organizations. To enhance opportunities for women's participation in income generation through involvement in development, the NCP aims to include women's development activities in all Integrated Rural Development Projects.

With regard to mobilizing the local panchayats, the policy of making District Development office allocate 20 percent of their HMG development grants to population-related activities is worth noting.

The population strategy outlined in 1983 also considers policy intervention with regard to spatial distribution of population, immigration and environment. These policy interventions are:

1. Programmes to initiate a comprehensive and planned migration process within the hills, and from the hills to the Terai, in view of the environmental conditions in the hill region;
2. Effective control of immigration in the Terai; and
3. Programmes to initiate a planned urbanization process in selected locations within the hill and Terai regions.

Since the population problem and its solution are matters of national priority, the NCP recommended that a number of amendments be made to the contemporary legal system. The population strategy sought the following amendments and modifications:

1. A legal provision for sterilization;
2. An increase in the minimum marriageable age for women from 16 years to 20 years;
3. Legalization of abortion under specified conditions; and
4. Appropriate amendments in existing inheritance laws with regard to unmarried women.

During the Seventh Plan (1985-1990), population policies are based on the National Population Strategy recommended by the NCP in 1983 and subsequently approved in

principle by HMG. The population planning objective stated in the Seventh Plan is "to strike out a balance between population growth and economic development by reducing the adverse effects on population structure and distribution that result from the pressure of unchecked population growth" (HMG of Nepal 1985).

Fertility Situation

The estimation of fertility levels and trends is a complex task for a country like Nepal where available demographic data is unreliable. Demographic data were scanty until the 1970s and the only sources of information were the censuses (1952/54, 1961, and 1971) and the 1974-75 Demographic Sample Survey. Births were considerably under-reported in these censuses and the survey. As a result, fertility rates were adjusted by the application of indirect estimation techniques.

The 1976 Nepal Fertility Survey made it possible to estimate more accurately fertility levels and trends. Following this survey, a series of other national sample surveys—the 1981 Contraceptive Prevalence Survey (CPS), the 1984 Nepal Fertility and Mortality Survey (NFMS), the 1986 Nepal Fertility and Family Planning Survey (NFFS), the 1986 Fertility, Mortality and Migration Survey (FMMS), and the 1991 Nepal Fertility, Family Planning and Health Status Survey (NFHS)—were conducted.

All surveys except the 1986 FMMS were carried out on a retrospective basis. The 1986 FMMS was a prospective study. All these surveys collected detailed fertility history data. The 1976 NFS, the 1986 NFFS, and the 1991 NFHS collected data for household and individual respondents and obtained information on birth history. The survey data have been found to be deficient in data quality (Goldman *et al.* 1979;

Tuladhar 1989; and FP/MCH 1987).

Age misreporting, and omission and displacement of births are prevalent in all these national sample surveys. However, the degree of data quality varies among these surveys. The omission and displacement of births occurring in the last five years before the survey are negligible in the 1976 NFS compared to other surveys' data. There is gross under-reporting of births in the last year of the 1981 NCPS, the 1986 NFS and the 1986 FMMS. Adjustment of births by less than 10 percent only was required in the 1976 NFS while fertility rates were adjusted by 28 percent in the 1981 NCPS, 45 percent in the 1986 NFFS and 42 percent in the 1986 FMMS. The 1984 NFMS suffered from very high non-response rates of 42 percent for women 15-19 and 26 percent for women 20-24.

Due to errors in other data sources, the 1976 NFS data are still regarded as the best source to understand the level and patterns of marital fertility in Nepal (CBS 1987). The analysis of detailed birth history data collected in the 1986 NFFS might hopefully provide more accurate fertility levels and patterns for the current period.

Various indicators of fertility indicate that Nepal has been experiencing persistently high levels of fertility between 1951 and 1981. The levels of Crude Birth Rates were around 45-48 births per 1000 population and the Total Fertility Rate (TFR) was at 6.3 children per woman during that period. The two surveys (the 1986 NFFS and the 1986

FMMS) suggest that fertility seems to have declined among older women (30-34 and 35-39) with an increasing trend for younger woman (15-19 and 20-24). These surveys indicate that TFR is around 5.8 to 6.0 children per woman. Because of the extent of adjustment made for under-reporting of births, one should take caution in relying on these figures until we come up with more reliable estimates based on detailed analysis of the 1986 NFFS birth history data or another round of national sample surveys.

Differential fertility suggests there is a marked difference in TFRs between urban and rural areas. Some educational differences in fertility do seem to appear, with the educated having lower fertility than the uneducated. But the proportion of the population who have some schooling is so small that this will have little effect on overall fertility.

Of the three proximate determinants of fertility, breastfeeding by far has remained the highest fertility-inhibiting effect followed by contraception. The fertility-inhibiting effects of contraception have increased both in rural and urban areas during the period 1976-1986. The increase in contraceptive use is still too low to bring about a significant decline in fertility. The fertility-inhibiting effect of marriage patterns has remained negligible during this period.

Despite data limitations, the above discussion on fertility estimates based on indirect techniques and proximate determinants provides conclusive evidence that the Nepalese demographic transition may be under way without any change in fertility as of yet. There is evidence in urban areas of a rapid rise in the use of contraception.

Policy and Programme Issues

Age at Marriage

The singulate mean age at marriage (SMAM) for women has increased from 15.4 years to 18.9 years during the period from 1961 to 1986. Increasing tendencies to delay marriage were observed in sub-sections of the population. Mean age at marriage is higher among urban, educated, Buddhist and Tibeto-Burman women than among their counterparts. Marriage of Nepalese females is still nearly universal and over 98 percent of women are married by age 35.

There are three forces of nuptial elements affecting Nepalese fertility, which can have implications for policy planners. The first is delayed marriage by a few years which is not to an extent which affects fertility. Second, marital dissolution in the older ages who still have reproductive capability has declined due to decreased incidence of widowhood. The third is the positive association between age at marriage and completed fertility for women married less than 10 years ago (Nepal FP/MCH Project 1977). Thus the negative effect of late marriage on completed fertility is at least partially counter-balanced by a higher tempo of early marital fertility among those marrying late in life. The overall effect on fertility of increased age at marriage has been neutralized by the decline in the incidence of widowhood and a tempo for early pregnancy. A possible result may be an increase in overall fertility in general.

If this trend continues, there could be a serious setback in future population

conditions. There is a room for two kinds of policy interventions. First, the present legal age at marriage must be increased considerably so that there can be a real effect on fertility. Second is a postponement of first pregnancy which will be dealt with in the family planning component. The former has been suggested by the National Commission on Population in its population strategy in 1983 as a policy intervention.

Breastfeeding

The data on breastfeeding indicate that breastfeeding is still nearly universal and over 95 percent of married women breastfeed their children for an average length of 24 months. Although the practice of breast feeding has not yet evidenced major changes, there are two matters of concern for policy implications as discussed in the country workshop. First, the child spacing effect of breastfeeding cannot be considered as reliable unless mixed with some other family planning method. Second, there is evidence that the length of breastfeeding is declining in some socio-economic groups. The practice of breastfeeding should be encouraged with an efficient birth-spacing method.

Abortion

Access to induced abortion is restricted by law. Nor is it socially or morally permissible in Nepalese society. It is legally prohibited to abort or aid in aborting. An abortion is possible only under rigid circumstances, such as 'if there is a possibility of physical deformity in the child' or 'if mother is mentally sick'. Despite these strong legal, social and religious forces there is accumulating evidence that the incidence of induced abortion is increasing (IDS 1985). A small-scale prospective survey in specific rural areas suggests that the total induced abortion rate is 3.6 per 1000 women of ages 15-49 who were observed for a period of six-month during the study period.

Although the prevalence of induced abortion is still small in the country, the fact is that there is an increasing tendency for women to have illegal abortions according to the study. There is a possibility of an increase in maternal deaths due to induced abortions performed by untrained personnel. An attempt should be made to reduce unsafe abortions.

Status of Women

The analysis of gender differences reveals that there are definite conflicting patterns of interest among household members. A greater number of husbands than wives value sons for economic, socio-psychological and cultural reasons. Likewise, more wives than husbands value daughters for economic and psychological reasons. Gender differences do appear in sending children to school. Boys are sent to schools while girls are kept away from school to substitute for boy's labour.

Of many social and economic factors that have been associated with lower fertility, improvements in the status of women are crucial, giving women access to the fruits of developments as well as influencing fertility. During the last several years, the

government initiated a number of strategies and programmes, particularly in the field of employment, labour and education. Pradhan (1989) expressed her concern that the government's strategies to improve the status of women take a narrow view of the status of women. They did not adequately address the self-employed women working in the household productive sector in the rural economy and have a weak support base on women's programmes and lack systematic integration in the overall national population and development strategies.

Demand for Family Planning

The main factors supporting high fertility in Nepal are socio-cultural, based on religion, security and the status of women. It is strongly supported by the unusually high value of children which arises from a continuing economic flow from the young to the old.

It is likely that demand for children will remain high unless fast changes in society take place. The government emphasizes the importance of education and employment opportunities for women in its five year development plans. Though various ministries and non-government agencies have integrated population education into their sectoral programmes to create demand for fertility control/regulation, almost all of these efforts are implemented in limited areas. As a result, these programmes have no or minimal impact on demographic processes. Often, they lack of adequate trained manpower, education materials and have a weak basis for monitoring and evaluation of the programmes.

As Caldwell and Caldwell (1984) indicate, more successful family planning programmes do not necessarily have to wait for a greater secularization of the society. Often secularization is segmented. National programmes can, through their information services, contribute to that secularization by helping to change attitudes towards marital, sexual and other relations. The very repetition of the message and its identification with government and social and political leaders will have some impact.

In the Nepalese context, IEC programmes of population and family planning face two fundamental problems: (1) a varied population consisting of many ethnic and caste groups (75 ethnic groups) who speak as many as 50 languages and dialects; and (2) mass female illiteracy (only 12 percent of females are literate). Problems faced by the IEC programmes are compounded by the geographical terrain of the country.

Various mass media have been used to generate awareness and demand for fertility control/regulation. Print materials, which have been used extensively both by government and non-government agencies, have little effect because they neither reach the mass population nor mean anything to the illiterate masses. A visual literacy study has shown that it is impossible to communicate ideas and information with pictures. Though the pictures may be recognized by villagers, the messages behind the pictures are never conveyed. Effective media such as films and television have use, but they have limited coverage and are meant for higher socio-economic groups only. Radio has the best potential to deliver messages. One out of every 35 people in Nepal owns a radio (Bhattarai, 1984). However, the use of radio to convey family planning

messages is limited to a total of one hour per week. Several studies indicate that the best source for disseminating information is the network of fieldworkers. In this respect, Nepal should learn more from the Bangladeshi and Indonesian family planning programmes.

Maternal and Child Health

Nepal is experiencing a steady decline in the infant mortality rate (IMR). The highest IMR recorded was 197 in 1950-54 and it declined to 156 in 1970-74 and 108 in 1980-84. The 1991 NFHS estimates that the IMR declined by 25 percent over 13 years period (1976-1989). The recent IMR figure (102 infant deaths per 1000 live births) is still one of the highest among the South Asian countries. Maternal mortality also poses a serious health problem. Available data from 1976 indicates that maternal mortality is 850 per 100,000 live births.

Nepalese planners feel that the reduction of infant mortality will bring about a considerable reduction in population problems. Until recently, maternal and child health (MCH) has been the most neglected component in the family planning and MCH programme. HMG's MCH strategy includes child spacing, oral rehydration, basic natal care, immunization, nutrition and acute respiratory infection. Effective implementation of at least three components, oral rehydration, nutrition and immunization, if not all six, will bring down infant and maternal mortality rates in the country.

The MCH programme should attempt to avoid high-risk pregnancies. Family planning is an effective way to prevent maternal and infant mortality because family planning can help couples avoid high-risk pregnancies. Pregnancies are considered high-risk if they are (1) before age 18, (2) after age 35, (3) after four or more children, and (4) spaced less than two years apart (Population Reports, J-27, 1984). In practice, the combination of these four types of high-risk pregnancy is more important than any one of the four considered separately. In a country like Nepal where women many young and have several closely spaced births before they reach age 20, they are doubly at risk. At the same time, older women also have many children, so their pregnancies fall into two high-risk categories. These types of women having been doubly at risk should be a special focus of primary health care programmes trying to reduce maternal and child deaths.

Family planning is probably the most effective way of preventing each of the four types of high-risk pregnancy, thereby reducing maternal and infant mortality in Nepal. Therefore, spacing methods, such as oral contraceptives, condoms, and natural family planning methods should be propagated to avoid high-risk pregnancies among younger women. For older women, intra-uterine devices, injectable and implants should be promoted to avoid such pregnancies. In addition, breastfeeding along with other methods should be encouraged.

Contraception

Knowledge of contraceptive methods among currently married women has been

steadily increasing from 21 percent in 1976 to 93 percent in 1991. The percentage of currently married women who know of a family planning method and have knowledge of service outlets has increased dramatically from six percent in 1976 to 74 percent in 1991. The prevalence of contraceptive use has increased from three percent in 1976 and 15 percent in 1986 to 24 percent in 1991. An increase in the contraceptive prevalence rate has been mainly due to increased acceptance of permanent methods.

The surveys revealed that the prevalence of sterilization use has been high and a large majority of current users were sterilization acceptors. The prevalence of contraceptive use varies according to the different demographic and socio-economic characteristics of women. The prevalence of contraception is substantially higher among older, high parity, urban, and educated women than among their counterparts. These older and high-parity women were generally those who have attained their desired family size and wished to end their childbearing years. These women, on average, have had four or more living children at the time of sterilization. The programme needs to be broadened by covering a wide range of population.

Political commitment. The success of any programme requires political commitment and some social pressure. Responsibility for the successful implementation of family planning programmes should not rest only on the Ministry of Health.

The formulation of population policies, implementation of the national family planning programme and co-ordination of various population activities need to be headed by a powerful agency. The regular monitoring of the programme performance should be done at a very high level. The National Commission on Population headed by the Prime Minister is no longer effective as a policy making or national coordinating body according to an expert evaluation team headed by Robert Pratt (1989).

The issue of whether there is a political commitment to the family planning programme is debatable. In the view of Moni Nag, there is not enough political commitment to the programme in terms of committed resources and efforts for achieving the declared objectives. There is a lack of mechanisms and government leadership in overseeing the implementation of the national family planning programme. Nepalese have much to learn from Indonesia on how to get the political commitment to advance family planning programme. Nepal needs to consider having a highly powerful national body which oversees coordination and implementation of national family planning programmes. This body should have legal status and be in a position to direct various ministries for supporting and taking an active role in implementing family planning activities.

Unmet need. The unmet need is approximately 33 percent among the currently married women of reproductive age according to a 1987 Nepal DHS In-depth Survey (Shreshtha, *et al.* 1988). The unmet need population classified according to socio-economic characteristics indicates that the 'unreached' population is high in the hills and among younger women (15-29 years) in rural Nepal. Special efforts will be needed to reach these groups.

The present strategy of emphasis on the expansion of services providing permanent methods of family planning must be revised. Only in this way, can the strategy reach young couples who either want children in the future or to retain their reproductive capacity, even though they do not want more children. For these groups, temporary methods, in particular injectable, intrauterine devices, and implants, need to be promoted.

The central facts of the non-use of contraception, according to the 1987 Nepal DHS In-depth Survey, are that *spacers* (those women who want to space their births) and *limiters* (those women who want to limit their births) have a lack of awareness that births can be delayed or spaced using contraception. Of those who knew of oral contraceptive pills, laparoscopy or vasectomy, both *spacers* and *limiters* reported that they did not adopt contraception for reasons of health side-effects, such as headache, weakness and nausea, heavy bleeding, and the effects upon breastfeeding.

The in-depth survey shows that the majority of the unmet need population has not had any contact with service providers or field workers. The immediate programme need is to improve the access to services by mobilizing field workers and effectively using mass media to disseminate information regarding where and how contraceptive services are available.

In the Nepalese family planning programme, there are a large majority of acceptors who discontinued using contraception because of either unforeseen side-effects or lack of resupply. The failure to deal with side-effects and complications was probably a major barrier to increased acceptance. The programme's attention should go to making contraception easily accessible. At the same time, the programme should improve its services by providing counselling, follow-up and courteous service.

Role of Non-governmental Organizations (NGOs)

The NGOs in Nepal have played important roles in supporting family planning programmes. Long before the government started the national family planning programme, the Family Planning Association of Nepal (FPAN) began its family planning information and services. FPAN has been working closely with the government in complementing specialized medical and clinical family planning services and VSC mobile camps. Social marketing of non-clinical contraceptives through the Nepal Contraceptive Retail Sales Company has been making some progress in the last few years. There are a number of NGOs which are performing quite satisfactorily with the concepts of community participation, self-reliance and the integration of family planning with other development programmes.

One of the drawbacks of NGOs in Nepal is a lack of potential for programme expansion. Many NGOs have been running family planning and population education programmes as pilot projects for several years. As pointed out earlier, there is a large unmet need population in various pockets of Nepal where the government cannot provide adequate information and services for various reasons. It is time now that the NGOs' experience and valuable human resources be used to strengthen the effort to reach the unmet population.

Policy and Programme Implications and Priorities

Based on the above discussions and my more than 20 years of experience in the programme, the following policy and programme implications are suggested. These are only a few suggestions which are, in my opinion, crucial for policy consideration to the effective population programme:

- (1) There is an urgent need to develop a management information system for monitoring and evaluation of the programme. At the same time, serious consideration should be given to undertake regular ad hoc surveys on fertility, contraceptive and health behaviour. While conducting such surveys, careful consideration should be given to survey goals and implementation mechanisms to have better quality data.
- (2) The family planning programme should give due attention to conducting operations research to find better ways of implementing effective service delivery.
- (3) The existing minimum age at marriage should be raised and the government should make some changes in administrative procedure to safeguard the law.
- (4) Efforts should be made to sustain the practice of breastfeeding. This would prevent a possible decline in current prevalence levels and length of breastfeeding. Because breastfeeding is not reliable for preventing pregnancy for individual women, the use of supplemental temporary family planning method should also be encouraged.
- (5) Although induced abortion is not prevalent, the legal restriction should be relaxed to prevent unsafe abortion.
- (6) There is an urgent need for a highly powerful national body which has legal status, to oversee policy formulation, coordination of population and development activities and implementation of the national family planning programme.
- (7) The family planning programme needs to be understood within the economic, social, and political context of Nepal. Services of the family planning programme have to be integrated with other development programmes at national, regional, district and village levels. Government authorities of other development programmes, zonal and district administrative authorities, politicians and social workers should be made accountable to the family planning programme.
- (8) The concept of family planning as sterilization in Nepal must be changed through the introduction of a new concept, such as family health, responsible parenthood, reproductive health.
- (9) Efforts should be made to provide family planning services to those areas where the unmet need population is high by increasing service outlets and improving supplies of various contraceptive methods, service quality and follow-up services.

- (10) Spacing methods, such as oral contraceptive pills, condoms, and other non-clinical methods should be promoted to avoid high-risk pregnancies among younger women. There should also be proper emphasis on the benefit of child spacing by promoting intrauterine devices, injectable and implants.
- (11) NGOs should be invited to participate in the national family planning programme and become equal partners in delivering family planning services and information in areas where the government cannot reach. Particularly, NGOs should be involved in creating demand for family planning and generate social pressure to make people more receptive to the idea of family planning.

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