CHAPTER XIV
POPULATION POLICY AND FAMILY PLANNING

INTRODUCTION

Nepal is one of the poorest countries in the world. The per capita income for the Fiscal Year 1984/85 is estimated to be approximately Rs.2,500 at the current price.

There is a widespread problem of poor health of the population of Nepal, one of the underlying problems being malnutrition. More than 90 per cent of the rural population drink polluted water and infectious diseases are widespread. And whatever health services are available, these are mostly hospital based and serve mainly the urban population.

The growing problem in economic and health conditions is exacerbated by the rapidly growing population. This linkage between population growth and economic and health conditions was clearly perceived by the government of Nepal.

In 1965, the late King Mahendra of Nepal declared: "In order to bring equilibrium between the population growth and economic output of the country, my government has adopted a policy of family planning". On Human Rights Day, December 10, 1966, the King of Nepal signed the United Nations Declaration on Population[1].

Population Policy

Development Planning in Nepal was started as early as the mid- 1950s. The First Development Plan was prepared for the period 1956-1961, and the second plan for the period 1963-65. In both plans, there was no specific population policy other than a resettlement policy to absorb the increasing population in the Hills. Attention was given to the problem of population growth only after the preparation of the Third Plan (1965-70), in which a chapter was devoted to "Population and Manpower", where population growth and its various consequences were clearly discussed (HMG of Nepal, 1965)[2]. In addition, the impact of health and family planning programmes on population growth was stressed in the plan, and provision was made for the delivery of family planning services.

The Fourth Development Plan (1970-75) was even more clear in its objectives in relation to population policy. For the period 1970-75, six areas were given high priority, the fifth of which concerned the effective use of manpower resources and population control. It stated:

> While setting the goals of economic development, it has become necessary to consider the effective utilization of available manpower and the control of population growth within desirable limits. Although the rate of growth of population in Nepal appears to be low in comparison with the growth rate in many countries, it is not a desirable rate in relation to available resources, especially cultivable land. The family

[1] Population Council, 1967. "Declaration of Population", *Studies in Family Planning,* No. 16.

[2] His Majesty's Government of Nepal, 1965. *Third* Plan (1965-70).National Planning Commission, Singh Darbar, Kathmandu, Nepal.

planning programme will help improve the situation and thereby uplift the standard of living of the people (HMG of Nepal, 1970)[3].

The chapter on "Manpower and Population" stressed two requirements for bringing about a substantial change in the birth rate. The first, was to bring changes in the economic and social conditions, cultural patterns and aspirations of the common man. The second point was to create an institution to implement a family planning programme (HMG of Nepal, 1970)[4].

The fifth Development Plan (1975-80) devoted an entire chapter to population policy. The plan stated that:

> Optimum utilization of manpower, consistent with the aims of broader economic growth and faster 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 resource endowments of the country (HMG of Nepal, 1975; Lohani, 1976)[5].[6]

In order to realize these objectives, the Government of Nepal adopted the following policies for the fifth Plan (1975-80) (HMG of Nepal, 1976)[7].

1. Achieve perceptible reduction in crude birth rate through such indirect but broad and basic determinants as social, economic, cultural,and educational development and reforms, as well as through direct antinatalist and preventive programmes of family planning and, maternity and child health care:
2. control the flow of immigration into the country to reduce this flow to insignificance.,
3. organize the internal migration from the Hills to the Terai, and also from rural to urban areas, in a systematic way and on the basis of a set programme;
4. in order to achieve an optimum spatial distribution of population, it is highly desirable that population growth in Nepal should have direct correspondence with the differing resource endowments of different geographic zones. Especially, more attention should be focused on the necessity of increasing the density of population in the Western Terai and particularly in the Far-western Terai ;
5. from the regional development considerations, it is desirable to develop small urban centers in hitherto unurbanized regions. Necessary civic facilities should be provided in the centers selected for such planned urbanization.

The Sixth Development Plan (1980-85) discussed the impact of population growth on different sectors, particularly on agriculture, forestry, labour force, education, health and urbanization. The plan stated its two population objectives as: 1) the annual population growth rate of 2.3 per cent will be regulated

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[3] His Majesty's Government of Nepal, 1970. *Fourth Plan* (1975-80), National Planning Commission, Singh Darbar, Kathmandu, Nepal.

[4] *Ibid.*

[5] His Majesty's Government of Nepal, 1975. *Fifth Plan* (1975-80), National Planning Commission, Singh Darbar, Kathmandu, Nepal.

[6] Lohani, G.P., 1976. "Search For a Population Policy", in proceedings of *Conference on the Implementation of Population Policies,* Jointly sponsored by Population Policies Coordination Board, Nepal, Ministry of Health, Nepal and the University of California, Berkeley FP/MCH Project in Nepal, pp. 18-23.

[7] See for English version Lohani, G. P. *ibid.* pp. 18-23.

and pre-requisites to bring down the population growth will be created in the Sixth Plan, and (2) problems of population distribution and migration will be tackled. The plan adopted the following policies : i) to introduce a family planning programme with particular emphasis on permanent methods in rural areas where fertility was high , ii) to intensify economic activities in the Hill areas in an effort to regulate the movement of population, and iii) to popularize the family planning programme among the people at large by adequate provision for publicity and extension of services (HMG of Nepal, 1980)[8].

During the Seventh Plan (1985-90), population policies were basically based on the long-term goal to bring down the total fertility rate at 2.5 per woman in the year 2000 A. D. The population planning objectives 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"[9].

Five policies were adopted for the Seventh Plan. They were:

- expand family planning services and meet unfulfilled demand for such services,
- integrate population programmes with development programmes,
- emphasize women's development programmes,
- increase participation of Panchayats and the class organizations, and
- control flow of immigration.

To implement population policies of the government as envisaged in the perspective plans, various government / private Institutions /specialized agencies were set up. The origins and functions of some of these major institutions particularly those of government organizations are discussed here.

Evolution of Population Related Institutions

The Family Planning programme was introduced first in Nepal by a non-government voluntary organization-Nepa1 Family Planning Association, in 1958. Its services included only information and education and were confined within Kathmandu valley only. An official population related activities came into existence when His Majesty's Government of Nepal included a chapter on "Population and Manpower" in the Third Plan (1965-70). During early part of the third plan period, services of family planning were available in the Kathmandu Valley through a Maternal Child Health Unit of the Department of Health Services.

In order to achieve a goal of bringing a balance between population growth and food production, the Government of Nepal created a semi-autonomous board called Nepal Family Planning and Maternal Child Health Board chaired by the Health Minister in 1968. The Board is empowered to develop policy and programme, implement and co-ordinate family planning activities. Since it has a responsibility of providing family planning and maternal child health services throughout the country, the FP/MCH Project under guidance from the board and administratively under the Ministry of Health became national implementing agency.

During 1970s, the government envisaged a need of have a high powered body to coordinate population and family planning activities. This has resulted, especially, when policy makers and planners realized that

[8] His Majesty's Government of Nepal, 1980. *Sixth Plan* (1980-85), National Planning Commission, Singh Darbar, Kathmandu, Nepal.

[9] His Majesty's Government of Nepal, 1985. *Seventh Plan* (1985-90), National Planning Commission, Singh Darbar, Kathmandu, Nepal (in Nepali).

population problem could not be solved only by family planning. The Fifth Plan (1975-80) called for the development of a Population Policy Coordination Board (POPCOB) under the National Planning Commission (NPC) in 1975.

Population Policy Coordination Board (POPCOB) and National Commission On Population (NCP)

The POPCOB was responsible for coordinating the work of the various ministries with matters pertaining to population changes. The POPCOB was chaired by a member of the National Planning Commission (NPC) and its members were representatives from various ministries, such as Health, Land, Home Affairs, Panchayat, Education, Agriculture and representatives from the Tribhuvan University (TU), Women's Organization and the Family Planning and Maternal Child Health Project. The government dismantled the POPCOB as it had been unable to meet its objectives (UNFPA, 1979)[10]. This was, however, followed by formation of National Commission on Population (NCP) in 1978 under the chairmanship of the Prime Minister.

The NCP was reorganized in 1979. The Prime Minister, again, chaired the NCP. The Vice-chairman of the National Planning Commission was ex-officio the vice-chairman of the NCP. The secretariat of the NCP was kept under the secretariat of the National Planning Commission.

The National Commission on Population (NCP) emerged as an independent organization in April 1982 with the specific aim of strengthening the government's capacity to deal with population issues under the chairmanship of Prime Minister. The reconstituted commission has provided a full-time Vice-chairman, an independent secretariat and representation to commission from, various organizations.

To discharge the above responsibilities/ functions, the commission (NCP) has set up four major divisions: i) Programme Development and Coordination Division; ii) Research and Data Management Division; iii) Information, Education and Communication Division, and iv) Administration and Law Division. There are number of units under each of these divisions.

Nepal Family Planning and MCH Project (FP/MCH)

The Nepal Family Planning and Maternal Child Health (FP/MCH) Project which is under the semi-autonomous Nepal Family Planning and Maternal Child Health (FP/ MCH) Board has a national responsibility to make family planning services and information available to all eligible Nepalese.

The FP/MCH Board chaired by the Minister of Health sets guidelines for the implementation of the family planning and maternal child health programme in the country. The FP/MCH Project which is administratively under the Ministry of Health spent its initial period integrating FP and MCH activities using health institutions in the Kathmandu valley (Taylor *et a.l.,* 1972)[11]. The MCH component was added to the family planning programme for two main reasons: (1) with Nepal's high mortality, it was felt desirable to provide services for surviving children than toward preventing future births, and (2) MCH might develop rapport for

[10] United Nations Fund for Population Activities, 1979. Nepal: Report of Mission on Needs Assessment for Population Assistance, UNFPA Report, No. 21, New York.

[11] Taylor, D. and Thapa, R., (1972). NEPAL. A Country Profile series of the Population Council, New York.

promotion of family planning among MCH clients, win their trust, and provide an excellent opportunity for family planning motivation.

At present, the FP/MCH Project provides the family planning and maternal child health services in 52 of the 75 districts[12] in three different settings: stationary, mobile and door-to-door. The stationary one is generally attached to a health institution, such as health posts, health centres and hospitals. In addition to the staff of the health institution, the FP/ MCH assigns a minimum of two workers to work full time on family planning and maternal child health service delivery. If the FP/MCH centre is attached to a health post, there will be two family planning workers (generally one of each sex). If it is attached to a hospital, there will be as many as five or more workers including one auxiliary nurse-midwife or auxiliary health worker and one public health nurse. The FP/MCH centre attached to a health post distributes condoms and oral pills to those who come to the centre. At the same time, the centre provides maternal and child health services including education, nutrition and environmental health care. The centre attached to a hospital provides additional services, such as sterilization (male and female), IUD and Depo-provera depending upon the availability of trained medical doctors and equipment. All of the FP/MCH workers are required to give follow-up services at acceptors' homes and motivation to potential acceptors within a radius of three miles from the centre. By the end of July 1986, there were 256 FP/MCH centres of this kind.

Some of the FP/MCH centres, particularly district offices, operate satellite clinics in nearby areas. In the satellite clinic, distribution of oral pills and condom, education in family planning, and maternal child health services are offered.

A large part of the country is covered by mobile sterilization camps. The first quarter of a fiscal year (July-September) is generally a period when almost all of the district annual plans are made in consultation with the central office. Each district office makes a plan for a sterilization camp (vasectomy, laparoscopy and mini-laparotomy) working out the required budget and supplies, and submits it to the central office for approval. Usually, these activities are carried out at the annual district officer's seminar. Camps can be divided into two categories. A laparoscopy or mini-laparotomy camp is organized by providing staff from the central office where almost all the trained medical doctors are stationed in various hospitals and the FP/MCH central clinic. A vasectomy camp is organized and run by the district personnel. District staff or the central staff conduct motivation and education campaigns. Camp are generally held with the help of local village Panchayat members and volunteers from Women's Organization, Red Cross, Youth Club, etc. Generally, every sterilization camp is assisted by the district level steering committee which consists of local elites. This committee helps in getting people's participation and bringing potential acceptors to the camp site. But there are instances where the previously organized camps were cancelled because of lack of trained medical doctors who would be willing to go to remote villages

[12] In order to gain the people's participation in running the family planning programme, there is a district level Family Planning and Maternal Child Health Coordinating Committee in each district. The committee is expected to help in the following activities: (1) to draw a tentative programme in connection with the FP/MCH; (2) to mobilize the local resources to run the sterilization camps; and (3) to select village panchayats for a panchayat based centre.

(Nepal FP/MCH, No date).[13]

The third setting is the Panchayat based centre. The first step in the evolution of the Panchayat based centre was the development of the area system in 1972, after it was realized that most villagers were not willing to come to the FP /MCH centre to obtain family planning services (Young, 1975). Under an area system, a family planning worker spends one or two days per week in a FP/MCH centre and the remaining four to five days in the field area motivating, educating and distributing condoms and oral pills to couples at home.

The FP/MCH Project spent a number of years finding an appropriate way to provide family planning and maternal child health services. And it tested the following types of experimental programmes (Guhhaju, *et. al.,*1975)[14].

1. A village-based field worker approach where the duties of the worker will include in addition to family planning activities (i. e., motivation and distribution of contraceptives) provision of limited immunization and rehydration services in an effort to reduce infant mortality and thus encourage adoption of family planning;
2. altered staffing patterns where husband and wife teams and more elderly and mature women are recruited as family planning workers and their performances compared;
3. an intensive worker approach which will include the utilization of other government extension workers and volunteer women combined with varying levels of mass media and education input;
4. a commercial distribution of contraceptives approach where selected commercial channels mill be utilized to provide contraceptives and
5. approaches which will test selected models of FP/MCH service delivery particularly as they relate to the utilization of manpower in areas of poor communication and difficult terrain.

At the end of the fiscal year 1975/76, 190 Panchayat based workers were appointed in selected Panchayats. This number was increased to 2,500 workers by the end of July 1986*. A Panchayat based worker is expected to provide door-to- door service in the following areas:

1. to maintain award register which identifies potential acceptors in his/her village Panchayat and date and method of family planning acceptance;
2. to motivate and educate on family planning;
3. to provide information on various family planning methods;
4. to distribute condoms and oral pills;
5. to distribute RD-Sol (Oral Rehydration Solution) for the treatment of dehydration;
6. to distribute iron tablets to mothers:

[13] Nepal FP/MCH Project (no date), Annual Report 2038/39, His Majesty's Government of Nepal, Ministry of Health, Kathmandu (in Nepali).

[14] Gubhaju, B. B., Tuladha,, J., Pande, B. P., and Stoeckel J., (1975). "Experimental Family Planning Programmes in Nepal", in proceedings of *Workshop Conference on Population, Family Planning, and Development in Nepal,* jointly sponsored by His Majesty's Government of Nepal, Family Planning Maternal and Child Health Project, and University of California, Family Planning /Maternal and Child Health Project, Berkeley, (August 24-29): 177-193.

* This figure was obtained from an unpublished official source.

7. to educate on sanitary hygiene;
8. to refer sick children and mothers to a health post, health centre or hospital and
9. to disseminate information about sterilization camps.

The field level activities are monitored by four regional and forty district offices. Each regional office is headed by a senior medical officer who is assisted by a senior public health nurse, a statistical assistant and an IEC* assistant in addition to administrative staff. Sole responsibility to carry out the district family planning and maternal child health activities lies with the district office which is headed by a district officer. To supervise clinics and Panchayat based centres, there are a number of intermediate supervisors. Approximately, one intermediate supervisor controls four to seven Panchayat based workers.

Technical assistance needed by the regional offices and district offices is provided by the six divisions located at the central office.

Integrated Community Health Services Development Project (ICHSDP)

The Integrated Community Health Services Development Project (ICHSDP) is another agency which is responsible for providing the entire range of basic health services including family planning. The idea of integrated community health services was first introduced in the Firth Plan (1975-80), as a policy to provide minimum health services as quickly as possible. This project looks after 23 of the 75 districts. The ICHSDP also provides its services in the three settings as described earlier in the FP/MCH Project section. In 1969, a Community Health and Integration Division was established within the Department of Health Services to deliver community oriented health services. A year later, it was transferred under the Integration Board constituted in the Ministry of Health (ICHSDP, 1982)[15].

Under the Ministry of Health, there are number of vertical projects such as the FP/MCH Project, Expanded Immmunization Project, malaria, T.B. and Leprosy. All of these projects have their independent field programmes. One of the policies of the long term health plan approved by the government was to integrated all vertical projects into basic health services. Under this policy, ICHSDP is providing its basic health services. Theoretically, the process of integration is to hand over districts by vertical projects to ICHSDP and ICHSDP in turn, hands over gradually to the Regional Health Directorate. The later process has no yet begun so far.

There are two types of health posts under the integration programme. The first one is of the "Primary Integration" type. The integrated primary health post provides the following services under the integration programme:

1. family planning motivation with emphasis on permanent sterilization methods; issue of condoms and pills to married couples and arrangement of sterilization camps;
2. nutrition monitoring and nutrition education including rehydration education;
3. health education;
4. smallpox surveillance;
5. expanded immunization programme (Immunization including smallpox vaccination, BCG, DPT and TT);
6. recording of vital events;

* Information, Education and Communication.

[15] Integrated Community Health Services Development Project, (1982). "Annual Report", Ministry of Health, Kathmandu, ,Nepal.

7. case findings, treatment and isolation of TB patients;
8. case finding, treatment and case holding of leprosy patients;
9. referral services;
10. treatment of common illnesses and
11. training of local health volunteers.

The second one is the 'fully integrated' health post which provides additional services of antenatal, delivery and postnatal care, both domiciliary and at health posts and malaria surveillance, treatment of cases and control measures.

Each health post under the integrated programme serves four to six *veks*[*]. One village health worker (VHW) is assigned to serve one *vek*. According to the 1980-81 annual report of ICHSDP, one VHW makes two visits a year in each household in the Mountains and six visits a year in the Plains and Hills. Wherever the ICHSDP has a responsibility for malaria surveillance and containment, each household is visited monthly.

The Integrated Community Health Service Development Project (ICHSDP) has 48 district health offices which supervise all the integrated health posts. Out of 48 district health offices, six are fully integrated, 17 intermediate and 25 primary. The family planning and material child health activities are fully served under the Integrated Community Health Development Project. The FP/MCH Project has no responsibility in the `fully integrated' districts with regard to service delivery. However, the FP/MCH Project provides commodities, particularly oral pills and condoms and facilities for sterilization and other special campaigns.

The UNFPA needs assessment team identified several problems for ICHSDP, particularly in manpower development, training, supervision, logistics and construction of health posts[16]. Because of these problems, the establishment of health posts is far below the target. According to the target, 700 new integrated health posts were to be opened by the fiscal year 1975/76, but here were only 644 such health posts of all types as of 1980/81.

Family Planning Budgets

It should be mentioned that it is very difficult to estimate the actual allocated budget and expenditure in the family planning programme in Nepal. It is very hard to impute the total cost for the family planning programme run under the various integrated projects and non-government organizations.

Table 14.1 provides an approximation of the expenditure for family planning, health[**] and total government programmes. It is to be noted that the expenditure for family planning programme had never exceeded one per cent of the total expenditure except in the fiscal year 1976-77. As compared to Bangladesh, the family planning programme's share of the total government expenditure is very low. In Bangladesh, 3.1 per cent of the total government budget was allocated to family planning in 1981. The family planning programme's share in the total health budget is also considerably smaller in Nepal than, for

[*] *A vek* on average covers one and a half Panchayats.

[16] Kanskar, V. B. S., 1979. "Internal Migration and Population Distribution in Nepal", Nepal: Report of Mission on Needs Assessment for Population Assistance, UNFPA report No. 21, New York: 137-152.

[**] Health budget includes family planning portion but not the population programmes which are separated from the Ministry of Health. It is extremely difficult to isolate budget/expenditure occurred in population as it is included in other projects.

Table 14.1- Family planning, health and total government expenditure by fiscal years in Nepal

Fiscal Year	Expenditure in million Rs.			Family Planning as percent of	
	Family planning programme	Health Ministry	Total Government	Total expenditure	Health expenditure
1968/69	2.02				
1969/70	4.00		683.80	0.59	
1970/71	6.89		769.50	0.90	
1971/72	7.50		889.50	0.84	25.50 ##
1972/73	5.33	151.24 #	982.80	0.54	
1973/74	7.95		1226.30	0.65	
1974/75	10.90		1513.80	0.72	
1975/76	18.50	120.75	1913.40	0.97	15.32
1976/77	23.93	162.48	2371.60	1.01	14.73
1977/78	14.12	164.06	3087.40	0.46	8.61
1978/79	18.88	178.34	2886.3*	(0.65)	10.59
1979/80*	17.45	72.20	2308.60	0.76	24.17
1980/81*	24.31	97.80	2731.10	0.89	24.85
1981/82*	29.65	152.80	3726.90	0.80	19.40
1982/83*	36.15	216.30	4982.10	0.73	16.71
1983/84**	41.71	219.90	5059.90	0.82	18.97
1984/85**	54.71	332.80	6729.90	0.81	16.44

Notes: *Actual expenditures as shown in the Sixth Plan and the Seventh Plan.

**Based on allocated or revised estimated budgets.

Figure inside parentheses derived using actual expenditure in denominator and allocated budget in numerator.

Fiscal year starts approximately in the middle of July and ends in the middle of July of the next year.

For years 1969/70 to 1973/74

For years 1970/71 to 1974/75

Sources:* The Nepal Family Planning and Maternal Child Health Project, Annual Report 2038/039, His Majesty's Government of Nepal, Ministry of Health, Kathmandu

United Nations Fund for Population Activities, 'Report of Mission of Needs Assessment for Population Assistance, Report no. 21, New York.

His Majesty's Government of Nepal (1970). Fourth Plan (1970-75), National Planning Commission Kathmandu

His Majesty's Government of Nepal (1980). Sixth Plan (2037-2042), National Planning Commission Kathmandu

His Majesty's Government of Nepal (1985). Seventh Plan (2042-2047), National Planning Commission Kathmandu

instance in Bagladesh[17]. In the fiscal year 1980/81, over 60 per cent of the FP/MCH Project's expenditure was borne by foreign agencies[18].

[17] Nortman, D. and Andrew, J., 1982 "Population And Family Planning Programmes: A Compendium of Data through 1981", 11th edition, The Population Council, New York.

[18] Tuladhar, J. M., 1984. *op. cit.*

Targets and Achievements

The national target[19] is set at every five years and from there specified for each fiscal year. Every year the target is revised at the beginning of the fiscal year according to the achievement of the previous fiscal year. The national target is divided among districts by district officers themselves keeping the previous year's achievement in view. The target number of new family planning acceptors are presented in Table 14.2. As can be seen from this Table, the target for the fiscal year 1980/81 was 150,000 new acceptors, of whom 27 per cent (i. e. 40,000) were sterilization acceptors. Of the 160,000 new acceptors in the fiscal year 1981/82, 25 per cent (i. e. 40,000) were sterilizations. Approximately three fourths of the target were temporary methods. Total national target has increased more than double in the fiscal year 1982/83 as compared to the fiscal year 1981/82. About four-fifths of the target is confined to temporary methods.

The third column of Table 14.2 indicates the number of new acceptors[20] recruited each year and the fourth column gives the percent of target achieved. Except in 1968/69, 1975-77 and the per cent of target achieved has always been more than 100. The ratio of new family planning acceptors per 100 married women aged 15-44 has been increasing year after year reaching 83 in 1981/82, but the rate is still far below other countries, such as Thailand (140 in 1980) and Indonesia (131 in 1980). However, the rate is much higher than that of Bangladesh (63 in 1980) and India (52 in 1980)21. The problem of the Nepalese family planning programme has been the inability to provide a desired contraceptive mix. Since the beginning of the programme in Nepal, the proportion of permanent users never exceeded 18 per cent of the total new acceptors except in the fiscal year 1968/69 (Table 14.3). The programme was dominated by a large proportion of condom acceptors which reached as high as 68 per cent of the total new acceptors in 1979/80. Oral contraceptives contributed approximately one-third of the programme (with the exception of 1968/69) and decreased steadily to approximately one fourth in 1981/82. As is obvious from Table 14.3 the proportion of IUD acceptors has been decreasing every year. Its contribution to total new acceptors was one fifth of one per cent (0.2) in 1984/85. Depo-provera contributed only 2.7 per cent of total new acceptors in the same year. However, the proportion of Depo-provera users nearly doubled from 1.4

[19] Demographic targets were set up in the *fifth Five-Year Plan* (1975/76-1979/80), to reduce the crude birth rate from 40 to 38 per thousand population and the infant mortality rate from 200 to 150 per thousand live births. In the sixth *Five-Year Plan* (1980/81-1984/85), the target is to reduce the total fertility rate by 0.5, that is from 6.3 to 5.8. These targets were translated into acceptors by contraceptive mix. A new acceptor is defined as a person who accepted a particular method at first time.

[20] The Nepal Family Planning Programme makes no attempt to distinguish between 'programme acceptor' and 'method acceptor' because of the difficulty of obtaining accurate data. For definition of 'programme acceptor' and 'method acceptor', see, Chandrasekaran, C., (1975). 'Acceptor Data', Chapter 2 in *Measuring The Effect of Family Planning Programmes on Fertility,* (edited by) Chandrasekaran, C, and Hermalin, A. I. IUSSP, Ordina Editions, Liege, pp.17.-53

[21] Rates for Bangladesh, India and Thailand were computed from data given by Nortman D. and Andrew, J., (1982). "Population and Family Planning Programs: A compendium of data through 1981", 11th edition, The Population Council, New Your,. The Indonesian rate is quoted from John A. Ross and Sir Poedjastoeti, "Contraceptie Use and Program Development: New Information from Indonesia", *International Family Planning Perspectives,* Vol. 9, no. 3, pp, 68-87.

Table 14.2- Family planning acceptor's target and achievement and rate of new acceptance per 1000 married women aged 15-44 by fiscal year

Fiscal Year	Family planning new Target	Acceptors achievement	Percent of target achieved	Rate of acceptance* per 1000 married women aged 15-44
1968/69	19400	7774	40.1	n.a
1969/70	16000	29740	185.9	n.a
1970/71	18000	34433	191.3	n.a
1971/72	35000	43838	125.3	21
1972/73	60000	65095	108.5	30
1973/74	80000	86079	107.6	39
1974/75	86000	98312	114.3	44
1975/76	140000	138634	99.0	60
1976/77	140000	126532	90.4	54
1977/78	140000	174106	124.4	72
1978/79	140000	165774	118.4	66
1979/80	140000	196534	140.4	77
1980/81	150000	216010	144.0	82
1981/82	160000	223215	139.5	83
1982/83	327200	284572	87.0	n.a.
1983/84	345400	302684	87.6	n.a.
1984/85	373400	339949	91.0	n.a.

Note: n.a. means information not available

Source: Nepal Family Planning and Maternal Child Health Project.

*Rate of acceptance is calculated based on denominator produced by the CONVERSE output.

Table 14.3- Percentage distribution of new acceptors by method and fiscal year

Fiscal Year	Method						All	Number of acceptors
	Oral pills	Condom	IUD	Sterilization		Depo-provera		
				Female	Male			
1968/69	17.4	25.1	15.2	-	42.3	-	100.0	7,774
1969/70	34.5	48.7	3.7	-	13.1	-	100.0	29,740
1970/71	30.5	54.5	2.1	-	12.9	-	100.0	34,433
1971/72	36.2	52.2	2.7	-	8.9	-	100.0	43,838
1972/73	36.9	54.9	0.9	0.9	6.4	-	100.0	65,095
1973/74	31.4	60.3	0.3	0.9	7.1	0.0	100.0	86,079
1974/75	27.4	66.9	1.1	0.7	3.8	0.1	100.0	98,312
1975/76	27.1	63.4	1.2	1.6	6.6	0.1	100.0	138,634
1976/77	26.3	59.1	0.9	4.3	8.6	0.8	100.0	126,532
1977/78	25.5	61.5	0.5	4.5	7.0	1.0	100.0	174,106
1978/79	22.9	64.5	0.7	6.8	4.2	0.9	100.0	165,774
1979/80	22.5	68.2	0.5	5.7	2.2	0.9	100.0	196,534
1980/81	22.7	65.1	0.6	8.4	2.2	1.0	100.0	216,010
1981/82	21.9	62.5	0.5	9.0	4.7	1.4	100.0	223,215
1982/83	23.5	58.4	0.6	10.0	5.8	1.7	100.0	284,572
1983/84	21.0	54.4	0.3	13.7	8.7	1.9	100.0	302,684
1984/85	21.3	57.8	0.2	18.0		2.7	100.0	339,949

Source: Nepal Family Planning and Maternal Child Health Project.

in 1981/82 to 2.7 in 1984/85. Thus, service statistics show that the majority of new acceptors (four-fifths) in Nepal's programme adopt temporary methods (condoms and oral pills).

BIRTHS AVERTED

The purpose of this section is to ascertain what would have been the fertility level had there been no family planning programme in Nepal, and estimate the number of births averted by the programme. A number of techniques are available to do this. A computerized model (CONVERSE) which is described in the UN Manual IX (United Nations, 1979)[22] is well suited in the Nepalese context because the Nepalese family planning programme has continued for more than a decade.

The CONVERSE model produces a series of demographic and contraceptive use statistics that indicate the impact of the family planning programme and results are presented in Table 14.4, while these estimates were carried out, information on service statistics was available upto 1981, therefore, estimation of births averted was done upto that time only.

Table 14.4 shows the magnitude of the differences in selected demographic and contraceptive use variables if projection is based on the presence/absence of the family planning programme. The programme impact is shown for three different levels: low, medium and high. The medium level impact will be discussed here as it may provide the most reasonable estimate of effects on fertility.

The ten-year (1971-80) Nepalese family planning programme reduced the crude birth rate to 42.9 in 1981 compared to 45.4 without the family planning programme. The percentage decline of the crude birth rate due to the programme was 0.4 in 1972 and increased gradually in the subsequent years to 5.5 per cent in 1981 (Table 14.5). The largest proportion of the decline can be attributed to women aged 30-34 whose births averted contribute almost one-third of the total births averted by the programme in 1981 (Table 14.6). Total female population after 10 years was 1.2 per cent less than it would have been if there were no programme. The total fertility rate in 1981 was reduced by about eight percent to

[22] United Nations, *1979. Manual IX: The Methodology of Measuring the Impact of Family Planning Programme on Fertility,* ST/ESA/Series A/66, New York.

Table 14.4- Demographic impact of ten-year (1971-80) Nepal family planning programme: Summary results

Item	Natural fertility	Family planning programme impact		
		Low	Medium	High
Year 11 (1981)				
Crude birth rate	45.4	43.4	42.9	42.4
Crude death rate	16.4	16.2	16.1	16.1
Crude natural increase	29.0	27.1	26.8	26.3
Population in year 11 (1981)				
Number (thousand of females)	7510.1	7435.7	7422.5	7402.7
Percentage reduced by programme	-	1.0	1.2	1.4
Total Fertility rate in year 11 (1981)	6.2	5.8	5.7	5.6
Age structure in year (1981)				
0-4	17.8	17.2	17.1	17.0
0-14	44.3	43.7	43.7	43.5
15-44	42.4	42.8	42.9	43.0
45+	13.3	13.5	13.4	13.5

Table 14.4 continued.....

Item	Natural fertility	Family planning programme impact		
		Low	Medium	High
Female children under 5 years				
per 1000 women aged 15-44;				
year 11 (1981)	420	402	399	394
Acceptors as % of eligible in				
year 10 (1980)				
15-44	2.1	8.6	8.7	8.8
15-19	0.4	1.7	1.7	1.7
20-24	1.8	7.0	7.1	7.1
25-29	2.6	10.5	10.6	10.7
30-34	3.7	15.7	15.9	16.2
35-39	2.8	11.8	12.0	12.2
40-44	1.7	6.6	6.6	6.7
Contraceptive use during year 10 (1980)				
as % of married women of reproductive age				
15-44	0	4.6	5.2	6.1
15-19	0	0.3	0.4	0.6
20-24	0	1.6	2.0	2.7
25-29	0	4.3	5.1	6.1
30-34	0	8.4	9.4	11.0
35-39	0	9.5	10.4	11.9
40-44	0	7.0	7.6	8.6
Percentage of reduction in marital				
age specific fertility rates				
year 11 (1981) and year 1 (1971)				
15-44	0	6.5	7.5	8.6
15-19	0	0.4	0.4	0.8
20-24	0	1.9	2.6	3.5
25-29	0	5.2	6.2	7.8
30-34	0	10.1	11.8	13.9
35-39	0	14.4	16.0	18.6
40-44	0	15.7	16.9	20.2

Notes: Low-uses proportion of condom acceptors not immediately discontinuing use as 0.200

Medium-uses proportion of condom acceptors not immediately discontinuing use as 0.400

High-uses proportion of condom acceptors not immediately discontinuing use as 0.700

Source: Tuladhar, J.M., 1984. The Persistence of High Fertility in Nepal, Ph. D. Thesis submitted at Australian National University.

5.7 With regard to martial fertility rate, the programme was able to reduce the total fertility rate by 7.5 per cent. The percentage decline was highest among oder women (30 years or older). In 1981 the highest fertility group aged 25-29 experienced a martital fertility rate 6.2 per cent lower than it would have been without the programme. In achieving ghese results, couple-years of use grew from a negligible level at the beginning of the programme to 5.2 per cent of the married women of reproductive ages in year 10 (1980).

Table 14.5- Percentage of decline in crude birth rate due to Nepal family planning programme by programme year

Programme year	Crude birth rate without programme	Family planning programme impact								
		Low			Medium			High		
		Births averted	Resulting crude birth rate	% of crude birth rate decline due to programme	Births averted	Resulting crude birth rate	% of crude birth rate decline due to programme	Births averted	Resulting crude birth rate	% of crude birth rate decline due to programme
1972	46.2	2522	46.0	0.4	2999	46.0	0.4	3714	45.9	0.7
1973	46.0	6395	45.5	1.1	7561	45.4	1.3	9309	45.3	1.5
1974	45.9	10060	45.2	1.5	11959	45.0	2.0	14808	44.8	2.4
1975	45.9	12764	45.0	2.0	15403	44.8	2.4	19363	44.5	3.1
1976	46.0	16846	44.8	2.6	20377	44.5	3.3	25673	44.2	3.9
1977	45.8	21036	44.5	2.8	24866	44.2	3.5	30611	43.8	4.4
1978	45.6	26592	43.9	3.7	31074	43.7	4.2	37798	43.2	5.3
1979	45.5	30973	43.6	4.2	36037	43.3	4.8	43634	42.9	5.7
1980	45.4	34445	43.5	4.2	40298	43.1	5.1	49077	42.6	6.2
1981	45.4	38838	43.3	4.6	45412	42.9	5.5	55273	42.4	6.6

Notes: Same as in Table 14.4

Source: Same as in Table 14.4

Table 14.6-Birth averted in each programme year, 1972-81, Nepal: Medium impact

Age group	Programme year									
	1972	1973	1974	1975	1976	1977	1978	1979	1981	1982
15-19	73	169	245	300	382	414	488	529	582	644
20-24	504	1168	1713	2108	2715	3022	3603	3941	4312	4766
25-29	808	2007	3129	3945	5165	6224	7657	8672	9412	10414
30-34	923	2321	3704	4796	6422	7966	10058	11713	13141	14833
35-39	506	1376	2294	3081	4140	5245	6692	8029	9221	10572
40-44	185	520	873	1174	1553	1994	2577	3154	3630	4183
Total	2999	7561	11959	15403	20377	24866	31074	36037	40298	45412

Source: Same as in Table 14.4.