CHAPTER XIV

POPULATION POLICY AND FAMILY PLANNING PROGRAMME IN NEPAL

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1. Population Policy in Various Plans

The first National Development Plan was launched for the period *1956-61* with the objective *of* increasing gross domestic product (GDP), provide employment and improve living standards *of* the people. The population related policies were to provide employment and to reclaim forests in the Terai region for resettlement.

The Second Plan *(1963-65)* gave priority for agricultural and industrial growth. Population policies were not formulated but there was a resettlement policy.

The first population policy was made during the Nation's Third Five Year Plan Period *(1965-70).* There was a chapter on "Population and Man Power". The chapter on health discussed the importance of family planning in reducing the Crude Birth Rate (CBR). However, it took two years to organize and formulate family planning policies and action programmes for the Third Plan. The family planning contraceptive services were actually available to married couples in *1966*[1].

A phased three year plan was made for the period *1967-70.* The objective was to reduce the CBR from an estimated *39.1* in *1967* to *38.1* per thousand per year by July *1971.* It was estimated that this reduction would require inserting *52,812 loops,* performing *8,125* vasectomies, distributing *1,949,760* condoms and *22,968* cycles of pills within three years. "The family planning service was greatly expanded through family planning and maternal child health (FP/MCH) clinics after the establishment of "Family Planning and Maternal Child Health Board) in *1968.*

The Fourth Plan *(1970-75)* described two ways to reduce the birth rate (i) by bringing changes in economic and social conditions as well as cultural practices of the common people, and (ii) the family planning programme.

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[1] Historically, the Family Planning Association of Nepal was established in *1959* and began to motivate and create awareness among people about the importance of family planning.

The target was to offer family planning services to 15 per cent of the married couples by the end of the plan period which amounted to offering family planning services to 312,000 married couples.

Based on the national target, regional and district targets were set. District level targets were set by considering the achievement of all family planning clinics in the district for the most recent two consecutive years, the number of clinics and the staff that would be available during the target period.

The population policies adopted during the Fifth Plan (1975-80) were as follows:

(i) Reduction in the Crude Birth Rate through basic developments and reforms in social, economic, cultural and educational aspects as well as through family planning and maternal child health programmes.

(ii) Regulation of external migration.

(iii) Regulation of internal migration from Hill to Terai (plain region) in a systematic way.

(iv) Achievement of the optimum distribution of population (more attention to be focused on the necessity of increasing the density of population in the Western Terai and particularly in the Far-Western Terai).

(v) Provision of basic facilities e.g.., school, hospitals etc.., to be established in the selected centres for urbanization.

The demographic target was set to reduce CBR from 40 to 38 per thousand during the plan-period. The family planning target was set to maintain a level of 60,000 effective family planning acceptors[2]. It was further estimated that family planning services would have to be provided to 2,000 laproscopy acceptors, 10,000 vasectomy acceptors, 10,000 IUD acceptors and 100,000 - 120,000 pill acceptors per year.

As can be seen, attempts were made to reduce the birth rate by direct and indirect means. During this period, family planning services were greatly expanded through the outreach workers. Temporary citizenship certificates were given to Nepalese citizens.

[2] Effective acceptors were those acceptors who continue the contraceptive method for the 12 months period.

The Sixth Plan (1980-85) included a chapter on population by dealing with both policy and programmatic issues. The demographic target was set to reduce TFR from 6.3 to 5.8 children per woman and to maintain the rate of growth of population at 2.3 per cent per year. Moreover, population distribution including migration was planned to be managed. The attainment of the decline in TFR was envisaged through provision of family planning services and improvements in socio-economic conditions. The family planning target was put to recruit 900,000 new acceptors.

However, the short term, medium term and long term goals of the national population policy were formulated in 1982. The overall policy strategy to attain the goal was stated as follows:

(i) High priority will be given to fulfill the existing unmet demand for family planning services.

(ii) In view of the two way relationship between population and development, population components will be integrated into the socio-economic development programmes, specially those related to agriculture, forestry, environment and rural development.

(iii) Improving the social status of women, in the family and the society through female education and employment outside agriculture which will help generate favorable impact an fertility level. Economic development of women will be given emphasis.

(iv) Considering the role of local communities in enhancing the acceptability of family planning at the local level, efforts would be directed towards mobilizing local people, the then panchayats, class organizations and governmental organizations in population related activities.

(v) Control of immigration.

Programmes were formulated to reduce the fertility level in the short run by placing emphasis on the family planning programme, and in the long run by placing emphasis on other programmes that would lead to change the attitude of the people in favor of a small family norm. Such programmes included raising the status of women by increasing their educational state and offering employment, decreasing infant mortality rate and interrelating population programmes with development plans.

With regard to mortality, the government gave priority to reduce the level by expanding services on immunizations, nutrition and maternal child health care programmes. The services were provided through health worker, maternal and child health centres, health posts and hospitals. Health checkups, distribution of vitamin and iron tablets were provided to mothers and children.

Regarding migration, the government adopted the policy to have proper regional balance. Priority was given to know the magnitude and causes of movements of migrants. Plans were formulated to provide job opportunities in hilly region to reduce migration movement from hilly region to the plain region. To regularise immigration, attention was focussed in issuing citizenship certificates and strengthening civil and vital registration system.

Plans were made to increase urbanization in a more systematic way and develop urban areas along with rural areas. Feasibility studies were planned to be undertaken to establish old age rehabilitation centres. Programmes were formulated for implementation based on above policy directives during the Seventh Plan (1985-90). The following specific targets were made for the Seventh Plan and up to the year 2000.

(i) Decrease TFR from 6.1 in 1985 to 4.0 children per woman in 1990 and then to 2.5 by the year 2000.
(ii) Decrease IMR from 1 11.5 in 1985 to 98 infant deaths per 1000 live births by 1990 and to 45 by the year 2000.
(iii) Increase expectation of life from 51.5 in 1985 to 54.4 years in 1990 and then to 65 years by the year 2000.
(iv) Limit the population size to 20.8 million by the year 2000.
(v) Decrease the rate of population growth to 1.2 per cent per year by the year 2000.

However, the basic human needs such as food, clothing, health, education, housing, drinking water and fuel would be provided to a population of 23.2 million by the year 2000 with the rate of population growth below 2 per cent per year by that time.

In fact, the policy strategy and programmes were borrowed from the national population strategy formulated by the then National Commission on Population in 1982.
The Eighth Plan (1992-97) emphasizes reduction in population growth, protection and conservation of environmental resources and acceleration of economic growth. The policy of the government is to facilitate and promote non government organizations and private sectors. The specific population targets up to the end of the plan period 1997 and up to the year 2000 have been set as follows:

(i) Reduce Total Fertility Rate from 5.8 to 4.5 children per woman by 1997 and then to 4.0 by the year 2000.

(ii) Raise the contraceptive Prevalence Rate (CPR) from 23 to 31.7 per cent of married women of reproductive age and then to 37.7 per cent by the year 2000.

(iii) Raise average life expectancy from 54.4 to 61 years and then to 65 years by the year 2000.

(iv) Bring down the current IMR from 102 to 80 infant deaths per 1000 live births and then to 50 per 1000 live births by 2000.

(v) Bring down the current mortality of children below five years of age from 165 to 130 per 1000 live births and then to 70 by the year 2000.

(vi) Reduce Maternal Mortality from 850 to 750 maternal deaths per 1000 live births and then to 400 by the year 2000.

(vii) Manage internal migration.

Population Programmes have been formulated to focus on the following areas:

(i) Availability of family planning contraceptive services.

(ii) Demand generation for family planning services

(iii) Population management.

(iv) Institutional arrangement.

(i) Availability of family planning contraceptive services: Contraceptive services are going to be provided as a part of the primary health care programmes through health institutions. Services will also be provided through mobile clinics, village health workers and women volunteers. Health institutions and NGO's involvement will be expanded along with the mobilization of local communities and local leaders.

(ii) Demand generation for family planning services: Programmes in this area include the following:

(a) Development of programmes to increase women's status.

(b) Integration of population and family planning education in development activities such as rural development, agricultural production activities, forest development and promotion of industrial development.

(c) Expansion of formal and non-normal education including Population Education at the school and at the university level.

(d) Development of Information, Education and Communication (IEC) activities by formulating national IEC strategy.

(e) Establishment of population information centers to facilitate systematic collection, analysis and dissemination of population related information at national and international levels, and

(f) Implementation of population programmes in those areas where environment is affected by population pressure.

(iii) Population Management: Strategies have been developed with a view to have balanced population distribution along with balanced urban and rural development. These will be achieved by developing and generating employment in hilly areas and developing small towns along East-West and North-South Nigh Ways. Programmes will be formulated to redistribute population in sparsely populated areas. More research on international migration is going to be conducted.

(iv) Institutional Arrangement: Institutional frame work and mechanisms will be developed at national, regional and sub-regional level for formulating appropriate policies and programmes and their follow-up and monitoring.

2. Institutional Arrangements for Programme Implementation in Various Plans

The Family Planning Association of Nepal was established in 1959 and on a limited scale, it undertook to create awareness among people regarding the need and importance of family planning, although this activity was not accompanied by actually offering family planning services. The family planning project was established in 1965 and was put in the maternal and child health section of the department of health. Efforts were made to offer family planning services and information through the existing maternal and child health clinics. Family planning services actually started to be offered in 1966. Services of IUD's, pills and condoms were made available; although the emphasis was on IUD's. Vasectomies were performed as a regular part of the general health services.

In the following year, there was an even greater expansion of the programme. The Maternal Child Health and Family Planning Section expanded its man power, paramedical training activities, and the provision of services inside and outside Katmandu valley.

USAID provided financial help for the family planning programme since 1967/68 and started Supplying contraceptive pills and condoms since 1968/69. Prior to USAID, the Swedish government helped the programme by supplying condoms in 1966/67.

His Majesty's Government decided in 1968 to run the national family planning and maternal child health programme in a more extensive and integrated way under the semi-autonomous Board named as "Family Planning and Maternal Child health Board". The chairman of the Board was then the Honorable Minister for Health with the secretaries from Ministry of Health, Ministry of Education and Ministry of Finance as members. Later, one of the members of the National Planning Commission was also included as a member of the Board. At the same time, Nepal Family Planning Association (FPAN) also increased its activities. It became a full-fledged member of IPPF in 1969.

During the Fourth Plan period (1970-75) the chairman of the FP/MCH Board was the Director General of Health Department with representatives from Ministry of Health, Ministry of' Education and Ministry of Finance as members. During the Fifth Plan (1975-80), a great step was taken to strengthen the institutional system.

A Population Co-ordination Board was established in 1975 for the formulation and co-ordination of population Policies and programmes. The Board was replaced in 1978 by the National Commission on Population under the chairmanship of the Right Honorable Prime minister. At the same time, the Minister for Health became the chairman of the FP/MCH Board. The chief of the FP/MCH Project became the member Cum secretary of the National Commission on population as well as of the FP/MCH Board.

During the Fifth Five Year Plan, family planning services were greatly expanded through FP/MCH Project, Integrated Community Health Service Development Project (ICHSDP) in tile Department of Health, FPAN and the commercial Contraceptive Retail Service Project, Temporary Citizenship Certificates were given to Nepalese citizens and the Registrar's office was set up to record vital events regularly.

Just before the beginning of the Sixth Plan (1980-85), the National Commission on Population Secretariat was made a Division of the National Planning Commission's Secretariat. The Vice-

chairman and the member cum secretary of the National Planning Commission became the Vice chairman and the member cum secretary of the National Commission on Population respectively. This was done to enhance the integration of population programmes with development activities. However, the National Commission on Population was reorganized in 1982 under the chairmanship of the Right Honorable Prime Minister with a full time Vice-chairman and a secretary to look after the day to day affairs of the commission.

According to the suggestions made by the National Commission on Population, HMG decided to offer wage commendation to sterilization acceptors to promote sterilization. The CRS project was made CRS Company in order to increase the marketing of temporary family planning methods. However, demographic factors were not given due importance in planning process.

The National Commission on Population was officially dissolved and the Secretariat of the commission was made the Population Division of the National Planning Commission Secretariat in 1990. At the top, the National Population Committee was formed in 1991 under the chairmanship of the Prime Minister. Its other members were Ministers or state Ministers for Health, Finance, Communications and Local Development, Chairman of the Population and Social Committee in Parliament Secretariat, the Vice-chairman of the National Planning Commission, with the Chief of the Population Division, National Planning Commission as Member-cum-Secretary.

The committee's mandate is to issue policy directives and to co-ordinate, monitor, and review all population programmes. The committee will give programme directives to consolidate its activities. There are five sectoral coordination committees also to coordinate, monitor and evaluate activities in respective sectors.

3. Demographic and Family Planning Targets and Achievements in Various Plans

The demographic targets and achievements in various plans are summarized in Tables 1 and 2 respectively which is followed by critical analyses of the same.

Table 1: Demographic and Family Planning Targets in Various Plans

Description / Unit	Plan Year	3rd (1965-70) 1967-70	4th 1970-75	5th 1975-80	6th 1980-85	7th 1985-90	8th 1992-97
1. Reduce CBR from (per 1000 per year)		39.1 to 38.1		40 to 38	42 to 40	41.6 to 27.2	37.5 to 30 8
2. Reduce TFR from (children per woman during 15-49 Yrs).					6.3 to 5.8	6.1 to 4.0	5.8 to 4.5
3. Population Growth Rate (percent per year)					2.3 to 2.3	2.5 to 2.0	
4. Reduce CDR from (per 1000 per year)					19 to 17	16.6 to 12.8	13.8 to 11.3
5. Increase Expectation of Life (years)						51.5 to 54.4	54.4 to 61
i. Total						52.9 to 55.4	
ii. Male						50.1 to 52.6	
iii. Female							
6. Reduce IMR from (per 1000 live births)						111.5 to 98.3	102 to 80
7. Reduce MMR from (per 1000 live births)							8.5 to 7.5
8. Reduce child Mortality (per 1000 live births) Rate from							165 to 130
9. IUD acceptors (New)		52.812	Offer contraceptive services to 15 percent of married couples	10,000		77,000	60,000
10. Sterilization i. Total		8,125		12.000		5,80,000	3,60,250
ii. Male		8,125		10,000			1,69,600
iii. Female		19,498		2,000			1,90,650
11. Condom acceptors (New)		(estimated)				13,66,000	2,54,600
12. Pill acceptors (New)		22.968		1,10,000		6,68,000	2 41 300
13. Depo-Provera acceptors (New)				(estimated)		2,34,000	3,17,950
14. Norplant acceptors (New)							59,950
15. Total New acceptors		103,403	3,12,000		9,00,000	29,25,000	12,94,050
16. Contraceptive Prevalence Rate (Percent of married women of reproductive age)							23 to 31.7

Table 2: Demographic and Family Planning Achievements in Various Plans

Description / Plan Year / Unit	3rd (1965-70) 1967-70	4th 1970-75	5th 1975-80	6th 1980-85	7th 1985-90	8th 1992-97
1. CBR (at the end of the plan)	43.0	43.6	42.2	41.6	37.5	
2. FR (at the end of the plan)	6.3	6.3	6.3	6.1	5.7	
3. Population Growth Rate (,, ,,)	1.99		2.37	2.50	2.37	
4. CDR (at the end of the plan)	23.1		18.5	16.6	13.8	
5. Life Expectancy (,, ,,)						
i. Total	41.1		49.5		54.4	
ii. Male	41.7		50.9		55.9	
iii. Female	40.5		48.1		53.4	
6. IMR (at the end of the plan)	172.6		123.0-	111.5	102.0	
7. MMR (at the end of the plan)					8.5	
8. Child Mortality Rate (at the end of the plan)					165	
9. IUD acceptors (new)	6,712	4,272	5,914	5.965	11,891	
10. Sterilization i. Total	8,232	23,400	81,425	2,31,262	2,21,169	
ii. Male	8,232	21,370	43,580	84,340	77,022	
iii. Female		2,030	37,845	146,922	1,44,147	
11. Condom acceptors (New)	17,713	1,95,295	5,10,750	8,07,780	9,43,384	
12. Pill acceptors (New)	11,831	1,04,504	1,97,402	3,00,373	3,82,532	
13. Depo-Provera acceptors (New)		106	6,089	25,021	1,11,054	
14. Norplant acceptors (New)					3,727	
15. Total New acceptors	44,488	3,27,577	8,01,580	13,70,401	16,73,7577	
16. Contraceptive Prevalence Rate(at the end of the plan)		2.3	6.8	13.8	22.7	

4. Analysis of Targets and Achievements

4.1 Third Plan Period (1965-70)

As can be seen from above, the demographic target was set for the last three years of the plan period and emphasis was placed to reduce the birth rate based on family planning services.

So far as family planning services were concerned, achievements were far lower than the targets especially for IUD acceptors. Sterilization and condom acceptors were close to the targets whereas pill acceptors were only 50 per cent of the target. Average pill cycles distributed per woman was 3.9 and the corresponding figure for the condom acceptor was 29 per year.

Achievements in demographic parameters were estimated from 1971 census. In fact, the estimate of the birth rate during the plan period (1965-70) was lower than the estimate for 1971.

4.2 Fourth Plan Period (1970-75)

The lower achievement in contraceptive services during the Third Plan Period prompted formulation of the target in terms of offering family planning services to 15 per cent of the married couples during the Fourth Plan Period. This amounted to offering contraceptive services to 312,000 married couples. In fact, family planning services were offered to 327,577 couples. Significant improvements were made in offering sterilization services. 6.5 pill cycles were distributed per pill acceptor and 20.3 units of condoms were distributed to every condom acceptor. Hence, targets for provision of contraceptive services were achieved with a marked improvement in the continuation rate of pill acceptors but without improvement in the continuation rate of condom acceptors as compared to the corresponding rates during the third five year plan period. The Contraceptive Prevalence Rate (CPR) rose to 2.3 per cent of married women of reproductive age in 1976.

4.3 Fifth Plan Period (1975-80)

The estimated of fertility as measured by CBR was 40 in 1975 while, in fact, it was estimated that the corresponding figure was 42.2 per thousand live births in 1981. The corresponding estimated figure was 43.6 in 1971. Hence, it can be seen that the estimate of CBR before the beginning of the Fifth Five Year Plan was lower than the actual level. Hence, the estimate of contraceptive acceptors

required to decrease tile CBR from 40 to 38 per thousand live births during the Fifth Plan Period does not reflect the actual level of services required. However, contraceptive services increased substantially during the Fifth Plan compared to those during the Fourth Plan. Pill, Condom and IUD acceptors increased by 89, 162 and 38 per cent respectively. Sterilization acceptors increased by 248 per cent, Depo-Provera injection became a programme-method rather than being an experimental method.

The continuation rate of pill and condom acceptors seemed to improve from what it was in the Fourth Plan as indicated by increased distribution per acceptor. In fact, the CPR rose from 2.3 in 1976 to 6.8 per cent in 1981. The percentage knowing at least one contraceptive method rose from 22 per cent in 1976 to 52 per cent in 1981. However, the fertility remained stagnant during the plan period.

4.4 Sixth Plan Period (1980-85)

Family Planning Services were offered to 1.4 million as against a target of 900,000 acceptors i.e.., 52 per cent more than the target during this plan period. Pill and condom acceptors increased by 52 per cent and 58 per cent respectively during this plan over those in the Fifth Plan.

Sterilization acceptors increased by 184 per cent with a remarkable achievement in female sterilizations. Female sterilizations exceeded male sterilizations vastly during this plan. IUD acceptors remained at about the same number while Depo-Provera acceptors increased about four fold over the previous plan period. The contraceptive prevalence rate increased to 13.8 per cent of married women of reproductive age whereas knowledge about at least one modem method of contraception reached about 56 per cent in 1986.

The remarkable achievement during this period was that fertility, as measured by FR, began to decline. The target was to reduce the TFR from 6.3 to 5.8 children per woman during the plan period. However, FR seemed to have declined from 6.3 to 6.1 children per woman.

In the beginning of the Sixth Plan, no other programmes were worked out to decrease the fertility level, such as placing emphasis on development variables. However, the effects of population control on other sectors such as health, education and others were worked out. During the mid-year of the Sixth Plan period, a detailed exercise was carried out to reduce the fertility level. Various

programmes were worked out to reduce the fertility level by placing emphasis on the family planning programme as well as on development variables. Those were tried to be carried out during the Seventh Plan.

4.5 Seventh Plan Period (1985-90)

A highly ambitious target was set to reduce FR from 6.1 to 4.0 children per woman during the Seventh Plan period. The fertility reduction target was translated into requirements of contraceptive services which far exceeded the achievements during the Sixth Plan. The targets of pill, condom, sterilization acceptors during the Seventh Plan were 75, 69 and 151 per cent higher respectively than the achievements during the Sixth Plan. In case of IUD and Depo-Provera acceptors, these targets were 13 times and 9 times as high as the achievements of the Sixth Plan. The rationale behind this target was that with full implementation of various direct and indirect activities to reduce the fertility level, backed by a desired level of family size of 3.5, and with an institutional set up to effectively mobilize human resources, this target could probably be achieved. Various activities were worked out to reduce the fertility level by direct and indirect means. Ninety one activities were formulated under the following headings:

I. Family planning services delivery system.

2. Integration of population and development.
3. Population information, education and communication.
4. Women and population.
5. Role of various political organizations and non government organizations in population.
6. Spatial distribution of population, immigration and environment.
7. Law and population and
8. Institutional arrangements.

However, after launching the program for one year, it was realized that it would not be possible to achieve this target. Hence, when basic minimum need programmes up to the year 2000 were worked out, the above (fertility) target of Seventh Five Year Plan was not taken into consideration. The achievements of targets during the Seventh Plan were very low for all contraceptive methods. This was not just because targets were very high during the Seventh Plan. The achievements during the

Seventh Plan with regard to provision of family planning services to new acceptors were not upto the mark. The achievements were slightly better with regard to pill and condom acceptors during the Seventh Five Year Plan Period compared to those during the Sixth Five Year Plan Period. For IUD and Depo-Provera acceptors, the achievements were 99 and 344 per cent higher respectively. However, for sterilization acceptors, the achievements were lower. The overall effect was a significant rise in the contraceptive prevalence rate form 13.6 per cent in 1986 to 22.7 per cent in 1991. The percentage of married women of reproductive age knowing any contraceptive methods increased from 56 per cent in 1986 to 92.7 per cent in 1991.

4.6 Eighth Plan Period (1992-97)

The Eighth Plan has given more explicit attention to development efforts than was the case in the past and more attention has been given to institutionalization issues. The specific development targets of the Eighth Plan have been shown in Table 1 and the following strategies have been mentioned to fulfill the above target.

(i) Create atmosphere for the small family size norm of two children through economic and social development programmes.

(ii) Raise the economic and social status of women.

(iii) Implement family planning programmes along with other health activities.

(iv) Expand non-governmental organizations and other private organizations to provide family planning services at the village level.

(v) Develop skilled manpower through training and communication programmes.

As may be seen, the family planning target for the Eighth Plan has been put in terms of continuing acceptors. However, new acceptors data are also available. Let us have a look at the achievement during the Seventh Plan and the target during the Eighth Plan.

As far as pill is concerned, the target is to recruit, 241,300 pill acceptors where as the achievement during the Seventh Plan was 382,532. Hence, it can be expected that this target might be achieved. However, average pill cycle distribution was planned to be increased from 6.1 per acceptor to 17.7 cycles per acceptor with an expected marked increase in continuation rate. The target for condom is to recruit 254,600 new acceptors whereas the achievement during the Seventh Plan was 943,384. But average condom distribution per acceptor was planned to be increased significantly from 20.0

during the Seventh Plan to 170.8 units during the Eighth Plan. Both pill and condom new acceptors are expected to get more than what they need for one year because old acceptors also need some. Sterilization acceptors are expected to increase from 221,169 during the Seventh Plan to 360,250 during the Eighth Plan, which is a significant increase. A great deal of services have to be offered in the case of IUD acceptors. The achievement was 11,891 acceptors during the Seventh Plan whereas these services have to be offered to 60,000 IUD acceptors, a five fold increase, during the Eight Plan. Similarly, in case of Depo-Provera acceptors, the target is 317,950 which is about thrice as high as the achievement during the Seventh Plan. Norplant acceptors have to increase from 3,727 during the Seventh Plan to 59,950 during the Eighth Plan. Moreover, the status of Norplant will be changed from an experimental method to a program method.

Hence, based on past achievements, it seems that targets during the Eighth Plan are very ambitious. At present, the contribution of sterilization is 78 per cent in contraceptive prevalence rate. Even if the contribution is reduced to 65 per cent in 2000, the sterilization has to be done on an average of 75,000 per year where as at present, it is 25,000 per year. Hence, even if the Amsterdam declaration (1989) urges an increase in CPR to 56 per cent in developing countries by the year 2000 or the Bali Declaration (1992) urges to attain replacement level of fertility by the year 2010 or sooner, the target has been set to increase the CPR level to 37.7 per cent of married women of reproductive age by the year 2000. This target also, as has been analyzed above, seems to be quite ambitious. Hence, a long and arduous task lies ahead during the Eighth Five Year Plan period.

This target, though ambitious, may not be impossible to achieve. The experience of other developing countries show that CPR can be raised to about 40 per cent by putting emphasis on family planning services along with maternal and child health services. It will speed up if quality contraceptive services are made widely available and socio-economic status of women raised. Of course, it is well known that development is the best contraceptive but it is equally well known that it will take a long time to decrease fertility level to a desired level by relying only on development activities. In fact, development is a continuous process. Some of the development activities which will influence population variables will have to be speeded up. The following socio-economic development policies and programmes which will be adopted during the Eighth Plan are expected to reinforce population policies and programmes.

(i) Family Planning services will be offered as a part of primary health care through female health volunteers, sub health posts and primary health care centres in each ward, village

development committee and electoral area respectively. The services would be made available and accessible even in remote parts of rural areas.

(ii) Temporary and Permanent family planning methods will be made available according to the preferences of the clients. Priority will be given to the concept of birth-spacing and the use of temporary birth control measures will be promoted.

Participation of local bodies and non-government organizations will be encouraged in the management of health institutions. Private sectors and foreign investment will also be encouraged in providing health services in the country. Emphasis will also be placed on health research activities.

(iv) Programmes will be launched for lengthening breast-feeding period, the delay in marriage and the postponement of the first birth.

(v) Information, education and communication programmes will be launched on a national scale which will help to promote female education, raise age at marriage, increase the value of the girl child and thus ultimately help to create the atmosphere of having two children per family.

(vi) Reduce Infant Mortality Rate to 50 per 1000 live births and Maternal Mortality by at least 50 per cent by the year 2000.

(vii) Raise the literacy rate to 67 per cent by the year 2000.

(viii) Conduct feasibility study of the compulsory primary education.

(ix) Expand secondary education through private sector and community organizations.

(x) Place special emphasis on female education. Female education has been encouraged at all levels. About 0.56 per cent of the total national budget for the education has been allotted for promoting female education. Modalities will be developed to increase girls' enrollment up to the secondary level and to reduce dropout rate.

(xi) Expand formal and non-formal education.

(xii) Programmes have been launched for women who are below poverty line to improve then' economic condition by involving them in various community development activities. Loans would be made available to women through commercial banks for income generating activities in farming and cottage industries. Non-government organizations would be involved for strengthening organizational capacity to launch women development programmes. In fact, special programs will be launched for the well being of women and socio-economically weaker sections of society.

(xiii) Aim at growth of economic development at 5.1 per cent per year in contrast to 3 per cent per year in the past.

(xiv) Emphasis has been given for the economic development of undeveloped and backward areas so that job opportunities will be created in those areas which in turn will reduce migration from these areas. The flow of out-migration from hill will be minimized by creating offfarm employment opportunities in hill areas. Small towns will be created on East-West high way and North-South roads so that these towns will absorb migration which would, otherwise, move to other areas. In fact, urban development will be promoted by making the process of urbanization complementary to the growth of the local economy.

(xv) Create environment for the aged people to spend their lives with dignity.

5. Conclusion

It may be seen that formulation and adoption of official population policies and programmes began currently with the nation's Third Five Year Plan (1965-70) to have an equilibrium between population growth and economic development. The Fourth Plan was contented with offering family planning services to married couples. The multisectoral population policy was formulated in the Fifth Plan. The Sixth Plan dealt with both population policies and programmatic issues. This continued during the Seventh Plan also. The Eighth Plan (1992-97) has given more explicit attention to development efforts than in the past and more attention has been given to institutionalization issues. As can be seen above, there have been frequent changes in institutional arrangements rather than on strategies and programme elements. Though population policies have been formulated about

30 years, there has not been a significant decline in population growth and fertility. While mortality has been declining continuously, fertility began to show declining trend since 1981 only. The present high level of fertility and the rate of population growth remain obstacles to progress. His Majesty's Government is aware that any delay in implementing effective population programmes will only magnify the problems in the future.

Plans are ahead to provide good quality family planning services, with political support from the highest level to local leaders at grass hood levels. Development factors which are of critical importance to the success of programmes have been given due emphasis. The mode of interaction between population sector and development sectors will be further clarified. Community participation is to be incorporated at every stage. Non-government organizations and private sectors are encouraged to work in population related areas. Programmes have .been designed for spatial distribution of population and more information will be collected about migration.

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