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Health, Family Planning and Population Policy & Programs of HMG/Nepal

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INTRODUCTION

Population growth, health, development and family planning are closely interrelated, each being a determinant and consequences of the other. Poor health, particularly of infants and children lead to high infant & child mortality. It has been observed that parents have a tendency to replace a child who died in infancy by producing another - known as "replacement effect", thus indicating a strong association between infant mortality & high fertility. The high infant mortality resulting from poor health will act as a deterrent towards making family planning program more acceptable.

High population growth again affects health through various ways. Firstly, population growth means close spacing of births which naturally will result in higher infant mortality. Secondly, in the situation of high population growth, pregnancies will be more frequent and thus making mother very much vulnerable and they will also bear less healthy children. Thirdly, infants are weaned prematurely when the mother becomes pregnant again and as consequence their nutritional level declines rapidly (World Bank, 1989). This amply shows that the use of birth spacing methods would contribute significantly to improve maternal and child health. Improved child health would inturn speed the adoption of spacing methods.

In the light of this background the paper attempts to focus on the present health status and family planning needs of the country & review the population policies & programs of HMG/Nepal briefly.

CURRENT HEALTH STATUS

The mortality level & the incidence of morbidity are frequently used as indicators of health status of the population. It should, however, be noted here that mortality level and health status may not always move in parallel to each other. With the development of many inexpensive and simple health technologies like oral re-hydration and immunization against selective infectious diseases, it has been possible to achieve substantial mortality decline without improvement in health conditions to a corresponding degree.

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Mortality

The country has witnessed a gradual decline in mortality level since 1960s. During early 1950s crude death rate (CDR) was quite high in Nepal and it varied between 30 to 44. The CDR in 1989 is estimated to be 15. Similarly, the infant mortality rate (IMR) which was around 260 in 1954 has declined to 124 in 1989. Likewise the life expectancy has increased from 36.8 years during 1961 - 71 to 52 years in 1989.

Several factors have contributed to this favourable development in Nepal. Improvements in medical technology including availability of life saving drugs, establishments of institutions, training of medical & para medical personal, involvement of international & local NGO's have contributed to this development. Control of epidemics, launching of various new health projects & more importantly the general concern of the government for overall development have also lead to this development. However, in spite of these favourable developments the mortality level in Nepal is quite high and thus lot more remains to be achieved if the goal of "Health of all by 2000 A.D." has to become a reality.

The current health status of the country has been summarized in Table 1 with the help of few relevant indicators.

Table 1

Selected Indicators on Health Status in Nepal

	Indicators	
1.	Crude Death Rate (per 1,000 population, 1989)	15
2.	Infant Mortality Rate (per 1,000 live births, 1989)	124
3.	Maternal Mortality Rate (per 100,000 deliverers, 1987)	1500-2000
4.	Life Expectancy at Birth (years, 1989)	52
5.	Proportion of children fully immunized	11
6.	Daily calorie supply (per capita, 1988)	2078
7.	Population (per doctor, 1990)	19392
8.	Population (per hospital bed, 1990)	4260
9.	Proportion of the malnourished children under six year of age disabled (1975)	70
10.	Proportion of children out of the total disabled population (1981)	28

Source: 1, 2, 4 & 6 World Development Report 1991 3, 5, 9 Social Sector Strategy Review, World Bank, 1989, 7 & 8 CBS/Nepal, 10 Population Census, 1981.

Morbidity

Some of the leading causes of morbidity identified in Nepal are: diarrhoeal diseases, parasite infections, upper respiratory infections, goitre, and morbidity associated with complications of pregnancy and child birth. Cretinism, blindness and other permanent disabilities afflict a large proportion of the population in Nepal. The major communicable disease of infancy and childhood are apparently, whooping cough, measles, tuberculosis, tetanus, diphtheria & poliomyelitis.

It should be noted here that at present only 11 percent of children are fully immunized in Nepal. 50 percent the children have received no immunization at all, and immunizable diseases still account for a large proportion of morbidity and mortality among children (World Bank, 1989).

Malnutrition

Malnutrition is still considered to be a great hazard to the general health of the population. Very high level of malnutrition among the children is reported in several studies conducted so far. Nepal Health Survey which was conducted in 1965-66 found that about 4 percent of all children below 9 years of age are affected by clinical malnutrition and also found the population of Nepal as a whole to be strikingly unhealthy. Similarly, in an anthropometic survey carried out in 1974, 71 percent of the surveyed children were reported to have "stunted growth" - Low height for their age and 19 percent were reported to have problem called "wasting" - Low weight for their height. The Nepal Nutrition Status Survey in 1975 found that 70 percent of children under six were malnourished in some form 50 percent to the extent that their physical development was notably impaired. The study also found high prevalence of disability and mental & physical retardation resulting from the deficiencies of nutrients such as Iron, Iodine, and Vitamin A.

Associated Factors

Major health and nutritional problems mentioned above are strongly associated with the general poverty. Lack of safe water and proper sanitation are some of the important factors that contribute to wide prevalence of diseases in Nepal. It has been estimated that at present only 22 percent the population are benefitted from piped drinking water facility. In the Nepalese context low literacy rate particularly female literacy can also be considered as a leading factor for the major health and nutritional problems.

Development of Health Services in Nepal

Until 1961 health facilities in the country were very much limited and heavily concentrated in certain parts of the country. Preventive health care facilities were very meagre and epidemic diseases were rampant. After 1956 various programs on preventive health services were launched. To name few: Malaria Eradication Organization, Leprosy and Tuberculosis Control Project, Small Pox Eradication

Project, Nepal Family Planning and Maternity anc Child Health Project. Integrated Community Health Programme, and Expanded Program of Immunization.

In addition to preventive health measures, impressive progress also have been made in providing curative health services. Since 1950's the country has been able to create an infrastructure for better health services and the delivery system. Prior to 1956 health facilities were restricted to 34 hospitals, 39 health posts and 649 hospital beds. Now their numbers have reached to 101 hospitals, 816 health posts, and 4329 hospital beds in 1989. Similarly, there has been a significant increase in the health manpower such as doctors, nurses and midwives, health workers etc.

In spite of launching various programs in preventive health along with infrastructural development the achievement in the health front is not to the desired extent.

Basic Needs Programme & Health Sector

One of the important element of HMG's Basic Needs Programme is health. The overall objective of the basic needs programme in health sector is to expand basic health services, so as to ensure universal primary health services by the year 2000 A.D. Priority is given to check the growth of population and improve the quality of life so as to increase the life expectancy of the people. Following targets have been specified in health sector:

- to reduce growth of population from 2.6 percent at present to less than 2 percent by the year 2000 A.D.; and

- to raise life expectancy from 51 years to 65 years by 2000 A.D.

To achieve these targets the programme developed in the health sector identifies its strategic as:

a) Infant mortality rate will be reduced to 45 by 2000 A.D. from its present level.

b) Total fertility rate will be reduced to 2.5 by 2000 A.D. from its present level of 6.2.

Thus, the programme aims at lowering the rate of growth of population by reducing fertility rate & infant mortality rate. Furthermore, the programme aims at increasing the life expectancy of Nepalese people through improved health and nutritional programmes.

FAMILY PLANNING NEEDS

In the contest of Nepal, the role of family planning programme need not be over emphasized. The use of some form of contraception has risen over time from about 7 percent in 1981 to almost 15 percent in 1986. This, no doubt, is a substantial improvement but this prevalence rate is still far below the required level for effective

population control. There is thus a need for launching family planning programme much more vigorously in the country. This observation could be logically justified due to the following reasons:

- Country has been experiencing a rapid population growth in recent years and there is an urgent need to check this unprecedented growth in population.

- The need of family planning becomes all the more obvious when one consider the fertility targets fixed by HMG for 2000 A.D. On the recommendations of the then National Commission on Population, The National Population Strategy submitted by the then National commission on population to HMG in 1983 aims at reducing the total fertility rate from 6.3 children per women in 1980 to 2.5 by the year 2000 A.D. This implies bringing down the population growth rate to 1.2 percent per annum by 2000 A.D. This further implies a contraceptive prevalence rate as high as 60 to 65 percent (Gonzalez, 1990). This change constitute a four fold increase. Furthermore, the total number of users would need to increase about a half million to 2.8 million over the next 16 years (Thapa, 1989). It should however be noted here that the targets proposed are very much ambitious.

- One of the strategic identified to achieve the targets fixed in health sector of the Minimum Basic Needs Programme of HMG is to reduce the infant mortality rate to 45 by 2000 A.D. In the absence of the massive programme of FP & MCH it is going to be a arduous task. Various studies have clearly shown that it is the close spacing of births which result in high infant & child mortality. The use of birth spacing methods would thus contribute significantly to improve maternal & child health & consequently to low infant mortality rate.

- There is a need for a more balanced contraceptive mix in Nepal. Because most of the increase in contraceptive prevalence rate (CPR) has been mainly due to sterilization (86 percent of current users in 1986) rather than temporary methods and since most are sterilized after having had more than four children there is very little impact on population growth. Birth spacing is not yet widely understood and its practice is very much limited. So the launching of family planning programme with more emphasis on temporary methods would go a long way in giving the desired result.

- According to 1986 Nepal Fertility and Family Planning Survey, among currently married fecund women of reproductive age, 59 percent either wanted no more children or wanted to delay their next birth - a clear situation of "unmet need". Since the CPR was 15 percent the "unmet need" would be around 44 percent. However, when more rigorous method was used, the unmet demand population accounted for only 33 percent of married women of reproductive age according to a 1987 Nepal Demographic and Health In - Depth Survey (Shrestha, et. al., 1988). It should also be noted here that a large proportion of potential "spacers" or limiters are not aware of the fact that birth can be delayed or spaced using contraception. Of those who knew of temporary methods both spacers & limiters reported that they did not adopt contraception for reasons of

health side effects. This has been reported in the 1987 In - depth survey. This clearly shows that there is a weak motivation for spacing or limiting births.

Owning to this large unmet need for family planning services HMG has accorded top priority to fulfil unmet need in its National Population Strategy.

REVIEW OF POPULATION POLICIES & PROGRAMMES

In the First (1956-1961) and Second Development Plans (1962-1965) in Nepal, there were no specific population policies. Both the plans laid emphasis only on resettlement policy as a means of absorbing the increasing population in the hills.

The Third Development Plan (1965-1970) devoted greater attention to the problem of population dynamics. A separate chapter on 'Population and Manpower' was included in the plan. Various consequences of population growth were discussed at greater length. Besides, the impact of health and family planning programmes on population growth was stressed in the plan and accordingly provision was made for the delivery of family planning services. During this plan only Nepal Family Planning and Maternal Child Health Board was formed in 1968.

The Fourth Development Plan (1970-1975) stated even clearer objectives on population policy. The objective of the Plan was the effective use of manpower resources and control of population growth. In order to curb population growth the plan recognized the need to bring about the required changes in the economic and social conditions, cultural patterns and aspirations toward life of the common man and the implementation of an effective family planning programme.

The Fifth Development Plan (1975-1980) devoted an entire chapter on population policy and the emphases given to population question was far greater than in the previous plan. The main objective of the population policy is to regulate the rate of population growth at levels conducive to the current and anticipated rate of economic development and to achieve a population distribution consistent with the geographical distribution of the physical resource endowments of the country, and thus assist in enhancing the standard of living of the people.

The Sixth Plan (1980-1985) discussed the impact of population growth on different sectors, particularly on agriculture, forestry, labour force, education, health and urbanization. Its objectives concerning population were: (i) The annual population growth rate of 2.3 percent will be regulated and pre requisites to bring down the population growth will be created during the Sixth Plan and (ii) problems of population distribution and migration will be tackled.

The Sixth Plan adopted three specific policies:

- to introduce family planning programme with particular emphasis on permanent methods in real areas where fertility was high.

- to intensify economic activities in the Hill areas in an effort to regulate the movement of population, and

- to popularize the family planning programme among the people at large by adequate provision for publicity and extension of serv ices.

The Seventh Development Plan (1985-1990) population policies are based on the National Population Strategy recommended by the then National Commission on Population in 1983. Upon the recommendation of NCP, His Majesty's Government adopted a target to reduce the total fertility rate from 6.3 to 2.5 by the year 2000 A.D. The population policies of Seventh Plan is basically guided by this long-term goal. The objective of the Seventh Plan as related to population is "to strike out a balance between population growth and economic development by reducing the adverse effects on population structure and distribution that results from the pressure of unchecked population growth." (HMG/Nepal, 1985). The National Population Strategy puts emphasis on five major policy directives, namely:

i) High priority for fulfillment of the current substantial unmet demand for family planning services;

ii) Integration of population programmes in all projects relating to environment, agriculture, forestry, and rural development;

iii) Emphasis on programmes that help to increase the status of women particularly female education and employment;

iv) Effective mobilization of local Village Development Committees, class organizations and non governmental organizations (NGOs) in population programme and

v) Regulation of steadily increasing immigration into the country.

Then NCP out lined detailed policies on each of the above thrusts for the formulation of a detailed plan of action. The policies out lined for each thrust, are quite comprehensive and the examination of each one of them requires separate discussion.

CONCLUSION

The paper endeavors to examine the relationship between health, family planning and population growth. It has been widely recognized that they are closely interrelated. Policy makers in Nepal appears to have realized this very well. Accordingly various policies integrating health and family planning have been designed and several programs have been implemented. In spite of that we have not been able to make any significant headway in this direction and thus arrest the rapid growth in population. This clearly signifies that there is a gap between policy formulation and policy implementation. Targets are highly ambitious. Policies and measures recommended in National Population Strategy have not been implemented fully. The current status of detailed plan of action associated with all the five major thrusts is also not very clear. On the

basis of the past experience, it is high time to review and examine all the population policy and programme and design a suitable one, accordingly.

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