

## Status Review: Health, Population and Drinking Water & Sanitation Sectors

Yagya B. Karki

### Introduction

Since the beginning of development planning in Nepal<sup>1</sup> all three -- health, population and drinking water and sanitation sectors have been identified as major areas in development planning process. It has been more than 35 years since Nepal initiated a programme to make family planning generally available to the public. The primary objective of introducing it has been the reduction of population growth in the country. His Majesty's Government of Nepal's efforts in balancing population growth with social and economic development during the last thirty five years (1965-2000) have been noteworthy but even then the population of Nepal, as shown by the 1991 census, has been increasing annually by, at least, 2.1 per cent<sup>2</sup>, registering an addition of 3.5 million over the level of 1981. According to the National Planning Commission, if this trend continues, Nepal's population will reach the 37 million mark by 2025.

Demographically, Nepal's population is very young, as the proportion of 0-14 age group in total population has remained at 40% or more since 1961. (The proportions of 0-14 population were 40.01%, 40.45%, 41.35%, and 42.28% in 1961, 1971, 1981 and 1991 respectively). Given this age structure, Nepal's population cannot stabilise before reaching 60 million by about the end of this century if mortality and fertility declines are moderate<sup>3</sup>. Unless large scale emigration or Malthusian checks like wars, famine, or disease take their toll, Nepal must be prepared to cater for at least 60 million people by the third quarter of this century.

Besides, due largely to high population growth income poverty, according to a recent report<sup>4</sup>, in Nepal has increased since the 1970s and now more than 50 % of the total population live on US \$1 or less a day while in the mid 1990s according to official statistics the corresponding figure was only 40%.

In order to address poverty, the development programs in the country must be sustainable. A program is sustainable if it continues its activities and meets its objectives year after year and makes plans for the future and fulfils those plans despite changes in the outside environment and develops diversified financial support so that its existence is not threatened by the loss of a single funding source<sup>5</sup>.

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<sup>1</sup> The First Plan was for the period from 1956-1961 and subsequently Nepal has formulated and implemented a series of Development Plans.

<sup>2</sup> CBS. 1993.

<sup>3</sup> Karki, 1993.

<sup>4</sup> The Kathmandu Post, April 26, 2000. Kathmandu.

<sup>5</sup> FPMD. 1998.

Different organisations can achieve sustainability through different means and by different routes but even then there are some common characteristics of sustainable organisations. They provide quality services to those who cannot pay the full cost of the services as well to those who can. This means that these organisations have developed mechanisms to subsidise the cost of services for the poor and underserved. Sustainable organisations are also able to adapt to changing environments and client needs. For example, a program that has traditionally served women in an urban setting might tailor services to meet the needs of other client group, such as adolescents. Finally, sustainable organisations seek to develop independent, diversified, and dependable sources of revenue while they become less and less dependent on external funds. Having a diversified and dependable source of funds gives these organisations greater control over their programs and greater flexibility and freedom to chart their own course<sup>6</sup>.

## Background

Although the official family planning programme was started only in 1965, family planning services and information were offered in Nepal as early as 1958 by an NGO. Attention to population planning was given only from the first Five-Year Plan (1956-61) when one objective of the plan was to deal with employment. The Second Three-Year Plan (1962-65) also continued with employment focus by introducing resettlement scheme. Only in 1965, the first year of the Third Five-Year Plan, HMG/N, officially endorsed family planning programme. By late 1968 the family planning programme was formally established by creating Family Planning and Maternal Child Health Board, which was responsible for the delivery of FP/MCH services to the entire population of the country.

The subsequent development plans<sup>7</sup> have given increasing attention to population planning including family planning, reproductive health and have also stressed the need to increase the status of women. Since the restoration of democracy in Nepal in 1990, HMG of Nepal has made further efforts to reduce population growth, improve the health standards of the general masses, increase access to safe drinking water and improve the environmental sanitation of increasing number of people. In order to review the efforts of His Majesty's Government of Nepal it would be better to present the base line on health, population and drinking water and sanitation for years around 1990.

In 1991 the Ministry of Health promulgated National Health Policy, 1991<sup>8</sup>. The health policy was made with the objective of bringing up-graded health services to

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<sup>6</sup> *Ibid.*

<sup>7</sup> The Fourth Plan (1970-75) clearly laid down population control as a major objective of the plan but did not set any quantitative targets except that the total population of Nepal was to be limited to 16 to 22 million. The Fifth Plan (1975-80), the Sixth Plan (1980-85), the Seventh Plan (1985-90), the Eighth Plan (1992-97) and the Ninth Plan (1997-2001) all have given increasing attention to population, family planning, reproductive health and development.

<sup>8</sup> MOH, 1991.

the majority of the population of Nepal through the extension of basic primary health services.

Given the seriousness of the demographic momentum and its consequence on the environment HMG/N has shown strong commitment to take the challenge by creating in 1995 a Ministry to oversee the population and environment concerns. The Ministry of Population and Environment (MOPE) is committed to enforce the population programs properly and timely by co-ordinating with several line ministries, NGOs and the private sector.

MOPE is now in place to take the population concerns and issues seriously with due considerations to the Program of Action of the International Conference on Population and Development (ICPD) held in Cairo in 1994<sup>9</sup>, the Fourth World Conference on Women held in Beijing in September 1995<sup>10</sup> and key actions for the further implementation of the POA of the ICPD approved by the UN General Assembly in July 1999<sup>11</sup>.

The National Planning Commission in 1992 reviewed previous plans, diagnosed major population and health problems (drinking water and sanitation included), set goals to improve the health conditions of the people of Nepal and to reduce the pressure of population on resources accordingly adopted a number of strategies to meet the health and population goals by 1997 -- the last year of the Eight five-year Plan.

The major problems identified by the Eighth Plan were as follows:

1. Geophysical difficulties of making basic health and population services accessible to the people in the high mountain and mid hill regions while in the plain areas -- the Tarai, the problem was to cope with the increasing number of clients flow to service facilities over time.
2. Until 1990 the targets set for different plans in drinking water and sanitation sectors were too ambitious; as a result the achievements were low.
3. Flaws in administrative and financial rules and regulations impeded timely transfer or recruitment of skilled health manpower needed in different parts of the country. These flaws delayed decision making process. Also identified was the lack of sufficient and general and refresher training for the health workers.
4. Insufficient and inadequate housing facilities for health and population service centers.

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<sup>9</sup> UN. 1994.

<sup>10</sup> UN. 1995.

<sup>11</sup> UN. 1999.

5. The grass-roots level institutional arrangements were not available to carry out drinking water and sanitation programs.
6. The drinking water and sanitation projects in general were too costly and called for long gestation period.
7. Delay in budget release from the center as well as non-utilization of the released budget in the districts concerned. In this respect the document points at the administrative and technical constraints of the government.
8. Shortages of medicines and instruments required for service facilities as well as timely repair and maintenance of them.
9. There was no grass-roots level participation (low involvement of NGOs, private sector and Users' Committees) in the implementation of drinking water and sanitation projects. Handing over completed projects to the local bodies without participation from the early stage of projects did not guarantee sustainability.
10. Slow logistics, delay in purchasing of land required for construction of health facilities, slow contractual work were also pointed as impeding timely delivery of health services in several parts of the country.

The Eighth Plan with the objective of resolving the above problems and aiming to implement the Alma Ata Declaration of "Health For All by 2000 AD" and to balance population growth and socio-economic development to fulfil peoples' basic needs laid down 7 objectives (4 in health, 1 in population and 2 in drinking water & sanitation) and 52 policy guidelines (22 in health, 5 in population and 25 in drinking water & sanitation). For implementation purposes it also set its priorities in health in the following order:

1. Extension of primary health services down to the village level;
2. Improvements of physical facilities and management of health services;
3. Emphasis on the promotion of temporary methods of contraception; and
4. Promotion of local participation in the implementation of health services.

A number of programs were envisaged to improve the health of the people and address population issues in the Eighth Plan; they included:

1. Basic Primary Health Service: Programs included under this were
  - preliminary treatment of common diseases
  - immunization
  - MCH services
  - family planning
  - management of essential drugs

- health education
  - food and nutrition education
  - education on clean drinking water
  - sanitation and environment
  - malaria, Black Fever and encephalitis
  - TB control
  - Leprosy control
  - Diarrhea control and
  - Respiratory disease control
2. Curative Services: Programs were designed to upgrade the quality of service provided by the curative centers such as hospitals. There were also plans to increase the number of hospital beds in different hospitals during the plan period.
  3. Ayurved and other traditional systems: Plans were designed to expand Ayurvedic services to other parts of the country too.
  4. Goiter and Cretinism control: For the hill and mountain population iodine deficiency is a major problem. In order to address this problem HMG of Nepal started the promotion of iodized salt program in 1972-73 and this plan also made provision to expand this program in different parts of the country. The target was to reduce goiter incidence from 42% to 35% by 1997.
  5. Environmental Health Program: Environmental health program with respect to the use of hygienically clean water, latrine construction, insects control, foodstuff preservation, fumes and smoke free urban life were the major activities planned in this plan period.
  6. Drug Management: To ensure quality and regular supply of drugs necessary rules and regulations were to be enforced.
  7. Sexually Transmitted Diseases and AIDS: To control the hazards emerging from the spread of STDs/HIV/AIDS, STD/AIDS control program was started in Nepal in FY 1988/89. Although sexual mores are strong in Nepalese culture because of mobile characteristics of the people and deepening poverty the potential for the spread of STDs/HIV/AIDS was predicted to be high. Therefore the Eighth Plan made provision for the prevention of these diseases through prevention education and expansion of treatment facilities.
  8. Epidemiological Program: The Eighth Plan continued to carry on with the epidemiology program to control zoonosis, rabies and other infectious diseases.

9. Other programs included development of health laboratories, nursing improvement program, out reach programs, establishment of Nepal Health Research Council, Health Manpower Development, Management of Health Organizations and Miscellaneous Programs.

## Financing<sup>12</sup>

For the health sector, the estimated budget for the Eighth Plan period was Rs.5.62 billion. Of the 15 sub-sectors Basic Primary Health Service Sector absorbed the most budget (about 73 percent<sup>13</sup>). Within this sub-sector nearly half (36%) was allocated for the FP/MCH project. For curative services a little over 13% budget was allocated.

A significant proportion of health sector resources (54% of total public expenditure, 1994/95) comes from donor agencies. Many of these supports are for short-term projects and the donor agencies committed them with the assumption that the government would immediately ensure their sustainability. Given Nepal's state of development such expectations are unrealistic<sup>14</sup>.

The financial resources allocated for the health sector ranged from 3.17% to 4.89% of the total actual spending and the gap between actual spending and allocation varied from 27% to 32%<sup>15</sup>. Not only absorptive capacity is weak (about 70% of allocated budget spent) but also HMG does not seem to have up to date and reliable information on health expenditure, particularly out of pocket expenditure and external funding. HMG does not routinely collect data on user fee collection by public facilities and expenditure at district and grass-roots level through HMG grants and locally raised funds.

In 1995/96 the overall health expenditure was low by international and regional standards at an estimated per-capita expenditure of Rs. 513 or US\$ 10.26<sup>16</sup>. If this per capita expenditure is to be believed Nepal would then still need an additional amount of Rs. 3 billion (or US \$40 million) a year to provide basic health services to its 23 million people<sup>17</sup>. In the health sector, therefore, the government has a challenging task of how to mobilize more resources to meet increasing health costs.

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<sup>12</sup> To cite an example only data on health financing is discussed here because nature of resource allocation and actual spending do not vary a great deal between different sectors of line ministries.

<sup>13</sup> NPC, 8th Plan, pp. 523-524.

<sup>14</sup> MOH, Feb. 2000.

<sup>15</sup> MOF, Budget Speeches of the FYs 1993-94 to 1996/97.

<sup>16</sup> MOH, Feb. 2000.

<sup>17</sup> WB, 1993, according to which US\$ 12 is needed to provide basic health service to a person, pp.67-68.

## Strategies

During the Eighth Plan period, the MOH, MOPE and NGOs produced a number of strategies to implement different health, population and drinking water and sanitation programs. Some of the strategies are listed below:

### 1. Female Community Health Volunteers, National Strategy

The Female Community Health Volunteers, National Strategy was prepared to meet the 8th Plan goal of establishing FCHVs in all 75 districts of the kingdom (p. 1). The long term objective of the FCHV program was to promote active involvement of village women in motivation/education and service delivery activities related to MCH and FP to contribute to targeted reduction in TFR, IMR and MMR.

### 2. PHC Outreach, National Strategy 1994

The PHC Outreach, National Strategy 1994 was designed in line with the National Health Policy 1991 of bringing the health services to the grassroots; it aimed to improve the accessibility and coverage of PHC by implementing 3 to 5 PHC outreach clinics per VDC per month.

### 3. Integrated Health Management Information System (MIS)

The MIS Strategy, was designed to monitor progress which enables health workers to document, analyze and use information to improve Quality and Coverage of PHC services at all levels. The data are also processed annually which are published as ANNUAL REPORT. Because of this strategy the first ANNUAL REPORT was produced by the MOH for the FY 2051/52(1994/95). This report not only analyses the performance of the previous year but also identifies possible actions to correct unwanted situations for the years to come.

### 4. Second Long Term Health Plan 1997-2017

The SLTHP 1997-2017 was a follow-up to the First Long Term Health Plan 1976-92. In view of the importance of the health sector the SLTHP was prepared which has laid down performance indicators for the next 20 years and calls for the development of annual plans, programs, strategies along with budget and technical manpower estimates. As a result several sub-sectors of health have developed and implemented strategies in line with the objectives and priorities of the SLTHP. The Ninth Plan health sector development strategy is also guided by this plan.

## 5. National Reproductive Health Strategy, 1998

The NRHS, 1998 was primarily the outcome of the ICPD which recognized RH as a crucial part of overall health and pivotal to human development. The focus of ICPD was to empower women and provide adequate and reliable RH services to the poor and marginalised sectors of the population. In collaboration with external development partners the MOH, initiated working on the NRHS in 1996 which culminated in a formal issuance of the strategy in June 1998. The integrated package of RH services defined includes six major areas of interventions:

- Family planning,
- Safe motherhood,
- Reproductive tract infections, sexually transmitted diseases, HIV/AIDS and infertility secondary to RTIs/STDs,
- Prevention and management of abortion complications,
- Adolescent RH, and
- RH problems of elderly women including reproductive tract cancer.

Within the MOH, the FHD is responsible to implement the Strategy. The pyramidal health care referral system, mentioned below, is followed in implementing the strategy.

## 6. National RH/FP IEC Strategy, 1997-2001.

The National RH/FP IEC Strategy, 1997-2001 was developed by the National Health Education, Information and Communication Center, DoHS, MOH, with the objective of addressing the RH needs through IEC programs.

In the population sector separate population strategies are not available except in the Eight Plan document where strategies are given as in other sectors. The same is true for drinking water and sanitation sector. The Scope of Work of the MOPE<sup>18</sup> also looks like a strategy but there is a lot of overlap between the health and the population sectors. Apparently the MOPE is functioning as an advocacy organization on population issues.

### Stakeholders

The National Planning Commission is primarily responsible for planning and providing policy guidelines on health and population issues. These guidelines and strategies are implemented by several Ministries; they include:

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<sup>18</sup> MOPE, 1995.



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| 1. Ministry of Health                   | 2. Ministry of Population and Environment    |
| 3. Ministry of Education and Culture    | 4. Ministry of Local Development,            |
| 5. Ministry of Labor                    | 6. Ministry of Housing and Physical Planning |
| 7. Ministry of Women and Social Welfare | 8. Ministry of Agriculture and               |
| 9. Ministry of Industry                 |  |

In addition, a number of NGOs involved in basic health/primary health care programs have their own strategies. For instance, the Family Planning Association of Nepal has a 10-year Strategic Plan (1994-2003). This was developed following the ICPD 1994. Only this year FPAN is revising the strategic plan as a result of the ICPD+5 recommendations 1999. Similarly many NGOs and INGOs (see Appendix A) have their periodic strategies for program implementation.

Also all donor agencies involved in health and population programs have their own strategic plans. The Ministry of Health, Department of Health Service's Annual Report lists most bilateral, multilateral, local NGOs and INGOs with brief descriptions including strategies involved in health programs.

The NGO/Private sector/donor agency representatives serve as advisers. Also the donors provide technical as well as financial supports to the design, development and implementation of strategies.

### Program Impact

By the end of the Eighth Plan health facilities were expanded down to the village level in many parts of the country. Besides government facilities, there is a large number of private and non-governmental organisations, both national and international, involved in providing health and population services to the people of Nepal in different parts of the country. Many of these organisations are specialised in specific service.

According to the 1996 Nepal Living Standard Survey some 41% households mentioned having access to the nearest health facility within a walking distance of half an hour<sup>19</sup>. Despite several problems encountered while implementing the Eighth Plan programs and strategies there were gains made during the plan period as shown in Table 1 below.

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<sup>19</sup> CBS, 1996. NLSS, Vol. I, p.43.

Table 1: Performance indicators in population, health and drinking water and sanitation sectors laid down in the Eighth Plan (1992-97)

Ser. #	Population and Health Indicators	Baseline 1991/92	Targets for the 8th Plan Period	Achievements	Percent achieved
1	TFR	5.8	4.5	4.6	98.3
2	Expectation of life at birth	54	61	56.1	92.0
3	IMR	102	80	74.7	93.4
4	Under 5 mortality rate	165	130	118	90.8
5	Maternal Mortality Ratio (Population sector)	850	720	475	66.0
6	Maternal Mortality Ratio (Health sector)	850	750	475	63.3
7	CPR	24.1	32	30.1	94.1
8	Pregnant and obstetric services		1,704,000	833,951	48.9
9	Services to children below 5 years		1,485,000	1,649,415	111.1
10	Producing Female health Volunteers		63,000	46,427	73.7
11	Producing Trained Birth Attendants		15,000	12,559	83.7
<b>Drinking Water</b>					
12	Percentage of population benefiting (Rural)	39	72	61	84.7
13	Percentage of population benefiting (Urban)	67	77	62	80.5
14	Percentage of population benefiting (Total)	42	72	61	84.7
<b>Sanitation</b>					
15	Percentage of population benefiting (Rural)	3	9	16	177.8
16	Percentage of population benefiting (Urban)	34	48	51	106.3
17	Percentage of population benefiting (Total)	6	13	20	153.8

Source: Items 1 to 5, Eighth Plan, 1993, p. 627 (population sector and also mentioned in the health sector, p. 504 but item 6 MMR target is different) and items 7-17 from 8th and 9th Plans.

Other things remaining the same, these improvements made on the health and population fronts could be attributed to materialisation of the objective of the new Health Policy 1991 which stressed the expansion of primary health care services to the rural people. The new policy has adopted a pyramidal health care referral system according to which a small local facility provides referrals to larger district level facilities, which in turn refers patients to major hospitals where specialised treatment is available. There are four basic types of primary health care facilities in the country: hospitals, primary health care centres/health centres, health posts and sub-health posts. There are three different types of hospitals - central (tertiary level hospitals), regional (secondary level hospitals) and district hospitals, the first referral point for rural health facilities. By the end of the Plan period there were 100 PHCCs

and 3,199 SHPs. Besides, a total of 12,559 trained TBAs, 46,427 FCHVs and several thousands Mothers Group members are involved in health programs.

The performance in drinking water sector was not beyond 85% of the targets while in the sanitation sector it was over 100%. One of the reasons put forward for low performance in drinking water was the non-involvement of local bodies in the early stage of the projects<sup>20</sup>.

## Challenges

Despite successes the major challenges faced by the health sector are<sup>21</sup>:

1. The policies, programs and strategies of the Eighth Plan were certainly comprehensive and guided by grass-roots level needs but the results are however, not up to the expectations. The challenge is that in the past too similar policies and programs were promulgated but they lacked effective implementation. Despite largely achieving the set targets the pace of improvements in health do not compare well with the other South Asian countries leaving Nepal at the bottom of the development ladder (Table 2). The challenge for Nepal is how to compete with other South Asian countries in its efforts to improve the health standards of the people.

Table 2: Comparison of some major health indices among South Asian countries, 1998

Health indicators	Nepal	Bangladesh	India	Pakistan	Sri Lanka
IMR	77	73	70	91	16
U5MR	107	96	62	120	18
TFR	4.4	3.1	3.2	4.9	2.1
Expectation of life at birth: Male	58	59	62	61	71
Expectation of life at birth: Female	58	58	64	63	76
Maternal Mortality Ratio	540	440	450	NA	60
CPR	29	49	41	24	NA

*Source: The World Bank, 2000.*

2. The World bank<sup>22</sup> documented the burden of diseases for Nepal. Half of all deaths are due to infectious and parasitic diseases, and, perinatal and reproductive disorders. The highest risk groups are children under five and women of reproductive age. Although under fives represent only 16% of the population they account for 50% of the Disability Adjusted Life Year lost (DALYs<sup>23</sup>). Infectious disease, perinatal disorders or nutritional deficiencies

<sup>20</sup> Ninth Plan, 1998.

<sup>21</sup> They can be verified by field observations, dialogues with stakeholders, donors, etc.

<sup>22</sup> WB, June 2000. Although the final report came out in June 2000, the data used for analysis were from the 8th Plan period.

<sup>23</sup> DALY combines Potential Years of Life Lost as a result of death at a given age and Years of Life lived with Disability, using appropriate disability weights depending on the severity of illness. One DALY is thus one lost

account for 80% of the under five deaths. It is also found that until age 44 females are 25% more likely to die or suffer serious disability than males. It is no wonder that female life expectancy is lower than that of male. This also implies that activities that contribute to better health at home and at health care facilities outside of the home are male biased. In the context of the Nepalese social and cultural value system which generally favors males it is a big challenge to address women's health.

3. Despite policy formulation and political rhetoric for equity in health, the present health delivery system does not facilitate equity. There are no clear cut user fee schemes available in the government sector. Although equity calls for special attention to the poor the public facilities are enjoyed more by the relatively better-off.
4. Government health facilities need to be substantially improved

Despite the report from the government that almost every VDC has a sub-health post (see program impact above) the utilization of government health services by households is very low -- only 13% while the corresponding proportions using other, non-government, health services was 24%. In urban areas the proportion using government health services was only 10% while the rest used other health service facilities. Overall only 8% respondents thought that government health service was good and for 33% it was bad. Regarding the availability of medicines only 30% respondents said that all medicines were available at the health facility<sup>24</sup>. All these indicate that the government has a major challenge in making service centers attractive and effective.

5. For a resource poor nation like Nepal community based programs have potential for the development of sustainable programs. Some NGOs such the FPAN in certain projects has successfully tested sustainable community based health projects (see Appendix B) but they are not as yet adopted by the government. Paradoxically, FPAN itself has not replicated the successful sustainable model in its other project areas. Another sustainable project is primary health care project in Dolakha and Ramechhap which is a community based project but its impacts are yet to be assessed<sup>25</sup>.
6. Although the Eighth Plan allocated more resources to the primary care in practice it does not seem to have worked. The resources are increasingly taken away from the primary care to the secondary and tertiary care. The share going to primary care, for example, fell from 76.8% of public expenditure in 1991/92 to

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year of healthy life. **Source:** Murray, C.J.L. and Lopez, A.D. The Global Burden of Disease. Summary. WHO, Harvard School of Public Health and WB. 1996.

<sup>24</sup> UNICEF, 1998.

<sup>25</sup> SDC/HMG. 1991.

57.2% in 1997/98<sup>26</sup>. The process of decision making is perhaps influenced by political hierarchy.

7. Nepal has one of the highest MMR in the world but until now concrete programs to address this serious health issue are not forthcoming. It must also be understood that effective family planning program can reduce MMR. Some efforts have been made by projects supported by external development partners but they still need to be scaled up.
8. Since the restoration of democracy the private sector is expanding but proper rules to regulate it are absent. Without effective regulations the private sector cannot be expected to promote equity in health care. As a result quality of care increasingly goes against the poor and humanity.
9. Health financing is another area that calls for serious analysis to make it consistent with the policy of equity. Such an exercise is valuable for proper allocation of resources in relation to burden of diseases, gender sensitivity and geographic locations. Due to the lack of reliable health economics data this exercise can pose a challenge for the government to carry out.
10. DALY analysis indicates that Nepal still has to focus on infectious diseases, women, children and under-served areas<sup>27</sup> but recently the HIV/AIDS pandemic is also affecting Nepalese population. Given Nepal's' girl trafficking problem and mobile male population this new health problem calls for additional resources. Therefore, Nepal now has to meet the costs of providing basic service plus the costs for servicing fast growing HIV/AIDS problem. Designing effective and innovative HIV/AIDS programs is a new major challenge in the health sector.

#### Major challenges faced by population programmes

Despite continuous efforts made by the government machinery, NGOs and the private sector to reduce population size, the population of Nepal is growing unabatedly. Several studies indicate that the major challenges faced by population growth reduction programmes are:

1. High fertility: overall and young age fertility

The Crude Birth Rate (CBR) in Nepal has been declining but at a very slow pace. For the early 1950s and 1960s CBR was estimated at 45 to 50 per thousand population which did not seem to have come down until the early 1980s (CBR was 47/1000 in 1961 and 42, 42.9, 41.6 and 37 in 1971, 1981, 1991 and 1996 respectively<sup>28</sup>). More specific measurement of fertility known as the Total Fertility Rate (TFR) has started declining but its pace of decline is also

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<sup>26</sup> MOH, Feb., 2000.

<sup>27</sup> WB. June 2000.

<sup>28</sup> MOPE, 2000, p. 14.

slow in Nepal compared to other South Asian countries. The TFR in Nepal has declined from 6.3 in 1976 to 4.6 in 1996<sup>29</sup> while in Bangladesh, India, Pakistan and Sri Lanka it has come down to 3.1, 3.2, 4.9 and 2.1 respectively<sup>30</sup>. Another challenging factor is that the young age fertility (15-24 age group) has declined very little (8.5%) in the last 20 years, although the overall TFR declined by 27% and the decline was high (above 40%) for older women.

2. Relatively low performance of the family planning program.

Although nearly all women of reproductive age know at least one modern method of contraception the current use (Contraceptive prevalence rate) is only 28.8 percent. In Nepal the CPR in 1976 was 2.9% and it increased to 28.8% by 1996 resulting in annual percentage point increase of 1.33 while in Bangladesh between 1975 and 1997 the corresponding figure was 1.66<sup>31</sup>.

3. Family planning method mix heavily tilted towards permanent methods

Contraceptive method mix in Nepal is heavily tilted towards permanent methods because of all contraceptive users 67% were terminal method acceptors in 1996 and this share has hardly changed (69% in 1976) in the last 20 years. In the absence of extensive availability of spacing methods and quality service the popularity of terminal methods has its own value even though by the time women go for sterilisation they are already over 30 and have on average 3 living children. The challenge for the programme is to meet the existing and future demand for sterilisation with good quality services.

4. Poor living conditions challenge increase in the use of spacing methods

Housing poses severe constraints on contraceptive choice and use in Nepal. Few couples sleep in a separate room, and the waste disposal systems of the developed world is absent. Several generations often live together, and the use of birth spacing methods by younger generations would be frowned upon by the elder family members.

5. Male dominance and preference for sons

The male/female share of contraceptive use has completely changed in favour of males in that in 1976 of all users 67% were male sterilisation acceptors while by 1996 the corresponding figure has gone down to 21% whereas the female terminal method acceptors has increased to 46%. This strongly reflects male dominance in Nepal. Virtually no couple practise contraception before having at

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<sup>29</sup> MOH, 1997.

<sup>30</sup> WB, 2000.

<sup>31</sup> Barkat, Abul, et al, 1997, p.34. CPR in Bangladesh increased from 5% in 1975 to 41.5% by 1996/97.

least one living son<sup>32</sup>. Religion and the cultural value system is one of the major challenges in the reduction of fertility<sup>33</sup>.

#### 6. High "unmet need" for family planning services

The "Unmet" need for FP services has remained high in Nepal; it was 28% in 1991 but by 1996 it was estimated to have increased to 31.4%<sup>34</sup>. In addition, the 1996 survey estimated the "unmet" need for spacing at 14.3 per cent and that for limiting 17.1%. Clearly, greater efforts are needed to change "unmet" need for spacing to "met" need. The total "met" need of 28.5 per cent is greater than the "unmet" need only by 1.3 per cent, suggesting that CPR could be almost doubled if the "unmet" need were fulfilled. Very little research has been done to understand the non-use of contraceptives by couples<sup>35</sup>.

#### 7. Shortage of contraception

Recently, injectable contraception has gained popularity; its use has increased by 10 folds between 1986 and 1996 to 5.1 per cent. This is probably due to its comparative convenience in its application. However, meeting the demand for spacing methods, such as injectables, condom and Norplant has been a major challenge for Nepal<sup>36</sup>.

#### 8. High mortality

The high growth rate of population is in part attributable to the success of health policies and programmes. The infant mortality rate has fallen from over 200 per 1000 live births during the early 1950s<sup>37</sup> to about 79 in the mid 1990s<sup>38</sup>, while life expectancy has risen from about 28<sup>39</sup> years to about 59 years now<sup>40</sup>. Although maternal mortality ratio has declined from about 850 per 100,000 live births<sup>41</sup> until mid 1980s to about 539 now, it is still the highest in the whole of South Asia - Bangladesh 440, India 450 and Sri Lanka 60<sup>42</sup>. Therefore, continued efforts are needed to improve the quality of service and management capacity of health facilities so that the pace of mortality decline can be speeded up which has a direct bearing on fertility reduction.

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<sup>32</sup> Karki, 1988.

<sup>33</sup> *ibid.*

<sup>34</sup> MOH, 1997.

<sup>35</sup> MOH, IEC Strategy, 1996.

<sup>36</sup> According to a calculation carried out by donor agencies and HMG in 1998 Nepal's unmet need for spacing methods in dollar terms was 16% for 2000 and 24% in 2001. In dollar terms they were respectively falling short of \$728,000 and \$758,000 (Needs Assessment of Contraceptives in Nepal, March 1998, MOH and KfW, Kathmandu).

<sup>37</sup> Vaidyanathan and Gaige (1973)

<sup>38</sup> MOH, 1997.

<sup>39</sup> Vaidyanathan and Gaige (1973)

<sup>40</sup> MOPE, 1998.

<sup>41</sup> NPC, 8th Plan, p.502.

<sup>42</sup> WB, 2000.

9. Relatively low level of social and economic development -- low literacy, education particularly among females

Social development in general is low in Nepal and it is particularly so for women. Low literacy combined with low or virtual absence of decision making power of women contributes to high fertility as women do not make decision about their reproductive rights. The number and spacing of children are largely determined by either husband and/or other seniors in the family such as the mothers-in-law, etc. It has, unfortunately, been noticed that the gender gap has widened<sup>43</sup>.

10. Unplanned population movement

Population movement within Nepal and between Nepal and India is said to be enormous because of the open borders. Among the internal migrants most move from the highlands to the lowlands. For instance, in 1981, of the total 1.3 million lifetime migrants 85.1 percent originated in the highlands and 68.8 percent of them moved to the Tarai lowlands<sup>44</sup> and in 1991, of the total 1.2 million lifetime migrants 83 percent migrated to the Tarai from highlands<sup>45</sup>. Unfortunately no reliable data are available on international migration to make any estimates or adjustments. In recent years, Indian migrants seemed to have swamped most Nepalese urban centres. Gurung<sup>46</sup> suggests for effective migration policies in the interest of nation building the government has to review Nepal-India -1950 Treaty, boundary regulations, citizenship policy, trade, industry, labour and employment, urbanisation and land use policies. Also he suggests to strengthen vital registration system and regional development concept.

#### Major challenges faced by drinking water and sanitation sectors

1. Increasing shortage of drinking water

Shortage of drinking water has been felt acute particularly in Kathmandu valley<sup>47</sup>. In 1999, in Kathmandu and Lalitpur demand for drinking water was estimated at 123.8 MLD while the total supply was only 103.6 MLD. At present drinking water requirement is 150 MLD for Kathmandu and Lalitpur but the supply is only one-third of the demand in dry season and two-thirds in other times<sup>48</sup>.

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<sup>43</sup> UNFPA, 1996.

<sup>44</sup> Gurung, H., 1989.

<sup>45</sup> K.C., 1995.

<sup>46</sup> Gurung, H., June 2000.

<sup>47</sup> Shortage is certainly acute in other urban centres but data are not available.

<sup>48</sup> MOPE, 2000.



## 2. Lack of understanding of cleanliness and hygiene

According to a survey diarrhoea occurred in 15% of children aged 0-36 months in Nepal which is directly related to quality of water and sanitation. Most women acknowledged this as a major health problem<sup>49</sup>. Expansion of safe drinking water and sanitation facilities and education, therefore, bears special significance in the health sector. But villagers think that cold water from natural springs has no substitute although it is often contaminated at the source. Also in rural areas environmental sanitation is still not appealing to the rural folks as they think that open air toilets are convenient and free. Besides, certain ethnic communities utilise human excreta for pig farming which prevents them from building basic pit latrines.

## 3. Waste disposal

Solid waste disposal is increasingly becoming a major problem in big cities such as Kathmandu valley. With fast growth of population and urbanisation the residents of the valley are finding it increasingly difficult to get rid of solid wastes in the city. With the assistance of GTZ, in 1986 the Solid Waste Management and Resource Mobilisation Centre (SWMRMC) established a plant to process solid wastes but it was later stopped on the ground that it was too close to the urban area (Teku)<sup>50</sup>. HMG since then has not established an alternative plant. These days, apparently, solid wastes have become power bargaining weapons for politicians.

Apart from sector specific challenges there are a number of challenges which are common to all three sectors which are:

### 1. High political commitment hardly translated into practice

The policies and programmes on population and health envisioned in different development plans are ambiguous. The commitments are not materialised due to the lack of concrete implementation strategies. Different plan documents do lay down strategies but they are hardly refined at the time of actual implementation.

### 2. Little partnership between governmental and non-governmental organisations and the private sector

The GO/NGO/private sector partnership has not been very cordial in practice. This has led to duplication of services, sub-standard outputs, top down decision making, inefficient use of resources and the lack of trusts among the service providing agencies in health and population programmes.

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<sup>49</sup> UNICEF, March 1996.

<sup>50</sup> MOPE, 2000.

### 3. Persistent high poverty

Economic and social development has taken place during the last four decades. Indicators like literacy, education, life expectancy, contraceptive prevalence rate, population coverage by mass media and transportation facilities have all increased. However, the pace of development was not fast enough to raise living standards for the bulk of the population. Nepal remains one of the poorest of the poor countries despite completing eight development plans or four decades of centralised development planning. The growth of real GDP in Nepal has been relatively low; it has hovered around 1.9% per annum to 8% during the last three decades; worse in recent years. Consequently both the proportions and absolute number of people living below the poverty line have increased in the recent past. The low performance of the economy in recent years compounded by the persistent high growth of population -- above 2% per annum, have resulted in raising the number of people falling into destitution. The incidence of income poverty in the last decade, i.e., the 1990s, has worsened than in the decade before that. During the mid 1980s the proportion of population in Nepal under the poverty line was estimated at 36.7 per cent and the situation was worse in the mid hills -- 45.5% and in the high mountains 37.5% while in the Tarai it was slightly better -- 28.4 per cent. By 1996 the incidence of poverty deteriorated as the national level poverty line increased to 42% and in the high mountains and the Tarai it increased to 56% and 42% respectively. Only in the mid hills it appears to have improved slightly -- the incidence of poverty reduced from 45.5% in 1984/85 to 41% in 1996<sup>51</sup>. The fast growth of population was largely responsible for reducing returns from development investments.

### 4. Implementation of decentralization policy is challenging

HMG is committed to decentralization. It is, however, reported that this has hardly been put into practice. Besides, there are no clear operational guidelines to implement programs on a decentralized basis. Decentralization can also be harmful as certain vested interest groups can utilize it for their own benefits.

### 5. Sustainability of programs

Still more important issue is sustainability. Sustainability has three perspectives, viz., program sustainability, institutional sustainability and financial sustainability. For overall sustainability all three must be taken into account. Local innovative models need to be tested for sustainability at the community level. Gradual reduction of donor dependency also calls for proper and in-depth understanding of sustainability. Sustainability does not mean doing away with external partner assistance. It should mean use of external assistance in a sustained manner.

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<sup>51</sup> NPC, Ninth Plan and Karki, Y. B., July 2000.

6. Designing a balanced use of resources is challenging

It is also important to know shares of expenditure by salaries for manpower, program and logistics. It is reported that at lower levels of service delivery the share of salaries is far too high which negatively contributes to sustainability even if user fees are introduced.

7. Lack of coordination

Coordination within the Ministerial Departments and Sections and between the Ministries and the NGOs and the private sector always surfaces in any analysis and discussion. Coordination is lacking not only in the government sector but also in the NGO sector despite the fact that there are many (I)NGOs involved in delivering health and population services to the people.

8. The government along with the private and the NGO sector has to thrash out certain regulations with respect to program implementation. Increasing number of NGOs are carrying out health programs but the work is apparently duplicated. In view of the scarcity of resources it is imperative to work out clearly how the government, the private sector and the NGOs should effectively implement their programs by minimizing duplication.

9. Related to the above issue is the question of monitoring of health and population programs. Only since FY 2051/52 MOH has been producing fairly comprehensive Annual Report by incorporating NGO activities too. This still needs to be improved in that every investment that is made by any institution/agency should also produce plausible results and the monitoring mechanism should be able to trace them by institution/agency, field of specialization, geographic areas and other important variables.

10. Lack of trained health/professional manpower is another big issue. Although the structure of the health system is comprehensive the manpower needed to flesh it up is seriously lacking. This requires quality training programs on a continuous basis.

11. Another serious complaint is the frequent transfer of manpower without rhyme and reason. This has particularly become serious since the 1990s. The frequent change of government leadership has negatively contributed to this. As the saying goes, "a rolling stone gathers no moss" the frequent change of manpower affects implementation of programs seriously.

12. Fortunately, from the list of donor communities, it is evident that there is immense interest among them in the development of Nepal. The government and the civil societies in Nepal should have the capability to capitalize on this potential. This also seriously calls for good governance and unambiguous

political commitments. Attention must be paid to it before the donor community label Nepal as a "donor fatigue" country.

13. To bring about speedy improvements in health and population indicators the standard of living must be raised, i.e., the poverty must be addressed. Nepal's population will increase sharply for some time to come, and so development must be at a pace sufficient to ensure higher standards of living, while meeting the demands of population growth. The scale of national investment must take account of this double requirement. The 20/20 initiative endorsed by the 1995 World Summit for Social Development must be implemented effectively. In Nepal, although absorptive capacity has to be improved, the respective share of government and donor assistance for the social sector in 1997/98 stood at 14.2/10.3 as against the internationally suggested norm of 20/20<sup>52</sup>.

#### Health, Population and Drinking Water & Sanitation Programs in the Ninth Plan and 20-Year Plan

In the light of the experiences gained by the end of the Eighth Plan and to respond to the challenges discussed above, the National Planning Commission, by involving the MOH, the MOPE and other relevant ministries and agencies, has come up with the Ninth Plan document as well. The Ninth Plan, carrying on with the major thrusts of the previous plan, has also emphasized the equity aspect and has made commitment to meet the needs of the poor through the delivery of an essential health care package (EHCP). The major strategies of the MOH that were discussed earlier are to be carried out during the Ninth Plan period too. The role of the government in the health sector falls into three clear components:

- To ensure that an EHCP is available to all regardless of ability to pay;
- to ensure policies and strategies are in place for health needs that fall outside the essential package and
- To regulate the private health sector.

The MOPE in the Ninth Plan has continued with the earlier plan by emphasizing

- two child family norm,
- promotion of integrated population programs with other sectors and
- regulating international migration.

The programs are mostly advocacy and promotional types. The ministry's main strategy is to involve relevant sectoral ministries and local units in its advocacy programs. As the MOPE came into existence only towards the end of the Eighth Plan, it now has a plan to prepare a 20-Year Population Prospective Plan. Just as in the previous plan, there are a lot of overlaps between the MOH and MOPE in population programs.

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<sup>52</sup> NPC, 20/20 Initiative for Basic social Services. Kathmandu, 2000.

The Ninth Plan has listed 11 strategies to implement drinking water and sanitation programs. The strategies include:

- involvement of the local bodies from the early stage of project selection,
- carrying out of environmental impact of a project with the involvement of the local stakeholders,
- mobilization of local NGOs in support of Users' Committees,
- selection of appropriate technology,
- assurance of water quality,
- better institutional arrangements in that a locality with up to 500 population will have the authority to operate independently while the quality control is to be supervised by the central public corporation,
- carry out legal reforms to ensure water quality,
- subsidy to potentially beneficial projects, encourage private sector and adopt sustainable strategy,
- repair, maintenance and improvements to be carried by local/private agencies,
- strengthen manpower capacity, improve co-ordination between different levels of authority, and
- monitor and evaluate projects regularly.

For the Ninth Plan and 20-Year Plan a new set of targets have been fixed in population, health and drinking water and sanitation sectors which are reproduced in Table 3.

The last two columns were calculated by the author. Although health problems are serious in the country, the performance indicators set for the Ninth Plan period as well as the 20-year plan appear to be moderate. For instance, the TFR in 1996 was 5.09 and in 1996 it went down to 4.60 yielding an average rate of decline of 0.098 per year and many studies show that the pace of fertility decline is relatively slow only after attaining TFR of 3.0 per woman. If the health programs are also aimed at reducing population growth the targets should be challenging too.

In October 1999, a Steering Committee was formed under the chairmanship of the Minister of Health to carry out Health Sector Strategic Analysis to operationalize the SLTHP and to reassess the capacity of the health system. The MOH (February 2000) has produced a report entitled "Strategic Analysis to Operationalise Second Long Term health Plan, Nepal". Along with the situation analysis the document lays down four specific action issues for the government to focus which are:

1. Strengthening of health services delivery;
2. Decentralization;
3. Strengthening of Public-Private-NGO mix and
4. Strengthening of sectoral management.

Table 3: Population, health and drinking water and sanitation performance indicators for the Ninth Plan and Second Long Term Health Plan (1997-2017)

Ser. #	Population and Health Indicators	Baseline	9th Plan	2017 or 20- year targets	Yearly rate of change in 9th Plan period	Yearly rate of change in 15-Year period
		1996/97, Last Yr. of 8th Plan	(97/98- 01/02) Targets			
1	TFR	4.58	4.20	3.05	0.08	0.08
2	CPR	30.1	36.6	58.2	1.30	1.44
"3	Percentage of females aged 15-19 married	42.1	36.1	-	1.20	NA
4	IMR	74.70	61.50	34.40	2.64	1.81
5	Under 5 mortality rate	118.00	102.30	62.50	3.14	2.65
6	Expectation of life at birth	56.10	59.70	68.70	0.72	0.60
7	Maternal Mortality Ratio (Health sector)	475	400	250	15.00	10.00
8	Obstetric service by trained manpower (%)	31.5	50.0	95.0	3.70	3.00
9	Birth of infant below 2500 gm	-	23.0	12.0	NA	0.73
10	CBR	35.4	33.1	26.6	0.46	0.43
11	CDR	11.5	9.6	6.0	0.38	0.24
12	Basic/essential health service accessibility (% of people)	-	70	90	NA	1.33
<b>Drinking Water</b>						
13	Population served by drinking water facility (%)	61	100	100	7.80	NA
14	Population served by pure drinking water facility (%)	15	25	40	2.00	3.00
<b>Sanitation</b>						
15	Percentage of population benefiting (Rural)	16	36	-	4.00	NA
16	Percentage of population benefiting (Urban)	51	60	-	1.80	NA
17	Percentage of population benefiting (Total)	20	40	-	4.00	NA

*"NOTE: Item # 3 is mentioned in the Population Sector only.  
NA = Not applicable*

*Source: Ninth Plan, 1998, p. 223 and p. 656*

### Challenges for the Ninth Plan

Almost all the challenges that were faced by previous plans will also be faced by the current plan too. A few challenges that lie ahead during the implementation of the Ninth Plan are worth mentioning here.

1. The Ninth Plan stresses the EHCP but examination of the use of scarce financial resources indicates that they are increasingly taken away from the primary care to the secondary and tertiary care. The share going to primary care, for example, fell from 76.8% of public expenditure in 1991/92 to 57.2% in 1997/98<sup>53</sup>. The process of decision making is perhaps influenced by political hierarchy. In order to implement the strategies laid down in the Ninth Plan the civil service must be made immune to politics and due recognition must be accorded to the professional cadre.
2. In view of the lowest / worst health indicators<sup>54</sup> in Nepal compared to the other major South Asian countries it would be justifiable to revise the performance indicators set for the SLTHP, i.e., for 2017. Accordingly, it is also important to operationalise annual performance indicators for different areas of the country but because of the shortage of area specific information this can be a daunting task at least for some years to come.
3. Unavailability of scientific epidemiological, costs and public health data is rendering difficulties in properly designing programs and monitoring them in a timely fashion.
4. Still another challenge on the social development front is the absence of operational strategy that takes into account the vulnerable groups and hard to reach areas of the country. Attempts to address these issues will hopefully reduce social and political tensions in the country. This calls for dedication, commitment, magnanimity and long term vision on the part of leaders who command the nation.

## Conclusion

The people of Nepal are caught up in economic hardships not only due to the depletion of nature resource base<sup>55</sup> but also because of relatively low performance of the economy. Despite high fertility norm people single out the deteriorating hill environment and the economic cost of raising children responsible for their hardships; they spoke in support of a shift towards smaller family size if they could. Those families who had good land are now only moderately well off. Inheritance customs continually divide large estates between several sons; thus more sons means less land for each. Many villagers, therefore, linked the poverty of the people to large family size<sup>56</sup>.

HMG of Nepal has been sponsoring population and health programs for a long time. The problem is that while to the government it may be beneficial to limit family

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<sup>53</sup> MOH, Feb., 2000.

<sup>54</sup> Nepal seems to perform better than Pakistan with respect to IMR, U5MR and CPR.

<sup>55</sup> Karki, 1994.

<sup>56</sup> Karki, 1982.

size, parents may desire a large family for prestige or economic reasons. About 90% of the population are Hindus and value sons much more highly than daughters. Girls are economically useful until they marry and leave home while sons also provide old age security.

These great obstacles to the Government's aim of reducing the birth rate can possibly be overcome by carefully designed population policies, correctly implemented. These should take into account the experience of other countries with similar problems. Three and a half decades of family planning programmes have contributed to some reduction of fertility and improvements of health standards but not to the extent the other neighbouring nations have achieved. The Government at least in policy documents propagated integrated population programmes but they have not reached the community level to the extent desired. What is now needed is the integrated, multidimensional approach which emphasises literacy, education (particularly for women) lowering infant mortality and providing contraceptives along with follow-ups.

Information, education and communication programmes must be reinforced by health or community workers at the village level who can teach the villagers - the involvement of women must be encouraged here. Perhaps at this stage local NGOs can be effective as they can mobilise the community better than the government officials. Perhaps the urban sanitation problem can also be resolved by involving the local NGOs, civil society organisations and the private sector; this is the time of bottom-up approach where the majority should be able to voice their concerns.



## Stakeholders/Institutions

The MOH, MOPE and the NPC are the main institutions responsible for the development and implementation of the health sector policies, programs, and strategies. For implementation, other line ministries, NGOs/INGOs and private sector organizations are also responsible. They are mostly as follows:

## Government ministries include:

MOH	Ministry of Health
MOPE	Ministry of Population and Environment
MLD	Ministry of Local Development
ML	Ministry of Labour
MWSW	Ministry of Women and Social Welfare
MOA	Ministry of Agriculture
MOEC	Ministry of Education and Culture

## NGOs include:

FPAN	Family Planning Association of Nepal
NTAG	Nepal Technical Assistance Group
BPMHF	B. P. Memorial Health Foundation
AMK	Ama Milan Kendra
WOREC	Women's Rehabilitation Centre
NRCS	Nepal Red Cross Society

## Private sector includes:

CRS	Contraceptive Retail Sales
NFCC	Nepal Fertility Care Centre
IIDS	Institute for Integrated Development Studies
New Era	Research Agency
VaRG	Research Agency

## Donor agencies include:

UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund

USAID	United States Agency for International Development
IPPF	International Planned Parenthood Federation
DFID	Department for International Development (UK)
GTZ(PHCC)	Deutsche Gesellschaft für Technische Zusammenarbeit (Primary Health Care Project)
AusAID	Australian Aid
SDC	Swiss Agency for Development and Co-operation
JICA	Japanese International Co-operation Agency
NORAD	Norwegian Agency for Development
KfW	The German Development Bank
WB	The World Bank
WHO	World Health Organisation

INGOs include:

AVSC	Association for Voluntary Surgical Contraception
BNMT	Britain Nepal Medical Trust
CEDPA	Centre for Development and Population Activities
CARE	Care International
TAF	The Asia Foundation
FHI	Family Health International/ Population and Reproductive Health
FHI	Family Health International/HIV/AIDS Prevention and Control Program
INF	International Nepal Fellowship
JHU/PCS	Johns Hopkins University/ Population Communication Services
JHPIEGO	Johns Hopkins University Program for International Education
NHLA	Norwegian Heart Lung Association
UMN	United Mission to Nepal
ADRA	Adventist Development and Relief Agency

TLMI	The Leprosy Mission International
UoH	University of Hiedelberg
VSC/Canada	
JSI	John Snow Incorporate
MSI	Marie Stopes International/Sunaulo Pariwar
HKI	Helen Keller International
MDM	French Medical and Sanitary Aid
NLR	Netherlands Leprosy Relief
PLAN International	Plan International
OXFAM	
SCF, USA	Save the Children Fund, USA
SCF, UK	Save the Children Fund, UK
REDD BARNA	Save the Children Fund, Norway
SCF, Japan	Save the Children Fund, Japan
WN	World Neighbours
WE	World Education
ACTIOAID	Action Aid, UK

## Community based sustainable primary health care project

In 1979 the Japanese Organization for International Cooperation in Family Planning (JOICFP) assisted the FPAN to start Integrated Family Planning Project in 15 VDCs of Kavre district. Later in 1986 Primary Health Care Delivery system was developed based on the valuable experience gained in earlier years. FPAN negotiated with the local villagers and asked them to manage the service unit by themselves while basic training was provided by JOICFP. The clients were also charged cost price for drugs. In order to manage the program Local Cooperation Committee was formed. The money from the sale of drugs was ploughed back to the local revolving fund which was used to replenish the stock. Also in each VDC local Health Cooperation Committee was formed to sustain the local Community Based Primary Health Care unit. The local CBPHC units in 1993 were converted into local NGOs. Now these local units are self sustaining and the efforts made have paid off as supported by the following indicators.

Health indicators of VDCs with CBPHC units, Kavre.

Particulars	Present figures (1996+)	Baseline (1979++)	National figures (1996*)
Contraceptive prevalence rate	53.1	5.8	28.8
Infant mortality rate	63	NA	79
Maternal mortality ration	317	NA	539

+FPAN survey conducted in 1996. ++FPAN Baseline survey conducted in 1979.

\*MOH, 1997.

Through local CBPHC unit the villagers enjoy basic primary health care services, sanitation education, safe motherhood training and education, family planning services and counseling and recently they have also started adolescent reproductive health education too. Because of the pioneering role played by the CBPHC units in village health matters they are increasingly recognized by local bodies and even outside agencies. The VDC office allocates its funds to them as well<sup>57</sup>.

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<sup>57</sup> Shrestha, S. January 1997.

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