Background

Located in the mighty Himalayas, Nepal has a largely rugged terrain. With relatively little cultivable land to support its 30-million-plus population, Nepal too is fighting the problem of population explosion due to its high fertility rate, like many other countries in the South-East Asia Region.

The population pyramid (Figure 1) reveals a Nepalese population that is largely constituted of children and youth. With such a high proportion of the population either currently in the reproductive age group, or on the threshold of it, the growth momentum will continue to increase the population size for at least a generation to come, even in the face of best efforts to contain the fertility levels.

Situation Analysis

The overall situation is shown by relevant demographic and health indicators in Table 1.

Table 1: Key indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population (in millions), 2011</td>
<td>26.5</td>
</tr>
<tr>
<td>Population growth rate, 2001–2011</td>
<td>1.35%</td>
</tr>
<tr>
<td>Population density (people per square km), 2011</td>
<td>180</td>
</tr>
<tr>
<td>Urban population, 2011</td>
<td>17%</td>
</tr>
<tr>
<td>Population &lt;15 years of age, 2011</td>
<td>34.9%</td>
</tr>
<tr>
<td>Total fertility rate, 2011</td>
<td>2.6</td>
</tr>
<tr>
<td>Contraceptive prevalence rate, 2011</td>
<td>49.7%</td>
</tr>
<tr>
<td>– Pill</td>
<td>4.1</td>
</tr>
</tbody>
</table>
Nepal and Family Planning: An overview

Figure 2: Trends in Fertility

<table>
<thead>
<tr>
<th>Year</th>
<th>Births per woman for the 3 years prior to the survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996 NFISH</td>
<td>4.6</td>
</tr>
<tr>
<td>2001 NDHS</td>
<td>4.1</td>
</tr>
<tr>
<td>2006 NDHS</td>
<td>3.1</td>
</tr>
<tr>
<td>2011 NDHS</td>
<td>2.6</td>
</tr>
</tbody>
</table>

Source: Nepal DHS 2011 (Key findings).

<table>
<thead>
<tr>
<th>Method</th>
<th>Method Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injectable</td>
<td>9.2</td>
</tr>
<tr>
<td>– Implants</td>
<td>1.2</td>
</tr>
<tr>
<td>– IUD</td>
<td>1.3</td>
</tr>
<tr>
<td>– Female sterilization</td>
<td>15.2</td>
</tr>
<tr>
<td>– Male sterilization</td>
<td>7.8</td>
</tr>
<tr>
<td>– Condom</td>
<td>4.3</td>
</tr>
<tr>
<td>– Traditional or natural methods</td>
<td>6.6</td>
</tr>
</tbody>
</table>

Unmet need 27%

– Spacing 10
– Limiting 17

Median age at first marriage 17.8
Median age at first birth 20.2

Crude birth rate (per 1000 population), 2011 24.3
Maternal mortality ratio (per 100 000 live births), 2011 170
Infant mortality rate (per 1000 live births), 2011 46
HIV adult prevalence (age 15–49 years), 2011 0.3%


Total fertility rate (TFR)

Fertility rates in Nepal have been gradually dropping over the decades. While the TFR was 5.8 in the 1970s, it gradually reduced to 5.1 births per woman in 1985 and then to 4.1 in 2001. In the past few years, owing to intense efforts towards population stabilization by the Government of Nepal as well as partner agencies, the country saw a sharp decline in TFR to 3.1 in 2006 and to 2.6 in 2011 (Nepal DHS 2011) (Figure 2). The fertility rate shows an inverse trend when mapped against the socioeconomic status of women, with women in the lowest wealth quintile having a fertility rate of 4.1 as against 1.5 for women in the highest quintile (Figure 3).

The reduction in TFR is also reflected in the gradually changing shape of the population pyramid of the country. In 2001, children under 15 years of age accounted for about 45% of the total population. This has reduced to less than 40%, with the “bulge” in the pyramid shifting upwards towards the adolescent and youth population.

Figure 2: Trends in Fertility

Source: Nepal DHS 2011 (Key findings).
Contraceptive prevalence rate (CPR)

The steep reduction in TFR can be attributed to an impressive increase in the use of contraception in Nepal over the past 10 years. As can be seen in Figure 5, the CPR in Nepal for modern methods showed a marked increase in the decade from 1996 to 2006. Based on the national DHS in 2006, CPR for modern methods stood at 44.2%, while overall CPR (including traditional methods) had increased to 48%. A large proportion of this success in improving women's acceptance of modern contraceptive methods can be attributed to the Nepal Health Sector Programme Implementation Plan launched by the Government of Nepal in 2004.

The rising trend in CPR, however, was not reflected over the next 5 years. According to DHS 2011, the CPR for modern methods remained almost unchanged at 43%. Owing to an increase in acceptors of traditional methods of contraception to 7% of all women, half of all married women were using some method of contraception during the 2011 survey.
While the interregional differences within the country were minimal, the use of contraception by women residing in urban areas was significantly higher than by their rural counterparts. While over 54% of urban women in the reproductive age group were using a modern method of contraception, only 42% of rural women were doing so in 2006 (Figure 4).

Figure 5: Trends and urban-rural divide in modern contraceptive use

![Graph showing trends and urban-rural divide in modern contraceptive use.](source)

Source: Nepal DHS 2011 (Key findings).

Figure 6: Trends in CPR, 1991–2006

![Graph showing trends in CPR, 1991–2006.](source)

Source: Nepal DHS 2006 and 2011

**Contraceptive method mix**

The method mix pattern observed in DHS 2006 and 2011 in Nepal was similar to the findings of DHS 2001. Permanent methods, that is, female and male sterilization accounted for more than half of the modern method mix (15% and 8%, respectively). Among temporary-spacing methods, injectable contraceptives were the method chosen by one fifth of all contraceptive users. As seen in figure 6, there has been an increasing acceptance of the pill over the years. While pills and condoms each accounted for contraceptive preferences of about 4% of all married women, IUDs and implants – despite showing an improving trend over the years – continue to find very few takers in the overall picture of contraceptive use mix in the country.
Unmet need for contraception

As can be seen from Figure 7, almost 40% of all births in 2001 were the result of an unwanted pregnancy. The 2011 survey found that while the fertility rate was 2.6, the ideal family size for a Nepalese couple is about 2 children (2.1 for women and 2.3 for men).

About half of married women do not want any more children and, of these, 23% are already sterilized. Another 14% want to wait for at least 2 years before the next birth. Overall, about 27% of married women had an unmet need for family planning, signifying a minimal improvement from the 28% found in the 2001 survey. Of this, 10% have an unmet need for spacing the next birth for at least 2 years, while 17% have an unmet need for limiting the family size.

Source: Nepal DHS 2011 (Final report).
Adolescent fertility

The adolescent fertility rate in Nepal is relatively high and the second highest, after Bangladesh, in the South-East Asia Region (Figure 8). According to DHS 2011, it stood at 81 births per 1000 girls aged 15–19 years, which although a reduction from 98 per 1000 as estimated in DHS 2006, is still high compared to the regional average of 54.

While the median age of girls at first birth is 20.2 years in Nepal, 23% of women aged 25–49 had given birth to their first child before they were 18 years of age, while 2% had become mothers before they were 15 years of age. According to DHS 2011, 17% of women aged 15–19 had either already had a baby or were pregnant with their first child.

As most births take place within the realm of marriage, age at marriage is a very important determinant of age at first birth. The median age at marriage is gradually increasing in Nepal. DHS 2011 pegged the median age at marriage at 17.5 years for girls and 21.6 years for boys. More than half of girls (55%) are married before the age of 18. The median age at first sexual intercourse is 17.7 years for girls and closely follows their median age at marriage, thus signifying that for most girls sexual debut takes place within the context of marriage. However it is not so for the men, whose age at sexual debut is 20.5 years and is about a year before their marriage.

The relatively high teenage pregnancy rate is linked to the low use of contraception among married adolescents. Less than 18% of married girls in the age group 15–19 years were using a contraceptive according to DHS 2011. It needs to be mentioned that the unmet need for contraception at more than 41% (largely for spacing methods) is highest in this age group as compared to other age groups in the reproductive span.

Access to family planning information and services

According to DHS 2011, knowledge of family planning methods is almost universal among Nepalese men and women, with 100% of currently married women and 99.8% of currently married men able to identify at least one method of contraception. Men and women were more familiar with
modern methods of contraception especially female sterilization, injectables, condoms and male sterilization. Relatively few men and women had heard about emergency contraception (39% and 29%, respectively). It is interesting to note that never-married men and women were more familiar with this method than currently married ones.

The public health sector is the largest provider of contraceptive services. For example, about four fifths of men and women in Nepal accessed the government health facilities for sterilization procedures, with the rest reaching out to hospitals run by nongovernmental organizations or the private sector. However, the private sector (hospitals and pharmacies) plays a larger role in the supply of product-based contraception such as pills, injectables and condoms.

**Current Family Planning Efforts**

Family planning services have been available in Nepal for over 50 years. At the start of this millennium, the Government of Nepal set a goal to meet the health-related MDGs in the context of Nepal’s country-specific challenges. In 2004, the Ministry of Health and Population committed themselves to the Nepal Health Sector Programme Implementation Plan phase 1 (NHSP-IP, 2004–2009), supported by 11 external development partners. This was extended and expanded in its second phase (NHSP-IP 2010–2015). The NHSP-IP focuses on reproductive, maternal and child health. The national family planning programme is an integral component of the same.

Due to inadequate funds as well as a loss of focus on family planning, the targets set for CPR and TFR have not been met. With an eye to reinvigorating family planning efforts, the Family Health Division of the Ministry of Health and Population is focusing on expanding the reach of family planning services through its chain of public health facilities such as primary health centres, health posts, subhealth posts, primary health centre outreach clinics and mobile surgical contraception camps. Satellite clinics have been initiated in all districts. Community health volunteers provide family planning counselling services and also act as depot holders of family planning products.

The public health sector is supported by various nongovernmental organizations such as Marie Stopes and the Family Planning Association of Nepal. A vibrant private sector that includes not just private clinics and hospitals, but also pharmacies, is also involved in the provision of family planning services and products. For example, the Sangini Franchising Network provides injectable contraceptives (local brand name: Sangini-Tin Mahine Sui) through a network of pharmacies present in all 75 districts of Nepal.

Other special efforts include the postpartum intrauterine contraceptive device programme launched by the Government of Nepal to meet the special demands of postpartum women. The pilot programme was implemented in six hospitals (five government and one private) in June 2011, and is now in the process of expanding through private-sector facilities nationally.

**Challenges and Opportunities**

1. **Sustaining the programme momentum**: The massive increase in CPR between 1996 and 2006 and concomitant reduction in TFR can be credited to the efforts of the Government of Nepal and non-governmental partners. However, the slight decline in CPR between 2006 and 2011 reflects a loss of momentum of the programme. Political will, with a focus on ensuring adequate fund allocation to the family planning effort, will go a long way in sustaining and building on previous efforts.
2. **Access to information and services**: Despite universal awareness about family planning efforts, uptake remains relatively low and there is a high unmet need. The Government, with support from non-governmental organizations and the private sector, needs to expand the reach of family planning products and services. The relatively recent initiatives by the Government of Nepal to provide family planning services through satellite and mobile clinics, as well as using community health volunteers as distributors of family planning products, provide the ideal platform to expand the reach of services to cover women even in the lowest wealth quintile.

3. **Appropriate method mix**: Like in many other countries in the South-East Asia Region, there is a high reliance among Nepalese couples on sterilization as a family planning method. Data show that a large proportion of women undergo sterilization after their third or fourth child, which does not have much impact on reduction in fertility rates and population stabilization. Focus on spacing methods, including relatively long-term spacing methods such as IUDs and implants, will go a long way towards population stabilization. It will also contribute to reduction in maternal and child mortality by increasing the inter-pregnancy gap.

4. **Adolescent fertility**: The gradual increase in age at marriage and age at first birth is an encouraging trend. The Government of Nepal, through its efforts to expand the reach of family planning services, has to focus on the special needs of both married and unmarried adolescents as unmet need for contraception is very high in the teenage group. In addition, as sexual activity among men begins before marriage, educating young boys about responsible sexual behaviour and increasing their access to contraceptives will contribute towards a reduction in overall fertility.

References: