

OLD AND NEW BARRIERS TO FAMILY PLANNING IN HUMLA, NEPAL: HOW THE URBAN/RURAL DIVIDE HAS WIDENED

Apryle Pickering
Kimber Haddix McKay

In Nepal it is better to have smaller families. There are fewer problems. In the village most women were having four to five children but now people are realizing that fewer children is better and they are adopting family planning. In the past we had no choice, we had to keep producing –Humli woman, now residing in Kathmandu

Nepal stands out among countries experiencing a demographic transition because it is the poorest country in the world undergoing the transition, and because fertility levels are dropping without any formal governmental pressure or family planning policy (Caldwell 1998). Comparison of data from the 2001 Nepal Demographic and Health Survey with earlier surveys conducted in Nepal indicate that fertility has declined steadily from 5.1 births per woman in 1984-1986 to 4.1 births per woman in 1988-2000 (NDHS 2002). There has been an 18 per cent decline in fertility among women under the age of 30, with the largest decline occurring between 1992 and 1997 (NDHS 2002). National scale survey data show broad patterns throughout the period of transition, but other tools can advance our understanding of the pace and character of fertility transitions, and how changing fertility strategies are understood, motivated and perceived by individual Nepalese women. Utilizing a combination of quantitative and qualitative data from fieldwork completed in Nepal in 2004, we show how women in rural Nepal continue to experience barriers to contraception and in fact that obstacles to controlling fertility are increasing for women in Humla District, a rural region in Nepal's northwest corner. The rural/urban divide that impacts access to contraception in Nepal has broadened dramatically since the Maoist insurgency began in 1996, and the drastic differences among rural and urban women in terms of education and access to family planning are now exacerbated by the presence and behavior of the Maoists and Army. Conditions in rural Humla, Nepal where the Maoist presence is heavy are producing a situation in which family planning is now virtually impossible for many women.

Availability of health care in Humla

In Nepal, the quest for good health is occurring in the context of the tremendous stress and anguish people are experiencing during the civil war.

Nepal's insurgency started in 1996 and sharply increased in intensity after the 2001 Royal family massacre. By 2005, Nepal had found its way into the ranks of the world's worst humanitarian and human rights disasters (Amnesty International 2005; Global IDP Project 2005). To date, nearly 20,000 people have been killed, 150,000-200,000 are internally displaced, and an estimated 1.8 million have fled the country (CBC News 2004; Douglas 2005; Global IDP Project 2003). People living in the countryside have been terrorized for five years, caught between the army and the rebels, forced to feed both sides from already insufficient food supplies, and unfairly named, beaten, or killed for 'supporting' one side or the other. Abduction of children for use as soldiers or as human shields, and forceful recruitment to mass rallies are two common ways that villagers are physically drawn into the conflict. Many unwilling rally participants have lost their lives from helicopter strafing by the army, and countless girls have been abducted and raped or used as sex slaves by both the Maoists and the army (Douglas 2005; Gersony 2003). Individuals employed by the government, most importantly for this project all government health workers, have fled villages in Humla due to the risks posed to them by the insurgency. As a consequence, villagers have no regularly available person to turn to for allopathic, 'western' medical treatment of the health problems that plague them today as much, if not more than ever before¹, nor to sources of reliable, safe, effective contraception. In the past, Humlis had two sources of health care, health care resources, and contraception: the national health care system and the projects funded by private non-governmental organizations (NGOs).

Neither of these options is currently available to most Humlis. Villagers are cut off from the national health care system by the fact that they often can not travel to Simikot in safety. On top of the already-daunting challenge of the several-days long walk over mountain passes separating many villages from Simikot, villagers now live in fear of abduction, violence, or other consequences of the suspicion with which the then Royal Nepal Army (RNA) and the Maoists treat people traveling from one place to the next. In fact, every Humli needs written permission from the local Maoist cadres in order to even leave their village. Because the Maoists are usually in hiding, it is often very difficult to find anyone to even ask for such permission.

The other source of hope on the health care horizon has been the efforts of the private organizations involved in health care delivery to Humlis. However, with the exception of one small organization focused on smokeless stoves, latrines, solar lighting and safe drinking water systems, all NGO and INGO activity in the district has been halted by the Maoists. Nearly all Nepali and foreign NGO activity is limited at present to Simikot, which is heavily armed and protected by the local RNA base, but is inaccessible to many villagers for the reasons discussed above.

Following the work of previous students of Nepalese fertility (e.g. Axinn 1993; Folmar 1992; Haddix 2001; Stash 1999; Tuladhar 1987), we examined some of the issues surrounding current Nepalese contraceptive usage by comparing the experiences of a group of urban Nepali women with the experience of a group of Humli women, with special attention to barriers to contraception facing Humli women today that have emerged as a result of the ongoing insurrection.

Study Design

The data presented in this paper were drawn from the 2001 Nepal Demographic and Health Survey (NDHS, 2002) and on field research conducted between June and August 2004 in the capital city Kathmandu.

Figure 1: Map of Nepal with Kathmandu and Humla indicated



Source: <http://geography.about.com/library/cia/ncnepal.htm>

Semi-structured interviews were conducted with 50 women between the ages of 22 and 59 (mean age = 33), of two communities currently residing in Kathmandu, and were supplemented with participant observation and open-ended group discussion. The two groups of women interviewed consisted of ethnic Tibetans from the remote Humla District of northwestern Nepal, who have fled the Maoists and their villages to reside temporarily in Kathmandu, and urban Newar women, descendants of the autochthonous inhabitants of the Kathmandu valley. All interviews were conducted with the help of native research assistants in English, Tibetan or Newar. Snowball sampling was used to construct the Newar sample. For the Humli sample, we met with all willing women from Humla residing in Kathmandu at the time of the

fieldwork. Interviews were conducted in homes or place of business with the interview translations taking place during the interview by the research assistant. All answers were recorded manually as the interviews proceeded. For the purpose of comparison between a rural and an urban population, we designated the ethnic Tibetans of the Humla District as 'rural' population since the Humli women we interviewed were all recent arrivals in Kathmandu and because they were being queried about their experiences accessing health care and family planning in their villages. Despite the fact that they were aware of the lacking health care options in their villages, most of the Humli women hoped to return to their villages when the Maoist conflict subsides and did not perceive of Kathmandu as a likely or acceptable place for permanent settlement. We considered the Newar women of Kathmandu 'urban'. University of Montana Institutional Review Board approval for this project was obtained prior to the beginning of fieldwork, and a confidentiality plan was instituted to protect the identities of all participants.

Theoretical Framework

It is well known that during the 1960s and 1970s the world began to experience a major decline in fertility with the onset of rapid fertility transitions in a majority of developing countries. The decline in fertility reopened a debate about the causes of fertility transitions, and that debate continues to this day. In fact, questions about why humans shift from large to small completed family sizes have motivated generations of scholars interested in population patterns, resource use and human evolution. Many attempts have been made to identify the mechanisms driving fertility transitions, yet precise identification of these mechanisms remains an elusive goal. Understanding the causes of the European fertility transition of the late 19th century, for example, has proven to be a major challenge to historical demographers, and no single explanation, applicable across countries (or groups within countries) is unproblematic. Notestein's early conceptualization of the demographic transition held that the positive changes brought about by modernization (especially in medical technology and its effect upon survival, occupational opportunities for men and women, and the value of children) inevitably drives fertility down (Notestein 1953). Since then a number of related positions have been developed by theorists attempting to further define Notestein's original argument. These can be separated into demand and ideational theories, and we highlight the primary positions influencing this project below.

On the demand side of the debate over fertility transition are positions such as Easterlin's new home economics model (1975), and Becker's human capital models (1975; 1991). These models of fertility change emphasize the value of children within households, the costs of raising children, and the

costs of limiting fertility. Such models carefully identify the economic evaluations that individuals can make in fertility decisions, and assume that the resulting calculus is within the purview of each decision-maker. In contrast, ideational theories like those developed by Freedman (1979), Lesthaeghe (1982), Lesthaeghe and Wilson (1986), Mason (1986), and Bongaarts and Watkins (1996) move away from the importance of material considerations and emphasize the effects that social and attitudinal forces have on fertility, in particular the importance of the powerful association drawn between modernity, affluence, and small family sizes. Bongaarts and Watkins' identification of the conditions in which early innovators in fertility regulation can have a domino effect throughout a region is one of the strongest positions in the literature to date in favor of ideational processes in demographic patterns. Their position is presaged in Caldwell's (1982) wealth flow models, which bridge demand and ideational approaches. Caldwell's argument started with the straightforward assertion that decisions about the production of children are contingent upon their value to parents. When children are perceived to be costly and to provide few benefits to their parents, fertility will be modified so that parents produce few children. This argument was later broadened with the suggestion that the perceived costs and benefits of children may be material, or they may be social (see for example Caldwell and Caldwell 1998).

In other words, collectively adopted *perceptions* of the costs and benefits of children sometimes determine reproductive behavior, irrespective of actual material conditions. Bongaarts and Watkins illustrate the mechanisms through which changing perceptions can be shaped and shared among members of a social community in their analysis of Watkin's social networks data from Luos in Kenya (Bongaarts and Watkins 1996). The assertion that social factors, in particular those influencing the perceived rather than actual costs of children, influence the total fertility rate, was an important departure from the basic assumptions of the then-influential demand theories of the fertility transition, since those theories are predicated upon the idea that fertility behavior, though shaped by social norms, is ultimately contingent upon the actual, material costs and benefits of children to their parents.

Many learned scholars of Nepalese fertility patterns predate our work, and we intend to add to the work of Stash with women of Chitwan (1999), Axinn et al (1991), Fricke (1997) and Fricke et al's (1993) with Tamang, and Folmar's (1992) work with caste Hindus of west central Nepal, each of which contributes importantly to refining our understanding of how small scale socio-economic and socio-ecological differences shape fertility preferences and behavior. In our work, following Bongaarts and Watkins (1996), we were interested in understanding how changing perceptions of the costs of children and changing perceptions of the costs of contracepting, were being influenced by the ongoing insurgency. Below we describe the patterns

differentiating rural and urban women and explore some of the different motivational patterns to contraception existing between the two groups.

Current Fertility Patterns

In Nepal there are many dramatic differences between urban and rural populations with respect to fertility. The 2001 NDHS showed that the total fertility rates (TFRs) for urban and rural Nepali women were 2.1 and 4.4, respectively (see Table 1). The 2001 NDHS also showed that among urban women, fertility rates decline rapidly after the age of 24, while in rural areas fertility decline is more gradual and delayed. Urban Nepali women appear to almost completely cease childbearing by age 40. The median birth interval is slightly longer for births in urban areas and the percentage of women who begin childbearing under the age of 20 in rural areas is double the rate in urban areas.

Table 1: Urban vs. Rural TFR, Median Birth Interval, and Teen Childbearing

Area	Total Fertility Rate (TFR)	Median number of months since preceding birth	Percentage of teens who have begun childbearing
Urban	2.1	32.3	12.6
Rural	4.4	31.8	22.5

Source: NDHS 2002.

The ethnographic and micro-demographic analyses of the experience of women we interviewed revealed other interesting differences between urban Newar women and the rural Humlis in our sample. In terms of nuptiality there were only small, statistically insignificant differences between our Humli and Newar informants (age at marriage of 21 and 22 years, respectively). However several interesting differences emerged when we looked closely at the fertility data. The first birth interval was significantly longer for the Humli women at 3.8 years, compared to the Newar first birth interval of 2.0 [t(39)=2.41; p=.02]. This is likely due to the practice in Humla of delaying a new bride’s move out of her natal household for up to two years after marriage (Haddix 1998). While rural women waited longer to begin having children, once they began having children, subsequent birth intervals are significantly shorter than those of the urban Newar women, with average interbirth intervals of 2.9 and 4.2 years [ANOVA P=.008 f1,25=8.39]. Rural Humli women also reported that 82 per cent had never used contraceptives during the period before the insurrection began, and no one could access contraception just prior to their migration to Kathmandu. While access to contraception was already poor for Humli villagers in the period before the insurrection, the possibility of spacing births or attenuating

the reproductive period with contraception was gone completely once the insurgents had destroyed the health care infrastructure. In sum, our data showed that the rural Humli women were waiting slightly longer to have children than their Newar counterparts, but go on to have them at shorter intervals and, unlike Newar women, show little evidence of being able to effectively control childbearing once some target fertility had been reached. The findings mirror those of Haddix (1998) and Haddix McKay's (2000) studies of Humli fertility, contraceptive prevalence and health care.

NDHS Family Planning Data: Urban vs. Rural

NDHS (2002) data show that some knowledge of family planning is nearly universal among Nepalese women and men. The contraceptive prevalence rate among currently married Nepalese women is 39%, and there has been a dramatic increase in the use of contraceptives during the last 25 years (NDHS 2002). Despite this increase, there continues to be considerable need for family planning services in the rural areas. Of currently married women in Nepal, 28 per cent report unmet need for family planning services. Of those women, 11 per cent report a need for spacing and 16 per cent have a need for contraception to cease further childbearing. The greatest need for family planning, however, is in the remotest rural populations such as Humla, where unmet need is even higher than that reported in NDHS (2002). According to NDHS (2002) the percentage of urban women using any modern method of contraception is 56.3, while among rural women it is only 33.2; among our Humli informants there is at present no reliable source whatsoever for contraception and contraceptive usage approaches zero in the villages.

Of the 25 rural Humli women in our ethnographic sample, 82 per cent had never used contraception of any kind, and all women reported that since the insurrection began, all of the sub health posts in their villages were closed or burned to the ground. They also observed that traveling for contraception to Simikot was a risky venture undertaken by very few women, due to the possibility of harassment, capture, or worse by the Maoists or the Army. Previously, contraception was available at the District health post, but this was an 8-16 hour walk that was seasonally dangerous and always an inconvenience. In contrast, 19 of the 25 urban Newar women stated that they were currently using one of various methods, and none reported disruptions to their ability to acquire contraception when needed after the beginning of the insurrection.

Tuladhar (1987) describes the links in Nepal between contraceptive use in the rural setting and the availability and accessibility of the family planning services; these factors directly influence women's ability to make choices about their fertility. Even before the insurrection began, Stash found that in southern Nepal, efforts to promote family planning programmes encountered many barriers, including the lack of rural health-care infrastructure, modest

government budgetary allocations and a terrain that hinders the delivery of clinical and surgical contraceptive services and supplies (1999). Our interviews with local women revealed that these barriers are a significant reason for the differences in contraception usage among rural and urban women in Nepal. Occasionally, in the era before the insurrection began, contraceptive services were available in the villages from traveling assistant nurse midwives (ANMs). But, as stated by one rural villager, this did not alleviate the bind in which they found themselves: "Family planning in the village was so hard. Sometimes there were shortages after you'd walked days to get the shot. Also the women in the villages that give them [ANMs] sometimes do not give them right and we would get sick." Another woman simply observed, "I had so many children because I didn't have family planning." By contrast, access to contraception was not an issue for our Newar informants. Even after the insurrection began, there were numerous clinics and hospitals throughout Kathmandu supplying family planning services. Our Newar informants reported that they freely discussed their options with their husbands and doctors.

"Most people think men become weak when sterilized, that they cannot do heavy work. But ... women have to go all the way to Kathmandu and many cannot afford it."

– A Humli woman

Humli women cite other reasons for not utilizing family planning services. For instance, many women complained that in the villages they had little choice as to the methods of contraception available, and the kinds available had extreme side effects. Weakness was a commonly reported side effect. "Village women have hard heavy work, we cannot afford to be sick from family planning", said one Humli woman. Local infections from contraceptive injections were reported as well as other adverse reactions. Without the ability to switch to other methods or types of contraception, Humli women had no choice but to endure the side effects or rely on natural methods; either option undermines their faith in the fit between contraceptives and their own bodies.

Humli women were also much more likely than their Newar counterparts in our sample to complain that they were not able to obtain their husband's approval to contracept. Their husbands were concerned about child mortality, and they could not afford to travel to the city to get reliable contraception that would not sicken their wives. These concerns were not mirrored in the experiences of the urban Newar women in our sample. Fear of side effects and other health concerns, along with the inadequate availability of contraception also appeared in the 2001 NDHS data seen below in Table 2.

Table 2: Main Reason for not Using Contraception

	Infrequent/ no sex	Menopause/ hysterectomy	Subfecund/ Infecund	Wants more children	Knows no method	Knows no Source	Health Concerns	Fears side effects	Other	Total % (n)
Newar	4.8% (2)	2.4% (1)	40.0% (17)	4.8% (2)	0% (0)	0% (0)	14.3% (6)	26.2% (11)	7.1% (3)	100% (42)
Humli	0% (0)	0% (0)	0% (0)	10% (1)	40% (4)	30% (3)	10% (1)	10% (1)	0% (0)	100% (10)
Total	3.8% (2)	1.9% (1)	32.7% (17)	5.8% (3)	7.7%(4)	5.8%(3)	13.5% (7)	23% (12)	5.8% (3)	100% (52)

Source: NDHS 2002.

Both Newar and Humli women were concerned about the side effects of contraceptive use, with 26.2% of the Newar women and 10% of the Humli stating fear of side effects as a reason for not using contraception. Humli women were however much more likely to report that they either did not know of a modern contraceptive method (40%), or they did not know where they could get contraception (30%).

There is no question that the insurrection has gravely impacted Humli women's ability to access health care; in addition to these issues, our Humli informants reported other disturbing trends. Despite the fact that the mean age of our sample was 33, an age after which Humli women would traditionally, have had more children, nearly 20% of them said that the insurrection had changed their notions about ideal family size. Some said bluntly that they did not want any more children, because the risk of them being abducted or otherwise involved in the violence of the insurrection was too high. Of a slightly smaller sample of 22 Humli women interviewed in detail about the impact of the insurrection on their family, 77% of them said that they were afraid that one of their children would be abducted by the Maoists, and in fact, 3 women (14%) had had at least one child taken by the Maoists. Currently, we are undertaking a new study of the impacts of the insurrection on the mental and physical health of Humlis and the trends we can see above will be examined in more detail.

Education and Fertility

In addition to the access issues described above, education is known to figure prominently in contraceptive usage and fertility decline/limitation in Nepal. Recent theoretical and empirical work in this area highlight the possibility that an individual's schooling experience will influence their fertility decisions, as well as the possibility that pressures to educate children will influence couples' fertility decisions (e.g. Axinn 1993).

According to NDHS (2002) data, a higher per centage of urban Nepali women attend school, and urban women obtain higher levels of education than the women of the mountain areas, such as Humlis (see Table 3).

Table 3: NDHS 2002 Highest Education Level

	No education	Primary	Secondary	Higher	Total Per cent (n)
Newar	46.9% (199)	20.5% (87)	27.4% (116)	5.2% (22)	100% (424)
Mountain People	90% (18)	5% (1)	5% (1)	0% (0)	100% (20)

Source: NDHS 2002

This pattern was also evident among the women we interviewed. While it was common for Humli parents to send their sons for some schooling, girls receive very little if any education at all. This mirrored findings of other students of Humli culture and child rearing patterns (e.g. Haddix 1998). In contrast, among the urban Newar women in our sample, 88% had some education and fully 84% went on to obtain college level degrees.

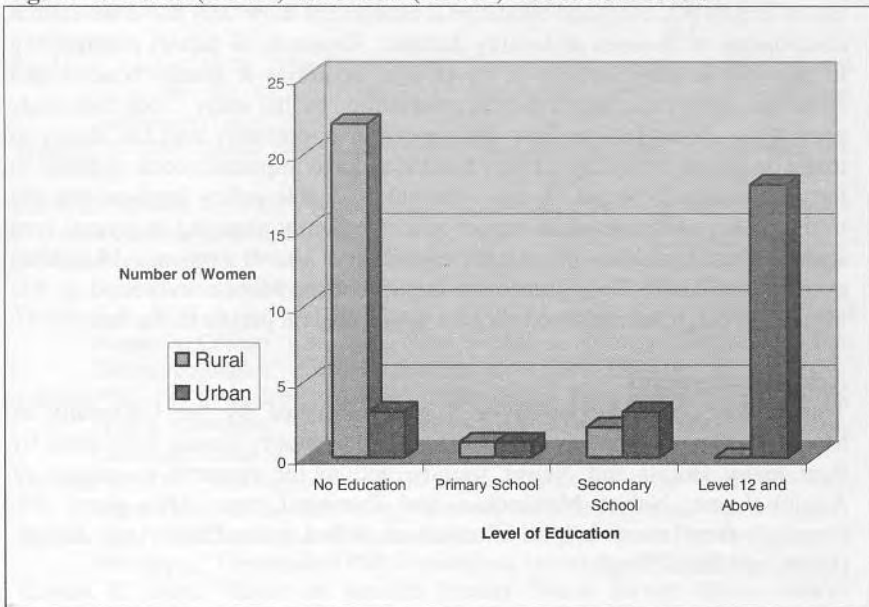
Table 4: Rural vs. Urban Level of Education in Nepal 2004

	No Education	Primary School	Secondary School	Level 12 and Above	Total
Rural	22	1	2	0	25
Urban	3	1	3	18	25

Source: NDHS 2002

Figure 4 and Table 4 demonstrate the dramatic differences between the two groups with respect to education. Currently, the situation is even more aggravated. Like Humla’s health posts, all schools have been closed by the Maoist cadres inhabiting the region.

Figure 4: Rural (Humli) vs. Urban (Newar) Education Levels



Lacking education in Humla reflects the generally low level of socio-economic development in the region; it also underscores the plight of women with respect to fertility limitation. Women often complained to the authors about feeling foolish, stupid or uncivilized compared to high caste, urban medical practitioners, who are regarded as superior and whose treatment is not questioned. Due to illiteracy, women can not read the directions on their pill packets nor information that might otherwise be provided to them to help them determine proper usage of the products. The general scenario is one in which women feel disempowered and even degraded by the mere thought of questioning the doctor at the District health post. ANMs are considered to be more approachable, but for reasons discussed above, are not regarded as reliable sources of contraception.

Conclusion

A pattern in which urban women effectively access contraceptive services while their rural sisters languish in villages without healthcare or access to family planning is not new; but the severity of access problems in Humla even before the insurrection began is notable, and the total loss of ability to access any family planning services once the insurrection began warrants further consideration and attention.

The differences between rural and urban Nepali women with respect to their use of family planning and educational attainment show why these are central components to theories of fertility decline. Research on factors contributing to ongoing fertility declines in developing countries is greatly needed, and anthropologists can make a critical contribution to this study. This case study provides a closer look at how differences in opportunity and the ability to make decisions regarding fertility limitation have impacted recent patterns in fertility decline in Nepal. It may also hold valuable policy implications due to the strong evidence of an unmet need for family planning in a rural area such as Humla, and the gross under-education of Humli women. More than ever before, due in large part to the impacts of the Maoist revolution on life in rural Nepal, it is crucial to bring the needs of rural people to the fore.

Acknowledgements

This research was supported by a grant provided by the University of Montana. The authors are grateful for the hospitality shared with them by their many Humli and Newar friends, and to the research assistance of Angjuk Lama, Nabita Manandhar, and Tsering Lama. This paper also benefited from many helpful discussions with Leonie Exel, Anna Sarena Howe, and Sonal Singh.

Note

1. Including but not limited to diarrheal and upper respiratory track disease, tuberculosis and pneumonias, anemia and malnutrition, congestive heart failure and birth complications (Haddix 2000, Haddix McKay 2003, 2005).

References

- Amnesty International. 2005. Available at: <http://www.amnestyusa.org/countries/nepal/index.do>. Accessed November 8, 2005.
- Axinn, William G., T. Frick and A. Thorton. 1991. "The Micro-Demographic Community Study Approach—Improving Survey Data by Integrating the Ethnographic Method." *Sociological Methods and Research*. 20:2, 187-217.
- Axinn, William G. 1993. "The Effects of Children's Schooling on Fertility Limitation". *Population Studies*. 47:3, 481-493.
- Blake, Judith. 1968. "Are Babies Consumer Durables? A Critique of the Economic Theory of Reproductive Motivation." *Population Studies*. 22:1, 5-25.
- Bongaarts, John and S. C. Watkins. 1996. "Social Interactions and Contemporary Fertility Transitions". *Population and Development Review*, 22:4, 639-682.
- Caldwell, John C. 1982. *Theory of Fertility Decline*. New York: Academic Press.
- Caldwell, J. and P. Caldwell. 1998. "Regional Paths to Fertility Transition". Conference on Global Fertility Transition.
- CBS News Online. 2004. "Nepal: Kingdom in the Clouds." Available: www.cbs.ca/news/background/nepal. Accessed on November 9, 2005.
- Cleland, John and German Rodriguez. 1981. "The Effects of Socioeconomic Characteristics on Fertility in 20 Countries". *International Family Planning Perspectives*. 7:3, 93-101.
- Coale, J. Ansley. 1973. "The Demographic Transition Reconsidered. International Union for the Scientific Study of Population". International Population Conference, Liege.
- Douglas, E. 2005. "Inside Nepal's Revolution". *National Geographic*. November: 46-65.
- Easterlin, Richard A. 1975. "An Economic Framework for Fertility Analysis". *Studies in Family Planning*. 6:3, 54-63.
- Folmar, Steven. 1992. "Wives' Roles in Fertility Decision-Making among Nepalese Caste-Hindus". *Central Issues in Anthropology*. 10:1, 39-50.
- Fricke, T.E., W.G. Axinn and A. Thorton. 1993. "Marriage, Social Inequality, and Women's Contact with their Natal Family in Alliance Societies – Two Tamang Examples". *American Anthropologist*. 95:2, 395-419.
- Fricke, T.E. 1997. "History, Marriage, Politics, and Demographic Events in the Central Himalaya." In S. Greenhalgh (ed.), *Situating Fertility*. Cambridge: Cambridge Press. 202-224.
- Gersony, R. 2003. "Sowing the Wind: History and Dynamics of the Maoist Revolt in Nepal's Rapti Hills, Mercy Corps International". Unpublished Report.
- Haddix, K. 1998. "Marriage and Reproduction in a Polyandrous Family System of NW Nepal," Unpublished PhD Dissertation, University of California, Davis.
- Haddix, K. 2000. "Report on Baseline Primary Health Survey, Humla District, Nepal". *The ISIS Foundation*. Unpublished Report.

- Haddix McKay, K. 2003. "Challenges to health care access in Maoist Nepal". *Himalaya*, XXII(2): 43-46.
- Haddix McKay, K. 2005. "Social and Health Impact Assessment in Chauganphaya and Kholsi, Phase One", The Isis Foundation. Unpublished Report.
- Khadka, Rajendra S. 1997. *Nepal: True Stories of Life in the Road*. San Francisco: Travelers' Tales Inc.
- Nepal Demographic and Health Survey. 2002. Ministry of Health (Nepal), New ERA, and ORC Macro. Nepal Demographic and Health Survey 2001. Calverton, Maryland, USA: Family Health Division, Ministry of Health; New ERA; and ORC Macro.
- Notestein, Frank W. 1953. The Economics of Population and Food Supplies. Proceedings of the Eighth International Conference of Agricultural Economists.
- Stash, Sharon. 1999. "Explanations of Unmet Need for Contraception in Chitwan, Nepal". *Studies in Family Planning*. 30:4, 267-287.
- The Global IDP Project. 2003. Available at: http://www.idpproject.org/training/reports/Nepal_workshop_final.pdf. Accessed on November 8, 2005.
- The Global IDP Project. 2005. Available at: http://www.idpproject.org/global_overview.htm#6, Accessed on November 8, 2005.
- Tuladhar, Jayanti Man. 1987. "Effect of Family Planning Availability and Accessibility on Contraceptive Use in Nepal". *Studies in Family Planning*. 18:1, 49-53.
- Weinberger, Mary Beth. 1987. The Relationship Between Women's Education and Fertility: Selected Findings From the World Fertility Surveys, *International Family Planning Perspectives*. 13:2, 35-46.