

PERSONAL VIEW

Hindrances to Family Planning Program: Findings from Banke, Nepal

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ABSTRACT

Reducing population growth through programs is a high priority for many developing countries. Why particularly in the rural regions of these countries, do these initiatives fail? Using a case study of a recent initiative in rural Nepal between 1998 and 2002 as an example, this opinion piece discusses possible reasons for such failure and recommends that a broader strategic approach is necessary, particularly in relation to empowering women in these communities. Banke district, Nepal, is mainly rural, consisting of 47 villages. Scarcity of family planning provisions is a dominant problem in most parts of the district. District Public Health Office (DPHO), the major family service provider lacks resources and technical capabilities. In recent years, non-government organizations (NGOs) have been collaborating and coordinating their efforts with DPHO in order to cover the larger section of the district population. A local NGO called Banke Mahila Arthick Swawlamban Sangathan (BMASS) provided family planning services in 5 of the 47 villages of Banke district, Nepal, from 1998 through 2002. Outreach activities and clinical services were the two major components of BMASS family planning program. Outreach activities included door-to-door/mass counseling, street drama, and condom distribution. Clinical services that included counseling, testing, temporary sterilization, and referrals for permanent sterilization were provided through a centrally located static clinic and mobile clinics. BMASS family planning program had almost no impact in the target villages. There was no significant increase in contraceptive use, people's motivation to limit fertility, and number of people preferring a smaller family size. The contraceptive prevalence rate increased by less than 2% after 2 years of family planning program intervention. More than 80% of the family planning clients were reported to have discontinued contraceptive use within six months. The mean age of women at the time of first child delivery (16.2 years), total fertility rate (six children per woman), and the birth intervals (13-18 months) were reported to be the same for both periods: before and two years after family planning program intervention. Further assessment of the local factors revealed that women's lack of control over fertility and higher number of desired children could have hindered the community's response to BMASS family planning program. In the target villages a woman's fertility is dependent upon the preference of husbands and in-laws. The women in general are not empowered to voice their opinion with regards to delaying fertility, spacing child-births, and limiting the number of



children to be born to them. Higher number of desired children in the target villages is the outcome of low cost of child rearing and high benefits from the children. Children not only contribute significantly in household economy and provide old age security to their parents, but also consume less. To be effective, family planning programs need to be integrated into broader societal reforms that address rural economic development and the role of women in society.

Key words: children, desired number, family planning program, fertility, Nepal, women.

Introduction

The evidence from various countries suggests that family planning programs at a very low level of development may not have an impact in people's fertility behavior¹. The level of development is positively associated with the degree of women's control over fertility and negatively associated with the number of desired children. Women's control over fertility and the number of desired children are prominent factors in determining the impact of family planning initiatives. This personal view aims to explore these issues, highlighted by case study data from a family planning program in 5 rural villages of Banke district in Nepal (Fig 1). This is the first documentation that aims to identify the hindrances to family planning program in Banke district, Nepal.

Banke district is mainly rural, consisting of 47 villages and only one town (ie, Nepalgunj). The scarcity of family planning provision is a dominant problem in most parts of the district. District Public Health Office (DPHO), the major family service provider, lacks resources and technical capabilities. In recent years, non-government organizations (NGOs) have been collaborating and coordinating their efforts with DPHO in order to cover the larger section of the district population.

A local NGO called Banke Mahila Arthick Swawlamban Sangathan (BMASS) provided family planning services in 5 villages of 47 in Banke district, from 1998 to 2002. Outreach activities and clinical services were the two major components of BMASS family planning program. Outreach activities included door-to-door/mass counseling, street drama and condom distribution. Clinical services that

included counseling, testing, temporary sterilization and referrals for permanent sterilization were provided through a centrally located static clinic and mobile clinics.

Prior to the family planning and reproductive health project implementation, BMASS conducted a baseline survey among the target Village Development Committees (VDC) to collect demographic, health infrastructure and poverty data. Aggregates of demographic data obtained through the baseline survey indicated a very high fertility rate (ie, six children per woman), high population density (125 per square foot), and a very low rate of contraceptive prevalence (3.44%). Health infrastructure data indicated that each village had a health post barely equipped to provide minimum health services for minor illnesses. Health assistants who received intermediate levels of health training were assigned to provide paramedic services. For major illnesses, the villagers had to walk 6-10 km to the nearest hospital in Nepalgunj. Aggregate poverty data of BMASS baseline survey indicate that people living below poverty line accounted for more than 80% of the total population.

In 2000 (2 years after program intervention) local village women ($n = 102$) and VDC chairs ($n = 5$) were interviewed to assess the impact of BMASS family planning program. The participants were recruited using the snowball method. Married women between the ages of 15-45 years from each target village were selected based upon their availability for interview. The VDC Chairs were the local elected officials, all of them were men. The participants were assured of the anonymity. Verbal consent was obtained from each participant. Beside VDC Chairs, no participant had literacy skills, therefore written consent was impossible.



Figure 1: The 5 rural villages of Banke district in Nepal, site of the family planning program.

Participants were asked to provide information on the general impact of BMASS family planning program in target villages. The participants were also asked to compare contraceptive use, people's motivation to control fertility, and people's preference for family size for two periods: before and after two years of BMASS family planning program intervention.

The data were analyzed by comparing themes that emerged from various individual interviewees within a community. The overall themes within a community were compared with the identified themes of other communities. The themes across the communities were found to have striking similarities. The quantitative data maintained by BMASS were used to triangulate the qualitative data obtained through interviews. BMASS obtained household, labor-force, and



school enrollment data from the target VDC offices. The quantitative data presented here are the aggregates of the 5 target VDCs.

No community impact of BMASS family planning program

The impact of a family planning program can be seen in the form of increased use of contraceptives, increased motivation to control births and increased preference for a smaller family^{2,3}. However, the situation in BMASS target villages was the opposite. There was no significant increase in the rate of contraceptive use, no motivation to control births and no change in family size preference.

The contraceptive surveillance data indicates that the contraceptive prevalence rate increased by less than 2% after 2 years of the intervention of the family planning program (compared contraceptive surveillance data of 1998 and 2000). Although contraceptives were distributed free of cost, the actual use was limited to a handful of couples. People's receptivity to the idea of birth control was very low.

The communities reflected a lack of motivation to control births. A majority of people did not make use of the family planning services, despite their free accessibility. It was reported that the condoms and pills that were distributed free of cost in the communities were discarded by most of the recipients. The few people who actually used the condoms and pills did not continue to use them. The discontinuation was reported regarding the implants and for injectable users as well. The BMASS clinic log indicates that more than 80% of the total implants/injectable clients had discontinued within 6 months. There was no increase in the child interval, nor was there evidence of delayed fertility. The child interval (13-18 months) and average age (16.2 years) of women at the time of first childbirth were reported to be the same for both periods. People's preference for a large family size remained unchanged. The average number of desired children ($n = 4-7$) was reported to be the same for both periods. The total fertility rate (6 children per woman) remained unchanged after 2 years of family planning

intervention. (Nepal's total fertility was 4.87 children per woman in 1998 and 4.39 in 2003⁴.)

Such data allows us to conclude that the BMASS family planning program had almost no impact in the target villages. Further assessment of the local contributing factors revealed that women's lack of control over fertility and the number of desired children hindered the community's response to family planning intervention.

Women's lack of control over fertility

Women's control over fertility increases with the increase in women's economic power, women's education, and decreases with women's exclusion from the macro level socioeconomic sphere⁵⁻⁷. In Bangladesh, for instance, an increase in women's education, empowerment, mobility and access to mass media contributed significantly to enhancing women's control over reproductive decisions⁸.

In the target villages, a woman's fertility was dependent on the preferences of their husbands and husband's parents. The women in general were not empowered to voice their opinion about delaying fertility, spacing child-birth and limiting the number of children to be born by them. Women's lack of control over fertility in the target villages of BMASS program can be explained in terms of the low degree of women's economic power, lack of education opportunities and exclusion from the macro level of the socio-political process.

Women's lack of economic power in the target villages can be explained further in terms of the very low participation of women in the paid employment sector, low importance given to women's household and nurturing activities, and the patriarchal mode of property inheritance and resource mobilization. In 2000, less than 2% (aggregate of the 5 VDC) of women of the target villages were employed in paid agricultural and construction works. Because women were not engaged in direct money-making activities, they were not trusted to mobilize economic resources. The male members of the family made all decision with regards to the



mode of using movable and unmovable properties. Women's work outside home was considered to be detrimental to male pride and honor. In the mean time, women's household and nurturing activities are not valued as much as men's productive activities. In Nepal, until 2002, daughters were excluded from rights to inherit their parental property. The target villages were/are no exception with regard to property inheritance laws. Women's lack of economic power in the target villages was detrimental to their ability to make decisions about the timing of fertility, the number of children to be born by them, and the space between the children.

In the target villages the women had very limited education opportunities. The data from 1980 to 1998 indicated that female school enrollments were consistently below 1% (aggregate of 5 VDC). Of the total female students enrolled between 1980 and 1998 in the 5 VDC schools, 70% dropped-out at the primary level and 99% at the secondary level. In 2000, the illiteracy rate for females was over 90%, compared with 40% for males. The people generally believed that expenditure on a daughter's education was not profitable for the family, because daughters are handed over to the grooms on marriage. The wealthier families send their sons to the high schools in Nepalgunj; however, none of the families of the target villages were known to have sent their daughters to schools located beyond the village boundary. The lack of education inhibited women's confidence in discussing family planning practices and inhibited challenges to the traditional values and norms that favored high fertility⁹.

Role of religion

Social institutions such as the family, schools, government departments and religious bodies play important roles in enforcing women's low status in Nepal. The codes of Banke district's two dominant religions, Hinduism and Islam, contribute significantly to the control of women's sexuality by regarding women as intellectually and morally inferior to men while legitimizing masculine hegemony.

'Sexuality' includes the mobility and display of bodies, as well as sexual experience and choice. In the tradition of both religions, women's physical mobility and body display are inhibited by the veiling of their bodies and faces. Women's premarital sexual experience is stigmatizing, as is marital infidelity, while men's virginity is never questioned, and men's infidelity is usually blamed on the women. These factors increase women's dependency on men, both for protection from sexual blame and religious persecution.

The son preference that emanates from religious codes is another dimension in determining women's status in the family and in society. In Nepal, a husband may divorce his wife if she does not deliver a son within 10 years of marriage. However, if a women seeks divorce the bureaucratic process is never completed.

Exclusion from the macro-level socioeconomic sphere in the target villages was enforced through the institution of purdah. The three major components of the purdah institution are: (i) veiling women's body and face; (ii) restricting women's mobility, and (iii) keeping women out of the public sight¹⁰. Exclusion of women from the macro level inhibits women's ability to negotiate the decisions that affect their life chances. In the target villages, 90-95% of the total female population married before reaching puberty. Family-arranged marriage is common. Women's lack of freedom to determine who to marry and when to marry reduces women's ability to make fertility decisions¹¹.

People's desire for more children

The benefits and costs of children have been considered as key factors in determining the fertility levels. In societies at the lower level of socioeconomic development, the benefits of children are perceived in terms of direct economic contribution through child labor, and in terms of security for the old age of the parents¹². The costs of children include direct and indirect educational and other costs of childrearing¹³. People desire more children if the benefits from children exceed the costs of the children. The chance of



child survival is another determining factor of the desired number of children; the number of desired children declines with the increased likelihood of child survival¹⁴.

In the target communities the benefits derived from children exceeded the costs of the children. The culture of viewing children as old age security was heightened due to the lack of government or public homes for elderly, lack of retirement or pension benefits, and lack of other forms of financial securities. Public elderly homes in Nepal have not yet been mainstreamed and the few available are located in the major towns of Nepal, which are inaccessible to the people of the target villages.

Because Nepal is predominantly dependent on agricultural production, only a handful of the population is employed in the government or public sectors to earn retirement or pension benefits. In 2000, none of the residents of the target villages were known to have earned retirement or pension benefits. Insurance and securities (eg, bond papers) were far beyond the imagination of the financially poor population of the BMASS target villages. Therefore, the benefit of children in the form of old age security was highly valued in the target communities. This is true for most of Nepal, both in rural as well as urban areas.

Because there are no anti-child-labor policies in Nepal, most private sector employers use children as cheap laborers. In agricultural settings, the families can use their children to optimize family income without interference from the government. In the target communities, children provided a major economic contribution through their work. Children performed a variety of tasks depending on their age and sex. Older male children worked in the farm as agriculture laborers, and in the town (eg, in Nepalgunj or bordering Indian towns) as construction workers, rickshaw pullers, horse-cart drivers, and vegetable sellers. Older female children cooked, took care of children, herded cattle, fetched water and fuel, ground grain, cleaned house and sheds and, washed clothes. The younger male and female children helped their older siblings and parents on the farm and in the

house. Some of the younger male children were sent to be servants in the houses of large landowners.

The cost of children in the target communities was nominal. Child education is not mandatory in Nepal. Although primary education (up to grade 5) is free of charge, many parents in the target communities did not wish to send their children (especially the female children) to school. Most of the parents who sent their (mainly male) children to school did not want the children to continue education beyond primary level. Cost was not a factor, because the children used low cost stationary (eg, chalk and slate), and played with home made toys (eg, clay and wood toys). The major cost of children included food, shelter and clothing, which the children paid off by themselves through their work.

A lower chance of child survival was another factor major contributing factor in people's desire for more children in the target villages. Their children are susceptible to such diseases as diarrhea, malnutrition and TB. Due to the lack of access to well-equipped health facilities many infants and children die of such diseases.

In the target communities the average number of desired children was high due to high economic benefits from children, the low cost of child rearing, and the low chance of child survival. Consequently, participants demonstrated a low receptivity to the BMASS family-planning program intervention. The higher number of desired children has been found to be negatively associated with the use of birth control techniques. Multivariate analysis of Bangladesh data shows that the probability of contraceptive use is twice as low among women who desire additional children, compared with those women who do not want any more children⁶. Therefore, the likelihood of low community receptivity to family planning programs is high if people desire more children.

Recommendations

The evidence from Sri Lanka suggests that family planning programs are not the sole instruments that bring change in



people's reproductive intentions and behaviors¹⁵. The decline in Sri Lanka's total fertility rate from 5 children per woman in the 1960s to 2.1 children per woman in the 1990s is the function of policy reformation, socioeconomic development, institutional development and grassroots participation, in addition to contraceptive and family planning programs¹⁵.

In the communities targeted by BMASS, the impact of family planning programs could be enhanced by policy reinforcement, advocacy and networking. Fertility reduction is one of the major national agendas of Nepal. Appropriate policies and strategic plans have been developed to achieve nationwide fertility reduction. The National Family Planning Commission provides institutional direction to all family-planning initiatives. The national level policies and plans have been decentralized to district level and local level health entities to be implemented. Despite the explicit policies and institutional directions, the application of fertility reduction agenda remains problematic in much of Banke district, including the 5 villages targeted by BMASS.

Because women's lack of control over fertility and higher number of desired children appeared major hindrances to family planning program, the fertility reduction policy should have been integrated with other development policies that focus on women's and children's issues. Family planning programs should be components in the larger structure of the development programs.

Building community awareness is the most important step in improving the status of women and children. Local advocacy groups could have had significant impact in building community awareness. For sustainable advocacy, local community groups must form a coalition by networking vertically (on district, local and national levels) as well as horizontally (with other grassroots organizations). A coalition could be established as an institution that provides overall direction to local advocacy.

Finally, the gender-biased laws of Nepal must be transformed into strict gender-equal laws in order to have

nation-wide impact on all aspects of women's lives; and policies should be reformulated to enforce mandatory child education and to penalize child labor practices.

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