CHAPTER I

INTRODUCTION

1.1 Introduction

Nepal is a developing country occupying an area of 147,181 sq. km in South-East Asia. Topographically, more than three-fourths (77%) of its land is occupied by hills and mountains where about 53% of its population lives. The rest of the population lives in the plain Tarai belt that occupies 23% of the total land area. Administratively, the country is divided into 5 developmental regions, 14 zones and 75 districts. Districts are further divided into Village Development Committees (VDC) and municipalities. There are 3,915 VDCs and 58 Municipalities in the country. Each VDC is made up of 9 wards where as the number of wards in the municipalities range from 9 to 35 depending upon their size and population coverage (CBS, 1999).

Only 25% of the women in Nepal are literate as against 54.5% of the men (CBS, 1999). The life expectancy for women in Nepal is also lower than that for the men, which is an exceptional condition in the world and reveals the existence of grave gender discrimination. Life expectancy for men and women are 56 years and 53 years respectively (MPE, 1998).

The majority of the people (91%) live in rural areas. Subsistence agriculture is the main occupation of the majority of the people (81%). Economic growth of the country has been affected by the unprecedented growth of population. With the prevailing population growth rate of 2.3% per annum, the economic gain through developmental activities has remained largely concealed (CBS, 1999).

For dealing with the problem of rapid population growth, a private voluntary organization named "the Family Planning Association of Nepal" was initiated in 1959. In 1968, the government of Nepal also started a Family Planning and Maternal and

Child Health (FP/MCH) project under the Ministry of Health (MOH) for meeting the increased need for population control measures in the country. The National Health Policy, 1991 has emphasized FP/MCH as a priority service area in the country in reducing fertility rate and in promoting maternal and child health (MOH, 1991)

Presently, the family planning services are provided by both the governmental and non-governmental organizations. The government operated family planning services are integrated with maternal and child health services and are delivered through national, regional, zonal and district hospitals, primary health care centers, health posts and sub-health posts and in the community through village health workers and female community health volunteers.

In regards to contraceptive services, the temporary methods of contraception such as condoms, depo provera and oral contraceptive pills are provided on a regular basis from all the health service outlets. Other temporary contraceptive services such as the IUD and norplant are provided only through selected health service outlets, where specially trained health workers are available. Surgical sterilization services are provided at static sites (hospitals) and through seasonal mobile camps (FHD, 1995).

1.2 Background

The problem of population growth has been a global concern for a long time. The 1994 International Conference on Population and Development (ICPD) held in Cairo declared the population problem to be a top-ranking issue around the globe (UN, 1994). The global population is growing by almost 80 million per year and developing countries with high fertility rates contribute the most to this growth (UNFPA, 1998). High fertility causes a costly burden to the country as it reduces the opportunities for economic growth, increases the health risks to mothers and children and causes a negative impact on the quality of life of the people by reducing their access to nutrition, education and employment (Bulatao, 1998).

From the demographic transition point of view, Nepal is passing through the explosive stage of population growth (Park, 1994). In the last three decades as a result

of the implementation of public health programs and communicable disease control measures, the death rate has declined rapidly to almost half from 22.2 per 1000 population in 1976 to 11.6 per 1000 population in 1996. But a similar decline has not taken place in the birth rate. The birth rate decreased by one-fifth only, from 45.5 in 1976 to 37 per 1000 population in 1996 (MPE, 1998).

Rapid growth of population is a major issue to a poor country like Nepal. Nepal's economic development over time has been worsened by the unprecedented growth of its population. Almost 45% of its population is living below poverty line (MPE, 1998). Rapid population growth also increases rapid migration of rural people to urban areas for education and employment, thereby increasing the population density in urban areas and causing adverse impacts on the health and quality of life of the people.

With high fertility, the risk of maternal mortality and infant mortality also increases. High fertility by increasing the total number of pregnancies, not only increases the exposure to the risks associated with each pregnancy and childbirth, but it also increases the proportion of high risk pregnancies, such as teenage pregnancy, elderly pregnancy, frequent pregnancies and unintended pregnancies (Sharma, 1991). Use of contraceptives in regulating fertility is a child survival strategy as well. It is estimated that about 20 percent of child mortality can be reduced if all the first births take place after the mother reaches 20 years of age and another 20 percent of child mortality could be reduced if all births have birth-interval of more than 2 years (Thapa, 1991). Similarly children born to mothers over the age of 35 years are at 10-25 percent higher risk of dying than those born to the 20-30 years age group (Sullivan, Rustein and Bicego, 1994). In Nepal, as in most developing countries, maternal and infant mortality rates are very high and are reported to be 515 per 100,000 live births and 97 per 1,000 live births respectively (Pradhan, Aryal, Regmi, Ban and Govindasamy, 1997).

Contraceptives help couples to reduce and regulate fertility and assist the country in reducing the speed of population growth. Contraceptives also serve as important preventive measure for maternal and child mortality by helping women prevent unintended and mistimed pregnancies and by reducing exposure to risks

associated with each pregnancy and childbirth. Following the introduction of contraceptive services, the Total Fertility Rate (TFR) of Nepal has decreased by almost one-third i.e. from 6.3 per woman in mid seventies to 4.6 per woman in mid nineties (Pradhan, Aryal, Regmi et. al., 1997). However, this TFR is far from satisfactory. Under the present situation of TFR, a woman on average has 4 to 5 children, which is much higher than the replacement level of fertility, which the country aims to achieve. High fertility leading to high maternal and infant mortality and rapid population growth is a matter of great concern to the planners and providers of the family planning services in Nepal.

The low status of women in Nepal is another problem that needs consideration in improving the health of women and children. In Nepalese society particularly in rural areas, childbearing is central in defining woman's position in her household. Her status in her in-law's house will depend upon whether she is fertile and whether she produces a son (Schuler and Goldstein, 1986). This predisposes her to bear children soon after marriage and to have repeated pregnancies

Although both men and women have the role in regulating fertility, women have less access to health and contraceptive information and services than men do. As a result, decision making for family welfare activities mostly rests with the men. In regards to contraception, women are the primary sufferers of the consequences of high fertility. Yet, many women in Nepal have no say in controlling their fertility. In this regard, Ullah and Chakraborti (1993) indicated that by increasing women's ability to communicate with the husband about FP and establishing equal status relationship between the husband and wife can serve as an important intervening variable in women's decision to use or not to use a contraceptive method.

Based on the above arguments it is concluded that to achieve gender equity and increase the decision-making power among women, it is pertinent that women be empowered with the knowledge and necessary skills that they can use to identify what is good for them and to take actions that benefit them and their family. This is particularly important in fertility control programs. Improving and enhancing their

decision-making capability in fertility regulation can promote and maintain their health and the health and welfare of the family.

1.3 Need for the Study

The previous section has highlighted rapid population growth as a serious problem of Nepal with tremendous impact on the health and socio-economic upliftment of its people. It has also argued that high fertility is a product of lack of power among women to control their fertility

Following the country's effort for decades, the desire for smaller families has emerged among women in Nepal. But, a considerable proportion of them have still not been able to control their fertility. There is a discrepancy between the desired fertility and actual behavior, thereby resulting into preventable fertility. With increased fertility, the morbidity and mortality of mothers and children are believed to increase. Fewer children with increased spacing between births through the use of contraceptives not only helps in improving their chances of survival but also helps in improving the overall health of the family. Therefore, unless and until the women are empowered with the knowledge of contraceptive use, the reduction of total fertility rate to 2.5, maternal mortality rate to 250 per 100,000 and infant mortality rate to 25 per 1000 as targeted by the country to achieve by 2020, will not be possible (NPC, 1998). Only when women are able to take part in decision-making as to how many children to have and when to have them, the maternal and child deaths associated with closely spaced and frequent pregnancies will be reduced.

The fact that only 29 percent of the women in Nepal are using a contraceptive is a matter of serious concern. This means that more than two-thirds of the women in Nepal are not using a method of contraception possibly because they want more children or because they have an unmet need for contraception. In comparison to neighboring countries, the Contraceptive Prevalence Rate (CPR) in Nepal is much lower than that of China, Thailand and Sri Lanka which have CPR of 83%, 74% and 66% respectively (Bellamy, 1998). Furthermore, the huge discrepancy between the CPR of urban and rural area of Nepal (i.e.50% and 27% respectively) is of even more

concern (Pradhan, Aryal, Regmi et al., 1997). This raises the following questions: Why are rural women not using birth control methods? What will make them use contraceptives? Who will be the appropriate person to facilitate them to use a contraceptive?

With the view of reducing fertility and improving the health and contraceptive use status of women in rural community the Government of Nepal initiated the Female Community Health Volunteer (FCHV) program in the fiscal year 1988/89. FCHV are married women of the respective communities who, following a period of training on Primary Health Care (PHC) components, serve their communities on a voluntary basis (DHS, 1998). In relation to FP, these volunteers are expected to educate eligible women about contraception, to assist them in choosing a suitable method, and to refer them to an appropriate service outlet. They are also expected to distribute condoms and re-supply packets of oral contraceptive pills to women in the community.

FCHVs' performance however, has not been effective in meeting the FP need among rural women. Follow-up studies of FCHVs, revealed that FCHVs are not working fully, that their training was inadequate and that almost 90% of rural women had not received any FP related service or information from them in the previous one year period (Pradhan, Aryal, Regmi et. al., 1997; VRG, 1997). Another study indicated a lack of knowledge of FCHVs in relation to use and side effects of contraceptives and ways of dealing with such side effects as well as the advantages of different contraceptives (FPAN, 1994). These raise a series of queries: Why does this happen? Is it the question of lack of competence or a lack of motivation or lack of confidence to carry out the role on the part of FCHV? Does it have to do with the empowerment of the beneficiary group itself?

The training of FCHV is of a short duration--mostly less than 2 weeks. Most of the training programs for the FCHV use the top-down approach without involving the trainees in the identification of the health needs or health problems of the community. Apparently, such program lacks not only its relevance with the needs of the community, but also fails to build up a sense of ownership and commitment among FCHVs with the

planned health programs or activities. As a result, they are not able to perform their role or job responsibilities to the full benefit of the community as expected.

Therefore, it is pertinent that the FCHVs be empowered to enable them 1) to gain confidence and competence in carrying out fertility control services, 2) to arouse the felt-needs for fertility control among the eligible couples in the community; 3) to understand the contraceptive needs of the couples; and 4) to provide the basic family planning services as per the need of the couples by complying with the national fertility control measures. Thus the empowerment training for the FCHV is the key to overcome the barriers that results from the top-down approach in their training/education.

Empowerment of FCHV can be a cost effective and sustainable strategy to empower rural women in resolving the barriers to meeting their contraceptive needs. Being members of the respective communities, FCHVs can fill the socio-cultural and experiential gap between the community and health care professionals. Their "insider" orientation make them unique in understanding the culture as well as the strengths and limitations of the community they serve (Love, Gardner and Legion, 1997).

Therefore, the issue addressed in this study is what would be the appropriate model to empower female community health volunteers in order to enable them to act as facilitators in increasing the contraceptive acceptance among the rural women? The responsibility of FCHVs who are empowered is, then, to empower women in the community through awareness raising program to control their own fertility.

1.4 Objectives of the Study

The objectives of the study were:

(1) To develop a Model for the Empowerment of FCHV with the aim of increasing contraceptive acceptance among the Currently Married Women of Reproductive Age Group (CMWRAs)

(2) To test the Model of Empowerment in empowering FCHV in regards to increasing contraceptive acceptance among the CMWRAs in a rural community in Nepal

1.5 Operational Definition

The concept of empowerment was defined for the purpose of this study as consisting of the process and outcome. As a *process,* empowerment is assisting FCHVs in developing their awareness, competence and confidence in the provision of contraceptive services. As an *outcome* it was defined as a state of change in the performance of FCHVs in regards to their contraceptive services

1.6 Organization of the Dissertation

This dissertation is organized into six chapters:

- Chapter I includes the introductory part of the study.
- Chapter II consists of the review of literature.
- Chapter III explains about the model, used for empowerment of FCHVs
- Chapter IV includes the methodology to test the model.
- Chapter V is the analysis and interpretation of data
- Chapter VI contains the summary, discussion and recommendations.

Chapter I argue that rapid population growth as a major issue in Nepal with an urgent need for innovative programs in addition to the existing FP program to bring down the speed of population growth. The argument is based on the fact that (1) the rapid population has a deleterious effect on the human and socio-economic resources of the country, (2) the control of population growth is not a simple or an easy process, and (3) that high fertility exists in spite of the preference for small families.

Chapter II explores the causative factors for non-use of contraceptives. These factors are discussed using a precede-proceed model as predisposing factors, reinforcing factors and enabling factors. Many of these factors are modifiable, by using culturally sensitive approaches. Empowerment of FCHV is described as a suitable approach to establish a self-help and support mechanisms in promoting contraceptive usage among the women of reproductive age.

Chapter III discusses empowerment as an evolving concept. Development of the model for empowerment of FCHVs and a tentative model to empower FCHV is

discussed. The study intends to develop a sustainable mechanism by empowering FCHVs to implement FP education and service to rural women in promoting contraceptive acceptance.

Chapter IV describes the methodology used to test the empowerment model. The design for studying the process and outcome of empowerment is discussed. The study setting, population and methods of data collection along with the intervention are described.

Chapter V presents the study results in terms of the process and outcome of empowerment of FCHVs and impact on the CMWRAs. It includes the description of the qualitative and quantitative data obtained from FCHVs before, during and after intervention. It also describes the quantitative data obtained from CMWRAs and the health facility before intervention and 6 months after the intervention.

Chapter VI presents the summary of findings, discussion and recommendations of the study. It also presents the limitations of the study. This chapter is followed by a list of references and appendices that include instruments for data collection, protocol for the intervention and other related documents