

# Non-Governmental Organizations: Their Roles in Family Planning Program in Nepal

BISHWAMBHER PYAKURYAL\*

## BACKGROUND

The world population reached 5 billion in July, 1987, and it is increasing at a rapid pace. Three fourth of the world population live in the developing countries, struggling hard for survival, facing all sorts of deprivation. Rapid population growth is eroding the benefits of the economic development, placing enormous burden on their limited resources. Population explosion is one of the greatest problem the developing countries face today. Thus, no longer can the issue of population be looked upon as 'choice' but a necessity. Time has come for these countries, to create a climate for voluntary demand for smaller families. The tragedies of population explosion are avoidable. Preventive measures are available. Result-oriented action programs and government's firm commitment are therefore needed to realize it.

The LDCs must recognize that population is an internal factor in supporting or hindering development. Population policies, therefore, are part and parcel of socio-economic policies and the two should interlock and be mutually supportive particularly at the action level. The success that can be achieved in socio-economic measures leading to a perceptible rise in the standards of living, especially among the underprivileged, can provide a stimulus to a reduction in population growth. Since family planning is a major instrument in population planning, those measures which can lead couples to adopt the practice of family planning are of vital importance. While a government program is essential, it is not exclusively the responsibility of the government and that the role of the non-governmental organizations is of vital importance in promoting family planning for individual welfare and to reach demographic goals.

Nepal is experiencing multifaceted problems caused by unprecedented rate of growth of population. Most Nepalese live in conditions of extreme poverty and social deprivation. Average incomes (in cash and kind) are only about 38 cents US per day and that a large proportion of the population cannot feed themselves adequately; that nearly one-fifth of all children die before the age of five, and that for those who live, malnutrition, chronic illness and disability are continuing facts of life.

In relative as well as absolute terms, Nepal is one of the world's poorest countries - (only six countries have a lower reported per capita GDP). Other indicators of social welfare reflect a similar relative position. Table 1 illustrates Nepal's relative position with respect to some key development indicators.

\* Dr. Pyakuryal is an Associate Professor and Head, Central Department of Economics, Tribhuvan University, Kirtipur, Kathmandu, Nepal.

Table 1  
Indicators of Relative Underdevelopment-Selected Countries

	Life Ex- pectancy (Years 1987)	Per Ca- pita GNP (US\$) 1987	Infant Mortality per '000 birth	Under-5* Mortality (%)	Calorie Avail- ability (Calo- ries per capita per day) 1986
Bangladesh	51	160	121	18	1927
Ethiopia	47	130	155	38	1749
India	58	300	86	11	2238
Nepal	51	160	130	20	2052
Pakistan	55	350	-	-	2315
Sri Lanka	70	400	29	2	2401
Thailand	64	850	41	3	2333
Republic of Zaire	52	150	100	20	2163

Source: World Bank, World Development Report, 1989.

\*Nepal Social Sector Strategy Review, World Bank, 1989.

The current high rate of population growth in Nepal, estimated at 2.66 for 1971-1981 (intercensal exponential growth) is undermining efforts at economic and social development. Combined with a nearly stagnant agriculture sector, population growth has been rapid enough to keep the real value of agricultural output per capita approximately constant from 1976 to 1986. A solution to the population problem is therefore, must be found as a prerequisite for development and future provision of basic needs.

The threat posed by population has been the target of Governmental and Non-Governmental Organizations (NGOs) programs and has led to the specification of a formal population strategy. Population is also recognized as a fundamental component of the government's Basic Needs Program (BNP). Organizational problems together with the extraordinary constraints on logistics and supervision imposed by Nepal's terrain and communications infrastructure have restrained the population effort. In the face of these constraints, Nepal has increased the contraceptive prevalence rate (CPR), from 2.3 percent in 1976 to 7 percent in 1981 and 15 percent in 1986.

Although, Nepal's contraceptive prevalence rate remains on the low side of the selected list of Asian countries in Table 2, the effort that has been expanded over the last ten years to achieve the current level of 15 percent is recognized as a good basis for further program development.

In Nepal's traditional agricultural economy, large extended families are the accepted norm. Children contribute to the support of their families at a young age, and are perceived to be of great psychic, social and economic benefit to their parents. Yet, children are also an economic burden; they must be fed, clothed, housed, educated and cared for when they are ill. As Nepal evolves into a modern state, the cost of child-raising to the family and to society increases along with rising standards

Table 2  
Contraceptive Prevalence Rate (CPR) in Selected Countries, 1984-1986

Country	CPR
Nepal	15
Bangladesh	25
Burma	5
India	35
Indonesia	40
Pakistan	8
Sri Lanka	57

Source: World Bank, World Development Report, 1989.

of health, education and material welfare. A large dependent population demands a disproportionate share of private and public resources which might otherwise be invested in programs to stimulate economic growth and social progress.

Recent policy changes of the government in shifting the emphasis on the temporary contraception, serious consideration of women's welfare and community development programs, strategies to educate young couples on the health rationale, formulation of the innovative projects on income generation etc. are the reasons to overcome the mentioned problems.

A lot has been made recently of the potential role of NGOs in the development process. NGOs do play an important part in health, population and poverty alleviation efforts in Nepal and are responsible for some of the most notable success stories. They work on a small scale with intensive use of manpower and resources. This is the reason for their success, but it is also the factor which most limits their ability to expand while maintaining quality, and their high unit costs cannot be replicated across the system as a whole. Their principal contribution will thus remain as a source of experience and useful lesson to be adapted for wider use. The exception to this is probably in the family planning sphere and to lesser extent in health, where NGOs, particularly the Family Planning Association of Nepal - play a substantial role in the delivery of services at the periphery. Given the unlikelihood of a rapid increase in HMG's capacity to provide these services in the near future, these agencies will probably have an important continuing contribution to make.

In recent years, His Majesty's Government (HMG/N) of Nepal has given top priority to social sector development in Nepal. Realizing that development is a continuous process and that population program needs to increase its network, and government alone cannot fulfill the unmet needs, NGOs program was initiated in the late fifties. Further, with the establishment of Social Services National Coordination Council (SSNCC) on February 13, 1977, by His Majesty King Birendra Bir Bikram Shah Dev and Her Majesty Queen Aishwarya Rajya Laxmi Devi Shah as its chairperson, NGO's role was reiterated.

With this background, the present study explores the role of NGOs in family planning programs with special reference to the assessment of the contributions made by Family Planning Association of Nepal (FPAN).

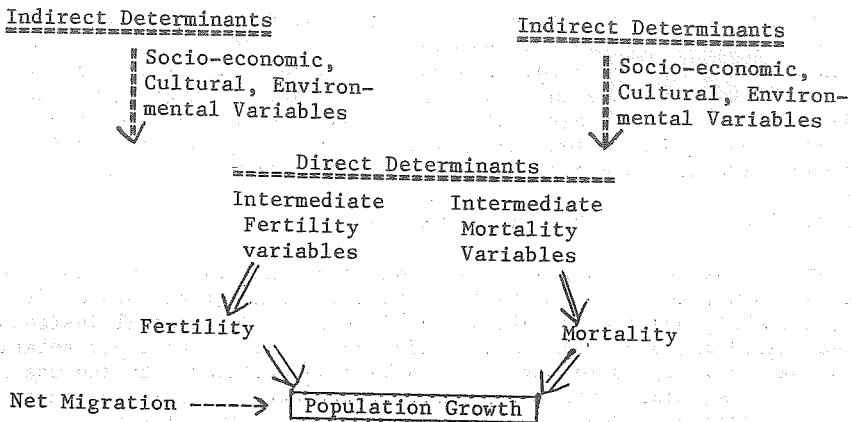
The present paper is organised as follows: Section 2 discusses briefly the conceptual framework of population growth and the role of NGOs as our intervening agency in this process. Section 3 discusses population growth and its structure in Nepal. Section 4 briefly highlights the role of NGOs in population program along with some findings of the effect of NGOs programs in population and family planning in Nepal and Section 5 concludes with some suggestions.

#### CONCEPTUAL FRAMEWORK OF POPULATION GROWTH

Studies of the causes of population growth and their changes often seek to measure impact of socio-economic and technical factors on fertility, mortality and the net migration of people. Substantial insights can be gained if, one tries to identify these factors and their relationships, particularly as to how they can be found related with the use of contraceptives, since that later influences fertility variables in a negative direction. The socio-economic and other variables which can be termed as the proximate determinants of population variables such as fertility, mortality and migration can be grouped into two categories namely, those that can affect directly to those variables and thus direct determinants and those that can affect these variables only indirectly that is indirect determinants. Use of contraception or sterilization or say age at marriage are such variables which can be termed as direct determinants of fertility. Similarly, the variable child and maternity health can affect mortality rate directly, so these variables can also be called intermediate variables. In the same way, education of a woman or say a man affect fertility or mortality but not directly. For example, education of women may induce for a relatively late marriage or may induce to use contraception. In both cases it will result into a lower fertility rate. So education of a woman can be taken as a variable under indirect determinants of fertility or mortality.

Conceptually, variables that affect directly the level of fertility are age at marriage, prevalence of contraception, permanent sterilization, induced abortion, etc. Similarly, the indirect determinants may be listed as education of the couple, employment of women, technology used in major economic activity and the level of income etc. The mortality variables were affected greatly by such determining variables as age at marriage, child and maternal health, institutional status etc. Relationships of their variables with fertility and mortality and ultimately to population growth can be shown as follows:

FLOW CHART  
ON  
POPULATION VARIABLES AND  
THE FACTORS AFFECTING



Thus, from the chart it is clear that any agency that are focussing on population program should concentrate on these determining variables.

POPULATION GROWTH AND ITS STRUCTURE

As mentioned earlier, the main source of data, related to all aspects of population in Nepal is census. Census taking in Nepal was started from 1911 and since then, it is being continued roughly after every ten years. Table 3 shows that the population of Nepal did not grow at a uniform rate throughout the census years, 1911-1981. There has been ups and downs in population growth until 1961. However, the population of Nepal is growing at a high rate since 1961. It is obvious from Table 3 that the population of Nepal declined by 1.2 percent between 1911 and 1920 and further by 0.7 percent between 1920 and 1930 too. The absolute decline in population size between 1911 and 1930 may be attributed, among others, to:

- (a) the effect of world-wide influenza epidemic in 1918 which has taken the lives of large number of people in Nepal too;
- (b) the heavy casualty suffered by the Nepalese serving with the allied forces during the First World War; and,
- (c) higher under-enumeration in 1920 as compared to 1911 and 1930, because of poor coverage in 1911, being the first census, and the fear of being recruited into the army for possible war against Tibet in 1929.

Table 3  
Population Size and Growth, Nepal, Census Years 1911-1981

Years	Total Population	Population Increase (%)	Annual Growth Rate (%)	Doubling Time (Year)
1911	5,638,749	-	-	-
1920	5,573,788	-1.2	-0.13	-
1930	5,532,574	-0.7	-0.07	-
1941	6,283,649	+13.6	+1.16	60
1952/54	8,256,625	+31.4	+2.30	31
1961	9,412,996	+14.0	+1.65	42
1971	11,555,983	+22.8	+2.07	34
1981	15,022,839	+30.0	+2.66	26

Source: Central Bureau of Statistics.

The actual scientific census taking in Nepal started only with the 1952/54 census, when a separate census organization was set up for conducting census. Training in carrying out the tasks of census was given to supervisors and enumerators. So, due to these activities, the 1952/54 census had better coverage compared to the previous census.

Table 4 presents percentage distribution of population by five year age-group and sex in the censuses conducted in 1971 and 1981. In 1971,

Table 4  
Percentage Distribution of Population by Five Year Age-Group and Sex  
(1971-1981)

Age Group	Percentage Distribution			
	1971		1981	
	Male	Female	Male	Female
0 - 4	13.59	14.70	15.47	15.34
5 - 9	15.23	14.95	14.52	14.65
10-14	12.09	10.35	11.95	10.75
15-19	9.41	8.71	9.04	8.63
20-24	8.61	8.78	8.28	9.54
25-29	7.84	8.26	7.41	8.07
30-34	6.63	7.42	6.09	6.92
35-39	6.64	6.25	6.00	5.89
40-44	5.19	5.36	4.90	5.13
45-49	4.22	3.76	4.28	3.95
50-54	3.51	3.42	3.77	3.44
55-59	2.29	2.17	2.44	2.15
60-64	2.38	2.71	2.49	2.40
65-69	1.23	1.24	1.31	1.19
70+	1.74	1.92	2.05	1.95
Total	100.00	100.00	100.00	100.00

Source: Central Bureau of Statistics.

there existed an excess of persons in the age-groups 5-9 than in the preceding age-group 0-4. But it might be so only when there is evidence of drastic fall in fertility and/or increase in childhood mortality.

The rapidly declining mortality without corresponding decline in fertility has further added the proportion of young people, particularly in the age-group 0-14. The proportion of young people (0-14 years) in the total population has increased from 38 percent in 1952/54 to 41 percent in 1981. These facts show that as the increasing number of young people enter into reproductive ages and have babies, the population of Nepal is likely to grow further, keeping other factors constant.

In Table 4, a higher proportion of females are observed in the age-group 20-24 as compared to age-group 15-19 in both the censuses of 1971 and 1981. But one would expect systematic decline in number, as well as proportion from the lower age-group to the higher age-group, an attribution, resulting from mortality increase with age. An exception of this rule could only arise from the history of differential mortality and migration by age cohort. But there is no evidence to show that the females in the age-group 15-19 were subject to higher risk of mortality than those in the age-group 20-24. Likewise, there is no evidence to show that females in the age-group 20-24 have had differential history of migration.

Thus, the finding of higher proportion of females in the age-group 20-24 compared to those in the age-group 15-19 may be attributed to upward shifting of the females from age-group 15-19 to 20-24. The females in the age-group 15-19 who were married and having children may themselves report their ages as 20-24 years to enhance their acceptability or position in the society. Moreover, age-shifting could be observed at higher ages. The proportion of people in the age-group 60-64 is found to be consistently higher than that of the proportion in the age-group 55-59 years. It may be because of people's intentional exaggeration of their ages as an attempt to elevate their social status. And the high proportion of people in the age-group 0-4 is due to high fertility and low mortality rates.

#### Fertility and Mortality Rates in Nepal

Current knowledge about fertility and mortality rates in Nepal and its variations and trends are very much limited. Number of studies have in the past tried to estimate these parameters historically or for a period of time using both census reports and survey reports such as contraceptive prevalence survey and other fertility surveys in Nepal. However, the estimates vary from person to person who try to estimate these parameters and from one study to another. In the early 1950s, Crude Death Rate was estimated quite high in Nepal. It was found varying between 30 and 44 per thousand child ever born in early 1950s and between 22 and 32 in early 1960s.

Table 5  
Estimates of Selected Mortality Indicators, 1952-84

Period/ Year	Crude Death Rates	Infant Mortality Rates			Expectation of Life at Birth			Source/Author
		Male	Female	Both	Male	Female	Both	
1952-54	30	-	-	-	-	-	-	U.N. (1960)
1953-55	44	-	-	-	-	-	-	Thakur (1963)
1954	36.7	260	250	-	27.1	28.5	-	@
1953-61	27.0	-	-	-	34.8	38.4	-	CBS (1978a)
1961	32.2	-	-	-	30.2	33.0	-	#
1961-71	21.4	-	-	-	37.0	36.6	36.8	CBS (1978a)
1961-71	-	200	186	-	42.9	38.9	-	Gubhaju (1979)
1971	24.0	-	-	-	41.9	39.1	-	\$
1974-75	19.5	141	123	133	46.0	42.5	-	CBS (1976)
1976	22.2	128	138	134	43.4	41.1	-	CBS (1977)
1977-78	17.1	110	98	104	-	-	-	CBS (1978)
1971-81	13.5	144	150	147	46.3	44.2	45.3	CBS (1987a)
1981	-	147	142	144*	50.8	48.1	49.5	CBS (1987a)
1984	10.9	-	-	110**	-	-	52.0	New Era (1986)

Note: For details of the source, please see bibliography.

@ Baidyanathan and Gaige (1973).

# Krotki and Thakur (1971).

\$ US Bureau of Census (1979).

\* Refers to 1978.

\*\* Refers to 1981.

There may be a number of reasons for such discrepancies. One of the reasons for these variations could be attributed to the different techniques adopted by the authors in estimating these rates. Baidyanathan and Gaige (1954) are found applying a quasi-stable population model for estimating Crude Death Rate during 1950s. They came to an estimate of 36.7 as the Crude Death Rate per thousand child ever born. Central Bureau of Statistics estimated 21.4 as the CDR for the intercensus period of 1961-1971. United States Bureau of the Census (1971), on the other hand, estimated 24.0 as the CDR during this period. Demographic Sample Survey (1976) estimated CDR as 19.5 for the period 1974-75. Again, Demographic Sample Survey (1978) found CDR equivalent to 17.1 per thousand during 1977-78. Recently, a study on population carried out by New Era (1986) estimated it as 10.9 for 1984. Thus, although the results for the same period varies from one study to another, all these studies show a consistent pattern of declining CDR in Nepal over time. As discussed above it was between 30 and 34 per thousand in early 1950s and it has come down to 10.9 during early 1980s.

#### Causes of Mortality Decline in Nepal

As noted above, infant mortality in Nepal has declined consistently from 1950s to 1980s. The estimates recorded above show impressive improvement in reducing Infant Mortality Rates (IMR) over years. This has



considerably improved the confidence of the parents about the survival of their children. A number of reasons could be attributed for the decline of the mortality rates. First and foremost among these attributes are the rapid expansion of public health facilities in Nepal. As one can notice, health facilities prior to 1950s were concentrated mainly on Kathmandu Valley and that was also focussed on some preliminary health care facilities. Preventive health care facilities were meagre and epidemic diseases like cholera, tuberculosis, small-pox, etc. were rampant. The non-availability of health facilities outside Kathmandu and the limited health facilities within Kathmandu were far less than adequate for preventing these diseases. Moreover, total lack of infrastructure development outside Kathmandu made it virtually impossible for people to take their children even to the border towns of India. Therefore, child mortality was quite common in Nepal. However, after 1950s, a remarkable change has been noticed in the health care facilities and prevention of diseases. Massive malaria eradication program launched during 1960s has virtually wiped this out from Terai resulting less death of children and adults. The opening up of new hospitals, health posts and health centres during 1960s has contributed significantly in providing the preventive and curative services to the people throughout the country. The leprosy, tuberculosis and the small-pox eradication project launched during the middle of 1960 has as well contributed significantly in reducing infant mortality in Nepal. The initiation of Nepal Family Planning and Maternity and Child Health Project in 1966 and the establishment of Community Health and Integration Division within the Ministry of Health in 1961 aimed for delivering more community-oriented health services within the Ministry of Health have all the more contributed in further reducing mortality rate in Nepal. Increased improvements in the literacy rates and knowledge about health and sanitation have also contributed to this.

#### Age-Specific Fertility Rates (ASFR)

Estimation of age-specific fertility rates are important to understand the behaviour of fertility as well as in pin pointing the target group for reducing fertility. There are several estimates of ASFR in Nepal, estimated both by CBS and other institutions and private bodies based on census data and sample surveys. However, almost all these estimates show a consistent pattern in fertility rates, increasing sharply from 15-19 to 20-24 age-groups, and a gradual increase from 20-24 to 25-29 age-groups and a continuous but gradual decline thereafter to 35-39 age-groups and a sharp decline thereafter. The age-group 25-29 is found as the peak fertility period.

#### Age at Marriage

The 1971 census and the National Fertility Survey of 1976 show a consistent pattern of the age of women ever married in Nepal. It shows that by 19 years of age, almost two-third of women of the age (60.7 percent census and 62.7 percent NFS) groups 15-19 already get married. By the time they reach 29 years of age, almost 98 percent of the women within 25-29 age-group get married. Similarly, by the time they reach 49 years of age, more than 99 percent of the women between the age-group

Pyakuryal: Family Planning Program in Nepal/19

Table 6  
Age-Specific Fertility Rates, 1971-1981

Year Period	Age-Specific Fertility Rates to Ages								TFR*	Source
	15-19	20-24	25-29	30-34	35-39	40-44	45-49			
1971	87	235	264	220	162	88	34	5.4	CBS (1987a)	
1974-75	114	270	297	260	169	89	50	6.2	CBS (1976)	
1976	138	305	284	252	170	95	34	6.0	CBS (1978)	
1977-78	127	294	294	252	180	92	24	6.2	CBS (1978)	
1981	81	241	252	232	197	145	111	6.3	CBS (1987a)	

\*TFR = Total Fertility Rate.

45-49 get married. Thus, the figure shows a universal marriage pattern in Nepal with almost none as unmarried. The percentage of women marrying at different age-groups clearly shows higher percentage of marriage occurring by the time they reach 25 to 29 years, coincidentally which is also the peak period as far as the fertility is concerned.

Table 7  
Percentage Distribution of Never-Married and Ever Married Women 15 Years of Age and Above 1971-1986

Age of Women	1971 Census (1)		1976 NFS (1)		1981 Census (1)		NFFS 1986 (2)	
	Never Married	Ever Married	Never Married	Ever Married	Never Married	Ever Married	Never Married	Ever Married
15-19	39.3	60.7	37.3	62.7	49.2	50.8	61.8	38.2
20-24	7.9	92.1	6.0	94.0	13.1	86.9	14.9	85.2
25-29	2.7	97.3	1.8	98.2	5.3	94.7	4.2	95.8
30-34	1.4	98.6	1.2	98.8	3.1	96.9	1.8	98.2
35-39	1.1	98.9	0.6	94.4	2.6	97.4	0.8	99.2
40-44	0.9	99.1	0.5	99.5	2.5	97.5	1.6	98.4
45-49	0.8	99.2	0.7	99.3	2.9	97.1	1.4	98.6

Source: 1. Central Bureau of Statistics (1987a).  
2. Ministry of Health (1987).

This pattern of marriage and fertility rates in Nepal explains at least partly the reasons for constant CBR over time. Census reports in 1981 and NFFS in 1986 show slight variation in the pattern of marriage among Nepalese women. Although, about 98 percent of women get married by the age 49, early marriage pattern among Nepalese women seems gradually changing between 1971 and 1981 or 1986. The 1981 census and 1986 NFFS report show almost 50 percent (only 38.2 percent in NFS) marrying at the age-group 15 to 19 as compared to over 61 percent marrying at this age-group in 1971 and 1976. But there has been only a marginal change in the proportion of women marrying by the age-group 25-29 in both these surveys. For example, about 95 percent of the women in the age-group 25-29 are found married in 1981 and 1986 as compared to about 98 percent in 1971 and 1976.

## Total Fertility Rate and Cumulative Fertility

The table given in ASFR shows total fertility rates remaining more or less the same between the years 1971 and 1981. Based on 1971 census, during 1961-71 inter census period, TFR is estimated as 5.45. The 1974-75 mid-term census estimated it as 6.2 and the 1981 census shows it as 6.3 between the years 1971 and 1981. Thus, TFR in Nepal seems quite high and not affected by the population programs carried out between 1971 and 1981. Cumulative fertility measured by the mean number of children ever born by ever-married women in their reproductive period shows increasing over time between the years 1971 and 1986. In the year 1971 women between the age-group 15 to 49 are found giving birth to 4 babies. The 1976 figure showed it as 5.7 and 1986 again as 5.7. However, the census report 1981 shows the cumulative fertility as 3.7. The estimate does not confirm the figures estimated preceding this period. The high level of population growth was a concern for population planners. As such, the family planning programs are found intensive after 1981.

Table 8.  
Mean Number of Children Ever Born by Current Age for All Ever Married  
Women, 1971-1986

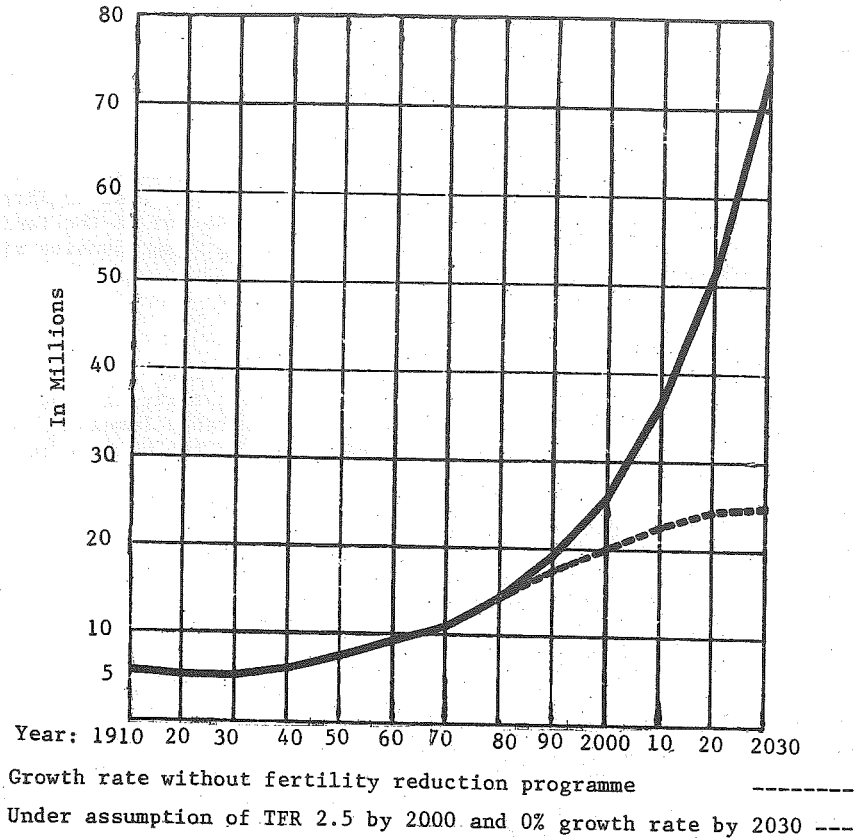
Age Group	1971(a)	1976(b)	1981(c)	1984(d)	1986(e)
15-19	0.3	0.3	0.4	0.5	0.5
20-24	1.1	1.4	1.2	1.6	1.5
25-29	2.2	2.9	2.1	2.9	2.8
30-34	3.1	4.1	3.0	4.0	4.0
35-39	3.7	5.1	3.4	4.8	4.8
40-44	4.0	5.5	3.7	5.5	5.5
45-49	4.0	5.7	3.7	5.8	5.7

Source: a. CBS (1975a).  
 b. Ministry of Health (1977).  
 c. CBS (1984a).  
 d. New Era (1986).  
 e. CBS (1987b).

## Long-Term Strategies on Population

In view of the increasing population, the low resource base of the country, the sluggish rate of economic growth, high rate of under-employment and growing environmental degradation, a national multi-lateral strategy on population with a long-term objective were prepared by National Commission on Population in 1983.

NEPAL  
Population Target & Projection  
1910-2030



This strategy is directed to reduce the population growth rate to 1.2 percent and the total fertility rate to 2.5 by the year 2000 A.D. Attainment of the TFR through showing down the rate of growth of population, will still result in an estimated projected population of about 21 million by the year 2000. Table 9 has been phased to reflect gradual periodic declines:

Table 9  
Fertility Targets During 1985-2000.

Year	TFR	Projected Population	Annual Growth Rate Percent
1985	5.8	16.3	2.2
1990	4.0	17.9	1.9
1995	-	19.4	1.6
2000	2.5	20.6	1.2

Life expectancy during the period is estimated to continue increasing at a rate of 0.5 per annum.

The task of achieving these targets is extremely arduous one to the lack of trained manpower and management capability, low level of literacy and other difficulties associated with the implementation of the family planning program. The need for a well conceived and comprehensive strategy of population control is, therefore clear.

#### ROLE OF NGOs IN POPULATION PROGRAM IN NEPAL

The development reality of the Third World countries at the present is the persistence of poverty and a declining availability of financial resources. Dehumanizing poverty persists at intolerable levels in most countries of this region. Under such conditions, if the welfare programs are typically governmentally executed, people in general do not look as their own, or as for their own welfare. Because of rampant ignorance and high illiteracy together with the conventional thinking of the tradition bound society, such programs do not make such headway. In such a situation, the non-governmental organizations have a critical role to play since they can effectively reach the people, convince them and produce results. The central development task should not be viewed primarily as one of transferring financial resources, but rather as one of developing the human and institutional will and capacity to put whatever resources are available to sustainable productive and adequate use in the service of people. It is within this context that we now see the emergence of private voluntary organizations (PVOs) or non-governmental organizations (NGOs).

#### Institutionalisation of Social Services in Nepal

Social welfare has a long history in Nepal. Charity and services were originally provided through religious institutions. The civil code of 1910 B.S. provided some protection for the disadvantaged in society, however not much social welfare development occurred until the modern period i.e., after 1951. Since 1962, there has been a mushrooming growth to voluntary social welfare organizations. However, the establishment of SSNCC has now institutionalised the social services in Nepal. With the aim of bringing coordination by avoiding duplication in the activities of the various social organizations which function in the strength of devotion and service rendered by the social workers, and also to bring

in uniformity in the national, foreign and international grant and aid and formulate policy and program to be applicable and implemented throughout the nation and last but not least to promote the interest of the child, the young, the women, and the helpless, His Majesty King Birendra Bir Bikram Shah Dev, by and with the advice and consent of the Rastriya Panchayat has made SSNCC Act in 1977.

Until now, forty-four International Donor Institutes have provided financial contributions to about 171 social organizations under six different committees of SSNCC. Out of 171 social organizations, about four NGOs, perform family planning and health-related programs. They are Family Planning Association of Nepal (FPAN), Nepal Red Cross Society (NRCS), Mother's Club and Ex-Service Men's Organization. However, as FPAN is the leading NGO associated with family planning programs, brief analysis is done about FPAN in the Present Paper.

#### Family Planning Association of Nepal (FPAN): Its Structure & Functions

Rapid population growth is not only an impediment for the socio-economic development of a nation but also an obstacle in raising the standard of living and the social status of individuals. In order to make our development efforts meaningful, it is necessary to strike a balance between population growth and economic development. Realising the fact, FPAN, a non-governmental, non-profit and voluntary social organization initiated the family planning (FP) program in September 18, 1959, through the establishment of a 'Family Planning Committee'. This Committee was formed by a group of medical doctors and social workers with the assistance from US based social organization "Path Finders". In 1960, FPAN acquired joint membership of the International Planned Parenthood Federation (IPPF) and in 1969 it became a fullfledged member of the Federation.

FPAN started to carry out its activities by voluntarily helping the individuals to plan their families through intensified information and education campaigns and through the provision of FP services. After years of services towards family planning and community development programs, it has been metamorphosed into one of the most leading non-governmental organizations.

At the initial stage, it started with three districts as its operational area but the Association now works through branches/action units and special projects. At present, there are 17 branch offices, 4 action units and 8 special projects operating in 25 of the 75 districts of the country. The total staff strength of the Association is over 700 with strong voluntary input coming from the different walks of life. The FPAN is headed by Her Royal Highness Princess Prekshya Rajya Laxmi Devi Shah as its President. The policy-making body of FPAN, the Executive Committee, is comprised of the distinguished personalities like members of National Legislature, medical practitioners, academicians, senior civil servants, businessmen and social workers.

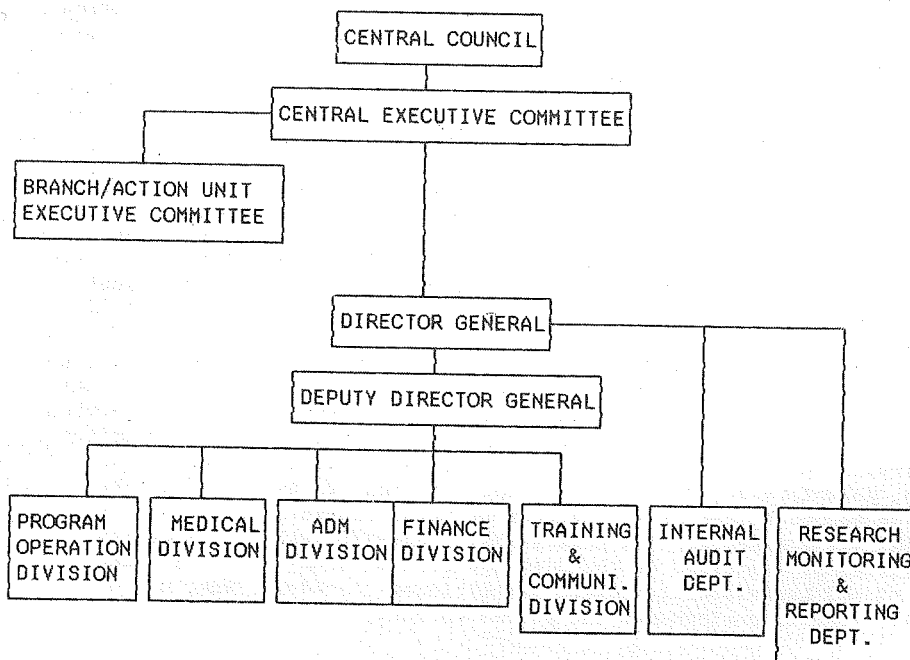
*Organizational Structure*

The highest body in the organizational structure of FPAN is the Central Council which is represented by six elected members from all the branches and members from concerned government agencies. This body is responsible for approving the Three-Year Plan and Work Program Budget, giving directives on policy matters and electing the Central Executive Committee (CEC). The Council meets once a year.

The CEC consists of 20 members and representatives from the Health Services Coordination Committee, Ministry of Health and National Commission on Population. The Committee meets at least four times a year and guides the FPAN Secretariat in carrying out its activities. The Executive Committee also forms different sub-committees and steering committee to facilitate its work. These committees are voluntary bodies and consist of experts in different fields. In total, there are nine sub-committees and steering committees.

All the members of the Central Council and Executive Committees are elected members of steering committees and sub-committees and are selected for a term of four years. A similar pattern is also followed by the branches. A brief organizational structure of the FPAN is shown below:

ORGANIZATIONAL STRUCTURE OF FPAN



### *FPAN's Role in Population Activities*

Over the last 28 years, FPAN has been actively engaged in the population activities of the country. It is proved to be the leading non-governmental organization to be involved in activities contributing to the population planning in the country through its innovative ideas in delivering services, creating awareness, both among people and policy makers, for the need of population planning, helping develop country's population policy, training manpower and encouraging people to carry it out throughout the country.

FPAN in the past has concentrated its activities more on permanent sterilization, free distribution of temporary family planning devices and creating awareness among people and the planners about the need for population planning in the country. However, with the changing determination and direction of the national goals and with its own experiences, FPAN has been changing its strategies over time. Currently, FPAN is giving more emphasis to the young couples, especially encourage them to use temporary devices, child spacing, and child and mother's welfare. The role of FPAN is defined as follows:

FPAN will continue to support National Population and Basic Health Need Program of HMG by providing family planning and mass education and services with an attention to young couples. Spacing methods supplemented by quality clinical services will be emphasised along with the adequate counselling and follow-up. Innovative and cost effective approaches will be promoted for greater degree of self-reliance. Priority will be given to women's and children's welfare and integrated community development programs. The FPAN aims to consolidate its management and operations for the next few years.

### *Current State of Family Planning*

Throughout the 1970s and 1980s, the constraints of poverty, illiteracy, poor health, the depressed status of women and high infant mortality combined with overwhelming difficulties imposed by the mountainous terrain have slowed all attempts to bring down Nepal's population growth rate. By and large, despite considerable governmental and non-governmental effort and an increase in current contraceptive usage from 3 percent in 1976 to 15 percent in 1986 as said above the national goals set for lowering fertility rates have not been achieved.

NGOs in Nepal focussing on population program were found concentrating their activities in such areas as population education, permanent sterilization, birth spacing through temporary contraceptive measures, child and maternal health, nutritional program and of course an income generating activities. Besides they have been successful enough to increase the legality of age at marriage. Expanded program on free primary school and adult education have all the more been an important landmark in this area. As discussed above, conceptually there are the basic population determining variables that have to be addressed for achieving some success in the population program.



At the present time, there is clearly an important contribution still to be made in family planning in Nepal by non-governmental agencies. It is, in this regard, that FPAN is advised to continue lobbying with the government in the years ahead to promote its own distinctive and independent view. The most important task facing is how it will translate its new program strategies for 1988-90 into realistic project activities. The intention of those in charge is not to make a radical break with the past but to largely maintain the present projects and gradually change their emphasis accordingly.

For almost twenty years, the government has supported the concept of family planning as a means to achieve population stabilization. In principle, it has advocated the use of broad spectrum of contraceptives. In practice, it has favoured the use of sterilization as what it hoped would be the most effective way to reduce fertility. This is well illustrated by Table 10, showing the contraceptive methods used by the Nepalese people.

Table 10  
Percentage of Married Women Reported to Have Currently Using a Specific Contraceptive Method.

Method	1976*	1981**	1986***
Male Sterilization	1.9	2.9	6.0
Female Sterilization	0.1	2.4	6.6
Oral Pills	0.5	1.1	1.1
Injectable	-	0.1	0.5
IUD	0.1	0.1	0.2
Condom	0.3	0.4	0.6
Total	3.0	7.0	15.0

\*Nepal Fertility Survey 1976.

\*\*Nepal Contraceptive Prevalence Survey 1981.

\*\*\*Nepal Fertility and Family Planning Survey 1986.

The government's overall policies do not appear to have changed significantly, except in the direction of shifting from a reliance on temporary "camps" where sterilizations have been performed to counting on a more regular schedule of sterilizations in hospitals and clinics.

In recent years, people concerned with population programs at governmental and non-governmental organizations have come to realize that their intensive focus on sterilization has resulted almost entirely in the provision of protection to couples who, because of the age and parity of the women, are nearing the end of their child-producing years. It is this situation that has led to the current push in some quarters for a new shift in family planning policies and associated program strategies.

The per annum expenditure on family planning in Nepal has usually ranged from 0.65 percent to 0.90 percent of the total government outlays. Family planning funding has most commonly constituted 15-19 percent of the total health expenditure in Nepal. However, neither the share of family planning expenditure in the total national outlay nor its share in the total health expenditures show any clear-cut trend over time. The total cost of family planning service delivery by the four main agencies of His Majesty's Government of Nepal increased from US\$ 0.4 million in the mid 1970s to about US\$ 2 million in 1982-83, at 1975 constant prices. This implies a five-fold increase in real cost.

The achievements made over the years in establishing infrastructure for the delivery of family planning services together with the development of a national organizational support ought to be reflected in changes in the awareness and acceptance of the family planning program in the country. This raises obvious questions: 'What has been the impact of the family planning program in Nepal?', More specifically, 'what progress and changes have occurred?', 'Which particular sub-groups of the population have experienced most of the impact?', 'What has been the impact of the program on fertility?', 'What are the prospects of a long-term impact on fertility, hence population growth?', etc.

Data from the three surveys namely, NFS 1976, NCPS 1981, and NFS 1986 make it possible to assess the achievements of at least one decade of family planning programs as well as to shed light on the future prospects of family planning in Nepal.

Awareness and use of contraceptives - the two most common measures of a program's impact - increased considerably during the decade 1976-86. The ratio of family planning knowledge to current use was about four to one in 1986. However, the level of use increased proportionately more than the level of knowledge in the most recent five-year period. Higher levels of awareness and use were positively associated with educational attainment, non-agricultural employment, urban residence, higher parity and higher age. Women in Terai region had the highest level of awareness and use, which is consistent with this region's much better transportation and communication facilities, and its more heterogeneous population, compared to the hills or mountains region. Further, the government has made special efforts in recent years to establish several village level family planning centres in the Terai region.

The family planning program's de facto policy to focus on sterilization can be further discerned from data showing that younger and lower parity Nepalese women were no more likely to know about the spacing methods of contraception than were older, high-parity women. It is therefore not surprising that the use of temporary methods of birth control remained very low in Nepal. Given that sterilization was the only widely known method of contraception across all age categories, it would appear logical for the eligible couples to perceive family planning as a synonymous with sterilization.

The overwhelming emphasis on sterilization, as it currently exists, is not a prerequisite for achieving the future fertility target. The current strategies for the promotion of family planning should be critically reviewed and modified, if the family planning program in Nepal is to effectively serve the needs of those who may need contraception for spacing births, but not necessarily for terminating child-bearing. Fortunately, the motivation to use family planning for fertility regulation appears promising in Nepal. Between 1976 and 1986, the number of children desired, by age, decreased by 14 percent among women ages 15-24 and by 12 percent among those aged 40-49. Overall, the mean desired number of children declined from 4.0 to 3.5 per women during the decade. Furthermore, about 45 percent of the women aged 15-29 who had heard of family planning intended to use family planning in the future. However, since sterilization was the only widely known method and no time reference was made as to when the women intended to use the method, the data on intention to use should be interpreted with caution.

#### CONCLUSION

In the above sections I have briefly outlined the growth and structure of population and its salient features such as fertility rate, mortality rate, age at marriage, etc. The high population growth in Nepal, particularly in the last decade has been a major concern to the population planner. The early and almost universal pattern of marriage among Nepalese women has significantly contributed in increasing the total fertility rate among them. Although with growing urbanisation, level of education, employment opportunity and above all the growing awareness on family planning among people has increased the contraceptive prevalence rate in Nepal thereby contributing directly and indirectly in making population program a success. Nevertheless, the dominance of rural population, poverty, and strong religious belief in preferring a son has limited the effectiveness of these programs significantly. Family planning programs in Nepal are therefore concentrating much more on population education, child and maternal health, birth-spacing and the income generating activities among the people. Although these methods involve long-time lag in producing visible results particularly in reducing the level of fertility, however, they seem to be the effective means in population program over a long period of time. Population planning is of course a long-term plan. It has to deal with the psychology of the people and the belief of the society. Therefore one should not be too optimistic in obtaining positive result within a short time frame.

Several steps can be undertaken for the future course of the program's direction and service delivery as well.

Policy makers should provide explicit direction by spelling out the need for a more balanced approach in the promotion of all methods of contraception.

Similarly, training programs for the health workers and motivators aimed at reemphasising the independent and unique role of reversible methods of contraception should be implemented.

Thirdly, IEC materials should be designed and experimented with, not only to dispel the prevailing misinformation and misperceptions about temporary methods of contraception, but to disseminate information on the health benefits for contraceptive use.

Fourthly, as the issue of cost-effectiveness is likely to be an increasingly important factor in delivery of family planning services, the program should identify ways to make each worker perform more efficiently and effectively. Furthermore, a better monitoring system to evaluate the performance of the providers and motivators should be formulated.

A comprehensive population program should be designed if the target set by the National Commission on Population is to be realized.

Finally, more frequent evaluations of the family planning program would provide critical information needed to correct existing deficiencies. The political will and the infrastructure developed over the years have led to significant achievements in the family planning sector in Nepal. However, the potential for making qualitative improvements in service delivery does not appear to have been concomitantly realized. This remains a challenge for the family planning sector leaders, program managers, providers, motivators and promoters in Nepal. Thus, the international agencies, too, should consider this challenge in designing, implementing and evaluating Nepal's family planning program.

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