CHAPTER – I
INTRODUCTION

1.1 Background of the Study

Practice of contraceptive device is one of the burning and perplexing issues in the current arena. Contraceptive use varies by age. Use is lower among younger women because they are in the early stage of family building and among older women (some of whom are no longer fecund) than among those at intermediate ages. For example, current use of a modern contraceptive method is 14 percent among currently married women age 15-19, raises to 60 percent among age 35-39 and then drops sharply to 42 percent at ages 45-49. Most women who are sterilized are over age 30, while inject are popular among women age 20-44(Tuladhar, 2006).

Family planning is a programme, which make family happy and satisfying by the use of appropriate management and mobilization of income and resource. Family planning is very important component to maintain the reproductive health of male and female. The main aim of family planning programme should be to enable couple and individual to decide freely and responsibly the number and spacing of their children and to have the information and means to do so and to ensure informed choices and make available a full range of safe and effective methods. Family planning is a systematized process through which medical science is applied to control and plan the number of children and their spacing as desired by the couple (Thapa, 2001). WHO defined family planning as a way of thinking and living, which is adopted voluntarily, upon the basis of knowledge, attitude and responsible decision by individual and couples to promote the health and welfare of the family (WHO, 2000).

The dictionary of demography defined "Family planning is a conscious effort of couples or individuals to control the number and spacing of births. Family planning is used synonymously with many terms – birth planning, birth control, fertility regulation, Planned Parenthood and many others. The term implies a general reproductive strategy, however, and should not be used to mean just contraception, since it comprises practices aimed both at preventing birth at certain times and at including them at others.

Abortion as well as contractive device remains one of the more difficult topics to study despite its widespread practice – estimates suggest that about one quarter of pregnancies worldwide end in abortion – because of the moral arguments surrounding abortion, the criminalization of the practice in many countries, and the clandestine nature of abortion for many women and abortion providers (Jejeebhoy & Koening, 2003). Social effect of contraceptive device is one of the challenging issues in the modern era.

Contraceptive measures were initially introduced in the west in the world in the early 1960 s as a form of fertility control to assist those who were in genuine need such as mothers with too frequent pregnancies impairing their health and that of their offsprings, spouses genuinely and legitimately desiring to contain the size of their family, nations with pressing problems of population growth. These indications presupposed the use of contraception in a family context. (Santamaria,1984).

The spread of contraceptive use within a society can be viewed as a diffusion process. The first stage is to become aware of and informed about contraceptive methods. In populations with family planning policies designed to increase contraceptive use, measuring the level of awareness of contraception also prvovides a useful measure of the success of information, education, and communication activities and may help to identify program areas that need to be strengthened (Tsui, 1985).

Family planning is the major component of reproductive health it can save human lives, controlling unwanted pregnancies, limiting the number of births, limiting birth to the healthiest age, avoid unsafe abortion, preventing transmission of sexually transmitted diseases (STDs), consequently reducing infant and child mortality in one hand, on the other hand it directly controls fertility and population growth. So the utilization of the family planning has been increasing day by day, as a means of birth control recognized early in the development process and has been viewed as reproductive health and right after the International Conference on Population and Development (ICPD) held in Cairo in 1994. The conference put human right, human development and individual well-being become the center of programme policies as it was recognized that individual health and well-being are a pre-requisite for women and men to want to have a small family size. The new thinking endorsed in Cairo was also that population growth can be stabilized and development efforts can be enhanced particularly by the development of women and improving the reproductive health (Thapa, 2001).

The family planning programme in Nepal from 1968 till today passed through many barriers that has affected its performance and subsequent achievement during the initial period till today, lots of changes took place in terms of government policy guidelines, priority areas, organizational set up, programme structure, and resource allocation. The government approach during the recent year has been to consider family planning as an integral part of Human rights and safe motherhood programme rather than a strictly target oriented family planning programme. The National Reproductive Strategy of Nepal has included family planning and counseling; information education and services as essential component of reproductive health and family planning (Acharya, 2002).

1.2 Statement of the Problem

Today world is facing a crucial problem of population growth. The rapid population growth has become a problem for the socio-economic development of the nation as a whole. So, it has become a serious concern to each and every-body concerned with the welfare of human kind.

Nepal is a developing country with poor socio- economic condition. Nepal has been facing the problem of population growth due to the lack of industrialization, low production and unemployment. In order to control population growth government of Nepal has systematically introduced many population programs since the third Five Year Plan. The status of Nepalese women is very low. The society makes it imperative for girls to get married as soon as they enter into puberty. Family planning is the spread of negative rumors, exaggerated truth of service providers and lack of adequate follow up care. Most people are out of accessibility, availability and affordability of family planning methods. Unmet need of family planning, side effect, low involvement of male in family planning, weak government programmes, religious and traditional believes, lack of skilled manpower are some obstacles in family planning services. Knowledge about family planning is universal but contraceptive prevalence rate accounted only for 39.6 percent in 2001 (Pathak, 2002).

In Nepal, Family planning programme is facing various challenges, among them low involvement of male in family planning programme. To achieve the goal of family planning services equal participation of male in family planning is needed. People attitude towards contraceptive has been changed, knowledge of contraceptive was found highest in Brahmins and Chhetry. Age is also the most important factor that affects the

utilization of family planning services. The uses of family planning methods increase with age up to 35-39 years and then declined with increasing age of women. Availability and accessibility of family planning services are one of the main reasons for the high use of family planning. The change in social and cultural norms motive increased use of family planning services. Religions, side effect on health and son preference are reasons for not using family planning methods (Thapa, 2001).

Because of low use of family planning method much more women are facing unintended pregnancy, abortion and related complication of pregnancy. The family planning programme still could not help people completely. People are not fully satisfied with the services. The use of family planning is evident that women can have safe and satisfying life. Various programs are lunched in order to provide family planning services to people since long time and to manage the over extending fertility of people but not succeeded in their aim because of various barriers and weak programs. The services of family planning are not uniform throughout the nation and thus even today a big gap exists about the knowledge, attitude and practice of family planning in Nepal. Thus this research is directed to understand knowledge, and practice of contraceptive device in Godawari Municipality-12 of Lalitpur district.

Present inquire is intended to answer what is the knowledge and practice of contraceptive device? What is the effect of contraceptive device towards social life?

1.3 Objective of the Study

The general objective of the study has to find out the knowledge and practice of contraceptive device of currently married women of reproductive age group (15-49 years) of Godawari Municipality-12, Lalitpur district,

- To assess the knowledge and practice of contraceptive device
- To find out the social effect of contraceptive among reproductive age women.

1.4 Significance of the Study

Knowledge and practice of family planning services in any area are affected by the education, occupation and place of residence. Use of family planning also varies from one cast to other, one region to other, also varies from one age group to another. Family planning programme works best when women are fully involved in the design provision, management and evaluation of services. Women empowerment and changing social tradition and norms may increase the rate of contraceptive users.

The case study will direct to provide knowledge and practice of family planning of this ward no.12 of Godawari municipality. This research will provide the specific information on related topic, which also helps policy makers, planners, administrators and demographers. It will also provide guidelines for similar types of study.

1.5 Organization of the Study

The thesis has organized into five chapters. Chapter I contains an introduction part of the study which includes: background of the study, statement of the problem, objectives of the study and significant of the study. Chapter II has devoted to review of the literature.Chapter III deals with research methodology including research design and methods of analysis.Chapter IV has included field experiences i.e..Analysis and Interpretation of Data and the Chapter V has included summary and conclusion of the study.

CHAPTER – II
LITERATURE REVIEW

2.1 An Overview of Family Planning

Family planning refers to the use of modern contraception and other methods of birth control to regulate the number, timing, and spacing of human births. It allows parents, particularly mothers, to plan their lives without being overly subject to sexual and social imperatives. However, family planning is not seen by all as a humane or necessary intervention. It is an arena of contestation within broader social and political conflicts involving religious and cultural injunctions, patriarchal subordination of women, social-class formation, and global political and economic relations.Attempts to control human reproduction is not entirely a modern phenomenon. Throughout history, human beings have engaged in both pro-and antinatalist practices directed at enhancing social welfare. In many foraging and agricultural societies a variety of methods such as prolonged breast-feeding were used to space births and maintain an equilibrium between resources and population size. But in hierarchical societies, population regulation practices did not bring equivalent or beneficial results to everyone. (https://www.encyclopedia.com)

Many societies have made the transition from high mortality and large family sizes to settings where most children survive, small families are desired, and most people control their fertility. In the early 1960s, the average woman could expect to have almost five children over her life, but now she can expect to have fewer than three children. The conscious use of contraception and abortion to control fertility thus assumes paramount importance in explaining basic aspects of contemporary human society. However, substantial differences exist in fertility and contraceptive levels and access to services between developed and developing regions of the world. For example, while in more developed regions women now have fewer than two children on average and nearly 7 in 10 women in marital or consensual unions use contraceptives (mainly sterilization, the pill, or the male condom), women in Africa have about five children on average and fewer than 3 in 10 women in marital or consensual unions use contraceptives (mainly the pill, injectables, and implants) (United Nations 2004). Other factors such as social

structure, culture, gender relations, and economic opportunities also con tribute to these regional differences.

Research and public policy emphases up until the early 1990s were grounded in arguments for reducing population growth, and the areas of abortion and reproductive health were not very visible. The 1994 International Conference on Population and Development (ICPD) in Cairo, Egypt, and its final document, the Program of Action, shifted the focus from overpopulation concerns and demo graphic targets to an emphasis on reproductive rights. An example of this shift is reflected in the increasing use of the concept of ‘‘unmet need for family planning,’’ which includes both contraceptive behavior and fertility preferences and reflects the situation of individuals who want to avoid or delay a birth but who are not using any method of contraception, as a justification for and indicator of family planning program efforts and needs (Casterline & Sinding 2000). Understanding why people are in this apparently paradoxical situation and how best to meet their contraceptive needs adheres to the overall approach of satisfying individual reproductive choice rather than meeting national targets. Recent studies point to lack of knowledge about contraceptive methods, social opposition to contraceptive use, and concerns about health side effects as important reasons for why women and men do not use contraceptives though they want to delay or avoid pregnancy (Casterline & Sinding 2000).

The ICPD conference also expanded sexual and reproductive health to encompass a broad set of issues beyond family planning, such as women’s rights to control their sexuality. Sub sequent policymaking, advocacy, and scholar ship turned to gender inequities that affect key determinants of sexual and reproductive health. The often unstated assumption that women hold full decision making power over their health has been supplanted by research on the influence of spouses, parents, and peers, gender based power and violence in sexual relationships, women’s status and access to resources, and neighborhood and community level characteristics. For example, while a community based family planning program in Ghana led to increased contraceptive use, there were related strains in gender relations in the communities and fears among women of beatings by their husbands if they used contraceptives (Bawah et al. 1999). There is also increased attention to how voluntary sexual intercourse is, especially for young women, and the

implications of these findings for women's rights as well as sexual and reproductive health (Jejeebhoy & Koenig 2003).

Historically, women's experiences dominated research studies and data on family planning, abortion, and reproductive health, since women were deemed more accurate reporters of reproductive events and perceived as the people ''at risk.'' Many data collection efforts in the 1960s were limited to married women and then expanded in the 1970s, and later in some regions, to include unmarried women. Evidence on men's sexual and reproductive health is mainly from the 1990s and 2000s. A recent worldwide study documented that men are involved in family planning decisions – many have discussed family planning with their partners and used methods to space or limit births – and many men who have an STI say they have informed their partners of the infection or have sought treatment (Alan Guttmacher Institute 2003). Nevertheless, established family planning and reproductive health care services are much better developed for women in most countries (though there are still subgroups of women who are underserved) than for men.

Recent research incorporates men's views and experiences by studying couples and their reproductive behaviors. Studies of couples reflect the broader social context in which decisions like contraceptive use are made, and evidence shows that partners have significant influence over one another's contraceptive behavior via their individual fertility preferences and approval of and communication about family planning. Couple studies have tended to focus on contraceptive use (including condom use for preventing STIs), and much less on abortion or other sexual and reproductive health outcomes. One methodological challenge which arises is when partners have different reports of the same behavior. For example, men have been shown to report much higher levels of condom use than do women, both in the aggregate and within couples.

With the continued decline of fertility worldwide, persistent inequities in sexual and reproductive health (including access to services), and the spread of disease, questions about the ways that women and men – as individuals and as partners in sexual relationships – can better achieve their childbearing desires and protect their sexual and reproductive health become increasingly important to address. Future directions for social research will include a focus on the contextual factors that shape individuals' use of contraception, abortion, and reproductive health services; the continued inclusion of men

in analyses of sexual and reproductive health; understanding the barriers to effective contraceptive use; ways to increase the dual use of contraceptive methods for pregnancy and STI prevention; the conditions under which risky or coercive sex occurs; greater attention to sexual and reproductive decision making; and new techniques to improve reporting of sexual behavior and abortion.

2.2 Theoretical Review

The idea of modern population control is attributed to Thomas Malthus (1766–1834), who in 1798 articulated his doctrine attributing virtually all major social and environmental problems to population expansion associated with the industrial revolution. However, as a clergyman turned economist, Malthus was opposed to artificial methods of fertility control. He advocated abstinence and letting nature take its toll and allowing the poor to die. some of the theories have been developed related to sociology of health. some of them are as below.

The Integrated Behavioral Model : The integrated behavioral model (IBM) grew out of social cognitive theory, the health belief model, and the theory of reasoned action (Montano & Kasprzyk, 2008). Basically, IBM posits that a small number of variables can explain a substantial proportion of the variance in any behavior in any population (Fishbein,2008, Yzer, 2012). Additionally, behavior follows from specific attitudes people hold about the behavior. Attitudes about the specific behavior are reasonable, but not always rational or even accurate. The best predictor of behavior is a person'sintention to perform that behavior. If someone intends to perform a behavior, IBM predicts they will do so, provided they have the necessary skills and abilities, and provided environmental factors do not interrupt their performance of the behavior. A person's intention to perform the behavior is determined by their attitudes toward the behavior, perceived norms regarding the behavior, and self-efficacy regarding the behavior. In IBM, attitude refers to how favorable or unfavorable a person believes his or her performing the behavior would be. Perceived norm refers to the social pressure one feels to perform the behavior. Social pressure regarding the behavior refers to whether important people value the behavior and whether peers are actually performing the behavior, as well. Finally, self-efficacy consists of an individual's beliefs about whether they are able to perform the behavior, regardless of their actual competence. Background

factors, such as socio-economic status, relationship factors, and education predict attitudes, perceived norms, and self-efficacy.

The Integrated Behavioral Model and Contraceptive Use : The first step in applying IBM to behavioral research, like contraceptive use, is to clearly define the behavior (Fishbein, 2008). A clear definition of contraceptive behavior is difficult because of the variety of contraceptives available, and the variety of contexts in which sexual behavior occurs. Fishbein (2008) recommends the following: identify the action (use), identify the target (contraception), identify the context (during vaginal intercourse), identify the time (every time). This is the first study to use the integrated behavioral model to explore contraceptive behavior that includes all forms of contraception (Wohlwend et al., 2014).

Attitudes toward contraceptive behavior include the beliefs, knowledge and expected consequences regarding that behavior (Pratte, Whitesell, McFarlane, & Bull, 2010). Research reveals the existence of conflicting attitudes about contraceptive use (Pratte et al., 2010; Ayoola et al., 2007). Attitudes that influence the intention to use contraception include the following: concerns about side effects, concerns about weight gain, and perceived health risks from using contraception (Homco et al., 2009; Ayoola et al., 2007). Many women do not use contraception because they believe they have a low risk of pregnancy, which in some cases means women believe they are infertile (Mosher et al., 2012; Homco, et al., 2009; Jones et al., 2002). Whether or not one deems the health care system that prescribes and dispenses contraception as trustworthy is an attitude that may profoundly influence the intention to use contraception (Yang, Matthews, & Hillemeier, 2011). Many studies have documented inaccurate knowledge about (a) how to use contraception and (b) how contraception works (Kaye et al., 2009; Homco, et al., 2009). Finally, mental health problems are associated with inadequate contraceptive behavior (Homco, et al., 2009; Maxson & Miranda, 2011). While many different attitudes determine one’s intention to use contraceptives, a thorough understanding of which personal benefits and expected consequences affect contraceptive use decisions of women of different ages and socioeconomic strata is not well understood.

Social Cognitive Theory: Social cognitive theory focuses on understanding the risks and benefits of changing one's behavior, developing self-efficacy, and assessing outcome expectations of the change in behaviour.

Transtheoretical model : This model posits that interventions should be tailored to assist individuals through the various stages of behaviour change by recognizing the steps of the process, which include thinking about a new health behaviour, implementing it, and adhering to it.

2.3 Empirical Review

UN (2004) states the Education is a crucial factor determining desired family size and sex preference. Higher the education lower the fertility and lower the education higher the fertility in various studies of many researchers showed higher rate of literacy (of husband and wife) decreases the family size and low rate increases the family size. Attainment of higher education is instrumental in reducing desired family size in Nepal. There is also strong relation between education and contraceptive device.

Family planning services are essential parts of reproductive health care and have saved the lives and protected the health of millions of women and children. Over the past 30 years, the development of modern contraceptive methods have given people grater individual freedom and enhanced their ability to plan their families. Contraceptive use has increase from less than 10.0 percent of couples 30-60 percent of couples today and family size has fallen from an average of six children in 1960 to less than three. However, today at least 350 million couples do not have access to full range of safe and effective modern method of family planning (Blanc, 2001).

The aim of Nepal's family planning is to attain replacement level fertility, i.e. TFR of 2.3 or there about. In order to achieve this, contraceptive use would have to be raised to around 70 percent. In order to provide service to these large numbers of couples the service delivery should be made accessible and available at every nook and corner of the country. Another change for family planning programme in Nepal is to increase the male participation. Male partner have to take at least equal responsibility in adopting family planning. However, only 28 percent were male users and 72 percent were female users. There is a great need to propagate message for males in Nepal to share the family planning responsibility (Pathak, 2002: 33).

From 29 percent of contraceptive users in 1991 increased to 53 percent in 1996. The increase in the rate is due to government new health policy 1991. There is also sustainable increase in ready accessibility in rural areas in 1996 than in 1991, but there is a marked different in rural – urban area. Still more than 50 percent of current users had no ready accessibility to contraceptive in rural areas in 1996, while 82 percent users in urban area were getting contraceptive locally (Pathak, 2001: 1-10).

In the context of Nepal using of family planning services is increasing over the year, however still one half of the current user have to travel for more than two hours to obtain the contraceptive. The demand for family planning services particularly remains high. The overall total unmet need for family planning has increased from 28 percent in 1991 to 31 percent in 1996. While the total met need has increase from about 23 percent to 29 percent during the same five-year period. Thus demand for family planning has increased substantially. The total demand for family planning has increased from 51 percent in 1991 to 60 percent in 1996 (K.C., et al., 2002).

Unmet need for family planning remained one of major issues in Nepalese family planning programme. Nepal's population policy has always given strong emphasis on meeting the unmet need but not much improvement so far, it might be due to the accessibility and supply factors, service quality, lack of adequate information and counseling about the use of family planning and lack of quality of reproductive health services. The higher percentage of rural women had unmet need than urban women (Acharya, 2002: 25-32).

Nepal family planning programme face various challenge, among them low involvement of male in family planning programme. To achieve the goal of family planning services equal participation of male in family planning is needed. However, only 28 percent were male users and 72 percent were female users. There is a great need to propagate message for males in Nepal to share the family planning responsibility (Pathak, 2002: 77-82).

People attitude towards contraceptive has been changed, knowledge of contraceptive was found highest in Brahmins and Chhetry. Age is also the most important factor that affects the utilization of family planning services. The uses of family planning methods increase with age up to 35-39 years and then declined with increasing age of women. Availability and accessibility of family planning services are one of the main reasons for the high use of family planning. The change in social and cultural norms motive increased use of family planning services. Religions, side effect on health and son preference are reasons for not using family planning methods (Thapa, 2001).

From a long course of time fertility is one of the natural processes but due to the modernization fertility performance is also changing. Nepal is one of the least developed countries where as the rate of growth of population is high. The total fertility rate is 3.1 children per women according to MOH (2007). Among the demographic changes that Nepal experienced in the last three decades, the decline in its total fertility rate (TFR) has been the most striking. The total fertility rate is the average number of children women would have by the end of their childbearing years if they survive all years and were subject during their whole lives to the fertility rates of a given period. It is expressed as children per woman. Total fertility rates in Nepal from 1980 to 2015. During this time, total fertility rates declined by more than half, from 5.62 children per woman in 1980–85 to 2.32 children per woman in 2010–15 (UNICEF, 2017)

Arokiasamy (2016) conducted a research on levels of awareness and perception of condom use among secondary level students in Kenya. A study was conducted to assess the levels of awareness and perceptions of condom use among secondary school students in the prevention of STDs in Bahati division of Nakuru North District, Kenya. This study adopted an ex post facto survey research design because the research design does not influence the cause or the effect of the current status of the phenomenon under study. The target population included 12,319 students and 52 teacher counsellors in the 52 secondary schools. A sample of 372 students and six teacher counsellors was selected from six schools. The study utilized 36 mixed secondary schools. Proportionate-stratified random sampling was used to draw the sample of 372 students from six schools. Data was collected through the administration of questionnaires. Data collected was analyzed using descriptive and inferential statistics with the aid of SPSS version 11.5 for windows. One of the findings was that the students expected the Guidance and Counselling departments in their schools to play an assertive role in creating awareness on sexuality issues affecting them. Following the finding, the study recommended that the Guidance and Counselling program be strengthened in the schools to enhance the awareness of sexual behavior and its related consequences.

Bhende (2011) accomplished a survey on men's perception about their role in those of wormen's decision about sex. Data from the 1991 National Survey of Men examine men's perceptions about their roles in relation to those of women in a couple's decision-making about sex, contraception and the rearing of children. A majority of men (61%) perceive that there is gender equality in sexual decision-making, and more than three-quarters

(78%) believe that men and women share equal responsibility for decisions about contraception. However, men are three times as likely 20 to say that women play a greater role in a couple's decisions about sex as they are to believe that men have the greater voice (30% compared with 9%). In contrast, men are more than twice as likely to perceive that men have a greater responsibility in contraceptive decisions as they are to say that women do (15% compared with 7%).

Jayaraman (2015) studied perception of Saudi women regarding the use of contraceptives. A cross-sectional study was conducted among Saudi women attending primary care centers of Al- Qassim Region. A structured questionnaire was developed to cover the research objectives. The dependant variable was the utilization of contraceptive methods and the socioeconomic variables were the independent variables. The results identified the low knowledge level of the participant women regarding the variety of contraceptive methods. Most participants and their husbands showed acceptance to the use of contraceptives for birth spacing. They preferred birth interval of 2-3 years. They intended to have from 5 to 10 children. There was a significant increase in contraceptive use among working women, 30 years and older, with a higher level of education, and those having a large number of children. Multiple regression models revealed that the significant determinants of the use of contraceptives were women’s working and education. The study recommended sustained efforts to increase awareness and motivation for proper contraceptive use.

Governments and society have accepted and enthusiastically promoted contraception, especially contraceptive steroid hormones, as the means of assuring optimal timing and number of births, an undoubted health benefit, but they seldom advert to their limitations and side effects. While the widespread use of contraceptive steroid hormones has expanded life style and career choices for many women, their impact on the women's well-being, emotions, social relationships, and spirituality is seldom mentioned by advocates, and negative effects are often downplayed. When mentioned at all, depression and hypoactive sexual desire are usually treated symptomatically rather than discontinuing their most frequent pharmacological cause, the contraceptive. The rising incidence of premarital sex and cohabitation and decreased marriage rates parallel. While there is wide, societal acceptance of hormonal contraceptives to space births, their physical side effects are often down-played and their impact on emotions and life styles are largely unexamined. Coinci-dental to the use of the pill there has been an increase in

depression, low sexual desire, hookups, cohabitation, delay of marriage and childbearing, and reduced religious practice. https://www. researchgate. net/publication /279963891

Unplanned births are tied to increased conflict and decreased satisfaction in relationships and with elevated odds that a relationship will fail. They are also connected with depression, anxiety and lower reported levels of happiness. Contraceptive access and consistent method use may also affect mental health outcomes by allowing couples to plan the number of children in their family.People are relatively less likely to be prepared for parenthood and develop positive parentchild relationships if they become parents as teenagers or have an unplanned birth. Close birthspacing and larger family size are also linked with parents' decreased investment in their children. All of this, in turn, may influence children's mental and behavioral development and educational achievement. https://www.guttmacher.org/report

CHAPTER – III

RESEARCH METHODOLOGY

3.1 Rationale For Site Selection

To obtain the relevant information for the study Godawari Municipality-12 is selected purposively. Bethegal, Makathalali and Dhapakhel are the important areas of Godawari Municipality-12. Researcher has not found any literature conducted such type of research till date as well as i have been working as a health person in the very area for five years therefore i have chosen this area.

3.2 Research Design

The research design has adopted in this study is exploratory as well as descriptive types. The fundamental objective of this study is to describe the actual situation of contraceptive device practise in Godawari Municipality-12. In this study the descriptive research design helps to know and to identify the knowledge and practice of contraceptive device among married women. On the other hand, the exploratory research design helped to explore and analyze the major social effects of the contraceptive devices in the study areas. The data obtained through the design has qualitative as well as quantitative in nature.

3.3 Nature and Sources of Data

Qualitative and quantitative both types of data was applied. The data was collected from the primary and secondary Source for obtaining required information. Primary data has collected from the field by using the tools like interview. The secondary data has obtained from different related sources like published and unpublished books, research reports, journals, newspapers and magazines, websites etc.

3.4 Universe and Sampling Procedure

Female populations between age group 15 to 49 years in the Godawari Municipality-12 has population of the study. Purposive sampling has used for the selection of the sample. Even though there is 1730 house hold in the study area, researcher purposively select 40

married and reproductive age group women from the study area by using purposive sampling method.

3.5 Tools of Data Collection

Interview is the main tool of data collection.

3.5.1 Interview Schedule

Interview is one of the major methods of obtaining information from respondents. Interview has held in the Godawari Municipality ward no.12. Respondents were female between age group 15 to 49 years. From one household, only currently married women of reproductive age group was selected. Interview helped to know knowledge, practice and social effect of contraceptive among reproductive age women.

3.6 Data Analysis and Interpretation

Data analysis is the main part of the research study. Researcher can get the raw data from field then it should be manipulated in suitable way of analysis. First, the collected data are edited to ensure their accuracy and completeness. Frequency table, percentage distribution, graphs and other method are also used to present the edited data. The required tables are generated with the help of Ms Excel program

3.7 Limitations of the Study

Each and every research study has their own limitation that determines the purpose of the study, time and cost. The study was based on sample data, which are collected through questionnaire and interview based on selected sample from Godawari Municipality-12. This study will cover only married women of reproductive age (15 – 49 years) in Godawari Municipality - 12. The study will cover only knowledge and practices of family planning devices. The sample size is not large i.e. (forty) only.

CHAPTER- IV

DATA PRESENTATION AND ANALYSIS

After collecting the primary data the data were checked, verified, modified and clarified to reduce possible errors. Simple mathematical process likewise percentage were utilized to analyze and interprete in this study. The analysis and interpretations of the data of the study has been presented about the knowledge and use of contraceptive among married women.

4.1 Demographic Characteristics

This chapter deals with some demographic and socio-economic characteristics of the household population. Demographic characteristics include age, sex, marital status and socio-economic characteristics include education attainment, major occupation and size of landholding etc of the study area.

4.1.1 Age and Sex Structure

Age is the most important variable. It shows the number of people consisting economically active population and development out of total population of the study communities.

Table 4.1: Population Distribution by Age and Sex According to 5 Years Age Group

Age Group	Male Percent	Female Percent	Total	Percent	Sex Ratio
0-4	9.28	10	17	9.4	88.5
5-9	.58	10	18	9.9	88.89
10-14	10.48	9.4	19	10.5	106
15-19	10.78	8.57	17	9.4	120
20-24	8.7	8.85	16	8.8	93.55
25-29	7.8	8	14	7.7	92.85
30-34	9.3	7.7	15	8.3	114.8
35-39	8.7	8.85	16	8.8	93.55
40-44	8	7.4	14	7.7	103.85
45-49	4.8	5.7	10	5.5	80
50-54	3.9	4.8	8	4.4	81.25
55-59	3	4	6	3.3	71.4
60 Above	5.68	6.57	11	6.1	82.6
Total	**100**	**100**	**181**	100.0	**95.4**

Source: Field Visit, 2019

Distribution of population by sex and five years age group has been presented in table 4.1 from table, it is clear that for both sex a higher proportion fall in early age group. Among total household population 48.83 percent of the population is male and 51.17 percent are female. The average size of household is 4.52 people per house which is lower than average national figure (4.70) based on 2011 census preliminary results. The sex ratio of the household is found 95.4 which is greater than national figure (94.0).

This table indicates that out of total population highest percent of population falls in the age group 10-19 is in male (10 percent above) and the highest percent of female is in male 0-9 age group 10% above). The lowest percentage of male population in the age groups of 55-59 and for female 55-59 age group also i.e. 3.0 percent and 4 percent. The sex ratio according to age group is higher for 15-19 year age group population which is 120.0 and lowest for 55.59 years **age** group i.e. 71.4 percent.

4.1.2 Caste /Ethnicity

This study area is inhabited by different caste/ethnic group such as Brahmin, Chhetri, Magar, Tamang Damai/Kami and Newar. In this study distribution of caste and ethnic group has been given below:

Table 4.2: Respondent's Distribution by Caste/Ethnicity

Caste/Ethnic Groups	Number	Percent
Brahmin/ Chhetri	17	42.5
Newar	12	30
Magar	2	5
Tamang	5	12.5
Dalits	4	10
Total	40	100.0

Source: Field Visit, 2019

As shown by the Table 4.2 the Brahmin/ Chhetri constitute 42.5 percent of the total married women on the study. The Newar are 30 percent populations, Dalits are (10%), Magar (5%), and Tamang (12.5%). It is shown that there was different composition of caste/ethnicity but the majority was Brahmin / Chhetri compare to others.

4.1.3 Marital Status

Marital Status is one of the important and socio-cultural and demographic aspects which are an important determinant of fertility.

Table 4.3: Distribution of Respondents by Marriage

Married Women	Respondents	Percent
18-21	14	35
22-25	20	50
26-29	4	10
30 above	2	5
Total	**40**	**100**

Source: Field Visit, 2019

Among the total respondents 35 percent had married under the age group 18-21, whereas 50 percent under 22-25, 19 percent under 26-29, 5 percent above 30.

4.1.4 Education Attainment

The data on educational attainment were collected for all respondent married women. Educational attainment is shown as below.

Table 4.4: Distribution of respondents by Education Attainment

Literacy Status	Respondents	Percentage
Literate	32	80
Illiterate	8	20
Total	40	100.00
Level of Education		
Just Literate	4	12.5
Primary Level	4	12.5
Lower Secondary Level	12	37.5
Secondary Level	8	25
Higher Secondary Level	4	12.5
Total	32	100.00

Source: Field Visit, 2019

The literacy status and level of education of the respondents of the study area is shown in the table above. It shows that 80 percent of the respondents were literate whereas 20 percent were illiterate. It shows that educational status of the study area is higher than the national literacy rate. The level of education of the respondents of the study area shows that the largest number of them had primary level of education which is 12.5 percent whereas the least of the respondents were in the level of Higher Secondary level.

4.1.5 Occupation

Occupation distribution of household head or person plays a vital role in the economic status of household. Economic status also determines the level of education status too. So the occupation of the household is most important variables. The occupational status of the study area is presented in table 4.5.

Table 4.5: Respondents distribution by Types of Occupation

Types of Occupation	Number	Percent
Agriculture	13	32.5
Business	6	15
Students	6	15
Services	3	7.5
Labor (Wages)	11	27.5
Level Not Stated	1	2.5
Total	**40**	**100.0**

Source: Field Visit, 2019

The table 4.5 shows that 32.5 percent of the married women reported their occupation as agriculture followed by students (15%), Business (15%), Services (7.5%), Labor (wages) (27.5%) and level not stated (2.5%). The highest percent of occupation was agriculture, which was 32.5 percent and the lowest percent of occupation was service which was 7.5 percent.

4.1.6 Religion

Most of the respondents were Hindu. According to CBS (2001), 80.62 percent populations are Hindu. Similarly Buddhist and Christian respondents were also found. The religious situation of the respondents is given in following table.

Table 4.6: Population Distribution by Religion

Caste/Ethnic Groups	Number	Percent
Hindu	30	75
Buddhist	6	15
Christian	4	10
Total	**40**	**100.00**

Source: Field Visit, 2019

Among the 40 respondents, majority of respondents were Hindu, they were around 75 percent of the total respondents. There were 15 percent Buddhist, 10 percent was Christian in the study area. In Nepal majority of people follow the Hindu religion and its rule and regulation. Data of the study area also found the same data of the national data of Nepal.

4.1.7 Family Structure

Family is the most important primary unit of social structure in Nepal. Basically nuclear and joint families are two types of family system in Nepal the respondent's types of family are given table 4.7.

Table 4.7: Family Structure

Types of Family	Number	Percent
Nuclear	28	70
Joint	12	30
Total	**40**	**100.0**

Source: Field Visit, 2019

Out of 40 household of study area, 70 percent households are nuclear family and 30 percent to the joint family. It proves that nuclear family is increasing and slowly joint family numbers are decreasing.

4.1.8 Size of Landholding

Most of the respondents depended upon agriculture. The distribution of cultivated land among the households is presented in the table 4.8.

Table 4.8: Distribution of Households According to Landholding

Size of Land	Number of Household	Percent
Landless	4	10
1-15 Aana	34	85
1-10 Ropani	2	5
11 Ropani above	0	
Total	**40**	**100.0**

Source: Field Visit, 2019

This table shows those 10 percent households do not have land. They are landless however 90 percent household have own land. Among them 85 percent have 1-15 aana followed by 5 percent who have 1-10 Ropani.

4.2 Knowledge and Use of Contraceptive Methods

This section is to examine the knowledge and use of contraceptive method among married women of reproductive age (15-49) years. Contraceptive services are provided through Health Post, PHC, Hospital, Clinic and other government and non-government sectors. But family planning programme was unable to need demand for the currently married women who want to limit birth. Those respondents who mention at least one name of contraceptive method are categorized under having knowledge.

4.2.1 Knowledge of Contraceptive Method

Acquiring knowledge of contraceptive method is an important precondition toward gaining access to and then using a suitable contraceptive method in a timely and effective manner.

In this study it was found that every married woman had heard about any of the contraceptive method. But they did not know how to use this method properly. Knowledge of contraceptive method of the respondents is given in following table.

Table 4.9: knowledge of contraceptive device among respondents

Contraceptive Method	Knowledge of Respondents N=40	Percent
Any Modern Method		
Male Sterilization	35	87.5
Female Sterilization	36	90
Depo-Provera	40	100
Condom	32	80
Implants	35	87.5
Pills	32	80
IUD	22	55
Any Traditional Method		
Withdrawal	12	30
LAM Method	7	17.5
Calendar Method	2	5

Source: Field Visit, 2019

For analytical proposes contraceptive methods are grouped in tow group in the table. Modern and traditional method, modern methods include male sterilization, female sterilization, Depo-Provera, Pills, condom, Implants, IUD and foam/Jelly. Traditionally methods include withdrawal and periodic abstinence. By specific method Female sterilization (90 %) appears to be the best known contraceptive method, followed by

Male sterilization (87.5%), condom (80%), Depo-Provera (100%), pills (80%), IUD (55%), Implants (87.5 %). Female sterilization has been gaining popular in this study area. Only few respondents are familiar with withdrawal, and periodic abstinence.

4.2.2 Sources of Information

The electronic media (radio, TV) are effective means for communication message about family planning. Majority of women have heard about at least one method of contraceptive. The respondent's source of knowledge shown in the given table:

Table 4.10: Distribution of Respondents by sources of knowledge

Sources of Knowledge	No. of Household (N=40)	Percent
Radio	24	60
TV	30	75
Newspaper	12	30
Health Worker	30	75
Husband	15	37.5
Friend	35	87.5

Source: Field Visit, 2019

The majority of women (87.5%) have heard of a family planning message from friends. which is followed by Health workers (75%) and TV. Radio (60%), and Newspaper (30%). It is shown that friends is the main source of knowledge about contraceptive.

4.3 Use of Contraceptives

Family planning methods are important for shaping family size, prevention of HIV/Aids and birth spacing. Availability of FP devices to the access to users has positive effect. It generally assumed to play the vital role in transition to lower fertility. The use of contraceptive may have significant impact on declining populating growth.

4.3.1 Practice of contraceptive device among respondents

Use of contraceptive is defined as the proportion of women who reported they were using family planning (contraceptive) method at the time of interview. The level of use is most widely it is measure of success family planning method.

Table 4.11: Practice of contraceptive device among respondents

Contraceptive Method	Users	
	Number	**Percent**
Male sterilization	3	7.5
Female sterilization	4	10
Depo-Provera (Injection)	8	20
Condom	2	5
Implants	6	15
Pills	3	7.5
Natural Method	7	17.5
Total	**33**	**100.0**

Source: Field Visit, 2019

As shown by table, 4.11 the use of contraceptive methods of married women are presented. It was 20 percent Depo-Provera (Injection) is a highest used method of all contraceptive, followed by natural method (17.5%), Female sterilization (10%), male sterilization (7.5%) condom (5%), Pills (7.5%). Above table clearly shown that the mostly used of contraceptive is Depo- provera among contraceptives users.

4.3.2 Occupation and Uses of contraceptive

Work status of women is a major determinant of fertility behavior, family size and birth space. The CPR was higher for those women who are engaged in farming occupation,

which engaged in non-farming activities. Contraceptive used by occupation is presented in table 4.17:

Table 4.12: Occupation and Uses of contraceptive

No. of Contraceptive User	Agriculture		Non Agriculture		Total	Percent
	Number	Percent	Number	Percent		
Yes	10	25	23	57.5	33	82.5
No	3	7.5	4	10	7	17.5
Total	**13**	**32.5**	**27**	**67.5**	**40**	**100**

Source: Field Visit, 2019

Tables 4.12 present that the percent distribution of married women who have used any methods of contraceptives. In these table 25 percent contraceptive users engages in agriculture out of 13 respondents, whose major occupation is agriculture. About 57.5 percent contraceptives user engaged in non-agriculture out of 27 respondents. Non agriculture included business, students, services, labor and level stated.

Analysis of data reveals that most of the respondents were engaged in agriculture and least respondents were engaged in business that used contraceptive device. It conclude that no relation between occupation and use of contraceptives.

4.3.3 Reasons for Non -Use of Contraceptive

All married women who were not using any contraceptive method further asked the reasons for non-using contraceptive method. Reason for not using contraceptive shown by given table.

Table 4.16: Distribution of Married Women by Reason for not using Contraceptives

Reason for non-use of contraceptives	Number	Percent
Against Religion	-	-
Sexual Displeasure	-	-
Wants son	4	57.14
Wants Daughter	1	14.28
Wants more children	-	
Fear of Side Effects	1	14.28
No Knowledge	1	14.28
Total	7	100

Source: Field Visit, 2019

Table 4.13 shows that 57 percent respondents stated that wants son is the main reason for not using contraceptive method followed by fear or side effects 14.28 percent, wants daughter 14.28 percent and no knowledge 14.28 among non-users of contraceptive devices. From this research we can say that some women are fear of side effects from the use of contraception. Many woman have traditional think about son they belief that, son is necessary to support for their old age.

4.3.4 Side Effects on Contraceptive Method

Currently married women who were using modern methods of contraceptive were asked if they had any side effect during period of used contraceptive device. The side effects on contraceptive method are shown given below.

Table 4.14: Response regarding the side-effect of contraceptives

Side Effects	No. of Respondents	Percent
Types of Side Effects		
Irregular Menstruation	13	52
Over Bleeding	2	8
Weakness	3	12
Weight Loss	2	8
Back pain/ Headache	5	20
Total	**25**	**100.00**

Source: Field Visit, 2019

As shown table 4.14 who used contraceptives 52 percent of the respondents reported irregular mensuration, 8 percent respondents weight loss, back pain/ headache (20%) and over bleeding (8 %) each. The major problems reported by highest percent of women are irregular menstruation and weakness. It means 38 respondents were suffering from some types of side effect.

4.3.5 Decision on Use of Contraceptive Method

Husband and wife communication is often considered to be major determinants of contraceptive method. A question was asked whether the respondents usually discussed her husband about contraceptive.

Table 4.15: Who Decide On Use of Contraceptive Method

Decide use of contraceptive method	No. of use	Percent
Husband	11	33.33
Wife	14	42.42
Both	8	24.24
Total	**33**	**100**

Source: Field Visit, 2019

Table 4.15 shown, that about 33 percent women reported that their husband decide to use contraception, about 42 percent women decided to use contraceptive method and 24 percent women reported that contraceptive use was a joint decision.

4.3.6 Source of Supplier of contraceptive device

The married women who reported of using a modern method of contraception where they obtained the method from are shown on the table below.

Table 4.16: Distribution of Contraceptive Users by Source of Supply

Sources of Supply	Number Who Usually go to get FPM	Percent
Health post	20	60.60
Outreach Clinic	9	27.27
Private Clinic	4	12.12
Total	**33**	**100**

Source: Field Visit, 2019

Table 4.16 shows that the majority of users received any forms of modern contraception from Healthy post (60%), followed by 27 percent outreach clinic (12.12%).

4.3.7 Failure of the use of Contraceptive Method

This research study aims to know efficiency to use method. The method failure question "Have you ever got pregnant while using family planning method?" was asked and the result is shown on the table.

Table 4.17: Failure of Contraceptive Method

Method Failed	No. of Respondents	Percent
Yes	2	6
No	31	94
Total	**33**	**100**

Source: Field Visit, 2019

The table 4.17 shows that out of 40 married women, among them 2 women 6 percent presents reported method failure when they used contraception and 94 percent married women were reported do not failure of contraceptive method. The analysis of data presents that the least respondents reported to fail when they use contraceptives.

4.4 Social effects of contraceptive device of health

Among the user of contraceptive device, the social effects that they stated has been described below based on the questionaire given to the respondents**.**

4.4.1 The use of contraceptive has developed one to be a better parents

Out of the 33 contraceptive users 30 respondents stated the positve impacts of family planning for the better parenthood. It has benifted mother by enabling her to regain her health after delivery, have enough time and opportunity to love and provide attention to her husband and children, Gives more time for her family and own personal advancement. For, Father it lightens the burden and responsibility in supporting his family, enables him to give his children their basic needs (food, shelter, education, and better future) gives him time for his family and own personal advancement. and When suffering from an illness, gives enough time for treatment and recovery.

4.4.2 Changes in life before and after the use of contraceptive

most of respondents views are the use of contraceptive device are unplanned pregnancis have been reduced and unsafe abortion which has ultimately reduced the risk of health. It has helped the respondents for the better education of their offsprings. Voluntary family planning reduces the number of unintended pregnancies, as well as maternal and newborn deaths. When a woman has the ability to make choices about contraception, her children are much more likely to be healthier, better nourished.

4.4.3 Reducing infant mortality

The respondents were of view that family planning can prevent closely spaced and ill-timed pregnancies and births, that reduces infant mortality rates.

4.4.4 Empowering people and enhancing education

All the respondents viewed that use of contraceptive enables people to make informed choices about their sexual and reproductive health. Family planning represents an opportunity for women to pursue additional education and participate in public life, including paid employment in non-family organizations. Additionally, having smaller families allows parents to invest more in each child. Children with fewer siblings tend to stay in school longer than those with many siblings.

4.4.5 Slowing population growth

The respondents have uniform answer that the use of contraceptive device is key to slowing unsustainable population growth and the resulting positive impacts on the economy, environment, and national and regional development efforts.

4.4.6 Health Hazards of regular pregnancy and way out to avoid the complications

Reducing adolescent pregnancies.Pregnant adolescents are more likely to have preterm or low birth-weight babies. Babies born to adolescents have higher rates of neonatal mortality. Many adolescent girls who become pregnant have to leave school. The regular pregnancy has caused uterus prolapse among the three respondent. This has long-term implications for them as individuals, their families and communities. A

woman’s ability to choose if and when to become pregnant has a direct impact on her health and well-being. Family planning allows spacing of pregnancies and can delay pregnancies in young women at increased risk of health problems and death from early childbearing. It prevents unintended pregnancies, including those of older women who face increased risks related to pregnancy. Family planning enables women who wish to limit the size of their families to do so. By reducing rates of unintended pregnancies, family planning also reduces the need for unsafe abortion.

CHAPTER-V

SUMMARY AND CONCLUSION

This chapter includes the glimpse of whole research prospects, its prospectus consequences. These chapter summaries the study and presents conclusion and main recommendation based on the whole study process and analysis.

5.1Summary

This study is mainly based on the data obtained from field survey which provides data contraceptive Awareness and use, differential in current use, accessibility of contraceptive and side effects associated with particular method being use reason for non-use of contraceptives. This study is based on primary data gathered from the perception of 40 respondents of 40 households through simple random sampling method. The contraceptive prevalence rate was not so sound.

As shown by the Table 4.2 the Brahmin/ Chhetri constitute 42.5 percent of the total married women on the study. The Newar are 30 percent populations, Dalits are (10%), Magar (5%), and Tamang (12.5%). It is shown that there was different composition of caste/ethnicity but the majority was Brahmin / Chhetri compare to others. The literacy status and level of education of the respondents of the study area is shown in the table above. It shows that 80 percent of the respondents were literate whereas 20 percent were illiterate. It shows that educational status of the study area is higher than the national literacy rate. The level of education of the respondents of the study area shows that the largest number of them had primary level of education which is 12.5 percent whereas the least of the respondents were in the level of Higher Secondary level. 32.5 percent of the married women reported their occupation as agriculture followed by students (15%), Business (15%), Services (7.5%), Labor (wages) (27.5%) and level not stated (2.5%). The highest percent of occupation was agriculture, which was 32.5 percent and the lowest percent of occupation was service which was 7.5 percent.

Among the 40 respondents, majority of respondents were Hindu, they were around 75 percent of the total respondents. There were 15 percent Buddhist, 10 percent was Christian in the study area. In Nepal majority of people follow the Hindu religion and its rule and regulation. Data of the study area also found the same data of the national data of Nepal. 10 percent households do not have land. They are landless however 90 percent

household have own land. Among them 85 percent have 1-15 aana followed by 5 percent who have 1-10 Ropani. For analytical proposes contraceptive methods are grouped in tow group in the table. Modern and traditional method, modern methods include male sterilization, female sterilization, Depo-Provera, Pills, condom, Implants, IUD and foam/Jelly. Traditionally methods include withdrawal and periodic abstinence. By specific method Female sterilization (90 %) appears to be the best known contraceptive method, followed by Male sterilization (87.5%), condom (80%), Depo-Provera (100%), pills (80%), IUD (55%), Implants (87.5 %). Female sterilization has been gaining popular in this study area. Only few respondents are familiar with withdrawal, and periodic abstinence.

The majority of women (87.5%) have heard of a family planning message from friends. which is followed by Health workers (75%) and TV. Radio (60%), and Newspaper (30%). It is shown that friends is the main source of knowledge about contraceptive. It was 20 percent Depo-Provera (Injection) is a highest used method of all contraceptive, followed by natural method (17.5%), Female sterilization (10%), male sterilization (7.5%) condom (5%), Pills (7.5%). Above table clearly shown that the mostly used of contraceptive is Depo- provera among contraceptives users. 25 percent contraceptive users engages in agriculture out of 13 respondents, whose major occupation is agriculture. About 57.5 percent contraceptives user engaged in non-agriculture out of 27 respondents. Non agriculture included business, students, services, labor and level stated.

Analysis of data reveals that most of the respondents were engaged in agriculture and least respondents were engaged in business that used contraceptive device. It conclude that no relation between occupation and use of contraceptives. 57 percent respondents stated that wants son is the main reason for not using contraceptive method followed by fear or side effects 14.28 percent, wants daughter 14.28 percent and no knowledge 14.28 among non-users of contraceptive devices. From this research we can say that some women are fear of side effects from the use of contraception. Many woman have traditional think about son they belief that, son is necessary to support for their old age.

Distribution of married women who are not using contraceptive method but to use in future. Among the married women who are not using contraception. 57.14 percent reported that they intend to adopt method in future 42.85 percent reported that they did not use any method in future. 52 percent of the respondents reported irregular

mensuration, 8 percent respondents weight loss, back pain/ headache (20%) and over bleeding (8 %) each. The major problems reported by highest percent of women are irregular menstruation and weakness. It means 38 respondents were suffering from some types of side effect.

Contraceptive users who respond to travel to reach sources of supply. Among them 60 percent contraceptive users have required 0-30 minutes to reach sources of supply, while 24 percent users required 31-60 minutes and 15 percent users reported 1 hour or above. Travel time is effective factor for the use of contraceptive. If it takes long time to get service, user do not want to take continue it. About 33 percent women reported that their husband decide to use contraception, about 42 percent women decided to use contraceptive method and 24 percent women reported that contraceptive use was a joint decision. Out of 40 married women, among them 2 women 6 percent presents reported method failure when they used contraception and 94 percent married women were reported do not failure of contraceptive method. The analysis of data presents that the least respondents reported to fail when they use contraceptives.

It has benifted mother by enabling her to regain her health after delivery, have enough time and opportunity to love and provide attention to her husband and children, Gives more time for her family and own personal advancement. For, Father it lightens the burden and responsibility in supporting his family, enables him to give his children their basic needs (food, shelter, education, and better future) gives him time for his family and own personal advancement. and When suffering from an illness, gives enough time for treatment and recovery. It has reduced the unplanned pregnancy. Due to the birth spacing the infant mortality rate has been decreased. It has helped for the better education of their offsprings. It has reduced some health hazards like low birth weight babies, uterus prolapses .It helps to slow down population growth and have positive impacts on the economy, environment, and national and regional development efforts.

5.2 Conclusions

The main thrust of the present study is to find out the awareness of any contraceptive methods, to identify the role of education in the use of contraceptive methods among currently women and to identify the socioeconomic and demographic determinants of the use of contraceptive methods.

This section deals with the major conclusion derived from the analysis of data collection from the respondents. This study points out the use of contraceptive method.

The recurrent pattern of contraceptive use among users is obtained dominated by implant and Depo-Provera in this study. There is strong evidence that the women who have literate have strong power of knowledge and use of contraceptive. So, we can conclude that higher the education higher the knowledge and use of contraceptives.

This study areas usually low use of permanent method indicates that the most of respondents want to fulfill or desire family size. It is also conclude that women use any kind of modern method after having to children. The most popular methods are male sterilization Implant, Depo-Provera, condom and other are nominal. There is positive relationship between number of living children and contraceptive use. It is also conclude that there is positive relationship between education and awareness and use of contraceptive. The most important reason for not using contraceptive is desire for son and fear of side-effect.

Finally this research identifies important factors that predict contraceptive use attitude . The use of contraceptive has positive impacts in society like better parenthood, minimizes the health hazards related to pregnancy, reduces infant mortality rate, family can invest time and money for the better education and health of the children as well as other members of the family. Ultimately, it helps the nation to get rid from the burden of over population growth.

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Appendix

Appendix 1

Interview schedule

Knowledge, Practice and Social Effect of Contraceptive Device: A Sociological Study of Women of Godawari, Lalitpur

Background information:

Name: ……
Age: …….. Religion:…… Cast:……..
Address: Ward No…… Household No……
Can you read and write? 1. YES:…… 2. NO:……
If yes, which level have you passed?
1. INFORMAL:…… 2. FORMAL…… (State the level)
How old are you when you are married? …… (Completed years)
Do you give any live birth till today? 1. YES:…… 2. NO:……
If yes, how many children do you have? (Live children)
1. TOTAL:…….. 2. SON:…… 3. DAUGHTER:…….
What was your age at the birth of your first child?……(Completed years)
What is your family's main occupation?
1. AGRICULTURE… 2. SERVICE… 3. BUSINESS:…… 4.LABOUR:…….. 5.COTTAGE… 6.OTHER…
If agriculture, how many months your own food production can support your family?
……(Month)
What is the main occupation of your parent's?
1. AGRICULTURE… 2. SERVICE… 3.BUSINESS:…… 4.LABOUR:…….. 5.COTTAGE… 6.OTHER…
Can your parent's read and write? 1. YES:…… 2. NO…

If yes, which level have they passed?
1. INFORMAL:…… 2. FORMAL…… (State the level)
How much do your family earn in a month? …….
Which of the below facilities are available in your house?
1. RADIO:-- YES:… NO… 2. TELEPHONE: -YES… NO…
3. PIPED WATER: - YES… NO… 4. TOILET- YES… NO…
5. TELIVISION-- YES… NO… 6. ELETRICITY: - YES… NO…

Knowledge of Family Planning:

1. Have you ever heard any Family Planning method? 1. YES… 2. NO…
2. If yes, what are they? (multiple response)
1. PILLS… 2. INJECTABLES:…… 3. IUD:……
4. CONDOM… 5.NORPLANT…… 6.MALESTERILIZATION:……
7. FEMALE STERILIZATION:…… 8. OTHER:…….
3. What are sources of information for Family Planning methods? (multiple response)
1.RADIO/T.V… 2.FRIENDS, NEIGHBOUR… 3.NEWSPSPER…
5. HEALTH WORKER… 6. HUSBAND…….. 7. OTHER….
4. Do you know where Family Planning methods are found? 1. YES… 2.NO….

5. If yes, where did they found? (multiple response)
1. HEALTH POST… 2. HOSPITAL… 3. HEALTH CENTRE… 4.HELTH WORKER… 5. FAMILY PLANNING CLINIC…… 6. OTHER……
6. What do you think about Family Planning method?
1. EXCELLENT… 2. GOOD… 3. BAD……4. SATISFACTORY…
7. If good, why? Because it helps: (multiple response)
……TO MAKE ECONOMIC CONDITION OF FAMILY ……TO MAKE SMALL AND HAPPY LIFE ……TO MAKE BETTER CHILD AND MOTHER HEALTH …….TO MAKE BETTER EDUCATION AND APPROPRIATE CARE FOR CHILD ..... DON'T KNOW

Practice of Family Planning Method:

8. Have you/your husband ever use any Family Planning method?
1. YES…… 2. NO…….
9. If yes, mention the specific method?
(CODE FOLLOW Q. NO.2)…….
10. What is the main reason you chose to use this method? (multiple response)
1. EASY TO OBTAIN…2. EFFECTIVE METHOD… 3. INEXPENSIVE…
4. NOSIDE EFFECT… 5. RECOMMENDED BY HEALTH

WORKER…
11. If you have not used any family planning method please specify your reasons? (multiple response)
1. SIDE EFFECT……. 2. FAMILY/HUSBAND DISAGREE…
3. RELIGION……. 4. NO EASY ACCESSIBLE…….
5. DESIRE FOR CHILD……. 8. OTHER……
12. Have you/your husband currently using any Family Planning method?
1. YES…… 2. NO……
13. If yes, mention the specific method?
(CODE FOLLOW Q. NO. 2)…….
14. If you are not using any method please specify your reasons? (multiple response)
1. SIDE EFFECT…… 2. FAMILY/HUSBAND DISAGREE…
3. RELIGION……. 4. NO EASY ACCESSIBLE…….
5. DESIRE FOR CHILD……. 6. OTHER……
15. How long have you/ your spouse been using this method?
……YEAR ……..MONTH ……
16. Who advise you to first use this method? (multiple response)
1. HEALTH WORKER… 2. FRIEND, NEIGHBOR… 3. HUSBAND…
4. FAMILY PLANNING CLINIC …. 5.OTHER…….
17. Have you ever been pregnant while using a Family Planning method?
1. YES…….. 2. NO…….

18. If yes, which method was that?

(CODE FOLLOW Q. NO. 2)……..

19. From where you get contraceptive method?

1. HEALTH POST… 2. HOSPITAL… 3. HEALTH CENTRE…

4.HEALTH WORKER… 5. FAMILY PLANNING CLINIC.....

6. OTHER……

20. Why did you use contraception? -multiple response _

1. TO SPACE THE BIRTH…… 2. TO PREVENT STDs/HIV……

3. TO LIMIT THE BIRTH……4. FOR PERSONAL REASON……..

5. OTHER.....

21. Did you experience any side effect while using contraceptive method?

1. YES…….. 2. NO……

22. IF yes, what is that? …….

Social effects of contraceptive device of health

23. Has contraceptive devic helped you to be better parent ?

1 Yes	2 No

24. If Yes, How ? **-multiple response _**

1 By slowing birthrate

2 By maintainig good reproductive health

3By having proper time to upbring the previous child

4 If any other

25. Is there any changes in your life by the use of contracetptive devices?

.....

26. what difference have you experienced before and after the use of contraceptive devices ?

    .....

27. Do you think that infant mortality rate has been reduced due to the use of contraceptive device ?

    .....

28. What is the importance of use of contraceptive device for the better education of a child?

    .....

29. In your opinion, do the use of contraceptive help to reduce population growth?

    .....

30. In your experience, what are the health hazards of regular pregnancy? and way out to avoid those complications ?

    .....