

CHAPTER – I

INTRODUCTION

1.1 Background of study

Nepal is one of the poorest and is ranked among the least developed countries in the world where almost one-quarter of its population lives under the poverty line. The latest Central Bureau of Statistics National census Report states that the Population of Nepal has grown up to 26,620,809 with the population growth rate of 1.40. Out of 187 countries, Nepal stands at 157th position in Human Development Ranking (HDI) with the HDI of 0.485 point (UNDP, 2011). The economic survey of 2011 shows the per capita income of a Nepalese man is \$ 645.

Family planning is one of the most prominent challenges of all developing countries in the world. The population is growing rapidly. Thus, family planning is one of the best ways to control the increasing population. To this purpose, family planning services are designed to provide a constellation of contraceptive methods that reduce fertility, enhance maternal and neonatal health, child survival and contribute to bringing out a balance in population growth and to socio-economic development, resulting in an environment that will help the Nepalese people improve their quality of life.

The population appears to have been growing rapidly during the past four decades in Nepal, due to the continuous decline in the death rates on the one hand and the continuing high fertility rate on the other hand. Nepal is supposed to have experienced one of its highest population growths, at a rate of 2.2 percent per annum, during 2001. It was reduced to 1.4 percent per annum during 2011 (CBS, 2011).

Though migration, fertility and mortality are all responsible for the change in the size of the population, human fertility is the major factor. Like most developing countries, Nepal is suffering from a high-fertility problem. Despite the existence of governmental and non-governmental family-planning programme, the total fertility rate in Nepal is 2.6 per woman (NDHS, 2011) which is higher in comparison with the other developing countries of the world. One of the important and responsible factors.

for this problem is a low contraceptive prevalence rate of 43.7 % in FY 2067/68, 43.1% in FY 2068/69 and 45.3 in FY 2069/70 BS. The twelve five-year plan emphasized raising the contraceptive prevalence rate up to 58.2 percent by the end of the 12th five-year plan and one of the Millennium Development Goal for Nepal is increase CPR 67 percent by the year 2015.

Nepal's family-planning programme was started with the organization of the Family Planning Association of Nepal in 1959 B.S. In fact, Nepal was one of the first countries of south Asia, where information about family planning was available through a non-governmental programme. Since 1968 the government of Nepal has been actively involved in providing family-planning service with the establishment of a Nepal family-planning and a maternal child-health (NFP and MCH project) project. Initially the family-planning programme was integrated with the maternal child-health services. Since in 1990, all the health services were brought together, family planning has become an integral part of the country's health services.

Currently, besides the governmental programmers', several NGOs and INGOs are also providing family-planning services, as well as information, education and communication related to family planning. Some of these institutions are (a) Nepal Family Planning Association (FPAN) (b) Care Nepal (c) Plan International (d) Nepal Red Cross Society (e) Mary Stoppes.

National Health Policy (1991) related to the National Reproductive Health and Family Planning (RH/FP) programme aims at increasing the coverage of the family planning services to the village level through health facilities and activities such as hospitals, Primary Health Care Center (PHCC), Health Post (HP), Sub-health post (SHP), Out Reach Clinic (ORC) and Voluntary Surgical Contraceptive (VSC) camps. FPAN and government family-planning program have trained and fielded community-level volunteers (TBAs, FCHVS) for the promotion of condom distribution and re-supply of oral contraceptive pills. It is expected that a high level of awareness will be reached very soon. The objectives of family planning pregame are as follows:

- i) Spacing or limiting their children
- ii) Preventing unwanted pregnancies

iii) Promoting adolescent reproductive health and

iv) Managing infertility

The status of currently using contraceptive methods among married but non-pregnant women is as follows : Any modern method – 45.3 percent, Method mix Condom – 3.6 percent, Method mix Pills 3.3 percent, Method mix Depo-Provera 8.0 percent, IUD 2.1 percent, Implant 2.2 percent, percent Sterilization 26.2 percent (Annual Report DOHS, 2069/70).

Family-planning services are a fundamental part of human society. They are needed not only for the sake of the individual but also for the family, the community and for the nation. Without family-planning services, an all-round development of the people and of the nation is impossible. The demand for a target population and of service providers is increasing gradually. Therefore, in the context of the global village many explorations are being done in the sector of family planning.

Most developing countries are suffering from a high fertility rate and a rapid population growth, including Nepal. Although the level of awareness concerning FP and contraceptive methods has risen since the 1991-96 period, the overall practice of family planning is still very low. Rural and urban differences are great. Most people do not have any knowledge of the importance of FP, what it means and why it should be practiced So, in the rural context, the utilization of FP services is very poor. According to NDHS 2011, the current CPR of Nepal for any modern method is 43.2 percent. Use of any modern contraceptive methods in rural Nepal is 42.1 percent as against 49.8 percent in urban areas. Among the ecological regions the use of the FP service is lowest in mountain areas (43.1) whereas in the Hills and Terai the CPR is 40.6 and 45.0 percent respectively. (NDHS, 2011)

According to NDHS 2011, current unmet need for family planning is 27 %. Among them unmet need for spacing is 9.6 and limiting is 17.4 percent. Unmet need also varies according to place of residence and ecological belt. Unmet need of family planning in rural and urban areas was 28.1 and 19.6 respectively. Rural peoples are depriving of contraceptive methods. Unmet need of family planning in mountain, hills and Terai is 24.3, 29.7 and 25.3 respectively.

While awareness of family planning is almost universal among Nepali women and men, there is still substantial variation in the use of family planning methods and in unmet need among different caste/ethnic groups. The met need for family planning is highest among Newar women (63 percent) and Terai Janajati women (64 percent), while unmet need in these groups is 20 percent and 16 percent, respectively. Conversely the highest unmet need is found among Hill Dalits (35 percent), Hill Janajati (34 Percent), and Muslim women (39 percent). (NDHS, 2011)

In Nepal the knowledge of family-planning services is not yet satisfactory. In the rural context, the knowledge of FP service is in a pitiable condition. The family-planning programme is a joint-venture programme of many GOs, NGOs and INGOs but they are not well-coordinated. This means that only some institutions are trying to focus on FP service in order to reduce (minimize) the fertility problems.

The programs of family planning services are not effective therefore. Besides, services are not utilized by the people, because of their lack of awareness, low socio-economic status and the influence of conservative concepts. Problems are moreover created due to the insufficient number and the irregularity and irresponsibility of the assigned health personnel, which has a bad impact upon upon the health institutions. In addition to this, people are deprived because of their frequent compulsive visits to health institutions, even from distant places.

Though the use of family-planning methods has been growing steadily, the rate of growing is still low in view of the present demand and supply of service. The family- planning programme is not successful. So, in order to make FP services more effective, formulation of education, communication and awareness campaigns have to be intensified and FP methods of clients' choice should be provided to the people, even in remote parts of the country whenever they need them.

The concept of early marriage, trends of superstitious beliefs concerning health and unhygienic health-care practices have greatly influenced the community. The great numbers of unplanned children and traditional delivery practices have deep roots in the community, in common with lack of education, lack of awareness of health and of health services. This lack of knowledge of a proper use of family-planning devices is the main reason why the community suffers from large family sizes.

There are many ethnic groups, in Sankhuwasabha. They have their own language, culture and life style. Majhi is one of these minor ethnic groups. They have a unique culture and way of living. They have a very poor educational as well as a socio-economic status. Tumlingtar is a developing village lies in ward No. 12 and 13 of the Khandbari municipality in the Sankhuwasabha district. The purpose sample is the Majhi community of the Khandbari municipality. The total population of Sankhuwasabha is 158742. The total population of Khandbari Municipality ward number 12 and 13 is 4449.

The trend of the family-planning programme in the Sankhuwasabha district is as follows: CPR for modern methods 31.33 %, Condom: 3.35, Pills: 2.42, Depo: 10.94, IUCD: 2.1 Implant: 2.64, Sterilization: 9.84.

The issues of a rapid population growth, poor socio-economic conditions, worsening of family health and of communicable diseases have all been a challenge to human civilization globally, except for some developed countries. Similarly environmental hazards, low rates of literacy, poor accessibility to physical facilities and to involvement in development opportunities are prominent in those countries where ignorance of FP services still prevails among the population. So to solve problems as mentioned above FP service could exist as a milestone. Furthermore, attention to review, analysis of the present context, making hypotheses, forecasting possible situations, exploring new dimensions, formulating policy, implementation of planning, the follow-up and evaluation of programmes in the field of family-planning services are all still necessary elements. This means that more and more tasks need to be done in this field. To promote family planning; (FPAN), NGO, INGO, the Ministry of Health and other health institutes have to work more actively in Nepal.

Sankhuwasabha is a one of the remote district of eastern Nepal with an area of 3486 square KM. the total population of sankhuwasabha district is 158742 including 75225 Male and 83517 Female populations. The average household size is 4.58, sex ratio 90.07 and population density is 46 in one square KM. (CBS, 2011) It consists of 25 VDCs and three municipalities. Health services have been providing help through the network of 2 PHCs, 17 health posts, 19 sub-health posts, three community health units, two urban health clinics, 324 Female Community Health Volunteers and 169 ORCs, along with the district hospital at Khandbari. Sankhuwasabha is a remote district as its geographical structure. Only district headquarter is connected with the major roads and airway connection with

Biratnagar and Kathmandu, which service most people cannot afford. Specialized and complicated cases cant managed by district they should take to Biratnagar and Kathmandu to obtain modern health service. (Annual Report, DHO Sankhuwasabha, 2070/71)

The Majhis are one of the indigenous peoples of the nation of Nepal - possessing their own language, dress, culture, etc. Majhis are not only polite and shy but also very much friendly and helpful. From the dawn of time the Majhi have had a special and intimate relationship with the rivers of Nepal. According to caste and ethnicity division of Government of Nepal they fall in Mountain/Hill janajati group. The main traditional occupation of the Majhi people is boat building and river transportation services in Nepal, with most Majhi living in the inner Terai near rivers. On average, Majhi people are dark brown in skin complexion, medium in height and well built, they have the classic Mongoloid features typical of East Asia. In Nepal a group of rivers is called Saptakoshi. It is made out of 7 rivers of Nepal which is Indrawati, Bhotekoshi, Tamakoshi, Sunkoshi, Arun, Barun and Likhu respectively. And these particular rivers are the main location of Majhi people of Nepal. The ancestral occupation of the Majhi people is to help other people in crossing the many rivers of Nepal in their Majhi made boats. By doing this they get coins from the benefiteres. Fishing was for their own sustenance. They do not farm fish in pools; just freely catch fish from the rivers. The Majhi also farm but they don't have enough land to fulfill their daily needs, the women especially sell "Marcha" an ayurvedic medicine for making wine and jand i.e. a special wine making of cooked corns in the markets, as well as mats made of pater. Majhi products are considered to be of exceptional quality. Today a tragedy is unfolding in Nepal. Modern bridges and government interference in their traditional working areas is destroying the traditional Majhi way of life.

The total population of Majhi is 83727. Least of them were live in Urban area (Urban population: 9621) whereas, more than 88 percent live in rural areas (rural population : 74106). Ecological population of Majhi in Nepal is Mountain: 7365, Hill: 40519 and Terai: 35843. Population of Majhi varies according to development region also 27940 Majhi were live in Eastern development Region, 48668 were live in central, 5208 in western, 1168 in mid-western development region and only 743 Majhi population were in Far Western Development Region. (CBS, 2011)

The total population of Majhi in Khandbari Municipality ward number 12 and 13 is 159 living in total 30 household. The male and female population is 86 and 73 respectively.

1.2 Statement of the Problem

In Nepal, for many women marriage and child-bearing will occur at an earlier age than the legal age of marriage, e.g. under 16 to 18 years, and child-bearing occurs almost exclusively within the confines of marriage. The consequences of child-bearing at an early age are babies with a low birth-weight, congenital complications, maternal and neonatal mortality. Adolescents who become pregnant within two years of menarche have a higher incidence of prenatal complications since their babies are still physiologically and anatomically immature. This implies that the health situation of the Nepalese people is quite serious.

Most developing countries are suffering from a high fertility rate and a rapid population growth, including Nepal. Although the level of awareness concerning FP and contraceptive methods has risen since the 1991-96 period, the overall practice of family planning is still very low. Rural and urban differences are great. Most people do not have any knowledge of the importance of FP, what it means and why it should be practiced. So, in the rural context, the utilization of FP services is very poor.

The above descriptive statistical figures show that the utilization of family-planning services is in a pitiable condition and therefore the quality of life is very poor. The Majhi people, who live at the Khandbari Municipality have a very low literacy rate, a low socio-economic status and they are highly influenced by conservative behaviour. Furthermore, Majhi people are marginalized and in fact deprived of modern resources. The utilization of FP services and maternal child health is low. For this reason I felt the need to investigate the utilization of family-planning services among the Majhi community in the Sankhuwasabha district of Nepal.

1.3 Objectives of the Study

The overall objective of the study was to examine the status of knowledge, attitude and practice of family-planning services among the Majhi community in the Khandbari municipality of the Sankhuwasabha district. The specific objectives were given below:

- i) To find out the demographic status of Majhi community.

- ii) To identify interrelationship between knowledge and practice of contraceptive devices among the Majhi community.
- iii) To find out the traditional values about contraceptive devices.
- iv) To find out the accessibility of the contraceptive devices in the community.

1.4 Significance of the Study

The main aim of the study was to find out about the utilization of FP services provided by governmental institutions. Although a family-planning programme was conducted four decades back, the result does not seem sufficient because of problems, such as high IMR, a high fertility rate and the still low contraceptive prevalence rate (CPR). (In this way, it has been tried to reach the target of family planning programme.) The family health status and traditional believes and practices of family planning was a significant part of the study. The study attempted to find out about the awareness of family-planning services and about the participation of community people in the health programme, arranged by local public and private institutions. It provided the actual national figures by generalizing the municipality level study, especially where family planning is concerned. Furthermore, the study was seek to find out barriers of, knowledge and practices of FP services in rural areas among the Majhi community. This research was helpful for other scholars who wish to get more information on Majhi ethnicity and the area. The study could used for local governmental organizations and policymakers. NGO's and INGOs as a baseline study in the field of family planning.

1.5 Delimitation of the Study

The following issues are the delimitation of the study.

- i. The study was based on ward No.12 & 13 of the Khandbari municipality in the Sankhuwasabha district.
- ii. The respondents were exclusively Majhi married women of reproductive age (15-49 years).

1.6 Definition of Terms Used

Community: People living in the same geographical area with a common goal.

Contraceptive devices: Preventive methods to help avoid unwanted pregnancies and to help birth spacing.

Depo: Depo-Provera (A kind of injectable hormonal family-planning method) Preventive method to help avoid unwanted pregnancies and birth spacing.

Health services: Services of health including preventive, promotive and curative services

Infant mortality (IMR): The annual number of death of infants under the age of 1 year per 1000 live births.

Child: Child under five years of age

Injectable: That which can be injected in the human body.

Laparoscopy: Female sterilization as a permanent family planning method.

Menarche: First incidence of menstruation cycle in a female.

Pills: Oral tablet of temporary contraception.

Pregnancy: The period during which a woman carries a developing fetus in the body after union of an ovum and spermatozoon. The duration of pregnancy is about 280 days.

Prevalence: Frequency of incidence.

Sterilization: Permanent method of contraception.

Total fertility rate: The average number of children a woman would have assuming her current age. The specific birth ratio remains constant throughout her child bearing years. (Usually considered 15 to 49 years).

Vasectomy: Male sterilization as a permanent family-planning method.

CHAPTER II

REVIEW OF RELATED LITERATURE

2.1 Theoretical Literature

Nepal's family-planning programme was started with the organization of the family-planning association of Nepal in 1959 B.S. His Majesty's Government adopted a policy of family planning and since 1965 B.S it commenced integrated service with MCP activities. The government supported the provision of family-planning services through the Maternal and Health Board, under whose umbrella Nepal's family- planning and maternal and child health project was established. At first, the services were concerned with the Kathmandu valley only. Later the services were gradually expanded, including other parts of the country. In 1968 a semi-autonomous body called the Nepal Family Planning and MCH board was established. The family-planning and maternal-child-health project is responsible for the delivery of FP/MCH services to the entire population of Nepal. The project included 40 district offices, which carried out the action programmes in 52 districts out of 75 districts of Nepal in 1996. The community health and integrated project under the Ministry of Health was responsible for providing family-planning services in the remaining 23 districts (BECHIMES/NCPS, 1998, cited by Gautam, 2006).

The ministry organization was restructured to accommodate a majority of vertical project staff members. In 1987, His Majesty's Government made a decision regarding family-planning services, which would be provided by integrating all vertical projects in all 75 districts. With the restructuring of the ministry the integrated community health services department project (ICHSSP) was abolished in 1996 and some new strategies for reproductive health were adopted.

NDHS stated that awareness is lacking of how to convert the need especially for temporary family-planning methods into a demand. Due to the rough training and lack of social support, women, children and marginalized ethnic groups are deprived of utilizing the health services that are offered at present. They mainly live in isolated communities, so that the villagers must sometimes walk a distance of 7 or 8 km. to access primary health services.

Due to a lack of family-planning services, the population is growing rapidly and, if this gets beyond control on a national level, it will play a key role in health problems. Nepal, a small country, has many problems concerning health and health services. Part of the major health problems are high TFR and RPG, low CPR and low CYP, a low nutritional status, lack of awareness of family-planning services and communicable diseases . Similarly, the poor quality and the inequitable distribution of health services, the poor accessibility of health services, defective decisions especially on the policy and planning level in the health sector, contribute to a poor status of Nepalese health. Poor management and an almost total lack of coordination, support and supervision in the health services are responsible for ruining the people's health. Poor management resources coupled with their scarcity, a poor transport and communication system, the increasing commercialization at the expense of deprived people are some of the ugly features deeply rooted in the health-care system.

Research in rural Nepal has also shown that there is a huge gap between the knowledge of mothers regarding family-planning methods and family health, and its practice, indicating a lack of access to health services. There is a similar gap between those who do not want more children and those who are actually using a method to alert or to avoid new births.

2.2 Empirical Literature

Kafle (2000) attempted the "Study on Family Health of Danuwar Community" at Panchkhal VDC of Kavre. He found that most of the women had heard about family planning. The effective communication medium was the radio. Male persons had undergone permanent sterilization more often than females, whereas females had used temporary devices. Depo-Provera use was higher than that of other devices. Most of the couples had undergone sterilization after more than four children. However, most of the women had preferred two children of either sex. A majority of the Danuwar people had obtained family-planning services through hospitals.

Poudel, (2001). Studied the socio-economic impact on RH in the Tharu Community of Semlar VDC Rupandehi. In his study he found that most of the people had got their information about FP through radio and television. Only 36.5 percent of the people had any knowledge of family planning, 20 percent of the people aspired to have two children for an ideal family. Among the people as a whole 30.4 percent used family-planning methods whereas almost all of the people with a secondary or higher level of education used FP

methods. A majority of family-planning users applied temporary methods, nearly 40.00 percent of the people performed the birth spacing for more than two years. A majority of the people were ignorant of reproductive health methods.

Shrestha, (2000). made a study of Factors Affecting the Contribution of Temporary Contraceptive Among Married Women in Bode, Thimi In his study he indicates that less continuation was found among those women faced with side effects or problems than among women who did not have any problems. The problematic group was mainly composed of women who were suffering from too much weight gain (43.84%) and (36.15%) women with an irregular menstruation. These complications are side-effects of injections.

Ray, (1999). in his study "Knowledge attitude and practices of family planning method in Muslim community", found that a majority of the respondents (85.00%) were not practicing contraceptive devices; only (15.00%) of the respondents were using contraceptives; male and female sterilization were (3.26%) and (2.17%) respectively.

New Era, (1990). has done an "Impact study on maternal child health and family planning project in Kavre district." It was found that the infant mortality rate had significantly declined between 1986 and 1990. The contraceptive prevalence rate had also significantly increased from 16.3 to 21.3 percent. The medical check-up rate of pregnant women had increased almost three-fold over four years due to the programme of JICA. Through the JICA programme, about one-third of the women had received TT during pregnancy. The JICA programme made the women aware of the need of using boiled (sterilized) tools for umbilical cord cutting, of feeding colostrums and of practicing breastfeeding. These practices were very high (90%) in the area where the programme had been conducted.

(Aryal, S.R. 1994). In "A study on married women's knowledge, attitude and practices of family planning methods" in Bakrang VDC of the Gorkha district, the researcher found that 61.7 percent of the respondents had knowledge of family planning methods, however, only 42.6 percent of the respondents were practising them. In regard to ethnic groups, the knowledge of contraceptives was found the highest in Chhetri, lower caste people using contraceptives were the lowest in number in comparison with their ethnic groups.

Gurung, Newar and Magar people have a negative attitude towards the family-planning programme. Fear of side-effects of using family-planning methods was found as the main

cause of this negative attitude. The reasons for not using family- planning methods were the desire of a son (40.5%), effects on health (37.9%), and the religion (41.2%) of respondents.

(Acharya, M. 1995). In the study "Status of female" the researcher made clear that Nepal had the highest maternal mortality in SAARC countries i.e. 850/1,00,000 live births, whereas Bangladesh had 650, Bhutan had 800, India 550, Pakistan had 600, Sri-Lanka had 180 per 100,000 live births. According to the census of 1991, the total fertility of Nepalese women was 5.6. The reason of this was a lack of FP knowledge and practices: 92.7 percent of the women who had recently married knew at least one method of FP. Only 24.1 percent of married persons used FP methods. FP methods were adopted only after 4 to 5 births had taken place. It would have been interesting from a social point of view to explore this for the whole of Nepalese society.

(Panta, 1995). In a study of socio-economic status and maternal and child health care practice with relation to fertility, the researcher found that more than 90 percent of the mothers were aware of the possibility of birth spacing. Despite this awareness only women were found to use contraceptives. The average fertility rate of women was found to be 3.66 percent. The TFR of illiterate housewives and mothers married at an early age was 4.2 percent or more, whereas it was much lower in educated women (2.4%), followed by service holders (3.2%) and mothers married after 26 years of age (3.5%).

Chaudhari, (2000). There has been a modest decline in the total fertility rate over the years. However, the fertility level remains high (TFR 4.5 in 1996); moreover progressively larger shares of all births occurring to adolescent girls have shorter birth intervals (about 2 years in 1996). It is an established fact that closely spaced births increase the risk of maternal infant mortality. Antenatal care among the mothers is unsatisfactory and an overwhelming majority of births remain unattended by trained health workers. Only 33 percent of women were with two TT shorts and 43 percent with one TT shorts (total 46%). Only a small proportion of births is delivered at the health centres. Home delivery continues to be the practice.

Poudel, (1999). studied "Effectiveness of contraceptive devices in Gitanagar VDC of Chitwan"; he found that (34.38%) of contraceptive users were from low economic

households, (45.2%) were from middle and (36.36%) from high groups. In this VDC he found that higher levels of contraceptive users were found in the middle income group.

UN, (1996 pp. 203-208). The WHO global estimate indicator showed that more than half a million women die each year of complications related to pregnancy and child birth. All but 4,000 of these deaths are taking place in developing countries; the maternal mortality ratio was estimated to be on average 450 per 100,000 births, which was about 1 maternal death for every 220 births. The total fertility rate in developing countries declined from 6.1 in 1965-1970 to 3.9 in 1985-1990. This fertility decline was almost completely three result of contraceptive use. On average, every woman had been able to avoid 2.2 unwanted births. A rough estimate is that in developing countries today, one out of every 100 woman is saved from an unnecessary death through family planning.

The international conference on population and development (ICPD) Cairo, 1994 represented the shift in focus in the population field as critical. Before ICPD, the concern lay with achieving demographic targets, largely through the provision of family-planning services whereas afterwards the focus shifted towards the broadly defined reproductive health services, which recognized women's reproductive rights and their need for empowerment. Human rights, human development and individual well-being became the centre of programme policies, since it was realized that for the individual health and well-being of both women and men, to have a small family size is a prerequisite. The new thinking endorsed in Cairo was also that population growth can be established and development efforts can be enhanced particularly through the development of women and by improving their reproductive health.

UNICEF, (1987 pp. 168-171). revealed that in Nepal, more so than in most other countries of the SAARC region, women have a shorter life expectancy than men. This was primarily due to the risk of child-birth. Almost 40 percent of Nepalese women have their first child between the ages of 15 to 19 years. Most births take place at home and an estimated 85 percent were attended by a traditional birth attendant, whose skill and qualities vary across different ethnic groups. Most of their lives are spent in pregnancy or with five or six births, each accompanied by one or two years of breastfeeding. UNICEF stated that 8 percent of the couples were not using contraceptive devices due to the fear of side effects. About 36 percent of women and 31 percent of men had undergone sterilization, 59 percent of the

women were using pills, 45 percent of them taking injectable and 36 percent of those using IUCDS.

According to the Nepal population report of 2007, however, the reproductive process remains a serious health problem for women in Nepal. The MMR (maternal mortality rate of 539 per 100,000 live births) is extremely high. Women do not marry at an early age but 42 percent of all married women give birth to a child by the teenage age of 19 years. The child-birth rate is still high in Nepal because of the influence of conservative concepts, which are responsible for the pitiable health condition of the Nepalese people.

Family Health Survey, (1996). In spite of the combined efforts of different associations, NGOs/INGOs and the government, there is a high 'unmet need' for FP services where the awareness level has reached 96 percent. A family health survey indicated that only 29 percent of currently married women are using modern contraceptives and a further 31 percent desire to use it. The breakdown of the unmet need is 17 percent (limiters) and 14.3 percent (spacers). This situation clearly challenges us to increase accessibility of FP by attending to the unmet need and to inform and educate the rest who have not yet expressed any desire of family planning services.

From the literature review given above, it was concluded that most of the maternal mortality, infant mortality and low-weight births are caused by the lack of information about FP services, MCH service and poor accessibility. Socially and economically poor people do not have the knowledge and awareness of reproductive health and family planning. Most people have small pieces of land, low income sources, a poor educational status and a large family size. It stands to reason that their reproductive health practices are influenced by their poverty. Female education is more effective than that of male education, resulting in a wider use of contraceptives, and the realization of the desired number of children. Most of the women's information source in the rural areas is the radio; higher-caste mothers have a higher socio-economic status and education; they utilized available health facilities more than others. The majority of the injectable contraceptive users suffered from too much weight gain and irregular menstruation. It is quite clear that there are many causes that affect family planning.

CHAPTER III

METHODOLOGY

3.1 Research Design

The study was mainly based on primary data and it was concerned mainly with the utilization of family-planning services in the Majhi community provided by governmental sectors, in the Khandbari municipality of the Shankhuwasabha district. To this purpose the researcher has assigned the task of carrying out a descriptive research into the community of selected wards. The following methodological procedure was applied in this study.

3.2 Population of the Study

The study site was Khandbari municipality ward number 12 and 13. The study area accommodates inhabitants of different caste as well as ethnicity. The study population was the Majhi community of the Khandbari municipality, in the Sankhuwasabha district. There were 30 households and total population is 159. My study population was Married Majhi women of reproductive age group. I was conducted household survey of them because of low population.

3.3 Sampling Procedure or Sample size

The total number of population of the Khandbari municipality is 26301 and total population of Majhi in Khandbari Municipality 12 and 13 is 159. Total household of Majhi community of Khandbari Municipality.

3.4 Data Collection Tools

An interview schedule had constructed to collect the necessary information. Data was collected by using standard interview questionnaire. The schedule is divided into five groups, as follows:

- i. Household information
- ii. Individual questions

- iii. Knowledge and practice of contraceptive devices.
- iv. Side effects after using contraceptive devices.
- v. Accessibility of family planning services.
- vi. Traditional values of contraceptive devices.

3.5 Validation of Tools

After preparing the research tools, the first draft was shown to the supervisor and improved according to the supervisor's suggestions, then the tools was administered to 5 married Magar women aged 15-49 years in the Khandbari municipality -10 of the Sankhuwasabha district as a pilot test. The research tools were modified according to the feedback obtained from results of the pilot study and suggestions provided by the supervisor.

3.6 Data Collection Procedure

First of all an interview schedule was translated into Nepali from English. After the researcher had properly managed to set up an interview schedule, he went to the municipality office and Tumlingtar health post, with an authorized letter provided by the Health and Physical Education Department. The researcher gave his introduction, his purpose of research and the persons that were relevant to the research. After obtaining permission from the municipality and suggestions of the HP in charge, the researcher visited different areas for collecting information. According to the suggestions he had given, the researcher makes door-to-door visits to the respondents' houses at a suitable (morning/evening) time to draw up the questionnaire schedule. The researcher continues this work, until complete information was not collected.

3.7 Analysis and Interpretation of Data

The data was collected through the interview schedule form of the field survey. The questionnaire was scrutinized in the field before the collection of facts. Before entering the data into the computer all responses were pre-coded. The data was entered in the software programme MS-Excel. The data was presented through simple statistical measures, such as frequency, mean, graph, percentage etc.

CHAPTER – IV

RESULT AND DISSCUSSION

Analysis and interpretation of data is an important component in every research. This chapter includes socio-economic and demographic characteristics and utilization of contraceptive devices of the respondents. It is also data elaborated and illustrated on the basis of availability of family planning services, practices and barriers of utilization of contraceptive devices, especially in five components i.e. knowledge about contraceptive devices, utilization of contraceptive devices, accessibility, traditional values about contraceptive devices and side effects after using contraceptive devices.

4.1 Age-Sex Structure of Respondent

Age-sex composition plays an important role in determining the population. A significant feature of any population is the distribution of its members according to age which facilitates the planners and policy makers in formulating an effective socio-economic development plan for the population of different age groups.

Following table shows that almost four in every ten respondents were less than 20 years. More than one fifth was 20-24 years age. Only least of them were more than 34 years of age.

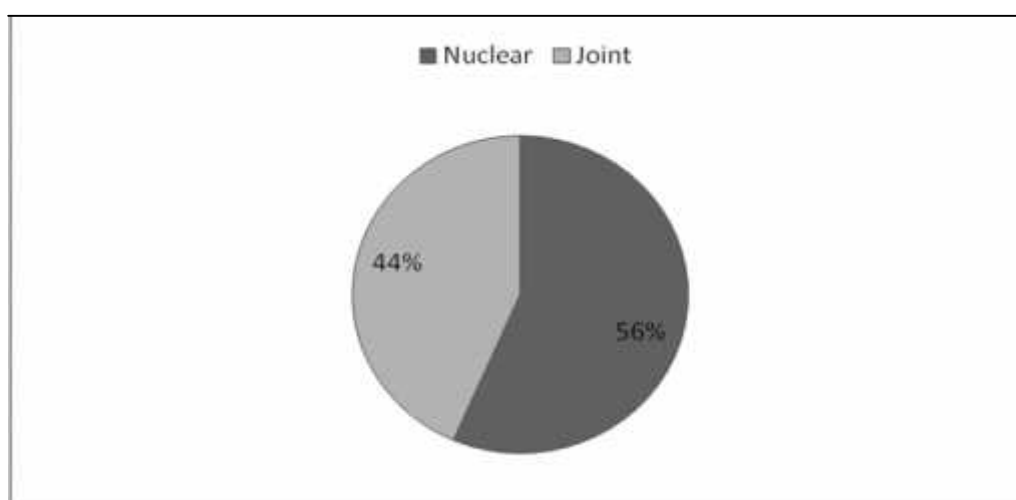
Table No: 1 Age and sex structure of respondent

S.N.	Age group	Number	Percentage
1	<20 years	9	39.2
2	20-24 years	5	21.7
3	25-29 years	3	13
4	30-34 years	4	17.4
5	>34 years	2	8.7
	Total	23	100

4.2 Family Pattern

Following pie chart describes that more half of respondents were live in nuclear family. Percentage of women live in joint family was found 43.5.

Fig : 2 Type of Family



4.3. Educational status

Among total 23 respondents six out of ten were primary level educated. Percentage of illiterate and lower secondary level educated was 13 percentages. Less than five percentage of respondents were higher level educated (i.e. more than SLC).

Table no: 2 Education status

S.N.	Educational status	Number	Percentage
1	Illiterate	3	13
2	Primary level	14	60.9
3	Lower secondary level	3	13
4	Secondary level	2	8.7
5	Higher education	1	4.4
	Total	23	100

4.4 Occupation

Most of the respondents were engaged in household works (i.e. 39.1 percent). Percentage of women engaged in agriculture and daily wages was 34.8 and 26.1 respectively.

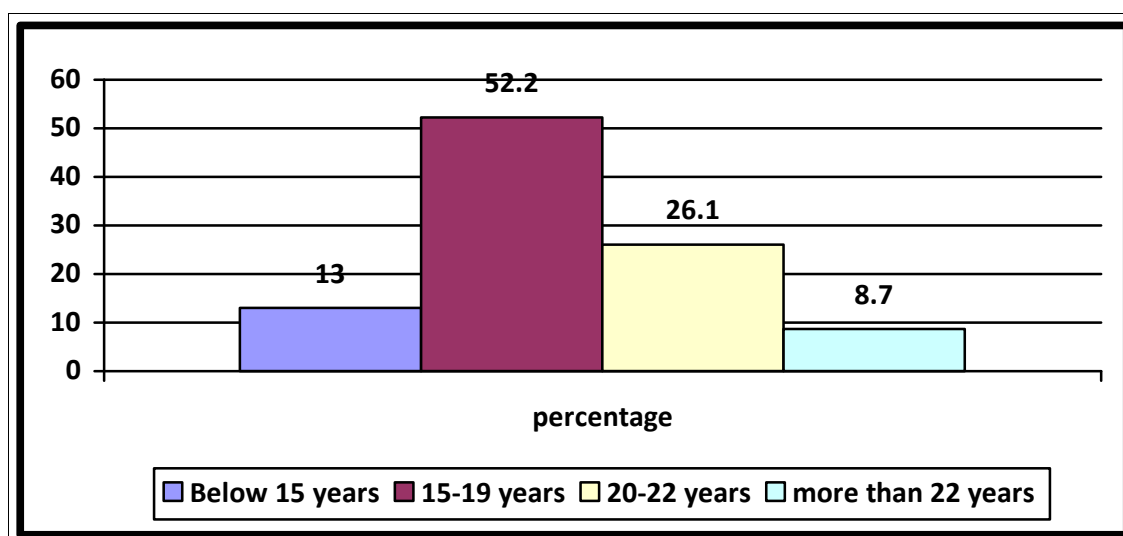
Table no: 3 Occupation of respondents

S.N.	Occupation	Number	Percentage
1	Agriculture	8	34.8
2	House wife	9	39.1
3	Labor	6	26.1
	Total	23	100

4.5 Age at Marriage

More than half of the respondents were married at the age of 15-19 years. About one fourth respondents were married at 20-22 years. A significant numbers of them were married before 15 years (i.e. 13 percent) and only 8.7 percent respondents were married after 22 years.

Fig no: 3 Age at marriage



4.6 Appropriate Age of Marriage

Higher number of respondents thought that appropriate age of marriage was 20-22 years. More than one fourth told 15-19 was appropriate age of marriage. Three in every ten told appropriate age of marriage was more than 22 years.

Table no: 4 appropriate Age of marriage

S.N.	Age group	Number	Percentage
1	Below 15 years	0	0
2	15-19 years	6	26.1
3	20-22 years	10	43.5
4	Above 22 years	7	30.4
	Total	23	

4.7 Sex Preference

More than six out of ten respondents did not prefer any sex during their child bearing. They easily accept whether it was male or female. Still more than one fourth of respondents prefer Male. Percentage of female during child birth was found 13.

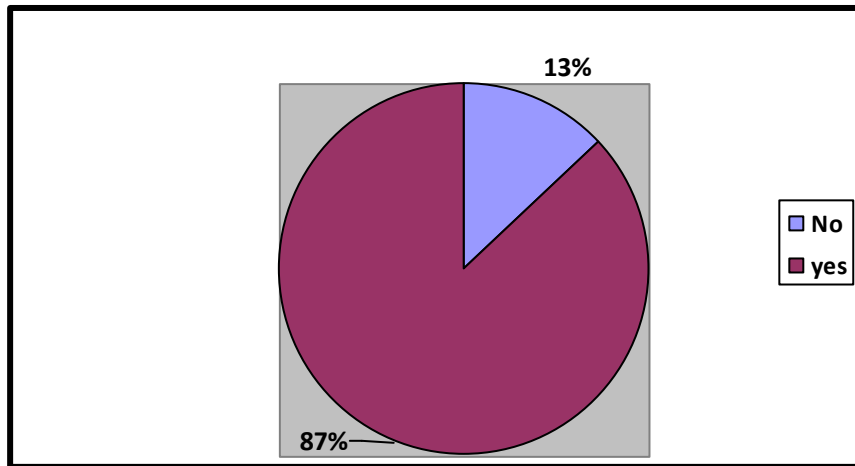
Table No:5 sex preference

S.N.	Sex	Number	Percentage
1	Male	6	26.1
2	Female	3	13
3	Either	14	60.9
	Total	23	100

4.8 Known about family Planning

More than eight in every ten respondents were known about family planning. Percentage of respondents who were unknown about family planning was found 13.

Fig: 4 Knowledge about family planning



Among total 20 known respondents, family planning is spacing of children was told by eight respondents. Birth limitation was told by seven and both spacing and limitation was told by five respondents.

4.9 Significance of Birth Spacing

There was various significance of birth spacing. Among total 23 respondents, more than half thought that birth spacing was for good health. One fourth of them told for education. 8.7 percent were told for finance and similar numbers of respondents were told others like happy family, goodness of life, national development etc.

Table No:6 Significance of birth spacing

S.N.	Particular	Number	Percentage
1	Good Health	13	56.5
2	Education	6	26.1
3	Finance	2	8.7
4	Other	2	8.7
	Total	23	100

4.10 Known about Types of Contraceptive Devices

Among total 23 respondents, more than four in five were known about both modern and natural types of contraceptive methods. About 13 percent were known about modern method. Only 13 percent of them were known about natural methods. 13 percent of respondents were unknown about contraceptive devices.

Table No: 7 knowledge on type of contraceptive device

S.N.	Particular	Number	Percentage
1	Modern	7	30.5
2	Natural	3	13
3	Both	10	43.5
4	Don't know	3	13
	Total	23	100

4.11 Major Source of Information about Contraceptive Devices

Among total respondents who were known about FP devices, four out of ten were known by listening Radio/TV, other sources of information were health workers/FCHVs, friends, relatives and others.

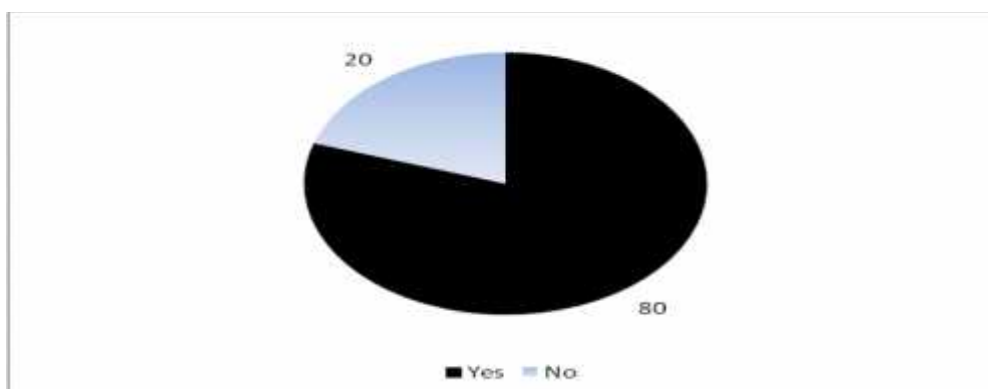
Table no: 8 Major source of information about contraceptive device

S.N.	Particular	Number	Percentage
1	Radio /TV	8	40
2	Friends/Relatives	4	20
3	Health Workers/FCHVs	6	30
4	Others	2	10
	Total	20	100

4.12 Ever Use Contraceptive Devices:

Among who were known about contraceptive devices 80 percent of them were ever used any contraceptive devices once in their lives. Two in every ten were never used contraceptive devices.

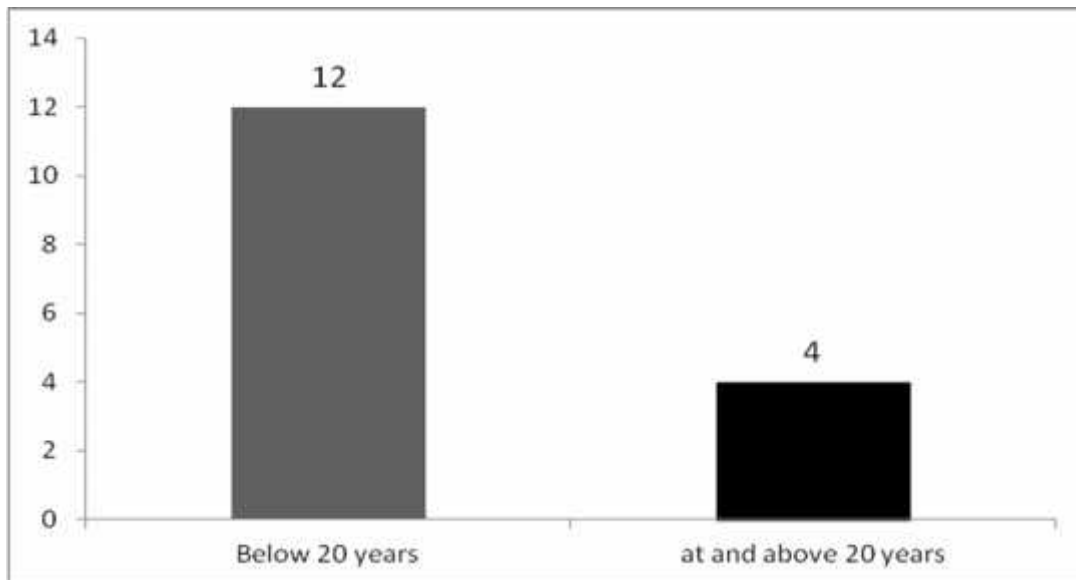
Fig: 5 Ever used Contraceptive Devices



4.13 Age at First use of Contraceptive Devices

Among total 16 ever users of contraceptive devices 80 percent of them were used before age of 20 years. Only twenty percent were used at and after the age of 20 years.

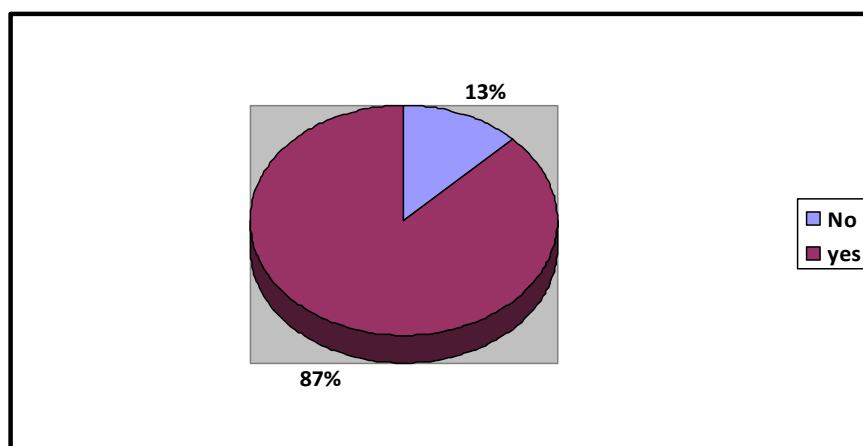
Fig: 6 Age at first use of Contraceptive



4.14 Current user of Contraceptive

More than eight among ten who ever used contraceptive devices were currently using any of the contraceptive devices. Percentage of respondents who ever used contraceptive devices but currently not using was found 12.5.

Fig: 7 Current user of contraceptive



4.15 Type of Contraceptive Currently Using

Following table shows that type of contraceptives and number of current users. Among total current users of contraceptives more than half (57%) were currently using Depo followed by Implant (28.6%), Pills (14.3%) respectively.

Table No: 9 Types of contraceptive currently using

S.N.	Contraceptive device	Number	Percentage
1	Depo	8	57.1
2	Pills	2	14.3
3	Implant	4	28.6
	Total	14	100

16 Reason Behind Discontinuation of Contraceptive Devices

Among total 16 respondents who ever used contraceptive devices, two of them were discontinued it. Half of them were discontinued because of fear of side effects, half of them thought not necessary of contraceptive devices.

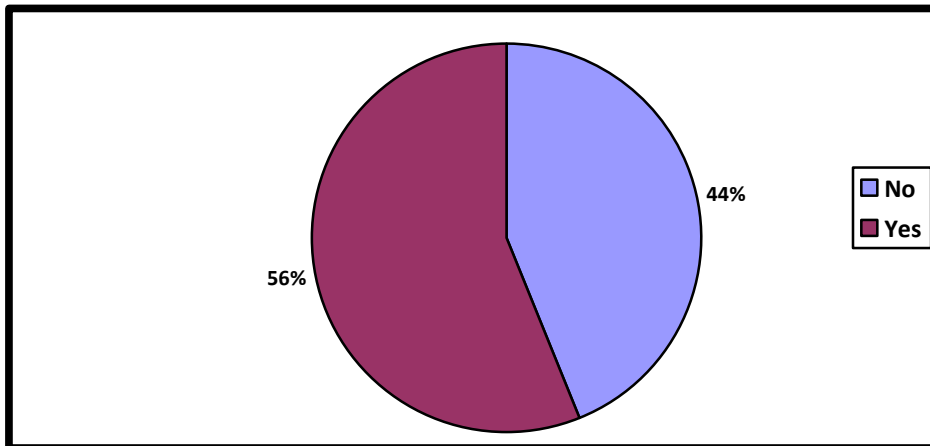
Table No:10 Reason Behind Discontinuation of Contraceptive

S.N.	Reason	Number	Percentage
1	Fear of side effect	1	50
2	Felt not necessary	1	50
	Total	2	100

4.17 Ever Felt Side Effect of Contraceptive

Among total ever user of contraceptives, more than half (56%) of them ever felt side effects of contraceptives. About four in every ten (44%) contraceptive users have not felt side effects of contraceptives.

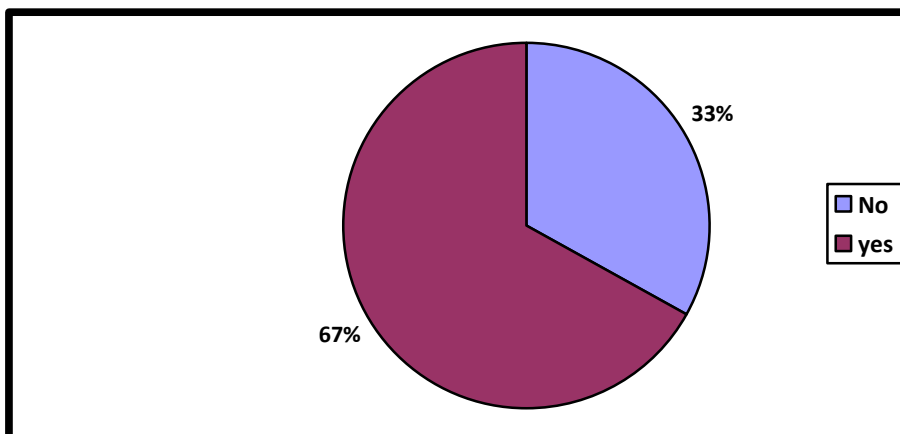
Fig: 8 Ever felt Side Effect of Contraceptive



4.18 Availability of Contraceptive Devices

About seventy percentage of total respondents thought that contraceptive devices were available whether they want to apply. But more than 30.4% thought that contraceptive devices were not available.

Fig 9: Availability of Contraceptive Devices



Among six who thought that contraceptive devices were not available, two of them felt fear to demand, two respondents thought there was no any service centre nearby (Governmental, Private) and two of them thought carelessness of themselves so that contraceptive services were not available.

4.19 Distance of Health Service Facility

Distance of health facility was measured by time to reach health facility by walking. About four in every ten respondents lived in those areas from where health facility was about one hour walking distance. More than 30% respondent's residence is more than one hour walking distance from health facility.

Table No: 11 Distance of Health Service Facility

S.N.	Time	Number	Percentage
1	About 10 min	2	8.7
2	About 30 min	4	17.4
3	About 1 hour	9	39.1
4	More than 1 hour	8	34.8
	Total		

4.20 Major Findings

The currently married women aged 15-49 years had different socio-economic and demographic characteristics. In addition, they had different perception about family planning methods knowledge and practices. The summary of the findings are stated as follows:

- a. The total population of the study area is 257 whereas 48.01 % male and 52.14 % female.
- b. About 56 % respondents lived in nuclear family.
- c. More than 39 % respondents were below the age of 20 years.
- d. About 52 % respondents have married at the age of 15 to 19 years.

- e. More than 60 % of respondents were primary level educated.
- f. Agriculture and house wife were found as major occupation of respondents.
- g. It was found that more than 60 % respondents did not think about sex preference, more than one fourth preferred son and 13% preferred daughter respectively.
- h. About 87 % respondents have knowledge about family planning methods, and 13 % of respondents have not any knowledge about family planning methods.
- i. Among known about family planning, 35 percent have understood family planning as limitation and 40 % respondents have understood that family planning as a means of spacing. Only 25 % of them told family planning as birth spacing and limitation tool.
- j. The study found that 56.5 % of respondents expressed their view about the significant merit of birth spacing is good health. Significance of birth spacing was for education was expressed by 26.1 percent.
- k. More than 30 % respondents were known about modern methods of contraceptive devices, natural methods of contraceptive methods were known by 13 % and both natural and modern were known by 43.5 %. 13 percent of respondents were unknown about methods of family planning.
- l. Radio/TV was found as popular source of information about contraceptive devices followed by health workers/FCHVs, relatives and friends.
- m. It was found that 80 % of respondents were ever used any type of contraceptive devices in their lives where 20 % were never used it.
- n. Seventy five percent of ever users were adopted contraceptive devices before the age of 20 years only 25 % adopted it after 20 years.
- o. Among ever users of contraceptive more than 85 % were currently using any type of contraceptive where more than 12 % were discontinued it.
- p. Among current users of contraceptive more than half of were using Depo, implant was used by 28.6 % where pills was used by 14.3 percent.

- q. Fear of side effect and felt not necessary of contraceptive was found as main reasons behind discontinuation of contraceptive devices among ever users.
- r. Among ever users of contraceptive more than 56 % were ever felt side effect during adoption of contraceptive. 43 % of them were did not felt side effect of contraceptives.
- s. Contraceptive services were easily available to about 70 percent of respondents where more than 30 % of respondents didn't access on contraceptive devices.
- t. Fear of demand, shyness of clients, on nearby service centre and carelessness of client itself were found as major reason behind inaccessibility of contraceptive devices.
- u. More than 70 % of respondent live more than half an hour distance from health facility.

CHAPTER –V

SUMMARY, CONCLUSION AND RECOMMENDATIONS

This chapter is organized to show the overall picture of the study. It is divided into major three parts, which are summary, major findings of the study and recommendations with area for further research.

5.1 Summary

The study "Utilization of Contraceptive Devices among Majhi community of Khandbari Municipality Sankhuwasabha District" is based on primary data. The study was delimited in only ward No.12&13 of Khandbari municipality of Sankhuwasabha district. By using purposive sampling, 23 respondents were selected from Khandbari municipality, who were married women between the age of 15 to 49 year.

The overall objectives of the study were examined the Utilization of Contraceptive Devices. The specific objectives of the study were to investigate the gap between knowledge of contraceptive devices and using practice of them. Similarly, to identify the reasons for use and non-use of family planning services among Majhi married women of reproductive age (15-49).

The utilization of health services in Majhi community of Sankhuwasabha was found not good due to several reasons like ignorance of family planning and services center, poor accessibility, poor participation of community people on health activities and fear of side effects were the main causes of not adopting family planning devices in the study area.

To fulfill the objectives of study, necessary information through interview schedules and observation were collected. The questionnaire schedules were divided into six sectors i.e. household information, individual questionnaire, knowledge and practice of family planning, side effects after using family planning devices, accessibility and traditional values of family planning etc.

In this study the collected data were analyzed manually and also with the help of MS-Excel computer software programme.

5.2 Conclusion

The research study was conducted to find out utilization of family planning services in Majhi community of Khandbari Municipality 12 and 13 of Sankhuwasabha district. The study focused in the respondent's knowledge and practices of using contraceptive devices in Majhi community provide by governmental sector and to find out the reasons for use and non-use of family planning services among Majhi married women of reproductive age (15-49 years).

The study found that more than 60 percent of respondents were primary level educated. Nuclear families are more than joint family in the study area. Most of the households' are farmers and they practice traditional agriculture- except few of them work in pottery making and labor. Age at marriage of female was found earlier. Most respondents were familiar with health post but it takes more than half an hour to reach the services provided by HF for majority of respondents form study area.

Knowledge about different family planning methods was high. Among them modern methods condom, Depo-Provera, male sterilization and female sterilization were well known to the respondents. This was mainly due to the mass media advocacy, and friends. Majority of the respondents have found ever used and currently using any kinds of family planning methods except 13 percent of respondents have still unknown about contraceptive devices. Among them, Depo-Provera, Implant and Pills were popular in couples.

Similarly, about one third of respondents were not using family planning methods due to the religious beliefs, fear of side effects and ignorance. The main reason associated in not intending to use any family planning methods in future was fear of side effects, felt not necessary and carelessness.

There are various factors that hinder the knowledge and practice of family planning methods such as ignorance, religious or traditional beliefs, poor accessibility of family planning methods and fear of side effects, etc.

In addition, mass media and advocacy of friends, husbands and teachers hold a very significant role for influencing and encouraging the respondents for promoting effectiveness of family planning methods.

5.3 Recommendations

Based on research findings, some points are recommended and listed as follows along with some more areas for further research. Utilization of family planning services are dependent variables, which depend on socio-economic status, awareness of people, accessibility and availability of health services. So, a holistic program should be launched including all aspects in study area. Utilization of Permanent method of contraceptive was found nil and male participation on contraceptive was found very low so responsible authority needs to launch awareness programme especially permanent methods.

Men's willingness to use contraceptives should be promoted by providing them with adequate and appropriate and explanatory information about them.

1. Every programme should consider bottom up approach, which should include the target people (equal male and female) from planning to impact evaluation phase.
2. All health personnel should be trained dedicated to services.
3. Nepal's health infrastructures are very limited and in poor condition, so, it should be extended well and managed.
4. Most of the respondents have the knowledge on family planning methods. It may increase contraceptive prevalence rate of the country in the future. To make family planning more effective, everyone should be informed about the advantages and disadvantages of each family planning methods in details.

5.5 Recommendation for Further Study

1. After drawing findings and conclusion of the study, the researcher came to a decision that there are so many study areas remain in this field. The research is a descriptive type of study therefore analytical research is necessary for research to a logical end.
2. The research has been conducted on small group of Majhi community only. So, it can't reflect detail practice of utilization in other communities and areas. To generalize the findings further research should be conducted all components of family planning in all communities and larger area.
3. The research on knowledge and practice should be done in rural and urban community.

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Appendix –A

Tribhuvan University
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Koshi Haraicha, Morang

Utilization of Contraceptive devices among Majhi Community of Khandbari Municipality

Request: Please answer the questions to the best of your knowledge (*as far as possible*) as the importance of the study will depend on your information. Your answer will be helpful to establish the utilization of family contraceptive devices in the Majhi Community, in order to improve it through the awareness in the community. The information will be used for this purpose only. Your answer will be kept strictly confidential.

These questions will be asked to married Majhi women of 15-49 years only.

District:

Household No.

Municipality :

Ward No.:

Family: (i) Nuclear (ii) Joint

A. Household Information

S.N.	Name of family	Sex			Age					Marital Status		Educational status			Occu Pation
		F.	M.	T.	0-5	5-15	15-30	30-50	50+	M.	F.	I.	L.	SLC	

B. Individual Questionnaire.

1. How old are you (Complete age) ?

Year

2. How old were you when you got married

a. Below 15 yrs. b. 15 to 19 years

c. 20 to 22 years d. Above 22 years

3. What was your husband's age when you got married?

a. Below 15 yrs. b. 15 to 19 years

c. 20 to 22 years d. Above 22 years

4. Which is the appropriate age for marriage in your opinion?

a. Below 15 yrs. b. 15 to 19 years

c. 20 to 22 years d. Above 22 years

5. What was your age when you got first pregnant?

.....years

6. What is your occupation?

a. Agriculture b. Government service

c. Business d. Labour e. Others (please specify).....

7. Which sex would you like your child to be?

a. Male b. Female c. Either

C. Knowledge and practices of contraceptive devices

8. Do you know about family planning?

- a. Yes b. No

9. If yes, what is family planning ?

- a. Spacing b. Limitation c. Others

10. What is the significant merit of birth spacing?

- a. Good health b. Education
c. Finance d. Others

11. How many kinds of family planning methods do you know?

- a. Modern b. Natural c. Both d. Don't know

12. What types of permanent contraceptive methods do you know?

- a. Vasectomy b. Laparoscopy c. Both d. don't know

13. What are your sources of information about contraceptive devices?

- a. Radio/TV b. Friends/ Relatives
c. Health workers/FCHVs d. Others

14. For whom or what is family planning an issue?

- a. Family b. Person c. People
d. Social respect e. Unknown

15. Does contraceptive device harm the family?

- a. Yes b. No c. Unknown

16. Did you ever use contraceptive devices?

- a. Yes b. No

17. At what age did you first use contraceptive devices?

- a. Below 20 b. Above 20

18. Which contraceptive device are you using currently?

- a. Pills b. Depo c. IUCD d. Implant
e. Condom

19. From what aspect do you adopt contraceptive devices?

- a. Economic b. Education c. Food
d. Health e. Others

20. How many married females use contraceptive devices in your family

- a. All b. Partial c. Not at all

21. How many years should be better for birth spacing?

- a. 1 yrs. b. 2 yrs c. 3 yrs
d. 3 to 5 yrs.

D. Side Effects after Using contraceptive devices

22. Your using of contraceptive devices is ?

- a. Interest b. Obligation c. Need

23. How are contraceptive devices as to effectiveness ?

- a. Well b. Better c. Best
d. No

24. Do you have any side effects after taking contraceptive devices?

- a. Yes b. No.

25. If yes, what are the problems?

- a. b. c.
d. e. Others .

26. Is contraceptive devices needed for a happy life?

- a. Yes b. No c. Unknown

27. What are the reasons for not adopting contraceptive devices in the community?

- a. Want of son b. Not allowed by family
c. Health Problem e. Others

28. What is the criticism passed on contraceptive users?

- a. Unsocial b. Unreligious
c. Undisciplined d. Unknown

E. Accessibility of Contraceptive devices

29. Are contraceptive devices available at any time?

- a. Yes b. No

30. If no, why?

- a. Too far b. No full-time service
c. Lack of Service centre d.. Unknown

31. What are the organizations that support the FP programme in the community

- a. VDC b. Club c. Women's group
d. Red cross e. Others

32. Does the local governmental health institute arrange any health activities ?

- a. Yes b. No c. Unknown

33. How far is the health institution from here by foot?.

a. About 10m.

b.. About ½ Hours

c. About 1 hour

d. More than 1 hour

34. What types of transportation are available to go to the health institute?

a. On foot

b. Animal back

c. Vehicle

d. Others (please specify)....

F. Traditional Values of Contraceptive devices

35. Is there any traditional restriction against the use of contraceptives?

a. Yes

b. No

36. Does your society accept sexual contact (a physical relation) between a male and a female before marriage?

a. Yes

b. No

37. Does your culture accept child-birth before marriage?

a. Yes

b. No

38. Does your tradition have a system of polygamy?

a. Yes

b. No