FERTILITY BEHAVIOUR IN CHAMAR COMMUNITY

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DECLARATION

I declare that the Mater' Degree thesis entitled in "Fertility Behaviour in Chamar Community " My own work , that it has not been previously submitted for any degree of examination in any other university, and that all the sources. I have used or quoted have been indicated and acknowledged as complete references.

………………………….

Pinku Karn

Date: - 2073/05/20

       05/Sep./2016

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RECOMMENDATION LETTER

       This thesis entitled "Fertility Behaviour in Chamar Community" has been prepared by Pinku Karn under my supervision. I recommend this thesis for examination by the research committee as a partial fulfillment of the requirements for the master's degree of Health Education.

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ACRONYMS

CBS	-	Central Bureau of Statistics
CDPS	-	Central Department of Population Studies
CEB	-	Children Ever Born
CMR	-	Child Mortality Rate
CPR	-	Contraceptive Prevalence Rate
DHS	-	Demographic Health Survey
FP	-	Family Planning
IUD	-	Intra Uterine device
LBS	-	Live Births
MMR	-	Maternal Mortality Rate
MOH	-	Ministry of Health
MOPE	-	Ministry of Population and Environment
NFHS	-	Nepal Fertility Rate
NPR	-	Nepal Population Report
RTIS	-	Reproductive tract Inflections
TFR	-	Total Fertility Rate
UN	-	United Nations
UNICEF	-	United Nations Children's Fund
VDC	-	Village Development Committee
WHO	-	World Health Organizations
FB	-	Fertility Behavior
NFFH	-	Nepal Fertility and Family Health
NGO/INGO	-	National/ International Non Governmental Organization
No.	-	Number
SBA	-	Skill Birth Attendant
UNFPA	-	United National Fund for Population Activities
TU	-	Tribhuvan University
WB	-	World Bank

ABSTRACT

This study entitled " Fertility Behavior in Chamar community of Asanpur VDC of Siraha District" was carried out specifically ward No. 4,5,6, and 7 of Asanpur VDC with aim of finding the demographic and socio-economic and knowledge and practice of fertility in Chamar community .

A month long field operation was launched in the study area. There are altogether 2500 households and 11000 population reside in Asanpur VDC. There are 150 Chamar households in Asanpur VDC. Among them the total population of Chamar 750. Out of then, there are 360 are male and 390 are Female. Out of 390, there are 120 female in reproductive age which is the sample size of this study. The study area and Chamar community were chosen purposively and respondents (i.e. 15-49 years Chamar women having at least on child) were taken by census method and interviewed through structured and semi- structured interview schedule.

Majority of the respondents had adopted early marriage, premature pregnancy, higher fertility and child loss experiences. Nearly one fourth o fourth respondents had an appropriate concept of family planning.

Illiteracy has been one of he vital cause for their high fertility level because of their early marriage and less awareness about family planning etc. But by the study it is seen that even some of the educated Chamar hesitate and do not use contraceptives because they have the deep rooted belief that children are the gift of god, therefore, not only the education for the uneducated but also the awareness about the demerits of populations growth and early marriage should be provided through NGOs, INGOs and even from the government sector, and it will, of course, result in diminishing their high fertility level and their life will ultimately become easier and more comfortable.

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CHAPTER – 1

INTRODUCTION

1.1   Background of the study

Health is the most important factor for the fulfillment of human needs and quality of life. It should be an easy access for them regardless of any caste, religion and economy boundaries. Today with the trend of rapid industrialization and modernization. The entire world is changing very fast, consequently increasing the gap between the haves and haves not. The direct impact of this gap between the rich and the poor ones have severely affected the health of the people, like in our developing countries. The historic " Almaata conference" organized by the WHO in 1978 with main agenda how to provide minimum (Basic) health services to the maximum people" was participated by the most of the countries of the world and made an amenities commitment to a global strategy of "Health for all by 2001. A.D. " and to the principles of primary health care through the Alma- Ata declaration. All the member's states were requested and also committed that not to foe form the responsibility to provide health services toothier citizens.

In addition to countries, Nepal is a land locked country itself of the Asia continent has launched the PHC programs within the periphery of its own limitation . Now it is about 25 years right after the Alma – Ata declaration but the expected outcomes of the conferences could not be reflected in actual sense. Further more, new health problems are existing in addition to the precious ones through out the world more especially in the developing countries , Malnutrition cycled with poverty, population exposing , environment degradation, life style related health problems, antibiotic resistance prevalence of communicable disease, etc. have threatened the health care system of the recent world. The right of the people to be healthy citizen and the responsibility of the government of provide health services toothier people both under questions.

Among these problems that the country has for face fertility behavior a problems has become the major health problem in our society. Human fertility is responsible for biological replacement and for the maintenance of human society. The growth of the

population the world depends entirely a human fertility. Fertility behavior is the process of giving birth which is interacted with environment and the environment is different societies. Within the biological limits of human fertility, several social cultural psychological as well as economic and political factors are found to operate and these are responsible for determining the levels and differentials of fertility (Bhende and Kanitkar, 2008)

Human fertility is a very complex process relation not only to biological components but also to social and economic components of society. The subject of human fertility covers a wide range of areas reflecting the complexity of this aspect of human behavior. It is influenced by a host of biological, sociological and economic factors (CBS, 2002). Only the reduced level of infant and child mortality may be strongly governing factors for fertility reduction in a largely uneducated agrarian society. Socio- economic and cultural mechanisms play active roles to persist their high fertility in Nepal. In this context education has a strong positive impact on both fertility and mortality. Caldwell's propositions that children usually have a greater chances of survive when the are born to highly educated mother (tuladhar, 1999)

It is a well known fact that rapid population increase is a serious threat to development efforts in the country. The task of providing note only food but also school housing, health facilities and employment for growing people in the developing countries, which is often double within 25-30 years is a challenging task (NFHS,1996).

The total fertility rate of Nepal in 2001 was recorded as 4.2 which comparatively high to some of the neighboring countries in Asia like India. (1.5) Bangladesh (3.5), china(2) and Japan (1)., Crude Birth rate (CBR) of Nepal was declined form 5 present in 200(PRB, 2009)

Fertility is generally determined by the psychological factors and their interplay with social cultural, economic and modernizing factors, societies and population sub- groups

within society's categories by their socio- economic characteristics have different level of fertility. Much more fertility is determined by various socio- economic and demographic variables. Also caste, ethnicity, region , culture women's Education, occupations preference use of contraceptive devices, age at marriage etc. affect the fertility behavior of any groups community. Chamar community is economically backward group and characterized by high fertility. In Chamar community early marriage is persistent mortality (infant and child) rate is also higher in this community compared to other communities).

Chamar is one of the Dalit caste in Hindu society of Nepal Chamar are living in different areas of Eastern and Central tarai region. Among them Chamar of V.D.C Asanpur of siraha district were the subject of the study.

Chamar is fall under Dalit caste or Jarijan so they might have different demographic pattern than that of other caste of Nepal. In this study the researcher has tried to analyze the fertility behavior affected by demographic and socio- economic factors of this community.

The census of 1952/54, 1961 and 1981 have provided information of various Language and regions of the people. None of there census collected information on the caste/ ethnicity of the country. For the first time 1991 census collected information on ethnicity (KC, 1993 P. 143-185), according to population monograph 2003 the total population of Chamar caste 1992 was 2,03919 which was 1.01 percent of the total population and reached 2,69,661(1.19 percent) of total population in 2001.

The Chamar is one of the disadvantageous group in terms of socially, culturally, politically and economically. There migh have the demographic pattern different from other caste/ ethnic minorities of Nepal. So this study tried to examine the fertility behavior and its socio- economic and demographic determinates in this community their

present study is conducted in siraha district where chamar considerably large in population.

Nepal is the country of multi – lingual, multi- religious and multi-cat/ ethnic society. According to census 2001, the total population of Nepal is 2,31,51,423 an annual growth rate 2.24 percent with total fertility rate 4.2 per women . out of 101 casts identified Chamar is one of them . Siraha district is in Sagarmatha zone, which is the mid eastern part of Nepal . its headquarter is in Siraha district is located between 82.02^0 to 82.05^0 longitude and 27.36^0 to 28.02^0 latitude. Siraha district surrounded by Saptari in the east , Udaypur in the north , Dhanusha in the west and India is the south. The total area of Siraha district is 2,95,500 hector there are 106 VDC and 2 municipalities in Sirha district.

1.2 Statement of the problem .

Nepal is a country having a rapid growth of population . as a result various socio-economic and demographic features are affected by various factors. Low literacy rate high infant and child mortality rate, low socio-economic status of women in the society, high economic value of children, traditional son favoring attitudes and practices are some of the significant factors contributing high level of fertility in Nepal, besides, house of contraceptive and limited access to contraceptive devices. Lack of community participation and low motivation in people are also the causes of high fertility in Nepal. Fertility behavior is the complex phenomenon, which may be affected by the social economic, religious, biological behavioral and cultural factors. Therefore, all these factors must be taken into account to explain fertility behavior.

It is obvious that the persistence of high level of fertility is the main cause of the present rapid population growth . therefore, for the control of population explosion the existing fertility rate must be reduced. The reduction of fertility is possible through development of socio-economic statues of people and effective implementation of family planning programs.

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At the early are of marriage is also one of the major factor determinate of fertility. The increasing age at marriage would have decreasing effect on the number of children ever born which ultimately result in decrease fertility level by declining the number of younger women exposed to pregnancy.

According to the Nepal marriage act, 2028 the legal age at marriage for the boys and girls are 18 years and 16 years respectively with the consent of guardians and 21 years for the boys and 18 years for the girls without consent of guardians. it is observed that during the last two decades form 1991 to 2991 the average age at marriage for females increased or 16.5 to 17.5 however in urban areas, there was an increase of more than one year in age at marriage in both sexes during the last two decade from 1991 to 2001,

The social structure of each society is interrelated with specific population levels. It is also closely related to environmental, technological and other material factors which intervene reproductive behavior . Moreover, there are significant caste differentials (Niruala and Shrestha 1997)

Low socio-economic statues of women in the society, high economic value of children, high infant mortality rate, socio- economic traditional favoring son, low literacy rate of women etc. are the some main factors that contribute to high level of fertility in Nepal. Beside the persistence of high fertility is also attributed to the lack of knowledge attitude and practice to contraceptive methods. In Nepal as a whole and special community and also every stage of life, irrespective of caste and ethnic groups has strong cultural stress to cause high fertility (Dahal, 1999).

In Chamar community generally the prevalence of fertility may be high because of their early marriage and their socio- economic , cultural and religious reason .
Contraceptive prevalence may below among Chamar because lack of knowledge about contraceptive use, which is also the factors for prevailing high fertility. Likewise employment also as equal as other variables. The majority of the women of this

community are engaged in household work. The main occupation of Chamar community is laboring like farming wages labour etc.

There are several studies related to fertility behaviour in different ethnic groups but these is no study carried out in this Chamar community". So this study focuses on fertility behavior of Chamar community.

1.3   Objectives of the study.

The general objectives of this study is to examine the fertility behaviour of Chamar community in relation to demographic and socio-economic variables, the following objectives were set as specific objectives:

1.3.1 To identify the demographic and soio-economic status of Chamar

1.3.2 To identify the knowledge and proactive of family planning methods.

1.3.3 To assess the knowledge and proactive of fertility in Chamar community.

1.4.   Research Questions

This study was based on the following research questions.

1.4.1 What are the socio- economic factors that contribute in high fertility behavior of chamr community.

1.4.2 What is the status of current use of family planning methods .

1.4.2. What are the factors associated with the knowledge and proactive of fertility?

1.5   Significance of the Study

The main purpose of the study is to find out the various socio- economic and demographic aspects of fertility prevailing in Chamar community. It is obvious that better understanding of fertility regulating behaviours is necessary in order to have control upon the fertility. The identification of the demographic and socio- economic characteristics of fertility differential among charms would help planner and policy maker for formulating others plants for the developing activities. Besides this study it will be more useful for

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future researches and academicians in their respective filed. The significance of this study are also stated as follows:-

1.5.1   This study will be helpful to know the fertility rate of Chamar

1.5.2   This study will be supportive to find out the socio- economic and cultural situation of chamar.

1.5.3   This study will be meaningful as literature to other researchers for further study in the Fields.

1.5.4 This study will help to study other societies as well.

1.6 Delimit ional of the study.

This study is bases on the sample data collection form siraha district. So , the findings may not be generalized for the other groups of people and throughout the country the determination of the study were as follows.

1.6.1   This study was conducted ward no. 4,5,6 and 7 at Asanpur VDC in siraha district.

1.6.2   This study is delimited Chamr women of 15-49 years of age which have at least one child.

1.6.3   Date were collected through structured and semi- structured interview schedule.

1.6.4   The result obtained form the study may not represent others areas and other communities .

1.6.5   It is a descriptive and quantitative type of study with a specific academic purpose.

1.6.6   This study follows purposive sampling method for selecting the Asanpur and Chamar community and follows census method for the selection of the respondents.

1.7   Definition of the Terms Used

1.7.1   Health Instruction: way of teaching health education is health instruction.

1.7.2   Knowledge: refers to the clear range of information and understanding of fertility behavior change.

1.7.3 Attitude: It reforest to the way of feeling, thinking or behaving the fertility behavior change.

1.7.4 Practice : It means the implementation of concept principle and method of fertility behavior change.

1.7.5 Contraceptive Devices: The preventive methods to help women to avoid unwanted pregnancies. It includes all temporary and permanent methods to prevent pregnancies.

1.7.6 Contraceptive prevalence rate: The number of currently married women aged 15-45 year using any method of contraception method or other wise, per 100 women of child bearing age.

1.7.7 Currently married women : Currently married comprises all those in consensual unions or married, including those who are not currently living but not divorced/ widowed.

1.7.8 Family Planning: Family planning refers to practices that help individuals or couples to avoid unwanted births to bring about wanted births, to regular the interval between pregnancies, to control the time at which births occur in relation to the ages of parent and to determine the number of children in the family.

1.7.9 Population growth rate: An algebraic sum of the natural growth rate(crude birth rate minus death rate) and the net international migration rate, expressed as a percentages.

1.7.10 Total fertility rate: The number of children that would be born to woman if she were to live to the end of her child bearing years and bear children at each age in accordance with prevailing age specific fertility rate.

1.7.11 Reproductive Health : Reproductive health is a state in which people have the ability to reproductive and regulate their fertility , women are able to go through pregnancy and child birth safely

CHAPTER –II

REVIEW OF THE LITERATURE

Fertility is considered as a major component of population change particularly in developing counties. Many scholars have been developed to examine the interrelationship between fertility and socio- economic and other variables which have consequence on reproductive behavior of women in society .

2.1   Theoretical Literature

Most of the developing countries are experiencing high fertility and low mortality resulting rapid population, growth. Nepal is also one of the least developed counties. Where the birth rate is still high and death rate is low to the formation ovaries obstacles and social development. There are various theoretical literatures regarding the study of fertility. The early writer concerned that there exists a trend of having fewer children in higher societies. Later the demographic transition theory and other social , biological theories also supported such views. Several philosophers had initiated several theories related to fertility. The theory of social capillary was first logical attempt at offering an explanation for the decline in fertility during a period of social and economic developed. Arsine dormant pointed out that a fertility must be small in order to rise in the social status.

The theory of diffusion of cultural lag explains how the concept of birth control spread over the world. According to the theory, in countries where fertility has been declining attitudes and practices conducive to diminishing fertility has been adopted first by the better educational environment and basically more favored groups of the city population and transition in the course of time to intermediate and Lowe status groups and to the rural areas (bhende and T. Kanitkar 2008).

In developing countries here fertility was initially high , improving economic and social conditions are likely to have little effect and social conditions are likely to have little effect on fertility, until a certain economic and social level is reached. But if that level is

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achieved, fertility is likely to enter a decided decline and to continue downward until it is again establish on a much lower plain (Bhende and Kaitkar , (2008)

The Un (1997) has attempted to study the relationship between the level of fertility with the various indicator of the level of social – economic development and economic development in bringing about the transition form high to low fertility.

Generally, fertility determined by the physiological factors and their interplay with social cultural , economic and modernization factors also. Societies and population subgroups within societies categories by their socio-economic characteristics have different level of fertility. Much more fertility is determined by various socio- economic and demographic variables. Also cat ethnicity, religion, cultures, women's education , occupation , sex performance m use of family planning devices, age at marriage affect fertility behavior of any groups and community. Being these variables supports that Brahmin, Chetri and Newar have lower fertility than other ethnic group (Risal and Shrestha, 1999)

According to J.C. Caldwell 1997 , " in a society , the fertility is high if children are economically useful to parents and low if children are economically useful to parents and low if children are economically not beneficial to the parents. " Children , in all primitive societies are economically assert their parents and naturally more children mean more wealth leading to high fertility.

Kingsley Davis (1963) propounded a theory in which he attempted to explain the decliner in birth rates in developing countries. It is known that even before the secular decline of birth rates in industrial countries mortality rates had started declining as a result of which the rates of natural increase had gone up . the former points out the multiple phase response to the growing rate of population growth was universal for people form both urban and rural area curtain/ led their growth rates (bhende and kanitkar 2008)

Ronald freeman (1995) , formulated a framework which deals with a normative approached. He suggested that intermediate variables are not always used to limit fertility and often their effect of fertility is an unwanted result of cultural patterns. He introduced tow types of norms or cultural patterns. He introduced tow types of norms or cultural patterns namely, norms about family size and norms about intermediate variables.

Women's education is associated with contraceptive use. There is signification difference in rate of use between wife's and husband's education similarly occupation. Candwell, (1997) claims that even in the transitional society there will be sustained high fertility level which are rational in non- agricultural urban condition as long the flows of wealth is predominantly from the younger to the older generation.

Goldcheider (1992) edited the book explaining in by different writes in various demographic variables like fertility and nuptial migration and fertility, family planning and fertility. Among then Doo sub kim, Philip Guest and Aphichat Chamratri, throng and western demographer focused on demographic transitions involving fertility and development pattern.

Decline in fertility level is attributes to change in family system the larger family tends to keep weak emotional link between husbands and wives a strong link between young children and their biological partiers. On the other hand the small nuclear family has strong emotional bonds and demands greater egalitarian son in family consumption (Caldwell, 1997), As children become more expensive and the return from investment tends to be less rewarding i.e. wealth flows are mostly form parents to children , there is no economic rationale in having a large family (Tuladhar, 1999)

2.2   Empirical Literature

The fertility of any country can be greatly influenced by the pattern of social and economic development . Low level of death and high level of fertility rate are the main factors of population increase in most of the less developed countries like Nepal a critical assessment of fertility level and trends are recognized in Nepal for which several studies on the fertility and its trends has been carried on. This study is concentrated on the fertility behavior in Chamar community of Asanpur VDC, of Siraha District.

2.2.1 Age at Marriage and Fertility

Marriage is a union of two opposite sex (man and women) which provides to keep sexual relationship legally and socially . in Nepalese society it is not allowed to give birth of

children before marriage . so the marriage is most essential even because family formulation starts after the marriage. Thus marriage plays a vital role for determining the fertility lever. Higher age at marriage is directly related to the low fertility of an individual as well as social level. It is observed 13.4 age at marriage for the women with 5 children ever born compared to 17.1 age at marriage for the women with 2 children ever born . the correlation between are at marriage and CEB was found to be 0.4174 in a study in Hill village of western Nepal (Acharya 1993).

Age at entry into sexual union is one of the important determinate of fertility and female age at marriage in Nepal is very low. The 1981 census concluded that by the time women reaches the age 20, half of the Nepalese women are married and 86% of them are married by age 25 years . (plant and Acharya 1998) increasing age at marriage will have decreasing effect on the number of younger women who are exposed to pregnancy (CBS, 2001) the number of children ever born (CEB) tends to decrease with increasing in the age at marriage (plant & Acharya 1988). The report form Nepal family health survey (1996) found that fertility seemed to be declining aver the past five years from TFR 5.09 in 1991 to 4.60 in 1996. this decrease in fertility rate is due to increase in age at marriage and rising contraceptive use over the past 25 years (MHO,1996)

2.2.2   Education and Fertility

 In Nepal considerable increase in the literacy rate for the total population aged 6 years and above have been observed between 1971 and 1991 then total literacy rate raised form 13.90% in 1971 to 39.6% in 1991. the total literacy rate raised form 13.90%in 1971 to 39.6% in 1991 and in 2001 A.D. it is 54.1% .

The male literacy rate increase form 23.6%in 1971 to 54.5% in 1991(CEB 1995. 377.3.78). However, total literacy rate is found 45% above 15 years aged population (CBS,2002) where the female literacy rate 23% and male literacy rate is lower so the level of fertility is high. The national fertility and health survey concluded that the total marital fertility rate (TMMFR) among women with secondary education is 4.0-4 lower than among women with no education 5.03 than for literate (Acharya, 1993).

Nepal family health survey 1996 showed a strong relationship between education and fertility women with at least secondary educational have total fertility rate TFR of 2.5 witch is less than half the rate among the women with on education with TFR of 5% where as women with primary education have TRF 3.78 per women (MOH, 1996). Education has been consider as a catalytic agent to reduce fertility in Nepal. Educated women are more aware of the issue of quality of children than uneducated (Risal and Shrestha, 1999).

2.2.3 Occupation and Fertility

Occupation is one of the socio- economic characteristics that identifies sub- groups with district level fertility professional being the lowest fertility group with farmers and other extreme age of range. Occupation of the husband has been wide recognize as the of the influencing factors of fertility. High fertility is associated with agriculture and mining lower rate of fertility has been associated with professional classes in urban industrial countries. (UN 1993).

The fax sensed to hold true eve in our country. According to Pradhan, Husbands' status of work plays an important role for declining fertility level. For example, women whose husbands were engaged in farming had higher fertility with 3.27 more CEB than of non – farmers with 3.19 mean CEB for women (Pradhan, 1989).

Working women in rural Nepal either works on farms or work of agricultural or wage labor (Dahal, 1992). Hilly women contribute 72% labor time to household production (Pradhan, 1999) and they also follow the high fertility in Nepal. Women in farms works are supposed to have a more children in Nepal. Their status is very low and they lag behind in educational attainment , in over all health including nutritional support in gainful employment patterns and non- sequential experience and almost unrestricted high reproductive behavior.

Generally woman's participating in production activates has significant impact on fertility. Work opportunity for women allow greater female freedom in decision making

encourage higher standard of living for the couple and their children. Most studies in demography have tried to relate women's work and employment with fertility. The constraint of time available for production activities under women's participation in the labor forces. The more children a women has to care for less the time, she can devote for other activities. Therefore, working women are found to be more sensitive about their forthcoming children . they control their fertility behavior by various methods.

2.2.4 Infant and child loss experience and Fertility

Mortality is the permanent disappearance of all evidence of the life. It can occur at any time after the birth. Infant and child mortality is one of the most important factors to determine the fertility , having high infant and child mortality leading the high fertility. The international conference on population and development (ICPD) held at Cairo in 1994" health program is focused on the issue related to reproductive health of women . the ultimate goal of reproductive health is to improve the health status of mothers of new born children so that maternal and infant mortality and morbidity can be redacted one of the pronounced demographic effects of reduced child mortality is the reduction of fertility.

Infant mortality rate is higher in most developing countries like Pakistan(91),Bangladesh (82), India(72) Afghanistan(150), Zimbabwe(80) and Nepal (79) where the fertility rate also higher in those countries. The total fertility rates were 5.6 in Pakistan 3.3 in Bangladesh , 3.3 in India, 6.1 in Afghanistan , 4.0 in Zimbabwe and 4.6 in Nepal in 2000(PRB,2000).
A positive relationship between infant mortality and fertility is found the mean number of CEB by age and martial duration of mother was invariable higher to those women with child loss experiment compared to women with out such experience. It is frequently argued that infant and child mortality experience. It is frequently argued that high info an and child mortality experience of Indic del and couples might affect on fertility (Adhikari , 1998).

2.2.5 Use of family planning and fertility

Family planning program is one of the most effective ways to control the high fertility . there are inverse relationship between use of contraception and fertility. Higher the use of contraception lower the fertility and vice- versa Unfortunately the family planning is not very successful, in developing countries the proportion of women using contraception was 18% and Nepal 29% in 2000 (PRRRB) 2000)

Nepal has the largest rural urban gap in contraceptive prevalence in south Asia. Therefore Nepal where the over whelming majority live in the rural areas have not been able to reduce fertility significantly compared to other southern Asian countries (Especially sri lanka, Bangladesh, India) which would be manly because of the poor level of family planning effort in the rural areas of the country (Pathak 1998)

The percentage of Nepalese women want to stop child bearing has increase substantially form 40% in 1981 to 59% in 1996 ever use of contraception has also increased form 4% of currently married women in 1976 to 27% in 1991 and reached 35% in 1996 (molt 1993) the contraceptive prevalence rate among currently married women was 29% in 1996 with the majority of women using modern methods . Despite these improvement one in three women has an unmet head of family planning (MOH 1996). Literacy is one of the determine factor for increasing use of contraception . wide spread illiteracy prohibits women form the access to information, education ICPD has recommended equal participation of both man and women in decagons making related to number of children Woven though the literacy of women is more catalytic to prolong the spacing and redacting fertility literacy of husband is equally important. More than fourth (26.5%) of the literate women were using contraception in age group 15 to 29 years which his almost higly by 3.7% points that prevalence of women with their.

Literate husbands. Similarly, the highest percentage of use of any method by literate women in Therese ages was observed at 42% 25-29 age group ./ it is also found that a counter illiterate part had sued contraceptive (Acharya, 1993).

2.2.6   Desired Family size and fertility

There is a direct linear relationship between desired number of children and fertility. Which may be related with age and parity of women. The majority of currently married fecund women do not want more children when reach age 30 or over. By that time the majority of them would have 4 or more surviving children and 2 or more serving sons (Tuladhar. 1999)

The developing countries ideal family size is greater than actual family size because of economic constraints. Freedom emphasized in the developing countries the ideal family size is greater than actual because the means of family planning are not fully available but in tradition and reindustrialize society, ideal family size is again greater than actual fertility for women who are physically incapable of achieving heri ideal. There is only one practical alternative to ideal family size which can be used to estimate the number of women who have already had more children than they would have wished and that in family size(freedom, 1959).

Dahal (1999) argued that of a women gives birth to daughter only, it is likely that the husband may marry another women to get a male issue. In other words. M their status of woman is valid and accepted fully the number of the family only when she produces children particularly son.

2.2.7   Income and Fertility

There economic gains form reducing fertility has been positively demonstrated on several studies most of the poorest people prefer more children who provide more working hands to their family and contribute to house hold income. Most of the poor people tend to support high fertility may times high then their rich people.

It shows that women of lower and poor groups tend to more children because of tow resolve. Firstly more children die in infancy and so these women have shorter location and non ovulation period before becoming fecund again and second are they need more

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children to replace the loss. So they continue to bear children up to late age in the context of Nepal the multipurpose household budget survey (MPHBS) conducted in 1988-89) found 43% of rural population and 41.4% at the national level fell below the poverty line more over this survey shows the range of family size of Nepalese poor people were 6.33 to 7.14 and household monthly income Rs. 497 to Rs. 113.1(express in 1988-89) NRB, 1980)

The statement in subsistence agriculture societies main source of income in land a large majority of landowner in the village cultivate land themselves (own operators) therefore their family labor requirement in order to produce on the farm their own fertility will be greater than landless.

2.3 Conceptual framework

Davis and Blake (1995) framework is one of the well- known framework which focused on the institutional mechanisms in society and listed eleven intermediate variables . These variable operate upon individual fertility between the factors biological social, psychological or cultural (Aryal, 1977).

Figure 2.1: Conceptual frameworks for Analysis
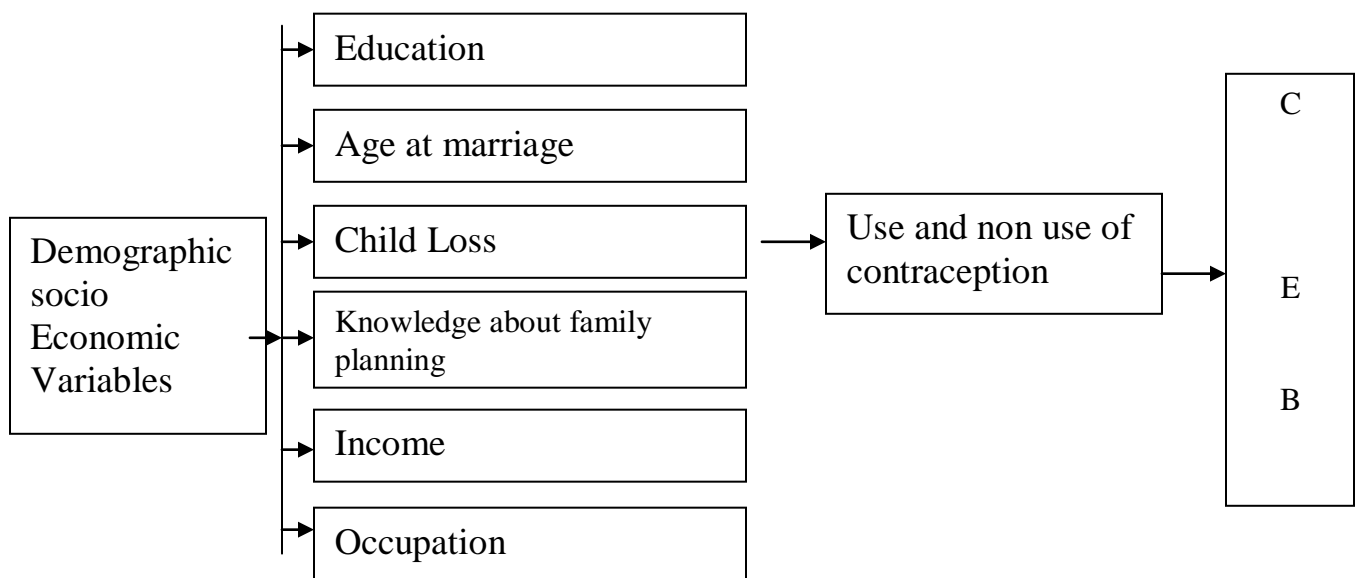
The study of socio-economic determinate of fertility is very complex phenomenon which is justified by the preceding discussion this conceptual framework deals with different socio- economic and demographic variables relating with fertility behavior in chamar community of Asanpur VDC of siraha district. This framework for the study advocates the education, occupation , income, age at marriage, ideal number of children and children loss empiric en affects. The fertility status of chamar community of Asanpur VDCin Siraha District of Nepal.

CHAPTER –III

METHODOLOGY

3.1 Research Design

This is a descriptive and quantitative type of study where data divided form respondents Chamar women 15-49 years having at lest one child) were described with the help of frequency and percentage.

3.2 Population of the Study

This study was conducted in Siraha district which is lies in eastern part of Nepal Siraha district has 106 VDC and 4 Municipalities. According to the Census 2001, total population of Siraha district is 4,62,380,. Out of them 2,28,958 are male and 2,33,422 are female . There are altogether 2500 households and 11,000 population reside in Asanpur VDC. There are 150 Chamar's household in Asanpur VDC amount them the total population of charm is 750 . out of them, there are 360 are male and 390 are female. Out of 390 there're 120 female in reproductive age which is the example size of this study.

3.3 Sample Design and Sampling procedures

The sample size of this thesis depict in table 1. the respondents were Chamar women of reproductive age (i.e. 15-59 years) who have at lest one child. The Chamr community and Asanpur VDC were taken purposively where as the sample were taken by using census method.

Table 1: Distribution of Sample Size

Asanpur VDC	Chamar HHS	Total Population	Male	Female	Sample size (size (reproductive age women having at lest one child) (30.77%)
Ward No: 4	20	100	50	50	14
Ward No: 5	30	150	80	70	20
Ward No: 6	50	220	100	120	38
Ward No: 7	50	280	130	150	48
Total	150	750	360	390	120

3.4   Construction of Tools

For the purpose of data collection, the researcher used mainly the interviews schedule which was developed on the basis of stated of started objectives. The tools were prepared according to the nature and objective of the study.

The interview schedule was semi- structured in nature the interview schedule was divide into tow parts : general information and information regarding knowledge and practice on fertility behavior (see Appendix).

3.5   Validation of Tools

The interview schedule was administered for pretest in 20 married women at Nipaniya VDC of Siraha district for required modification to make them more understandable simple valid and socially acceptable. Supervisor's remarks were also taken into process of validation of tools . pretest was conducted with the help of trained interviewers.

3.6   Data collection procedure

First of the researcher visited the VDC chairperson in charge of health post of Asanpur VDC and head of district health officer (DHO), with a request letter form department of health Education, R.R.T.J.M. Campus Golbazar and explained the objectives and importance of the study.

After getting approval form the VDC and DHO authority, researcher organized the meeting with social leaders, local NGOs and GOs personalities and members of the *Ama Samuha.* Then after the researcher entered in the community and start listing house hold adter listing households m the required respondents (i.e. 120 respondents) were and called using census sampling method. Then the researcher paid door to door visit and collected required data after explaining the purpose of study and making a favorable situation. The views, opinions and behavior express and observed by the researcher during the interview were recorded by keeping a note and it was kept confidential for ethical consideration . their duration of data collection as taken 14 to 20 days..

3.7   Method of Data Analysis and Interpretation

After collecting the necessary data form the respondents possible errors and inconsistencies were removed. The data were processed with the help of computer software program and care fully editor so as to ensure its quality.

The required frequency and table were generated on the basis of collected data and objectives of the study. Furthermore, the information was classified, categorized and sub categorized according to the nature of obtained data the data were analyzed through tables and percentages and they were used for processing , analyzing and interpreting the result . since this is a descriptive study the quantitative information were interpreted and explained in details. Possible discussion was added to clarify the collected information form the respondents. Statistically, mean and percentage were used to describe and explain the collected information after they were organized in table and figures.

CHAPTER –IV

ANALYSIS AND INTERPRETATION OF DATA

This chapter deals with analysis and interpretation of collected data. It highlights on some socio-economic characteristics and knowledge and practice on fertility in community of Siraha district the analysis and interpretation were made on the basis of interview schedule, observed fasts and reviewed literature. The analysis and interpretation of data re arranged in following topics.

4.1   Socio demographic characteristics

4.2   Knowledge and practice of FP methods

4.3   Knowledge and practice of fertility

4.1   Socio Demographic Characteristics

In this segment the socio- economic characteristics such as Distribution of religion, family pattern, status of cultivable land, literacy and educational attainment and occupations stateside discussed.

4.1.1   Distribution of Religion

Nepal was being only one Hindu state in the world before the popular Jana Andolan 11 April 2006. After the controversial proclamation of the reinstated House of Representatives (HOR) of Nepal declared Nepal is a secular state. In Nepal, Nearly 80 percent of the populations are Hindus . Thus, Nepalese society undoubtedly is influenced by Hidnu philosophy. In Vedic period, women were regarded as Goddess. Nowadays women of Nepal in Hidnu society are praised only in religious books but in practice they are not honored(hoshi, 1976). The religious status of the respondents has shown in the table. 2

Table 2 shows that the great majority (86.66%) was belonged to Hindu and rests (13.34%) were belonged to Christian religion. There were none of Islam and Buddhist followers in the study site.

Table 2: Distribution of the Respondents by religion

Religious Status	Number	Percent
Hindus	104	86.66`
Buddhists	-	-
Christians	`16	13.34
Muslims	-	-
Total	120	100.00

The table 2 shows that majority of the respondents were Hindus. In comparison to the national data 80.6 percent of the total populations the Hindus and 4.4 percent represents the Christian (CBS, 2002). Religion also determines various customs, which influence fertility behavior of the people. Marriage, Birth , safe motherhood and fertility behaviour could be influenced by religion of the individual . in other words, existing religious taboo in some societies plays an important role in fertility behavior. For instance in Hindu religion, preference would be given to son and in Muslims religion there is practice of polygamy that mat leads to fertility behavior .

4.1.2 Family Pattern

Family is a fundamental unit of a society. Family is a natural and social unit protected by society and state. Family is a group of person of different aged and sexes related by blows or marriage living under the same root with common provision of food and hearing the functions responsibilities and available resources of the group with each other family members are closely related to each other. Therefore , there is sympathy co- operation and friendliness. If these are problems, they have collectively attempt to serve them and get success eventually (rant et al. 2000) as family is a collective body of people related by blood or marriage . each member in a family should be responsible for MCH and should also assits in solving the family health related problems and its participation and involvement in every sensitive affair can prove to be go great value. The distribution of respondents by the type of family is shown in table,

Table 3 shows that the 68.34 percent of the respondents are belonged to a jog family yet substantial proportions of the respondents were found to have nuclear family.

Table 3: Distribution of the Respondents by Type of Family

Types of Family	Number	Percent
Nuclear	38	31.66
Joint	82	68.34
Total	120	100.00

The above information indicates that most of the respondents are still interest to live in joint family. Fertility behavior of Chamar women depend upon family pattern. A woman who belongs to joint family has higher charges to have good fertility behavior than in nuclear family . it is because they share household works and have leisure time to go for antenatal natal and postnatal care service which have direct effect in fertility behavior .

4.1.3 Status of Cultivable land

The majority of Nepalese people depend on agriculture. Most of the people get foods form their own cultivated land. Thus the main source of income is agriculture. They had got nutritious food from their own cultivated land. It has strong relationship with peoples manly as well as health. So, the researcher is very eager to known about cultivable land status and agricultural dependence which is shown it the table. 4

Table 4: Distribution of the Respondents by status of Cultivable and

Cultivable land	Number	Percent
Yes	73	60.383
No	47	39.17
Total	120	100.00

Above table 4 shows that 60.83 per cent of the respondents have their own land and 39.17 percent had not their won land.

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From the above information we can draw the conclusion that the people who have their own cultivated land consequently have better status of fertility behavior because they can have better economic condition and can afford the health care services . on the contrary the mothers who worked at others cultivated land did not get sufficient food and also they cannot afford health care services.

4.1.4 Literacy and Educational Attainment

Education always plays crucial role in all – round development of the nation. It is an important indicator of civilization for society. Literacy means the ability of reading and wring . those who can read and write are called literate. Literacy is perhaps the most important single means of attaining social and economical development and of opening the individual the door of innovative ideas and actions.

Similarly , education has been one of the most powerful determining factors of fertility because it enhances the personal social economic and poetical development past studies have revealed that fertility rate was low among educated person generally, educated parsons prefer late marriage and they are aware of big family size and use of family panning method use of safe motherhood services as well as STIs, HIV and AIDS . the literacy and educational status of the respondents are shown in table5.

Table 5: Distribution of the Respondents by Literacy and Educational Attainment of Respondents

Educational attainment	Number	Percent
IIIiterate	27	22.50
Literate	43	35.85
Primary	25	20.83
Lower Secondary	14	11.67
Secondary and SLC	8	6.67
Intermediate	2	1.67
Bachelor Degrees and above	1	0.83
Total	**120**	**100.00**

As shown in table 5, out of 120 majorities (77.50%) of the respondents were literate and 22.50 percent were illiterate. Among literates, 35.83 percent were literate without schooling . 2083 percent had competed primary level , 11.67 percent had complete lower secondary level, 6.67 percent had completed secondary and SLC,1.67 had completed intermediate and only 0.83 percent had completed bachelor and above level.

The above information revels that respondents have better educational attainment. The educational attainment of the respondent's amity has positive influence in fertility behavior.

4.1.5 Occupational status

Nepal is an agricultural country where 81 percent of total populations engaged in ago-based occupation (NPC, 1992). Occupational status of husbands and wives and fertility behavior of Chamar women has throng relationship. Many empirical studies have shown that people who have received higher educational attainment are involved mainly in series and some kids of business works. Similarly. Those of lover level are involved in agriculture , wage labor and household works. The occupational status of the respondents in shown in table. 6

Table 6: Distribution of the respondents by Occupational status

Occupational status	Number	Percent
Agriculture	26	21.66
Cottage industry	3	2.50
Service	1	0.83
Business	4	3.33
Agro- based labor	43	35.84
Non- agro- based labor	12	10.00
Household words	31	25.84
Total	120	100.00

The above table 6 shows that majority (35.84%) of the respondents were engaged in agro- based labor. The second and third major occupation of respondents was household works (25.84%) and agriculture 921.666%) respectively. Furthermore, 10 percent were engaged in non-agro based labor, 3.33 percent were engaged in business, 2.5 percent were engaged in cottage industry and only 0.83% is engaged in service.

The above information indicates that most of the respondents have not permanent source of income , out of them , some are low paid employees. Unemployed respondents replied that they had no money for seeking health care services. The researcher also observed that significant number of the respondents busy in Unproductive household chores , low paid jobs and agro- bade labor .they were also busy even in lactating period because most of them have economically backward. Hence , they had deprived form minimum basic needs such as rest , proper diet and adequate emotional support during location period that enhances the risk on health of the mother and child.

4.2   Knowledge and Practice of FP Methods

In this segment, knowledge on FP methods, source of knowledge about family planning and current use of FP methods are discussed.

4.2.1   Knowledge on FP Methods

Contraceptive use is the proximate determinate that has the greatest impact on fertility leaves in modern societies (bombasts and potter, 1983) Better educated women many have more status in the household and therefore have greater authority to speak openly with their husbands about their contractive preference (jejeenbhoy, 1995). Interviewing and analyzing responding response form both parents is an important step toward determining the extent of male involvement in contraceptive method choice and use. In the present study all the respondents (N= 120) were asked about the family planning methods with the assumption that they might have known . the responses are presented in table.

Table 7: Distribution of the Respondents by Knowledge of FP Method

Knowledge of family planning method	NO. Of respondents	Percent
Yes	45	37.5
NO	75	62.5
Total	120	100
If yes		
Pills	3	6.66
IUD	2	4.45
Depoprovera	10	22.23
Female sterilization	13	28.88
Male Sterilization	5	11.11
Condom	9	20.00
Norplant	3	6.67
Total	**45**	**100**

The table 7 Shows that the knowledge of the family planning method, the majority (62.5%) of the respondents were unknown to any kind of family planning methods only 37.5 percent respondents had some kind of knowledge on family planning methods.

Out of 120, only 45 respondents had knowledge on family planning methods . The highest percent of respondents (28.88%) had some knowledge of female sterilization. Only 22.23 percent had knowledge on Depo- Provera and 20 percent has knowledge on condom . Similarly , the respondent's knowledge on male sterilization (11.11%) Norplant and Pills (6.66%) and IUD (4.45%) respectively.

It reveals that almost all of the respondents had knowledge on different contraceptive devices Specially, most of the respondents had knowledge on female sterilization and Depo- Provera.

4.2.2 Source of Knowledge about family Planning

The knowledge about the family planning methods reduces the birth control,. When they were asked the questions about how they get the knowledge of family planning methods. They gave the answer as such which are presented in table 8.

The he table 8 shows the information about the family planning methods. Most of the respondents received information form radio/ F.M. (48%) similarly , Hospital (20%) relatives (16.7%) Health post(8.3%) and others (6.7%) respectively.

Table 8: Distribution of the respondents by source of Knowledge about FP

Source of Information	Number	Percent
Radio/ F.M.	58	48.3
Hospital	24	20.0
Relatives	20	16.7
Others	8	6.7
Total	120	100

It reveals that the most popular source of getting information regarding family planning methods was radio/ F.M.

4.2.3 Current Use of FP Methods

Family planning methods are important for shaping size, prevention of HIV/ AIDS and STIs and birth spacing . A availability of FP service/ devices to the accuses of users have positive effect. A availability of FP service encourages the users and gradually admonishes the hesitation and shyness. The data on current use of FP methods in study are given in 9.

Table 9 Distribution of the respondents by current use of FP Methods.

Current use of FP Methods	No. Of Respondents	Percent
Yes	25	20.84
No	95	79.16
Total	120	100
If yes		
Pills	10	40.0
IUD	1	4.0
Depo- Provera	9	36.0
Female Sterilization	3	12.0
Norplant	2	8.0
Total	25	100

The table 9 shows the status of current use of FP methods by the respondent. Out of 120, 25 (20.84%) of the respondents were found current used of FP methods. The most commonly used method was oral pills (40.0%) and Depo- Provera (36.0%) Followed by female sterilization (12.0%) Norplant(8.0%) and (4.0%) respectively.

The previously mentioned information reveals that the most popular family planning method was pills and Depo- provera.

4.3   Knowledge and Practice of Fertility

IN this segment age at first menstruation (Menarche) age at marriage, they of marriage and current marital status , mean age at marriage and children ever born (CEB) ideal number of children, age at first child birth and child loss experiences are discussed.

4.3.1   Age at First Menstruation (Menarche)

The initial appearance of the menstruation occurs about two years after the first appearance of the pubescent changes . The normal age change of menarche is usually 10-15 years. The responses of the respondents are given in table 10.

Table 10: Distribution of Respondents by Age of Their First Menstruation

Age of First Menstruation	No. of Respondents	Percent
Age<13	38	31.67
Age(14-16)	69	57.5
Age>17	13	10.83
Total	**120**	**100**

Table 10 shows that out of 120 respondents, majority (69) of the respondents' first menstruation was 57.5 percent at the age (14-16) year . Those whose first menstruation was below 13 years were 31.67 percent . Only 10.83% women had their first menstruation 17 and above.

4.3.2 Age at Marriage

Age at marriage of the respondents are the important socio-cultural variables. In our society, marriage is taken as a universal phenomenon that take place in human life. Marriage is also adopted for the continuation of generation. The table 11 shows the age at marriage of the respondents:

Table 11: Distribution of the Respondents by Age at Marriage

Age Group	Number	Percent
10-13	10	8.34
14-16	25	20.84
17-19	70	58.34
20-24	15	12.48
Total	**120**	**100**

Table 11 show that 8.34 percent women are currently marred who are within the age of 10-13 years. Out of the married, only 20.84 percent are fund to be at the age of 14-16 years and, 58.34 percent belong to 17-19 years and 12.48 percent belong to 20-24 years of age. The majority of married women were found in the age group 17-19 years i.e. 58.34 percent.

It is clear that early marriage is prevailing in this community. However, the causes behind it may be the low level of awareness and cultural values. The researcher could not find any one gets marry at the age of 24 and above.

4.3.3 Type of Marriage and Current Marital Status

Type of marriage and current marital status of wives is the important socio-cultural variables. In our society, marriage is taken as a universal phenomenon that takes place in human life. Marriage is also adapted for the continuation of generation. The table 12 shows the type of marriage and current marital status of the respondents.

Table 12: Distribution of the Respondents by Type of Marriage and Current Martial Status

Type of Marriage	Number	Per cent
Love marriage	13	10.84
Arrange marriage	102	85.00
Court marriage	4	3.33
Widow marriage	1	0.83
Total	120	100.00
Current Marital Status		
Together	98	81.66
Separated	2	1.66
Divorced	3	2.50
Husband not at home	16	13.34
Widowed	1	0.84
Total	120	100.00

Table 12 shows that 85 per cent performed arrange marriage i.e. traditional marriage, followed by love marriage (10.84%) , court marriage (3.33%) and widow marriage (.83%). Similarly, highest proportion of couples ' (81.66%) loved together. Furthermore, 13.34 per cent of the respondents' husbands were not at hone, 2.5 percent had divorced, 1.66 per cent had separated and 0.84 per cent of the respondents were widowed.

The above mentioned information reveals that there was trend of love and widow marriage except arrange . This can be the result of early sexual maturity, lack of entertainment materials, influence of modernity etc. The love marriage fosters the early marriage and has higher fertility and risks on reproductive health of women. The widow marriage also increases the fertility rate. These kinds of married couples have low social status in the family and community.

4.3.4 Mean Age at Marriage and Children Ever Born (CEB)

Marriage broadly defamed here to include consensual unions. This was formally recognized as civil or religious unions. In most societies, marriage is considered as the bedimming of socially sanctioned sexual relations and exposure to the risk of child bearing. The mean age at marriage of women in developing countries range from younger than 16 to older than 22 (Singh and Samara, 1996; West off et al., 1994). Among the many social and economic factors that potentially explain these differences in the timing of marriage. Empirical is considered as one of the most important factor to decide marriage time. Empirical studies have found a strong association between education and age at first marriage at both the individual and societal level (Singh and Samara, 1996). The mean age at marriage and CEB are shown in table 13.

Table 13: Distribution of the Respondents by Mean Age at Marriage and CEB

Age at Marriage	Number	Per cent	Mean AM (%)	Mean CEB (%)
Less than 15 years	23	19.16	13.96	2.53
15-17 years	34	28.34	16.39	2.68
18.20 years	54	45.00	19.39	2.57
21 and above years	9	7.50	23.44	2.5
Total	120	100		

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Table 13 shows that in chamar community of 17 Asanpur VDC, age at marriage of respondents were ranged from below 15 to 21 years above. Majority (54%) of the respondents' age at marriage was between 18 to 20 years and by 28.34 per cent of respondents' was in the age between 15 to 17 years. About 7.50 per cent of the respondents got marriage at 21 and above years of age. The entire respondents' mean age at marriage was **17.2 Years. Similarly, there was high CEB (2.68) whose AM was 16.39 years.**

The previously mentioned information reveals that there was trend of early marriage, which eventually enhance the child ever born (CEB), increase size of family and has bad impact on reproductive health of women. This can be the result of low socio-economic status of the respondents, religious and cultural beliefs of family, for the shake of prestige of parents, false beliefs of virginity among males etc. The researcher also observed that one husband has two wives in many households of the study area, which are the main causes of high fertility and poor reproductive health .

4.3.5 Ideal Number of Children

Ideal family size is correlated with number living children . In traditional societies Nepal, parents believe that birth of children entirely depends upon god and fate. The ideal number of sons and daughters in the past days seen very high, but the study shows that future plan to have ideal number of children for the respondents seen to be in around this replacement level. The available information are presented in table 14.

Table 14: Distribution of Respondents by Ideal Number of Children

Ideal No. of children	Number	Percent
0	6	5.0
1	9	7.5
2	60	50.0
3	20	16.66
4	10	8.34
5	10	8.34
5and above	5	4.16
Total	120	100.0

The table 14 shows that highest (50.0%) of the respondents their ideal number of children is 2 followed by 3 child (16.66%), 4 children (8.34%), 6 respondents did mot want to have any child. so, the above table 14 shows the respondents were too conscious about the total number of children, which determine the fertility behavior of the respondents.

4.3.6 Age at First Child Birth

In Chamar community most of the boys and girls marriage at early age. The early marriage has become the supportive factor for the growth of population . There is low literacy rate in Dusadh community. Therefore, they can not understand the causes of population growth. If mot more computation could be faced, lastly it can lead to death. The collected information about age at first child bearing from the stud area has been presented in the following table 15.

Table 15: Distribution of the Respondents by Age at First Child Birth

Age Group	Number	Percent
13 to 16	65	54.16
17 to 19	40	33.34
20 to 24	15	12.50
Total	**120**	**100**

The table 15 shows that large number of women bearing their first child at the age group of above 13 to 16 is 54.16 percent. Followed 33.34 percent at age 17-19 and 12.50 percent at age 20.24

It reveals that most of the respondents had got their first child at the age of 13 to 16 years of age which is considered as early child bearing . Such type of practice increases the fertility age and behavior which eventually increases the fertility .

4.3.7 Child Lose Experiences

The proportion of girls who bear a child before age of 20 varies widely among developing countries. The respondents of this area were no exception for this. Early child bearing of the respondents can shape and alter her entire future life. Adolescence

pregnancy and child bearing have a strong and unwelcome association with low levels of educational achievement for young women, which have negative impact on their position and reproductive health status (UN,1995).

Table 16: Distribution of the Respondents by Child Loss Experiences

Description	Number	Percent
Yes	70	58.33
No	50	41.67
Total	**120**	**100**

The table 16 shows that, in Chamar community of Asanpur VDC, 58.33 per cent of the respondents had experienced child loss during their reproductive age. There was also higher CEB (2.89) in child loss experienced respondents comparing with the no child loss experienced respondents (2.5). Similarly, the mean child ever born (CEB) of entire population was 2.61.

It seems that there is strong association between child loss experience and CEB. The higher the mortality of children the higher the fertility. This can the result or early marriage, low educational achievement, high IMR, preference to son, lack of proper health facilities, health education and increase women's status in family by education them.

CHAPTER – V

SUMMARY, FINDINGS, CONCLUSION AND RECOMMENDATIONS

5.1 Summary

The present study entitled "Fertility Behavior in Chamar Community of Asanpur VDC of Siraha District" specifically word No. 4, 5, 6, and 7 of Asanpur VDC of Siraha district was selected for the study . This study is based on primary data collected form the field survey in November 2009.

There are 150 Chamar's households in Asanpur VDC. Among the total population of Chamar is 750. Out of them, there are 360 are male and 390 are female. Out of 390, there are 120 female in reproductive age which is the sample size of this study. The study area and Chamar community were selected purposively and ample size by census method.

To carry out the study effectively, structures and semi-structured. Interview schedule were used for the purpose of gathering demographic data as well as their fertility behavior .

5.2 Major Findings

The main finding obtained by the analysis of data collected from sample survey were as follows:

5.2.1 Socio-Demographic Characteristics

1. Great majority (86.66%) was belonged to Hindu and rests (13.34%) were belonged to Christian religion.
2. About 68.83 per cent of the respondents are belonged to a joint family.
3. About 60.83 per cent of the respondents have their own land and 39.17 per cent had nit their own land.
4. Majorities (77.50%) of the respondents were literate and 22.50 per cent were illiterate.

   Among literates, 35.83 per cent were literate without schooling 20.83 per cent had

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completed primary level, 11.67 per cent had completed

Lower secondary level, 6.67 per cent had completed secondary and SLC, 1.67 had completed intermediate and only 0.83 per cent had completed bachelor and above level.

5. Majority (35.84%) of the respondents were engaged in agro-based labor. The second And third major occupation of respondents was household works (25.84%) and Agriculture (21.665) respectively. Furthermore, 10 percent were engaged in non-agro- based labor, 3.33 per cent were engaged in business, 2.5 per cent were engaged in cottage industry and only 0.83 per cent is engaged in service.

5.2.2 Knowledge and Practice on FP Methods

1. Jarority (62.5%) of the respondents were unknown to any kind of family planning methods.

2. The highest percent of respondents (28.88%) had some knowledge of female sterilization.

3. Most of the respondents received information from Radio/ F.M (48.3%) Similarly , Hospital (20%) relatives (16.7%) Health post (8.3%) and others (6.7%) respectively.

4. Out of 120,25 (20.84%) of the respondents were found current used of FP methods. The most commonly used method was oral pills (40.05) and Depo-Provera (36.0%) Followed by female sterilization (12.05) Norplant (8.0%) and (4.0%) respectively.

5.2.3 Knowledge and Practice on Fertility Behavior

1. Majority (69) of the respondents first menstruation was 57.5 percent at the age (14-16) years.

2. Eighty five percent performed arrange marriage i.e. tradithnal marriage, followed by love marriage (10.84%) court marriage (3.33%) and widow marriage (0.835)

3. Highest proportion of couples' (81.66%) lived together.

4. Majority (45%) of the respondents age at marriage was between 18 to 20 years and by 28.34 percent of respondents was in the age between 15 to 17 years.

5. The majority of married women were found in the age group 17-19 years i.e. 58.34 percent.

6. Majority (45%) of the respondents age at marriage was between 18 to 20 years and by 28.34 percent of respondents was in the age between 15 to 17 years.

7. Highest (50.0%) of the respondents reported their ideal number of children is 2, followed by 3 child (16.665), 4 and 5 children (8.34%) 6 respondents did not want to have any child.

8. first child at the age group of above 13 to 16 is 54.16 percent

9. about 58.33 percent of the respondents has experienced child loss during their reproductive age.

5.3   Conclusion

Education plays a vital role for determining fertility behavior. It resulted in high fertility because of the charms traditional and religious thinking about family planning . but fertility level among the educated is relatively low in comparison to uneducated.

The study in relation to fertility and marriage concludes that early marriage is the major cause of high fertility. The relationship between age at marriage and fertility were significantly related. So , the early marriage should be discouraged for the reduction of fertility in the study area. It is also necessary to encourage them to use contraceptive methods to reduce fertility.

Higher level of occupation plays an important role to reduce fertility . those women in unorganized sectors had relatively high level of fertility as compared the women of working in organized formal sector. The study shows when women loss her child, she will be motivated to replace her dead child. In this way higher child loss promotes women to reproduce more children. This study comes to the conclusion that the mortality rate of the children and infants should be controlled to reduce fertility rate.

5.4   Recommendations

Based on the Mojor findings and conclusion, following recommendations were made

5.4.1 General Recommendations

1. The educational status of study area was very poor. So, provide education for Chamar community is necessary. Education can be fostered by providing scholarship and quality education.

2. Most of the families were engaged in agro- based loabour to others' field. Therefore alternative employment should be promoted in Chamar community.

3. Since illiteracy is responsible for high fertility, non use of contraception and early marriage and pregnancy. Therefore, it should be eliminated form study area by giving education for all .

4. The C5555hamar community is dominated by so called high caste people therefore; discriminating practices against Chamar should be eliminated form the community.

5.4.2 Recommendation for Future research

Researcher in the days to come are heartily welcome to study on different area of fertility behavior such as :

1. Comparative study on fertility behavior of Chamra and other ethnic group .
2. Socio- cultural impact on fertility behavior.
3. impact of parental education in safe fertility behavior of their adolescents.
4. socio- cultural aspect of teenage pregnancies in Sirha district.

BIBLIOGRAPHY

Acharya , LB 91988) . the effective of child loss in fertility in Nepal. Nepal population journal. Vol. 7 NO. 7.Pp. 8.21.

…………91993). Nuptiality levels and trends in Nepal. In Bal Kumar K.C. (ed) Population and Development in Nepal , vol. 2. No. 3,Pp.15-25

Adhikari, R (1998). Fertility behavior among Chepang: A study of Bhaktikhor VDC of Chitwan District. An Unpublished M.A. Thesis Submitted to Central Department of Population Studies, T.U Kritipur.

Arya , R.H(1997). Theoretical explanation of fertility change . In Bal Kumar K.C.(ed.), Nepal Population Journal Vol. 6, No. 2 Ph 1-2

Bhende A. and Kantikar, T. (1996). Principles of Population studies. Bombay : Himalayan Publishing House.

Caldwell, John C.(1997) persistence of high fertility . Canberra: The Australian University.

CBS(2002) Statistical pocket book, Ramshah path: Central Bureau of statistics.

Dahal D.R. (1992). Determinatts of fertility in Nepal . In Bal Kumar K.C. (ed.) Population and Development in Nepal . Vol. 5 Pp. 1-15

Davis, Kingsley and J. Blake (1956). Social structure and fertility , an analytical framework. Journal of Economic Development and social change vol. 8. No 8, Pp. 95-115

Devkota, B (19990 A handbook of health research methodology, Kathmandu : Buddha Academic Enterprises.

Freedom , R. (1975). Sociology of human fertility. New work: Irkigton Publisher.

Gautam, C.R(2000). FDertility behavior of dusadh women. A case study of Mukundapur VDC in Nawalparasi district. An unpublished M.a. Thesiss Submitted to Central Department of Population Studies, T.U, Kritipur.

Ghimire, D (2004). Female road sweeper's existing knowledge and practices on family Planning Methods in Kathmandu Metropolotan City .An Unpublished M.A Thesis Submitted To Central Department of Population Studies, T.U. Kirtipur.

Jha, Ashok Kuamr (2065), Basic Health and Physical Education , Kath: M.K Publication and Distribution

Karki . Y.B (1995). Fertility behavior of Nepalese Country ,A cAse Study in Charkatirtha DC Lamjung, An unpublished M.A. Thesis Submitted to Central Department of Popualtin Studies.

T.U Kirtipur.

Kattle, K.R (2001) . Fertility behaviour of Kumar community : A cxase study Charktirth VDC, Lamjung An Unpublished M.A. Thesis Submitted to Central Department of Population Studies, T.U Kirtipu.

MoH (1986). Nepal Family health Surcey, 1996. Kathmandu : Family Health Division Department of Helath Service.

MoPE(2002). Nepal Population reprt, Kathmandu: MoPE:

Mudwari, N.R. (2002) Role of husbands in reproductive health of wives in Khairahani VDC, Chitwan District. An Unpublished Master's Thesis Submitted to HPPE Department, FoE, T.U.

Neupane.T.R. (1997). Determinants of fertility among Chamar in Asanpur of Siraha District: An Unpublished M.A. Thesis Submitted to CDPS, T.U.

NFHS(1996) Nepal demographic and health survey . Kathmandu MoH.

Niruala, B.B and Shrestha, D.P(1997) Does cat/ ethnicity matter in futility transition? An Analysis of Nepale data Nepal Population Journal, 6(18-37).

Pandey, N. (2005),Sexual health behavior of Bote and Kami community of Newalparasi District. An unpublished M.A. Thesis Bubmitte4d to CDPS, T.U

Risal, R.P and Shrestha, A. (1999) Fertility and its proximate determinants . Sounth Asia Studies of Population Policies and Programs in Nepal. Kathmandu: UNFPA. Pp. 22-70.

Singh, S. and Renee, S. (1996) Early marriage among women in developing countries international Family Planning Perspectives. Pp. 388-399.

Subedi, G. (1996). Contraception dynamics in Nepal. Population and Development Vol. 4 Kathmandu , Nepal

Thapa N.K. 92004). Knowledge of adolescent on reproductive health and rights. An Unpublished M.A. Thesis Submitted to CDPS, T.U.

Tuladhar, J.M. (1999) the persistence of high fertility in Nepal , New Delhi: Inter India Publications.

United Nations(1997). World population trend and policies. New hour: department of International and Social Affairs.

Wagle, R. (2001). Fertility behabior of Tamang community of Bageshwori VDC Bhaktapur. An Unpublished M.A Thesis Submitted to CDPS,T.U

Wells. E(1997) Involving men in reproductive health, Outlook, Pp. 1-7

WHOW (1999). Health situation in SEAR 1994-1997. New Delhi : WHO Regional Office for South East Asia.

Wilson, C(1985). Dictionary of demography . NY: Ronald Press Bisil Blackwell Ltd.

Wold Bank (1991) . World development report 1991. New York. Oxford University. Press

World Bank (1992). World development report, 1993. New York: Oxford University Press

APPENDIX

INTERNVIEWS SCHEDURE

Fertility Behavior Survey of Chamar Community for Second year Thesis, Central Department of Health, Education 2016.

Name of Respondent:-

Age	:-	Date	:
Occupation	:-	Word No:	:
Religion	:	Education	:

Type of Family : Nuclear / Joint

No. of Children

1. Are you married?

        a. yes   b. No

2. If yo are married, how old were you at the time of your first marriage?

        a. 10-13   b. 14-17   c. 18-21   d. 22 to above

3. What type of marriage have you had?

        a. Love marriage   arranged marriage

        love cum arranged marriage paper/ court marriage

        widow marriage   if other (specify) ………….

4.   What is your current marital status?

        Couples live together   separated

        Divorced   husband is not at home

        Widowed   left by husband

5.   Hove you given birth to any child ?

        a. Yes   b. No

6.   What was your age when your gave birth of first time ?

        a. age ……………………

7. What was your age at first menstruation?

        a. Year …………………….

8. How many children are living with your now?

        a. Song   b. Daughter   c. Total

9.Hoas your husband ever used contraception?

        a. User   b. No

10.   Do you want to use any method in Future?

        a. yes   n. No

11. What are mean children ever born and children positive?

        a. Death   b Live

12. How many children are living with you ?

13. How many members are there in your family ?

S.N	No. of the family member	Relation to HH Head	Age	Sex	
				Male	Female
1					
2					
3					
4					
5					
6					
7					
8					

14. When did you know about family planning methods?

        a. Before Marriage

        b. After Marriage

        c. No . Remember

15. Which of the following methods have you hear?

        a. Pills   b. IUS c. DePo   d. Condom

        e. Male Sterilization   f. Female Sterilization   g. Norplant

16. What is your source of Knowledge about family planning?

        a. Radio   b. Hospital   c. Relatives   d. Health Post

17. Have your ever attended any school ?

        a. yes   b. No

17. What is your educational status?

a. Literate   b. IIIiterate

19. What is the highest grade your completed an your family ?

Level	Male	Female
Literate		
0-5 Grade		
6-10 Grade		
Higher		

20. What is your and your husband current occupation ?

        a. Business b. Daily Wages   c. Service   d. House Hold

        b. Agriculture   .f. Pension   g. Student   h. Security guard.

21. What is your approximately monthly income?

        a. Rs. …………………….

22. Did you hear/ Know about family planning methods?

        a. yes   n No

23. Have you demanded more children ?

        a. yes   b. No

24. How many children have you desired?

        a. son   b. Daughter   c. total

25. Why do o you demand for additional children ?

        a. Husband desire   b. family pressure   c. religious belief.

        d. self interest   d. religious belief.   F. others

26. Are you pregnant Now?

        a. Yes   b. No c. Don't Know.

Pinku Karn