CHAPTER I

INTRODUCTION

This chapter presents the introduction of the family planning and current scenario of family planning worldwide as well as in Nepal. It has discussed the importance of family planning and the factors that affects family planning and women decision on FP methods utilization. It includes the objectives, significance and the limitations of the study.

1.1 Background of the Study

The current world population to date is more than 7,346,284,500 and the most populous countries (in a decreasing order) to date are China, India, United States, Indonesia, Brazil, Pakistan, Nigeria, Bangladesh, Russia, and Japan (UN; 2107). It has been assumed that the total world population will exceed 9.9 billion by 2050; an increase of 3.3% from an estimated 7.3 billion now (World Population Data Sheet, 2016). This increase in population has caused many difficulties, especially in developing countries because it has triggered limitation of resources along with a greater economic burden. In addition, the increased population has also resulted in water shortages along with insecurity of food and energy. High fertility has also increased the chances of health risks for mother and child, leading to poor quality of life, and reduces access to education, food, and employment (Mbizvo et al; 2014).

According to World Health Organization (WHO; 2015), family planning is defined as “Something that allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births "(p. vii). In addition, Family planning also includes education regarding proper spacing and methods (sexuality education), usage of contraceptive measures and other natural techniques for proper spacing between pregnancies and to reduce the number of unintended pregnancies.

The main problem of development in developing countries is rapid population growth. The population and development is related to each other and on the other hand the modernization, improved living conditions, which are the part of the development, can be expected to bring population growth down. Development may

not be possible as long as the current high rate of population growth continues (Pathak, 1998).

Family planning is hailed as one of the great public health achievements of the last century, and worldwide acceptance has risen to three-fifths of exposed couples (Amy 2018). It has been estimated that if family planning services were more widely available up to 42 percent of maternal death could be averted in the developing countries; the mean proportion of maternal death that could be averted is 24 percent (Pathak, 1998). When women have access to family planning, everyone benefits. Women and children are healthier. Families and communities can invest more in education and health care and poverty is reduced. Family planning has the power to save lives, yet 214 million women in the developing world who don't want to be pregnant aren't using modern contraception (WHO, 2015). They may lack access to contraceptive options, may face family or community opposition to family planning, or may be concerned about potential or real side effects. For 65 years, the Population Council has been changing the way the world thinks about voluntary family planning. Today, there is renewed global support for high-quality programs that provide information, services, and contraceptive supplies and the Council plays an important role in expanding access to these programs (Population Council, 2018).

The family planning use in developing countries has reduced the number of maternal mortality by forty-four percent (44%) which is about 270,000 deaths prevented in 2008 but could prevent 73% if the full demand for birth control were met **(**Armah-Ansah et al; 2018). However, simply keeping up with demand at current levels will be a challenge. In 1990, the United Nation Population Found, estimated that the fertility rate among women in the developing world was 3.8 births per women and that the contraceptive prevalence rate (the proportion of married women of reproductive age who practice contraception was 51 percent) (UNFPA, 9091). Having the number of children you want, when you want them, is called family planning. If you decided to wait to have children, you can choose one of several methods to prevent pregnancy. These methods are called family planning method, child spacing method, or contraception (UNFPA, 1991).

There are numerous methods of contraception. According to the Contraception Methods the methods can be categorized as Long-acting reversible contraception

(LARC), Hormonal contraception, Barrier methods, Permanent contraception, Emergency contraception pills and Fertility awareness (NICE, 2005).

Women's fundamental role is a housewife who has to be responsible for house caring and child rearing (Boonto, 2008). The decision-making in family is one of the ways of the female empowerment. Participation in decision-making process in household matters considers that a female is accounted for in the family. In all societies, the issue of women's participation and how they participate economically, socially and culturally is considered to be important. Family decision-making has changed over the last several decades. Changing roles of women, increasing women's education, and increasing participation of women in the labor force are important keys for family decision-making changes (Kiani, 2012). In developing countries, women play a vital role to the welfare of the family. They are basically viewed as the potential mothers and homemakers. Hence, decision-making power of women within the family has been looked upon as one of the important factors which may effect on well-being of the family (Sultana, 2011). The importance of husband wife decision making is well acknowledged by researchers (Corfman, 1987). It has been noted that women active participation at all levels of decision making is important in order to achieve equality and peace in family as well as the country. Despite the importance women participation in family decision-making, in third world countries, women decision making power is limited to some extent (Sultana, 2010).

The empowerment of women has been reported to be a key to using family planning (Do, 2012). In developing countries most partners give inferior positions to women in all aspects of decision-making (Bogale, 2011). Consequently, women are either under collective decision-making with their partners and/or entirely rely on the male partner's decision on issues that affect their contraception usage and reproductive life. In addition to family planning use, empowering women has an important role in the reduction of maternal and new born mortality by preventing unintended pregnancy and unsafe abortion (Family care international, 2005).

In many relationships, men dominate decision-making around family planning and contraception. Family and community members may also play important roles. Those making decisions may not discuss it with others involved. Key reasons for not using contraception include: opposition by a partner, male dominance in decision-making, and misinformation. One study found a positive relationship between

contraceptive uses among men with more equitable attitudes toward women (Herbert, 2015).

Independent decision making or decision making with communications with partners on family planning use has a substantial contribution to the improvement of maternal health (Wado, 2013). Similarly, ensuring family planning access and allowing women to decide independently on the use of family planning is important in preventing unintended pregnancy. Although women will be more benefited from their family planning use by achieving their human rights to health autonomy and decision making on family size, only less than one fourths of the developing countries are able to decide on family planning use by themselves (Carr, 2012).

1.2 Statement of the Problem

Family planning is a major issue for many developing countries where poor maternal and child health care services are practiced. Independent decision making or decision making with communications with partners on family planning use has a substantial contribution to the improvement of maternal health. Similarly, ensuring family planning access and allowing women to decide independently on the use of family planning is important in preventing unintended pregnancy (Abeba, 2016).

Every year, half a million women die of problem from pregnancy, childbirth, and unsafe abortion most of these deaths could be prevent dangers from pregnancies that are, too soon, women under the age 17 are more likely to die in childbirth because their babies are not fully grown. Their babies have greater chance of dying in the first year. Too late - old women face more danger in child bearing especially if they have other health problem or have had many children (Pathak, 1998).

Although, Nepal has invested 15 to 19 percent of its total health expenditure in family planning program, CPR of Nepal is very low as compared to other South Asian Countries. Beside this the knowledge of any modern method of family planning is nearly 100 percent among currently married women of reproductive age (15-49 years), but the utilization of family planning services is low, only 39 percent of currently married women of reproductive age (CBS, 2001). The main trust of national health policy relating with family planning program is to expand and sustain adequate quality family planning services at the community level through meeting the unmet

need of family planning i.e. contraception is increase over the years, instead of having a greater participation of NGOs and INGOs.

Several studies have been carried out in Nepal on use and non-use and knowledge and practice of family planning methods. This type of study done in Nuwakot district shows figure of married women who are currently using FP methods (Sushmita, 2016), data of temporary and permanent FP methods user on eastern Nepal (Uprety, 2106). Other studies on married women household decision (Dev, 2010) and (Marie et al, 2006), family planning knowledge and practice (Mishra, 2014) in Nepal were done previously. However, these studies are carried on different projects and areas. A study done by Sushmita, 2016 is based on the rural area of Nuwakot district and cluster sampling and probability proportionate to sample size was done to select the 109 study sample of 15-49 years married women (Sushmita, 2016). A study by Uprety, 2016 was done in Dhavi VDC of Sunsari district and non-probabilty convenience sample of 300 married women was included in the study. Dev, 2010 use the data from NDHS 2006 and Marie et al, 2016 use NDHS 2001 data whereas, Mishra, 2014 collected data form questionnaires and interviews from the respondents visiting HIV clinics in NauloGhumti Nepal, Kaski. Unlike these studies, our study was conducted in the urban area of the Kaski District and 132 samples were taken by descriptive research design to include all the diversified population from all ages and ethnic group residing in the study area. There is no study conducted in Pokhara Metropolitan City regarding the family planning and decision-making process of family planning. So, this study tried to compile all these factors on the same study focusing on following research questions:

1. What are the factors affecting use and non-use of family planning?
2. What is the scenario of decision-making process on family planning in the community?
3. What is the current status of knowledge and practice on FP?
4. What are the factors that affects decision making?

1.3 Objectives of the study

The general objectives of the study is to examine the factors affecting the status of family planning devices and decision making process in Pokhara Metropolitan City Ward No. 04,. The specific objectives of the study were as follows:

- To describe the knowledge and practice on family planning.
- To analyze decision making process on family planning.

1.4 Significance of the Study

Nepal is a diversified and pluralistic country in terms of ethnic, linguistic, and religious composition. Different groups of populations speak different languages, practice diverse cultures, and follow different religions. Family planning policy of Nepal was implemented in 1958. It was initially organized around vertical structures with central management and logistics and later integrated into other health programs like Expanded Program on Immunization (EPI), human immunodeficiency virus/sexually transmitted infections (HIV/ STIs).

Despite the remarkable progress in FP programs, unmet need is still at 27% in Nepal. Additionally, there is a wide variation in the utilization pattern of FP services across different ethnic groups and geographical regions. According to national level data, although 50% of currently married women were reportedly using FP methods, only 17% of rural Muslim women were found to have used any kind of contraceptive methods (Bogale, 2011).

Being an area of diversified society residing, somehow it can represent the current scenario of the family planning and decision-making process in Nepalese society. Thus, this study attempts to inspect the current status of women education and correlate it with reproductive health and its component family planning in Pokhara Metropolitan City Ward No. 04.

1.5 Limitations of the Study

- This study was limited to Pokhara Metropolitan City Ward No. 04 Kaski district.
- This study was focused on married women only.
- This study was carried out by making different groups of sample.
- This study was focused on decision making process on FP.

CHAPTER II

LITERATURE REVIEW

This chapter deals with the review of the knowledge and practice of family planning and its decision making by married women in different community. It has discussed the relevant literature relating to the factors that affects family planning and women decision on FP methods utilization. It specifically focuses on theoretical review, past studies on the subject in an effort to highlight the relationship of those researches and this research and a review of some of the literature on the variables of the research. The chapter also provides the conceptual framework that shows the relationship between the variables of the study.

2.1 Conceptual/ Theoretical Overview

2.1.1 Decision Making

Decision making is the process of making choices by understanding personal circumstances, considering alternatives, choosing the best option and implementing the decision (Young, 1998).The fact that a woman's power to make decisions may differ across topics implies that while a woman may have considerable power on some dimensions of the family life, e.g., on decisions regarding child bearing, she may have at the same time very little power to decide what friends or relatives to visit,or how much money she can spend in the next day. Such situations suggest that the study of women's power requires one to identify the different spheres of power and to analyze them separately (Casique, 1999). However, it is also useful to present a more general examination of what (or how much) power these women do have and, additionally, to predict what would be a wife's general level of power based on some individual, family and contextual variables. The studies about decision-making in family life show that males usually have power in economic resource. Male soften decide how to manage the general financial affairs of the family. This is what determines the framework of many other aspects of family life. A lot of very important decisions such as financial affairs were only made by husbands. Important decisions like children's education were often made by both. But women were just responsible for decisions which were considered to be unimportant and trivial by both husband and wife for instance, choosing the house interior decorations (Kiani, 2012).

Using a step-by-step decision-making process can help you make more deliberate, thoughtful decisions by organizing relevant information and defining alternatives. This approach increases the chances that you will choose the most satisfying alternative possible. According to Young (1998), decision making in family planning has several steps. The first one is understanding personal circumstance**.** The first step in making and choice about a family planning method is to understand own needs, priorities and reproductive intentions. In this step, he/she need to examine these personal issues and relate how these issues relate to method choice. Similarly, the second is considering alternatives. By relating information about contraceptive methods of own personal situation they can narrow the contraceptive options. They should know about potential side effects or inconveniences. They should consider on the adjusting to side effects, switching to different method or discontinuing contraceptive use and facing the risk of pregnancy. The next step is choosing the best option**.** In this step, they should compare the advantage and advantages of their different contraceptive options. The last step, in this regard, is implementing the decision. Once the decision is made on contraceptive choose, they should take gain information that they need to use the method safely and effectively. They should discuss how to use the method and what to do in case of side effects or other problems arise (pp. 27-29).

The role of women in family planning is vital. When women are empowered, they become active participants in decision-making for their family determining its size, for instance. Enabling women to make informed decisions on whether and when to have children therefore becomes imperative. However, despite the progress made through multiple policy and intervention implementations in the last few decades, there remain some challenges that need to be addressed because for many women in India access to contraceptives is still a problem. A significant number of these women belong to the urban poor population migrants who move from villages to towns and cities in order. Decisions about contraceptive use and childbearing may be confounded by unequal power relations, especially in more patriarchal societies (Andrze, 2008). A Study in Ethiopia by Dennis (1999) showed that because of the male dominance in the culture, women would be forced to bear large number of children. Similarly, the studies in sub-Saharan Africa showed also that secret use of contraceptives among women accounts for between 6 and 20% of all contraceptive

use which indicates problem of decision making power of women on contraceptive use (Biddlecom, 1998).

In many relationships, decision-making around family planning and contraception may not include, or may include to a greater or lesser extent, the potential child-bearing girls and women themselves. Men play a greater role in highly gender-stratified populations. Family (e.g. mothers-in-law) and community members (e.g. elders) may also play a role in decision-making. Those making the decisions may not discuss it with others involved (for varied reasons, e.g. lack of experience, or not feeling comfortable talking about sensitive issues)(Mishra et al., 2014).

A key reason for not using contraception is opposition by a male partner (Nalwadda et al, 2010). Participants in studies in Tanzania (Schuler, et al., 2011) and Uganda (Nalwadda, et. al., 2010) said that using contraception in secret or against the wishes of the husbands could lead to violence or divorce of the woman. A study in the Indian Uttar Pradesh region found 'restrictions on wife's mobility showed significant negative relationship with current contraceptive use' (Mishra et al, 2014).

Schuler, Rottach and Mukiri (2011) explore the role of gender norms in reproductive decision-making and contraceptive use in Tanzania, with six focus groups, and interviews with 60 young, currently married, men and women and 12 older people who influenced family planning decisions. They find that men's dominance in decision-making is a barrier to the use of modern contraceptives. While nearly all the male and female participants held discussions on family planning, the final decision is the man's.

However, they also find that the fear of side effects of contraception might be a more significant deterrent than male-dominated decision making. Most of the male participants who did not use contraception were against contraception as they were misinformed about side effects and feared it would harm their wives. As participants believed family planning to be a woman's job, men rarely sought information from reputable sources on family planning. The women participants also seemed to have similar misconceptions and fears about contraceptive. (Schuler, et al. 2011).

The same research in India found a significant and positive association with current contraceptive use among men who approached decision-making with high or

moderate levels of gender sensitivity and equitable attitudes toward women (Mishra et al., 2014).

On the process of decision making on family planning, counseling plays the vital role to take the action. Family planning counseling is the processes of helping clients make informed and voluntary decisions about fertility. Properly done, counseling help clients make good decision by ensuring that they have the information they need to make decision by helping them apply that information to their own circumstances, and by ensuring that they make their decisions voluntarily (Young, 1998).

2.1.2 Medical Sociology

Here, I have reviewed some theoretical insights related to the theoretical perspectives of medical sociology on health. The theoretical perspective of medical sociology emphasizes on the sociological specialties related to health concern of the society. Medical Sociology is a sub discipline that draws on the methodologies and middle range theories of substantive sociological specialties to elucidate important health, health services organization, and health care utilization issues (Mechanic, 1981). It came of age in the late 1940s and early 1950s in an intellectual climate far different from sociology's traditional specialties. Specialties like theory, social stratification, urbanization, social change, and religion had direct roots to nineteenth century European social thought. In the 1970s and early 1980s, the primary focus of interest within medical sociology was women's health rather than gender and health. Biological differences were emphasized, linked to women's distinctive reproductive system, with social research on the specialized services for childbirth, contraception, abortion, and infertility (Doyal, 1996). There are a number of social dimensions like social gathering, communal participation, co-working, and working for others which can have direct or indirect impact on the health and decision making.

Medical sociology plays important role in determining the health of individuals, groups, and the larger society. Social conditions and situations not only cause illness, but they also help prevent it. Talcott Parsons analyzed that, medical professionals are motivated by factors other than making money, such as caring for their patients. They perform a key noneconomic function by acting in the interests of the whole community, treating individuals specifically for their disease, without

passing judgement on them, and utilizing the best of scientific knowledge. At the same time, Parsons says that medicine is a major institution for controlling deviance in modern societies. It is not just a benign institution based on scientific care, but acts to check the deviant tendencies of individuals, who otherwise might try to escape their social roles (Kevin, 2002).

Medical sociology has not concerned itself with the knowledge claims of medicine. Mechanic's (1981) text book, for example, specifies 15 research areas in the sociology of medicine, not one of which refers to medical knowledge. This absence is characteristic, both of the sociology of health and of medical history, and has four general presuppositions (Wright and Treacher, 1982). First, since medicine and medical knowledge were taken for granted by sociologists, research tended to focus on the achievements of medicine, institutional developments such as hospitals and clinics, and proposed individualistic explanations of social change. In short: great advances, great hospitals and great men (White, 1996). Second, medicine was seen to be part of the natural sciences and granted an epistemologically privileged position. Thus its knowledge claims were not open to sociological enquiry in the same way as those of other professions. As such, both for medicine and the sociologists of it, a key conceptual component followed, namely that diseases were natural objects, and the social contribution to understanding disease was limited to epidemiology. This led to the fourth proposition, that for medicine to advance it had to distance itself from the social. The more abstracted from human relations it became, the more 'scientific', then the better it would perform (Kevin, 2002).

2.1.3 Feminism and Health

The relationships between women, health, and medicine are complex and contradictory. During the second-wave of the women's movement, feminists struggled to bring women's health issues to the fore. Today, their success is documented by the growing numbers of women practicing medicine, and by the increasing attention and resources devoted to women's health issues. Yet feminists remain critical of the highly gendered nature of medicine and its contribution to social inequalities. Feminists working both from within and outside the growing subfield of medical sociology have used one of its key concepts medicalization to explicate the negative consequences of institutional medicine for women. The continuing medicalization of women's lives is related to

key ideas about the body and important trends in the structure of medicine, particularly the growing importance and sophistication of technology (Kevin, 2002).

The argument is made that some instances of medicalization, including women's legal punishment for fetal abuse and coerced sterilization, herald a new medico-legal alliance that impacts the poorest of women most severely. Feminists relate the growth of the public health paradigm of medicine to the emergence of the medico-legal alliance in that both rely on the power of the state and represent the continuing medicalization of women's lives. Based on these insights, the need for a continuing critical and feminist sociological understanding of medicine is stressed and possible lines of inquiry are set forth (Deborah, 2015).

Early in 1970s, Feminist finds a strong connection between medical sociology and feminism. Health and illness was of vital concern to feminists and medical sociology, then in its ascendancy as a new sub-disciplinary field, drew on feminist insight. They shared a common disciplinary project which was to distinguish the biological from the social – in feminist terms, sex and gender – and claim the social as their own (Ellen, 2005). Feminist writers believe that the medical profession and pharmaceutical industries have given a low priority to developing male contraceptive pills which have fewer harmful side effects compared to contraceptives used by women. This shows that society is exploiting women and increase anxiety and stress for women there by suppressing their abilities and making life outside of family harder so that women resume their position as a housewife (Essays, 2018).

In general feminist health sociologists argue that medicine and patriarchy control women by enforcing passivity, dependence and submission as appropriate feminine traits. By focusing on the individual rather than their social location, doctors reproduce the situations that lead women to the surgery in the first place. Treating depression with drugs reinforces the traditional role of women which they are seeking to escape. In this the feminists also point to the role of multinational drug companies, who in their advertising ‘reinforce patriarchal, sexist attitudes, medical authority [and] patient powerlessness’ (Seaman, 1987).

2.1.4 Gender and Health

Sociologists have traditionally distinguished between ‘sex’, which is biologically given in male and female, and ‘gender’, which is the learned social roles that go with being masculine or feminine. This distinction is currently under examination since it is clear that the biological base is itself constructed by social groups and does not exist independently as some fact of nature. However the distinction does allow us to focus on the ways in which being socialized as a woman will affect your experience of health and illness (Kevin, 2002). Early research suggested that while *marriage* was beneficial for men’s mental health it was a negative factor in women’s mental health (Bernard, 1972). There is some evidence now though that marriage is healthy for women, and leads to fewer assaults and to fewer non-fatal accidents (Cheung, 1998). Family roles also appear to be good for women. As Arber has argued: ‘Family roles are important for women; women without children and previously married women have particularly poor health status especially those not in paid employment and living in local authority housing’ (Arber, 1991).

The two consistent findings relating to the health of women are that they are diagnosed as suffering from more ill health and, paradoxically, that they live longer (Kevin, 2002). Women are also over-represented in the health statistics as a consequence of their caretaker roles of children, for taking responsibility for other adults in the household, and for their extended family (Abel and Nelson, 1990). Women’s role as the caretaker of infants and children, especially when they are sick or receiving preventative health services, contributes to the medicalization of women. Some studies point out that women are over-represented in the health system, not just because they are sick, but because child care and birth have been medicalized, and because women are held responsible for the health of other adults in their domestic environment (Prout, 1988).

2.1.5 Patriarchy

Patriarchy is a form of social organization in which a male act as head of the family, household, holding relatively higher degree of power over females and children. In this system, men achieve and maintain social, cultural and economic dominance over females and younger males (Jary, 2000).

In a patriarchal society, women are treated as second class citizens, though there has always been an intricate but invisible bond between men and women. But these bonds never become the bond of humanity but of power most often women are

commoditized in this relationship. From the early part of their lives, they are taught to internalize the patriarchy ideology which is based on male supremacy. According to Ruth (1996), “Women as human being are standard, less intelligent, less moral, less able physically, psychologically and spiritually, small of body, mind and character often load and destructive" (p. 38). It is an assumption to dominate women to decide their fate and to shape their density.

Walby (1990) argued that patriarchy sustained by male domination against women. She also argues that patriarchy is sustained by the activeness of the state which is still patriarchy as well as capitalist and racist although there may have been some limited reforms such as equal educational opportunities and easier divorce laws which somehow protected women against patriarchy.

Patriarchy is the power of the father’s a family, social ideological, political system in which men by force direct pressure or through ritual, traditional, law and language, customs, etiquette, education and the division of labor-determine what part women shall or shall not play and in which the female is everywhere subsumed under the male (Gerdal,1896).

Thus, from the view point of patriarchy, the condition of women in the society is miserable and they are oppressed in the family as well as in the society, especially from the male part. They are limited within the household by making them mother.

2.2 Empirical Review

About two decades ago, much of the world’s attention centered on how to slow down the high rates of population growth that prevailed in most developing countries. When the international community met in Cairo in 1994 at the Conference on Population and Development, there was an emerging consensus that women’s reproductive health is important in its own right and that population control objectives should be integrated with broader social development goals and women’s reproductive health needs. The reproductive health framework of the Cairo Conference touches on issues such as birth control, abortion, sexually transmitted diseases, childbearing and women’s improvement generally (Lane 1994).

Safe motherhood and family planning is a vital component of reproductive health and prime concern with fertility. Women deserve best possible health care to go through a happy and healthy pregnancy and child birth. Safe pregnancy, safe

delivery and safe birth of new born are the major components of safe motherhood. If mother is healthy during pregnancy and after delivery and then, the infant may be healthy. Safe motherhood practice such as regular antenatal checkup during pregnancy, institutional and skilled birth attendants, and immunization of pregnant women against tetanus and early referral of complication can be helpful to reduce maternal mortality. Main objective of safe motherhood program in Nepal is to reduce mortality rate of women during pregnancy, natal and post-natal period (FHD, 1998).

2.2.1 Family Planning

Investing in women's access to and knowledge of family planning and reproductive health services reduces maternal and child deaths. By helping women make informed decisions about where and when to expand their family, Family planning services create healthier households (IMA, 2017).

It is now universally accepted that family planning services are essential for promoting birth spacing to reduce maternal and infant mortality. It has been estimated that if family planning services were more widely available upto 42 percent of maternal death could be averted in the developing countries; the mean proportion of maternal death that could be averted is 24 percent (Pathak, 1998).

2.2.1.1 Global Context

The world fertility survey showed that use of family planning methods varied widely from 69 percent in South East Asia to 11 percent in Africa. The survey also revealed that approximately 300 million couple in the reproductive age range did not want more children, but were not using any method of contraception. These figure indicated a significant unmet need for family planning (WHO, 1995).

According to UNFPA projections, based on the current level of contraceptive prevalence the number of family planning users will have increased by about 108 million by the end of the decade, owing to the growing number of women entering the reproductive age range each year. Moreover, if contraceptive prevalence were to be increased to 59 percent of married women of reproductive age, the number of family planning users would grow by 186 million by the year 2000 (UNFPA, 1991).

As reported in Ethiopia Demographic and Health Survey (2011), early marriage is directly related to education, 27% of young women with no education were married by age 15, compared to just 2% of young women with secondary or

higher education. And as women's level of education increases, the mean ideal number of children decreases, the women with no education have 4.1 children on average whereas women with secondary or higher education have 2.9 children on average.

In Ethiopia, the study on knowledge assessment revealed that most of the men respondents (75%) reported having knowledge on concepts and benefits of family planning methods. About 62 % of male respondents listed two or above family planning methods, while only 14 % of them able to list all the family planning methods used by men, 50 % only one method mainly condom, while 30 % did not know about the family planning methods to be used by men. About 40 % men respondents reported 2 years and above the interval between two consecutive pregnancies, 31 % between 1 and 2 years and 23 % reported above 2 years (Ogunjuyigbe, 2002). The concept of family planning was well known to respondents: 760 (94%) women and 795 (98%) men responded ever having heard of it (Ujuju, 2011).

In Malawi study, all of the participants reported that they were not using contraception before the intervention. After the intervention, 78% per cent of the intervention arm and 59% of the comparison arm reported that they were using family-planning methods with their wives. Of those men in the intervention arm who reported family-planning uptake, 56% reported using condoms, and 41% and 14% reported using injectable and the birth-control pill, respectively (Bayray, 2012).

In the Nigerian study, almost (99 %) of men were aware of the existence of modern contraceptives, and most of them were aware of at least two modern methods. Awareness of the condom was highest (98 %) (Cleland, 2011). The most popular source of information about family planning among them was the radio (93 %) (Ijadunola, 2010).

A study done in rural Uganda revealed that almost 98.1% of married women know about the FP methods and the sources of FP information are health providers, friends, media, husband and so on. The major source of information is health providers i.e., 40.9 % (Stephen et al, 2016).

Contraceptive use by couples in developing countries is very low. This is 6% in Pakistan, 27% in Bangladesh and 43% in India compared to 87% in Japan and China (Park and Park, 2005).

A study in India by Gupta (2014) in slums area of Varanasi, showed that 95% of women had the knowledge about family planning however 62.0% were married before reaching the age of 18. Also, 46.8% of illiterate women had 1-2 year gap between their two children. These results revealed that education as one of a factor which influenced the family planning.

2.2.1.2 Nepalese Context

Nepal, a small country located in the foothills of the Himalayas, shares boundaries with India and the Tibetan region of China. Nepal has a rich cultural heritage, and its society comprises a diverse mix of ethnic groups, each maintaining its own ancient cultural legacy. The predominant religion is Hinduism, though Buddhism is also widely practiced. Matters related to family life, especially marriage and childbearing, are for the most part dictated by traditions and norms, even as the country's development progresses (Mona, 2002)

According to Nepal DHS 2011, Contraceptive Prevalence Rate (CPR) is increased from 39.9% in 2001 to 49.7% in 2011 which is just below the South-East Asia reginal average i.e. 57.5%. This survey reported that Total Fertility Rate (TFR) is decreased from 4.1 in 2001 to 2.6 in 2011. Though the CPR and TFR is increased the adolescent fertility rate in Nepal is relatively high and the second highest, after Bangladesh, in the South-East Asia Region. According to DHS 2011, it stood at 81 births per 1000 girls aged 15–19 years, which although a reduction from 98 per 1000 as estimated in DHS 2006, is still high compared to the regional average of 54. While the median age of girls at first birth is 20.2 years in Nepal, 23% of women aged 25–49 had given birth to their first child before they were 18 years of age, while 2% had become mothers before they were 15 years of age. According to DHS 2011, 17% of women aged 15–19 had either already had a baby or were pregnant with their first child (Nepal DHS, 2011).

A study form Nuwakot district reported that most of the married women have good knowledge of family planning and the main source of information is radio and television (97%). 65.0% of Illiterate women have poor knowledge of FP while 94.1%

of women who have higher level of education have good knowledge. The reasons for not adopting FP methods are because of husband abroad (43.4%), need of child (11.3) and due to side effects (39.6%). (Sushmita, 2016).

A study in eastern Nepal demonstrate that radio is the main source of family planning information and 98% of married women have heard about the family planning. Only 80% of married women have used FP methods and 54.7% of them use injectable (Depo porvera), a temporary FP method (Uprety, 2016).

A study done by Pradhan in 1997 reported that the use of family planning shows a corresponding increase but is still low. In 1996, only 29% of currently married women were using a contraceptive method, including 26% who were using a modern method. Female sterilization was the most widely used method (12%), followed by male sterilization (6%), injectables (5%), condoms (2%) and pills (1%) (Pradhan, 1997).

In Nepal, the legal age at marriage with parental consent is 18 for both sexes and 20 in cases of marriage without parental consent. Despite the law governing marriage, more than half of all women aged 20-24 were married by the age of 18 years and 14 percent by the age of 15. About 42 percent of women aged 15-19 had over been married. However, the mean age at first marriage for women has increased by four years over the last four decades (Human Rights Watch, 2016).

2.2.2 Decision Making

The magnitude of women's decision-making power on family planning among currently married reproductive age women was found to be high several studies. Factors, such as women's and husbands' primary and above education, age category (34–44 years), occupational status of women and their husbands were found to be related with the decision-making power of women on family planning utilization (Abeba, 2016).

2.2.2.1 Global Context

The association of spousal communication with family planning use is widely recognized. Lack of communication about family planning may be associated with misperceptions about a spouse's views on family planning, which, in turn, may inhibit mutual decision-making (Dodoo, 1998).Both male and female can play the role in decision making process, so they both contribute equally on family planning.

A study done in Africa in 2014, Forty-four per cent of men agreed that men should determine family size while 54% disagreed; 29% agreed that men should make the decision about when to adopt family planning while 69% disagreed; 9% of men agreed that men should decide which family planning method to adopt while 88% disagreed; 34% of men agreed that men should decide what to do about an unwanted pregnancy while 64% disagreed (Marius, 2014).

In Nigeria, consistently, less than a quarter of men individually initiated discussions on such issues as when to achieve pregnancy, when to avoid pregnancy, and the use of contraceptives in the year prior to the study (Ijadunola, 2010). More than half (56 %) of men, in Ethiopia reported no discussion with their wives on related issues of family planning use and believed that it is a natural process and need not to be discussed. However, 44 % believed that discussion on these issues should be always initiated in the family. Similarly, 78 % of them reported that decision were generally taken jointly with wife, while 21% felt that all decision related to family planning should be taken by wives alone. Another 12 % felt that elder family members and relatives, external power should decide (Ogunjuyigbe, 2002).

A study done in Zambia in 2014 examine the effect of joint contraceptive decision between spouses and found that 2/3rd of the married women made joint decision regarding family planning. The utilization of family planning methods may be affected by wealth of the family. They reported that women from poor family had the lowest (22%) use of FP methods (Namuunda, 2014).

A study from India in 2017 found that 62% of women use FP methods. The study showed 61.2% of unemployed and 54.5% of professional women took decision and use FP methods. Occupation of women had not significant relation with FP acceptance. Also, 69.9% of illiterate women don't decide on using FP methods and found the significant relation between education and family planning utilization (Vijayasree, 2017).

2.2.2.2 Nepalese Context

Regarding the context of Nepal, women are still backward from different perspectives despite the introduction of several rules and regulations, plans and policies to increase the women literacy rates, this may lead to the lesser activeness in decision making process as compared to their husband. More recently, the

government has come to realize that women can play a more important role in making decisions regarding the family planning and the development of the country as a whole. The government has taken legal steps to improve the lives of women throughout the country

Fact Sheet, Nepal (2008) found that in Nepal, several reproductive health problems can be seen in the urban and rural areas for example, early marriage, teen age pregnancy, unsafe abortion, high maternal mortality etc. Nepal's adolescent population (aged 10-19 years) is approximately 6.3 million while the population of young people is about 8.8 million. About one fourth of the total population consists of adolescents. Likewise, the legal age at marriage with parental consent is 18 for both sexes and 20 in case of marriage without parental consent. Despite the law governing marriage, more than half of all women aged 20-24 were married by the age of 18 years and 14 percent by the age of 15. About 42 percent of women aged 15-19 had over been married. However, the mean age at first marriage for women has increased by four years over the last four decades.

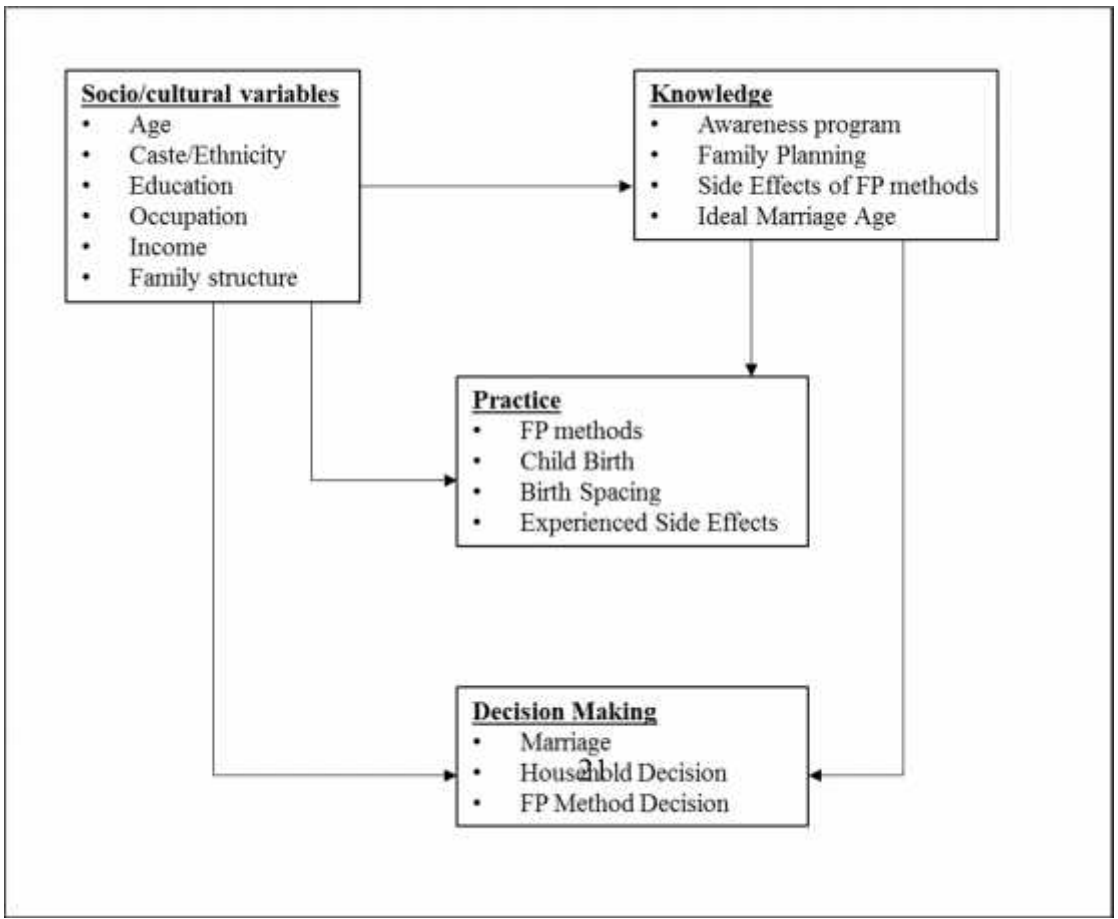
From a study carried out by Mona Sharan in 2002, 80% of women discuss family planning with their spouse; 54% had done so within the past year. The vast majority of women i.e.; 81% reported that their husband made a decision of family planning, but this proportion having a family planning discussion in the past year were lower because women knew their husband's desired number of children. The use of family planning methods is higher in which the wife made family planning decisions (60%) and those in which the husband made decisions (58%). This shows the important role of women in couple to take the use and non-use of family planning methods (Mona, 2002).

A study done by Dev et al. (2012) in Nepal, had analyze the household decisions making ability of the married women. They reported several factors like age and number of living children, employment, residence, ecological zone, socioeconomic and development region can influence the decision-making process of married women. They found that the married women with higher education level participates more in the decision making, 55.8% women with SLC and above/ higher education participate in decision of her own health care, 60% women on major household purchase, 65.4% women in daily household needs (Dev et. al, 2012).

Another study done in Nepal showed that Women's education had a strong, positive association with the family planning. The family planning utilization is higher in urban i.e., 79%. The decision making and use of family planning is higher in the educated women (60%). 50% of the women use to discuss about FP with their husband. Husband occupation showed significant differences in discussion and decision on using FP methods while women's occupation does not show (Marie, 2006).

Taken together, most of the researches have tried to relate the social factors like age, gender, ethnicity, occupation, income and education on use of family planning. Previous studies show the sources of information and utilization of FP may be vary on different geographies. Some of the studies have done on the FP decision making by married women which showed the education, occupation, women family background can influence the decision-making process on use and non-use of family planning. However, these kinds of studies have some between the relation of knowledge and practice of family planning and household and family planning decision making ability of married women on different ethnicity and education level of married women. Similarly, decision making on FP methods can be affected by marriage age, child birth, birth spacing and side effects experienced by methods. So, I (researcher) tried to include these all factors on this study to fulfill this gap.

Figure 2.1. Conceptual Framework



The above conceptual framework has incorporated the major variables to be addressed in this study. The most of the variables relate to the social factors like age, gender, ethnicity, occupation, income and education on use of family planning. Previous studies show the sources of information and utilization of FP may be vary on different geographies. Some of the studies have done on the FP decision making by married women which showed the education, occupation, women family background can influence the decision-making process on use and non-use of family planning. However, these kinds of studies have some between the relation of knowledge and practice of family planning and household and family planning decision making ability of married women on different ethnicity and education level of married women. Similarly, decision making on FP methods can be affected by marriage age, child birth, birth spacing and side effects experienced by methods. So, in this study, the researcher focused on family planning decision and the knowledge and practice of family planning of the married women to fulfill the gap in the research literature.

CHAPTER III

RESEARCH METHODOLOGY

This chapter provides a systematic way to solve the research problem as well as to attain the objective of the present study. The procedure or methods that have been used to obtained the objective and evaluate the facts are given below:

3.1 Research Design

The design of this research study is basically exploratory and descriptive. It is based on field study methods, in which the researcher herself collected data. The knowledge, practice and decision making of family planning methods were measured by age of women, occupation of women, literacy status of women, behavior of husband, and many more. Descriptive research was done to provide an accurate description of observations of phenomena which deals with "what" question. The descriptive research design was used to assess the opinions, behavior of a given population.

3.2 Rationale of Selecting the Study Area

Pokhara Metropolitan city ward no. 04 was selected for the area of the study. Pokhara is the provincial capital of Gandaki Pradesh and headquarter of Kaski district where multiple ethnic and religious people live. The area of the study has diversified settlement of population in terms of ethnicity, religion, and culture which may represent the culturally rich country.

3.3 Universe and Sampling

The universe of the study was Pokhara Metropolitan city ward no. 04. Married women of age 15-49 years were taken as the population for the study and they were questioned to get the exact information for the study. There were only 247 households in the study area and 195 married women, where I questioned to 132 married women of the age up to 49 years old. The respondents were selected according to non-probability convenience sampling method.

3.4 Nature and Source of Data

The study was based on both primary and secondary data. Primary and quantitative data are mainly taken in the study. The primary data were collected through interview using a well-structured questionnaire. In order to collect information for the research, self-admi questionnaire was used and those lists of questionnaires were distributed directly among the respondent. The study period for data collection span over period of two weeks. The questionnaire are translated to Nepali language and distributed to the respondent for their convenience. Similarly, secondary data were collected from the related previous published and unpublished researches, thesis, journal articles, reports etc.

3.5 Technique of Data Collection

Data was collected by using interview schedule. The schedule included the questions related to family planning and decision-making on family planning. The data collected were authentic and biasness. The interview schedule consists of only married women aged 15-49 years. The respondents were selected by using non-probability sampling method, i.e., convenience sampling strategy. The data were collected through the interview.

3.5.1 Interview Schedule

Well-structured interview schedule was developed to conduct with individual married women of the study area. Likewise, unstructured interview that facilitates the research was also conducted. The interview was conducted with key informants and the interview schedule was constructed with the help of different variables like age, sex, occupation, caste and level of education. The questionnaires were translated in the Nepali language during the time of interview.

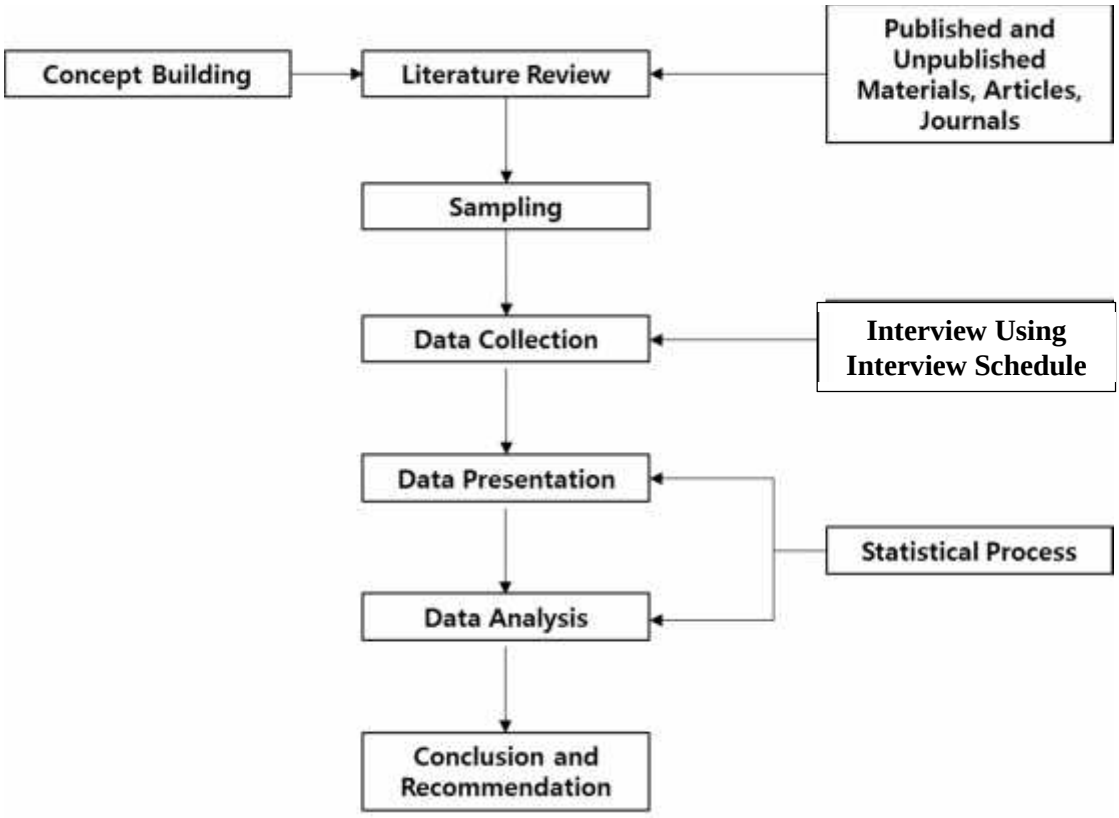
3.6 Data Processing and Analysis

The collected raw data were checked and verified manually in the field to reduce possible errors. Then the data were analyzed descriptively. Quantitative data were presented in terms of percentages. The analysis process of the data includes frequency tables and cross tabulation, which are consistent with objectives. All the information acquired were uniformly and correctly entered and tabulated. The analysis had been done by simple statistical process and procedure with the help of calculator and MS excel and represented in percentage.

3.7 Ethical Considerations

In this research study, issues relating to the ethical conduct of research such as informed consent, confidentiality, privacy and anonymity were upheld. According to Saunders et al. (2009), ethics is the norms or standards of behavior that guide moral choices about our behavior and our relationships with others. Participants and respondents were given full information on the purpose and objectives of the study in order for them to make informed decisions as to whether to partake or not. Moreover, all information concerning the identity and personality of respondents were treated with utmost confidentiality. Additionally, all information gathered was used for the sole purpose of this research study. Choices about our behavior and our relationships with others. Participants and respondents were given full information on the purpose and objectives of the study in order for them to make informed decisions as to whether to partake or not. Moreover, all information concerning the identity and personality of respondents were treated with utmost confidentiality. Additionally, all information gathered was used for the sole purpose of this research study

Figure 3.1. Flowchart of the methodology for this research work



CHAPTER IV

SOCIO DEMOGRAPHIC PROFILE OF RESPONDENTS

This chapter provides some socio-economic and demographic characteristics of respondents in the study area. Socio-economic characteristics provide the education level of respondents, occupation, caste, and religion and families source of income. Demographic characteristics deal with age and type of family.

4.1 Age of Respondents

Age is one of the important factors to be considered while analyzing the decision making role on family planning services among married women of age group 15-49 years. As already defined women of reproductive age are the age between 15-49 years, therefore, the age bar should be considered strictly.

Table 4.1 : Distribution of Respondents by Age

S. No.	Age of women	No. of respondents	Percentage

1	15-19	3	2.27
2	20-24	13	9.84
3	25-29	31	23.48
4	30-34	39	29.54
5	35-39	33	25.00
6	40-44	9	6.81
7	45-49	4	3.03
Total		**132**	**100.00**

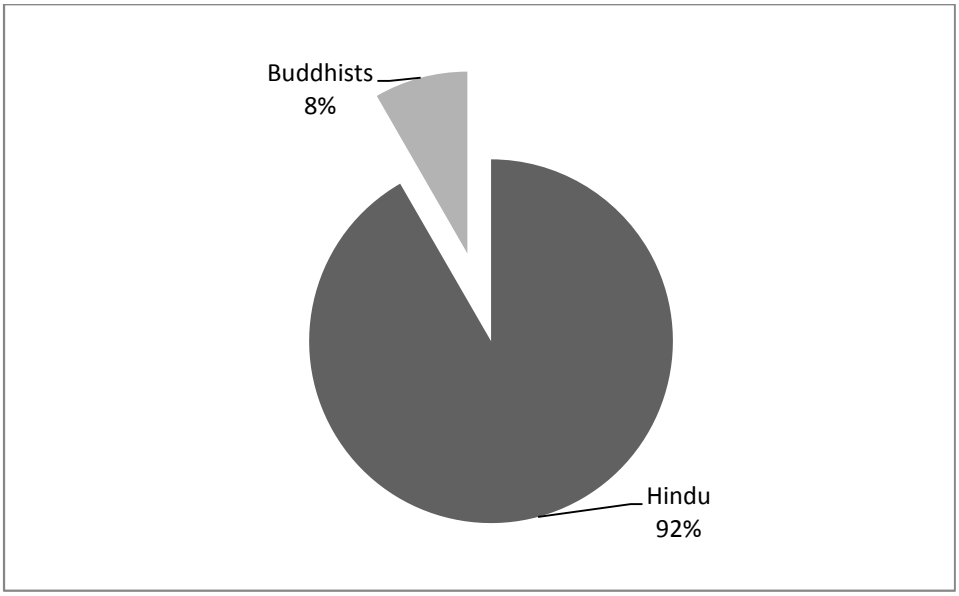
Source: Fieldwork, 2021

The age distribution of married women of reproductive age is presented in Table 4.1. shows that highest in total 29.54% women were aged 30-34 years followed by 25 % who are 35-39 years, 23.48 % are aged 25-29 years, 9.84 % women are aged 20-24 years, 6.81% women are aged 40-44 years and 2.27% women are aged 15-19 Similarly, only 3.03% women are in age group of 45-49 years.

4.2 Religion of Respondents

Religion describes the beliefs, values, and practices related to sacred or spiritual concerns. In recent years, particularly after the onset of multi-party democracy in Nepal, religion has become a sensitive topic in ethnically diverse Nepali society. The following figure shows the religious structure of the respondents:

Figure 4.1. Distribution of respondents by religion



Source: Fieldwork, 2021

Above figure shows the religion of married women. It shows that in this study area overall 92 % women are Hindu, and only 8 % women are Buddhist.

Nepal was previously Hindu country so the majority of population more than 80% are Hindu nationwide. Similarly, in the research area also majority of the population believe in the Hinduism. Most of the mountainous region population follow the Buddhism however the migration of the population may change the status. So here in the research area also Buddhists are very lesser on comparison to the Hindu.

4.3 Literacy status of Respondents

Literate person is defined as a person who can read and write and perform simple mathematical calculations independently. Nowadays awareness of education is increasing in the whole nation and government is also conducting various program for the women education so most of the respondent are literate.

Table 4. 2: Distribution of Respondents by Literacy

S. No.	Literacy Status	Number of Respondents	Percentage
1	Literate	125	94.69
2	Illiterate	7	5.30
Total		**132**	**100.00**

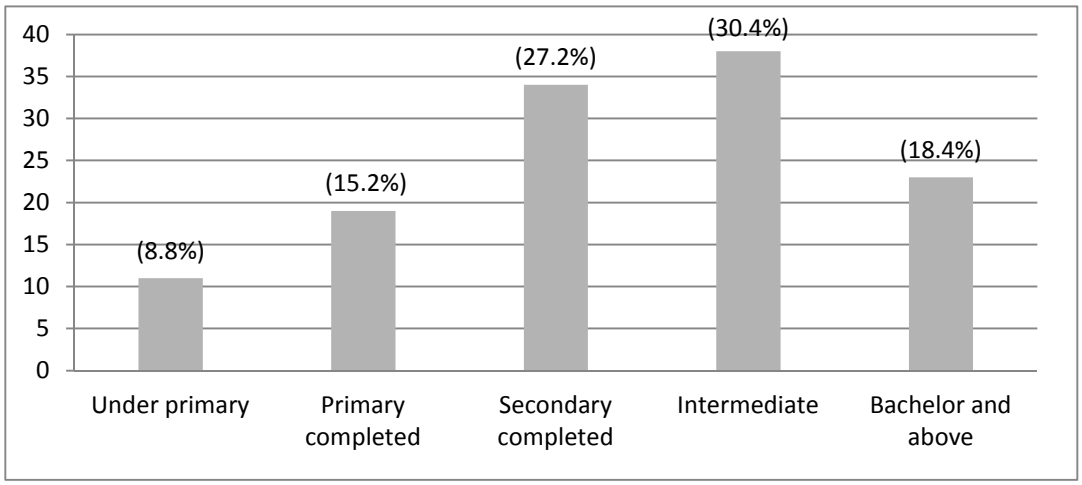
Source: Fieldwork, 2021

The data for literacy status of the married women is presented in Table 4.2 About 94.69 % women are literate while only 5.30% women are illiterate in this study area. The selected area of the study is the urban area of the Kaski district. Since the district is already declared literate, most of the population here are literate. However, the illiterate people are from old age and women.

4.4 Education of the Respondents

Education is the backbone of an advancement of society and developments. Education plays vital role in every field. Women's education plays dual role in her family i.e. for herself and her children. The structure of school level education with primary education of grades 1-5, secondary education of grades 6-12, and remains in practice. The long term goal of the government as indicated in the Ninth plan document has already integrated the higher secondary education (grade 11 and 12) with the secondary level education.

Figure 4.2. Education level of respondents



Source: Fieldwork, 2021

Above figure shows the educational attainment of the literate respondents. Out of the total 125 literate respondents 38(30.4%) respondents have intermediate level, 34 (27.2%) respondents have completed secondary level, 23(18.4%) respondents have bachelor or above education and 19(15.2%) respondents have primary level education. Only 11(8.8%) respondents have under primary education in the study area. In our study, we categorized the education level as by Nepal education system. Those below the grade 5 is categorized as under primary, those who completed grade

5 is categorized as primary completed, who completed grade 10 only is categorized as Secondary completed, Intermediate for those who studied 11 and 12 and rest are those who studied Bachelor and above.

Because the literacy rate is also higher in this study area only some of the older and low income group are under primary education. Nowadays, most of the houses have good income and women education awareness program women education level is increasing. Education also plays the role for the better security of life so women herself are also completing their formal education before marriage, or they continue their education after marriage also.

4.5 Occupation of Respondents

According to International Labor Office guidelines, occupation of economically active persons are persons who engaged or intent to engage in the production of goods and services included within the boundary of production of the system.

Table 4. 3 : Distribution of Respondents by Occupation

S. No.	Occupation	Number of Respondents	Percentage
1	Self-employed	33	25.00
2	Government services	2	1.51
3	House wife	66	50.00
4	Private services	19	14.39
5	other	12	9.09
	Total	**132**	**100.00**

Source: Fieldwork, 2021

Table 4.3 presents occupation of married women. Data shows that most of the respondent reported their main occupation as household activities i.e. 50.00%. The share of private services is 14.39% among the occupational categories considered, 1.51% women are engaged in government services, while 25.00% women are self-employed, 9.09% women are engaged in labor on daily basis earning in the study area.

In this area most of the married women are dependent to their husband so they do only household jobs, like cooking, taking care of the children, etc. Though the

educations of the respondents are higher, nominal numbers of the married women do the job in private sector. Private sector and self-employment will pay higher so this may be the reason that more respondents are doing job in private sector and they are self-employed.

4.6 Caste and Ethnicity of the Respondents

Caste is a form of social stratification characterized by endogamy, hereditary transmission of a style of life which often includes an occupation, ritual status in a hierarchy, and customary social interaction and exclusion based on cultural notions of purity and pollution. Basically, Caste is the hereditary classes of Hindu society. The summary of the caste of the respondent in the survey is highlighted below:

Table 4.4: Distribution of Respondents by Caste

S.N	Caste	No. of Respondents	Percentage
1	Brahmin	43	32.57
2	Chettri	39	29.54
3	Janajati	31	23.48
4	Dalit	19	14.39
	Total	**132**	**100.00**

Source: Fieldwork, 2021

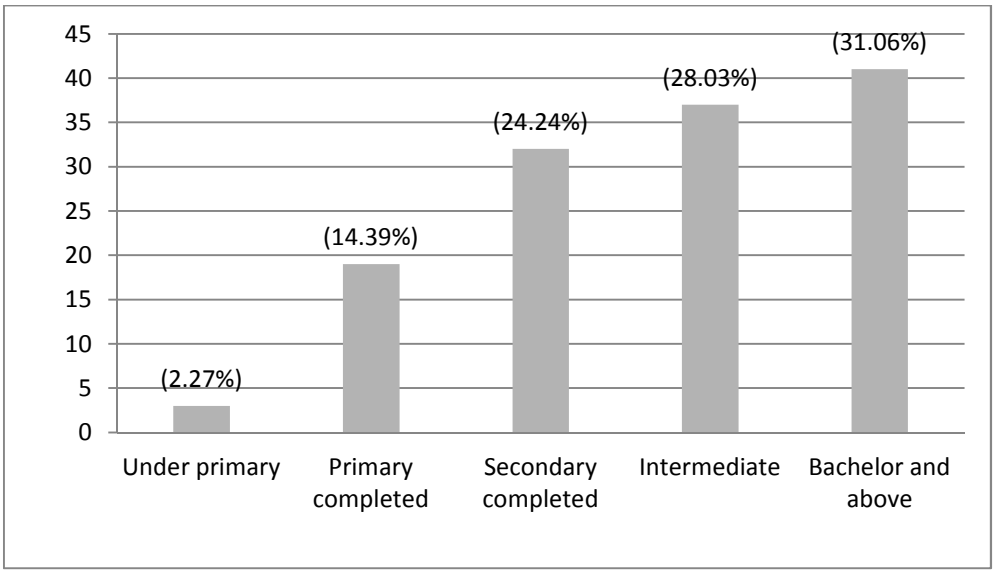
Table 4.4 presents distribution of caste of the respondents. Table 4.4 shows that most of the respondents i.e. 32.57% are Brahmin followed by Chettri with 29.54%. Similarly, 23.48% belong to Janajati and Dalit are 14.39% in the study area.

Brahmin and Chettri are the local caste of the area while other are immigrant in this area. Though they are new the populations are increasing nowadays due to the better opportunity in the city area. Due to the better opportunity and facility nowadays more people are settling in this area also so the distribution of the caste may have variation yearly.

4.7 Academic Qualification of the Respondent's Husband

Education may give a degree in engineering or psychology, but if someone has little to no life skill or common sense, they will have problems with simple day to day issues and other tasks. Husband qualification also plays important part in the marriage life. Generally, if the husband is better educated the marriage will be happier.

Figure 4.3. Education level of respondent's husband



Source: Fieldwork, 2021

Above figure shows the educational level of the respondent's husband. Out of the total 132 respondents' husband 41 have bachelor level and above education, followed by intermediate, secondary and primary level completed i.e. 37, 32, and 19 respectively. Whereas 3 respondent's husbands are under primary level Universities and colleges hugely affect education status of the nearby population. Since the Prithvi Narayan campus is near to this study area must of the people education level are bachelor and above. Some of the respondent's husbands are continuing their study after marriage also. However, studying is directly related to the earning of the family so the group with lower income source could have quit their education and join for the household earning. Similarly, the immigrant family who came here for the better lifestyle may not have the schools and colleges near before so they may have lack of higher education.

4.8 Occupation of the Respondent's Husband

Husband's occupation is a crude measure of social class. The standard expectation is that the wives of agriculturalists will have the highest fertility, while women married to men in higher status, white collar occupations will have the lowest.

Table 4.5: Distribution of Respondent's Husband by Occupation

S. No.	Occupation	Number of Respondents	Percentage
1	Self-employed	45	34.09
2	Government services	6	4.54
3	Private services	41	31.06
4	Foreign Employment	19	14.39
5	Others	21	15.90
	Total	**132**	**100.00**

Source: Fieldwork, 2021

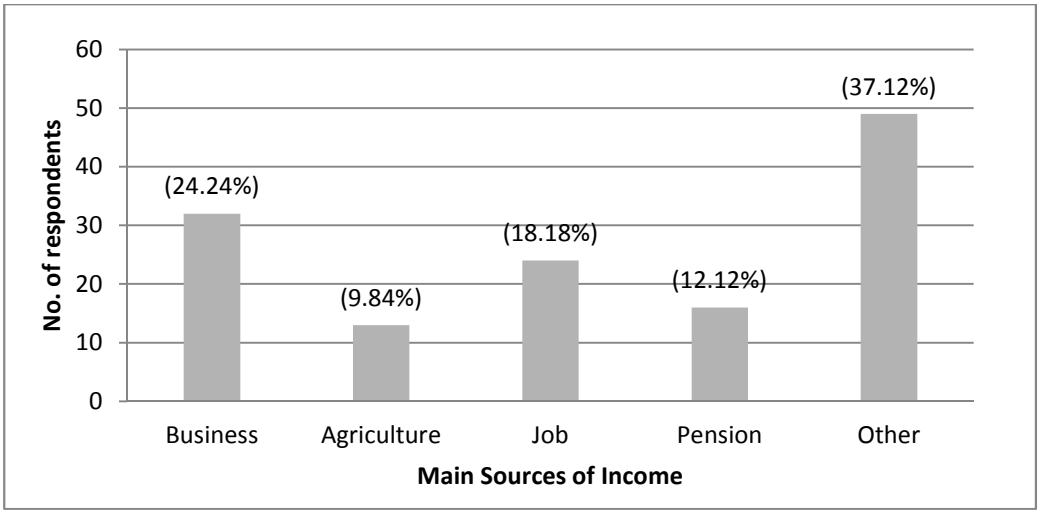
Table 4.5 shows, highest number of respondent's husband i.e. 45 (34.09%) are self-employed. Similarly, 41(31.06%) are engaged in private services and 6(4.54%) are engaged in government services and 19(14.39%) are in foreign employment. However, some of the respondent's husband are labor, pension etc. are classified as others i.e. 21(15.90%).

The study area is the Pokhara city and most of the household rely on the husband income, must of the respondent's husband are self-employed and engaged in the private sector. The Pokhara city is also the famous tourist place in the country so the population also have chosen their occupation on tourism sector.

4.9 Main Income Source of Family

This study shows the different type of income sources that are found in course of sampling population. Main sources of income in family are Business, Agriculture, Job, Pension and others.

Figure 4.4. Distribution of main Sources of income in respondents by household



Source: Fieldwork, 2021

Figure 4.4 shows that 32(24.24%) of respondent's family main source of income is Business whereas, 24(18.18%) are job, 16(12.12%) are pension and 13(9.84%) are in Agriculture. However, some of the respondent's family main sources of income are foreign employment, labor, house rent etc. Which are classified as others in this study and the number is 49(37.12%)

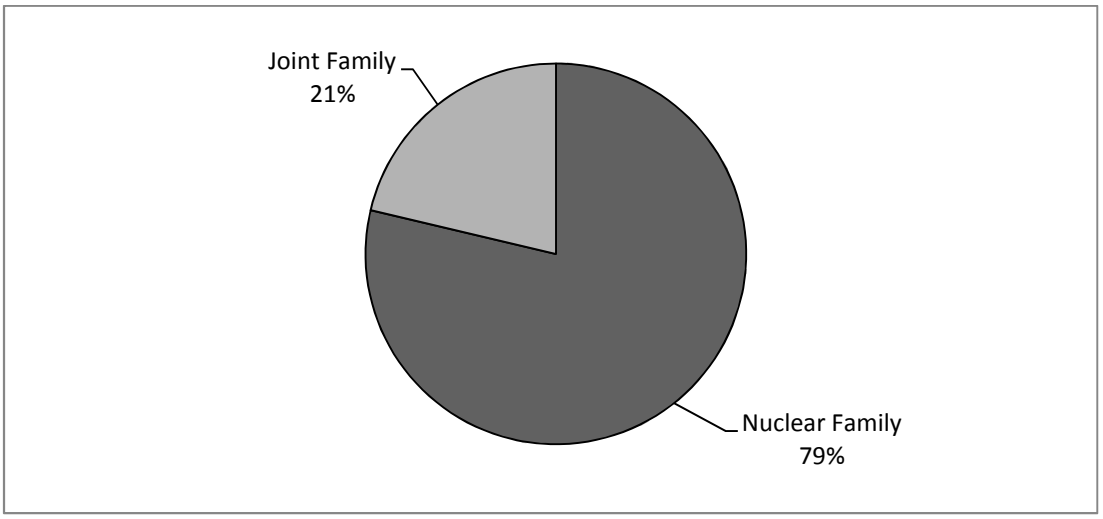
Nepal is the agricultural country, despite of this due to lack of land and agricultural facility lesser number of populations do agriculture for their household activity. The area of the study is urban area so the most of the household they prefer to do their own business for their daily income. This area is also known to produce national military as well as foreign military so the job salary and pension after the retirement also can be seen as main income source on some of the houses. Other income sources of the income are the daily labor, foreign employment, the saving money of the abroad students, etc.

4.10 Family Structure of Respondent

A joint family is considered bigger compared to a nuclear family because a joint family includes grandparents, uncles, aunts, cousins, and in-laws, aside from the typical mother, father, and children. However nuclear family is small. A lot of people also prefer a nuclear family. One of the reasons that a nuclear family is ideal to them is because there are less issues happening within the household compared to a joint family, wherein there are many personalities that you need to get along with. In joint family the important household decisions are taken by elder member. Nuclear family has more freedom compared to a joint family. The reason for this is maybe there are

more adult supervision and more rules to follow in a joint family. The family structure of the respondents has been given in the figure below:

Figure 4.5. Respondents Family Structure



Source: Fieldwork, 2021

Figure 4.5 shows majority of the respondents live in nuclear family while only 21% of respondents live in joint family.

Many believe that a nuclear family is the best arrangement, yielding numerous advantages especially freedom from their parents and financial stability. While the reasons behind the joint family may be the poverty, traditional culture and to enjoy the company of each other. One of the factor for choosing joint or nuclear family may be the education of the couple.

CHAPTER V
KNOWLEDGE AND PRACTICE OF MARRIED WOMEN ON FAMILY PLANNING

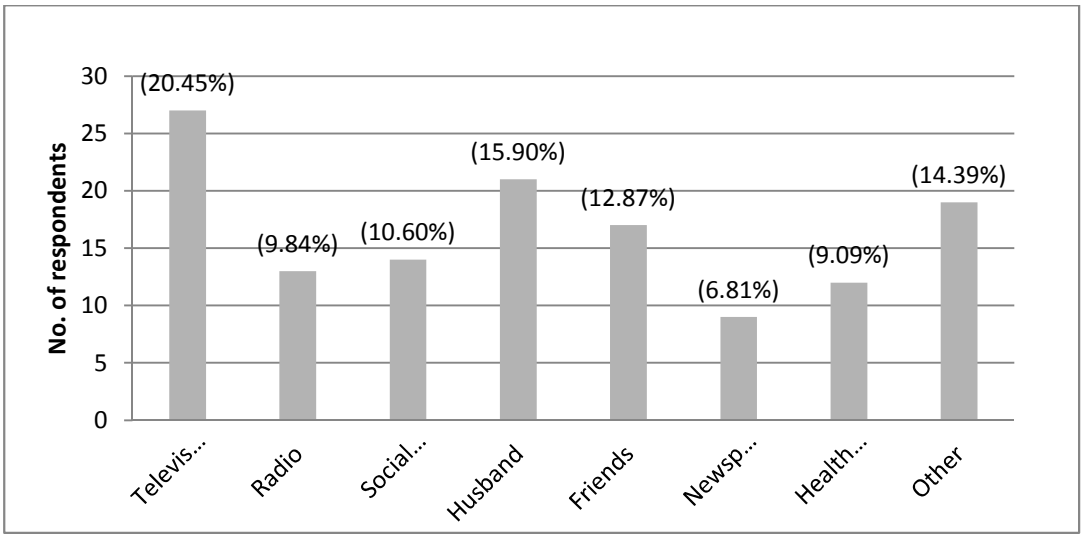
An Expert Committee (1971) of the WHO defined family planning as “a way of thinking and living that is adopted voluntarily, upon the basis of knowledge, attitudes and responsible decision by individuals & couples, in order to promote the health and welfare of the family group and thus contribute effectively to the social development of the country”. The WHO lists several reasons for the lack of motivation in family planning: lack of accessibility to contraceptive methods; fear of side effects and approbation based on social and religion sentiments; the quality of education on the subject that can also be linked to provider bias. Most of reproductive age women know little or incorrect information about family planning methods. Even when they know some names of contraceptives, they don’t know where to get them or how to use it. These women have negative attitude about family planning, while some have heard false and misleading information. All these reasons can be directly linked to the lack of awareness associated with the inability of education to dispel ill formed ideologies.

This chapter analysis of the knowledge and practice of the FP in the research area and includes the source, knowledge of birth spacing, use of FP methods and its practice in their family life.

5.1 Source of Knowledge on FP methods

There is great role of source or communication media for family planning to give information for the respondents. Television, Radio, Friends, etc., can be the good source to disseminate the awareness of family planning. The figure below shows the status of knowledge on FP methods:

Figure 5.1. Source of Knowledge on FP Methods



Source: Fieldwork, 2021

Figure 5.1 shows that most of the respondents i.e., 27(20.45%) knew about family planning methods through television. Likewise, 21(15.90%) knew from husband, 17(12.87%) from friends, 14(10.60%) from social media, 13(9.84%) from radio, 12(9.09%) from health workers, 9(6.81%) from newspaper and 19(14.39%) knew from other sources. Other sources included the pamphlet, poster, theater, drama, and so on. I observed the relationship between the knowledge on family planning methods and social variables. The educated women got the knowledge of family planning from health workers, social media and newspapers whilst the less educated and uneducated women obtained the knowledge from their husband and the friends.

Nowadays, media plays the great role to disseminate any news and information rapidly and effectively. Television is the good option for source due to its availability, cheaper and addiction to watch frequently. Though the radio is cheaper and used to be popular a decades ago but with the increase in earning radio is now replaced by television in most of the houses. Similarly, there is increasing trends of smart phone users so do the social media users which help to share the knowledge about family planning methods. Here in the study area also it shows the similar results the most of the FP methods knowledge are disseminated through the television, followed by husband, friends, social media and health workers. Despite of its cheaper price and availability of newspaper everywhere, most of the Nepalese married women are house wife and they prefer to stay on home most of the time, so here in this area also newspaper disseminate the lesser knowledge to the respondent.

5.2 Knowledge towards child bearing age by Education

Women can get pregnant and bear children from puberty when they start getting their menstrual period to menopause when they stop getting it. The average woman's reproductive years are between ages 12 and 51. The ideal age of child bearing is after 20 years and before 30 years. This age range is associated with the best outcomes for both mother and baby.

Table 5.1: Respondents Knowledge towards child bearing age by Education

S.N	Education	Frequency							
		20-30 years		Doesn't Matter		Don't Know		Total	
		No.	%	No.	%	No.	%	No.	%
1	Illiterate	4	57.14	2	28.57	1	14.28	7	5.30
2	Under Primary	7	63.63	1	9.09	3	27.27	11	8.33
3	Primary Completed	9	47.36	-	-	10	52.63	19	14.39
4	Secondary Completed	27	79.41	2	5.88	5	14.70	34	25.75
5	Intermediate	37	97.36	-	-	1	2.63	38	28.78
6	Bachelor and above	23	100.00	-	-	-		23	17.42
	Total(N)	**107**	**81.06**	**5**	**3.78**	**20**	**15.15**	**132**	**100.00**

Source: Fieldwork, 2021

Table No 5.1 shows that most of the respondents i.e.,81.06% know about the ideal age of child bearing. However, 15.15% don't know and 3.78% of the respondent think it doesn't matter to have a child in any age. All the respondents who have education bachelor and above knows the ideal age of child birth.

The knowledge about the child bearing age is directly related to the education level and their social participant. Here also most of the women are educated or actively participating in the social activities so they know much more about the child bearing age and the relation between the age and the pregnancy. However, some exceptions

may be due to their view that women should give birth to their children as soon as they can after marriage.

5.3 Respondent Knowledge about Birth Spacing

Birth spacing is the practice of waiting between pregnancies. A women's body needs to rest following pregnancy**.** Knowledge of birth spacing plays a vital role in determining the rate of FP method using. Most of the people don't apply in their life but they think it is better to space the birth.

Table 5.2: Respondents Knowledge about Birth Spacing

S. No.	Birth Space Year	Number of Respondents	Percentage
1	2 Years	48	36.36
2	3 Years	37	28.03
3	4 Years	21	15.9
4	More than 4 Years	26	19.69
	Total	**132**	**100.00**

Source: Fieldwork, 2021

The Table 5.2 shows that the respondent views on the suitable time of birth spacing. 48 respondent (36%) think birth spacing between two children should be 2 years whereas 28% and 15.9% respondents think it should be 3 years and 4 years respectively. Only 19% respondents think more than 4 years gap is good.

Knowledge of the FP and birth spacing is related to the education, so the scientifically ideal birth spacing duration is 18 months and here also the most of the respondents think the 2 years birth spacing is the best. Some factors like occupation, studying, and economic status of the people may change the personal view towards birth spacing.

5.4 Respondent Practice on Birth Spacing

Though the knowledge of birth spacing seems better in the society the practicing this is different. There are number of FP methods, women and men may choose birth spacing. They may choose to avoid sex during the fertile days of woman's cycle or they may choose to use the FP methods.

Table 5.3: Respondents Birth Spacing practice

S. No.	Birth Space Year	Number of Respondents	Percentage
1	Less than 2 years	16	18.39
2	2-3 years	48	55.17
3	More than 3 years	23	26.43
	Total	**87**	**100.00**

Source: Fieldwork, 2021

Table 5.3 shows 18.39% of the respondents on the study area have less than 2 years birth spacing while giving birth to their children. Likewise, 55.17% have 2-3 years and 26.43% have more than 3 years of birth spacing.

Because most of the respondent have good knowledge about FP and FP methods, it can be directly related to the birth spacing. Though the married women has good knowledge on birth spacing they cannot practice it on their life because it is not solely decided by married women. Several factors like pressure from relatives, forced from husband, economic condition, unwanted pregnancy and so on can play the significant role on practicing birth spacing.

5.5 Distribution of Respondent on FP Awareness Program

Family planning is the practice of controlling the number and spacing of children through the use of modern contraceptive methods and natural or traditional methods, e.g. withdrawal (WHO 2015). Challenges to method uptake among minority groups include lack of awareness, lower socioeconomic status and cultural sensitivities. FP awareness program help the individual to understand about the fertility and the use of family planning methods its pros and cons. This type of program is usually conducted in community and in health care services.

Table 5.4 : Respondent participation in FP awareness program by Caste

S.N	Ethnicity/Caste	Frequency					
		Participated		Not participated		Total	
		No.	%	No.	%	No.	%
1	Brahmin	13	30.23	30	69.76	43	32.57
2	Chettri	15	38.46	24	61.53	39	29.54
3	Janajati	4	12.90	27	87.09	31	23.48
4	Dalit	6	31.57	13	68.42	19	14.39
	Total(N)	**38**	**28.78**	**94**	**71.21**	**132**	**100**

Source: Fieldwork, 2021

Table 5.4 shows only 28.78% of respondents have participated in FP awareness programs whereas most of respondents i.e.; 71.21% have not participated in any kind of formal FP awareness program. Most of the Chettri respondents are participate in FP awareness program whereas most of the not participated respondents are Janajati.

Nowadays, Family planning awareness is common in the society because it is not only related to birth spacing; it is related to the reproductive health of the parents and child and economic stabilization of the family also. Several NGOs, INGOs and health related social organizations use to give this type of awareness education to the community. Though, it is important for the happy family only $1/4^{th}$ of the respondents from the research area have participated in the FP awareness program. This may be due to lack of time to participate or the program is not conducted in the research area. Nowadays, the people can gain information from social media and television about the family planning methods. This may be the reason why most of the respondents had not participated in the FP awareness program.

5.6 Discussion and Response of Respondents with their Husband

Men's role in FP has been highlighted at various public health conferences and in messages from donor agencies, governments and the media. This is particularly important because, in certain societies, the man's consent is required to make reproductive health decisions and a lack of male involvement places the heavy burden of reproductive health decision-making solely on the woman. Husband opinions on

FP use may therefore result in additional barriers to use. If both partners acknowledge communicating about the desired number of children and using FP, these couples are more likely to be using contraception, as better communication increases partner support in using contraception to space/limit childbearing.

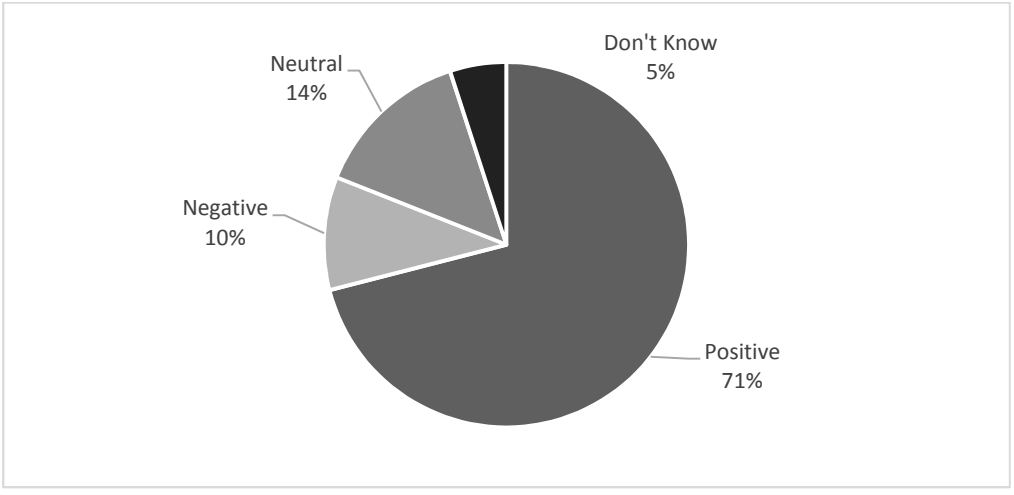
Table 5.5 : Respondent discussion on FP with husband by Caste

S.N	Ethnicity/Caste	Frequency					
		Discuss		Do not discuss		Total	
		No.	%	No.	%	No.	%
1	Brahmin	36	83.72	7	16.27	43	32.57
2	Chettri	38	97.43	1	2.56	39	29.54
3	Janajati	25	80.64	6	19.35	31	23.48
4	Dalit	14	73.68	5	26.31	19	14.39
	Total(N)	**113**	**85.60**	**19**	**14.39**	**132**	**100.00**

Source: Fieldwork, 2021

Above table represents the data on respondent discussion on FP methods with their partner. In the study area out of 132 total respondents, most of the respondents i.e., 85.60% respondents use to discuss about FP with their partner. While only 14.39% don't have discussion with their husband on FP. We found that most of the Chettri respondents use to discuss about FP with their husband. The following figure shows the details:

Figure 5.2. Response of Husband on FP methods



Source: Fieldwork, 2021

The figure 5.2 shows the distribution of responses of husband on the FP discussion by their partner. Among the total 113 partners who discussion in the FP methods, 71% of respondent's husband give the positive response while only 10% of husband give negative responses. Whereas, 14% husband have neutral response and only 5% of respondent cannot judge the response of their husband regarding the FP discussion.

Though the discussion of FP with the partner is important for their happy life some of the respondents do not discuss. This may be due to the male dominance house or lack of the confident to talk with their partner about the FP methods. Although, FP discussion is quite common and most of the people know about FP nowadays the response can be varied according to the behavior and thinking of the person.

5.7 Respondent on FP Devices User

Using contraceptive methods is the easiest method for a couple to avoid pregnancy and enjoy a tension free physical relationship. People have used birth control methods for thousands of years. Today, we have many safe and effective birth control methods available to us. The methods can be categorized into temporary and permanent. Temporary methods include withdrawal, barrier, intrauterine and hormonal methods whereas Permanent methods includes sterilization implant and tubal ligation.

Table 5.6 : Distribution of Respondents on FP Method User

S. No.	FP method	Number of Respondents	Percentage
1	Temporary	118	89.39
2	Permanent	9	6.81
4	Not User	5	3.78
	Total	**132**	**100.00**

Source: Fieldwork, 2021

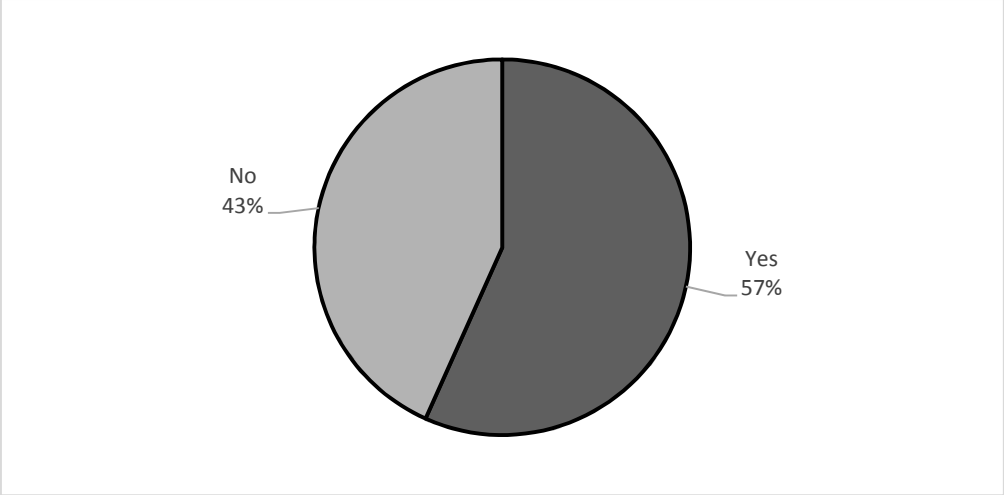
Table 5.6 shows, 89% of respondents i.e., 118 respondents use the temporary FP method followed by 6.81% i.e., 9 respondents use the permanent methods of FP while only 3.78% are non-users.

Using the FP methods is very common everywhere nowadays however the types of methods can be varied depending upon the interest, economic condition, side effects of the FP methods and availability of the services. This situation is different 2-3 decades ago when the FP is not well known and due to lack of availability and economic condition some people couldn't use though they are interested about FP.

5.8 Experience Side Effects of FP Devices

Notice of the side effects can affect the use of FP methods. If a woman uses contraceptive device that harm her health, probably she will not use the device again. The side effects of the device depends upon the physical condition of the users, their age, number of children, etc. So, it is one of the important factors in this study. The following figure shows the data related to this concern:

Figure 5.3. Experience side effect of FP methods



Source: Fieldwork, 2021

Figure 5.3 shows the distribution of FP using respondents and the side effects noticed on the use. Among 127 FP methods using respondents, 72 i.e., 57% of respondents noticed the side effects while 55 respondents i.e., 43% did not noticed the side effects of the FP methods. It shows that the majority of the respondents were aware on the side effects of family planning methods as they noticed the effects.

Table 5.7: Distribution of Respondents who Experienced Side effects

S. No.	Side effects	Number of Respondents	Percentage
1	Irregular Mensuration	32	44.44
2	Bleeding	7	9.72
4	Weakness	18	25
5	Others	15	20.83
	Total	**72**	**100.00**

Source: Fieldwork, 2021

Above Table 5.7 shows the specific side effects of the FP methods noticed by the respondents. Most of the FP users 44% experienced the Irregular mensuration which is followed by weakness i.e., 25%. While 9% have bleeding and 20% experienced others side effects like nausea, muscle pain, headaches and so on.

Already mentioned, the side effects depend on the age, physical condition and number of children, it is variable to person to person. All of the medication has some side effects but the beneficial part will be more. So, in the research area here we informed some common side effects of the FP method using. If the side effect is frequently observed and serious to the health of user it may affects the result of the study.

CHAPTER VI

DECISION MAKING PROCESS OF MARRIED WOMEN IN FAMILY PLANNING

Women play a crucial role in the economic welfare of the family. Women perform different tasks depending on their Socio-economic structure, number of people in the family, the nature of professions they are involved in and many other factors. Women are traditionally less involved in decision making at all levels. Their important role is not recognized and, therefore, still not accepted in decision-making. The share of women in community decision-making structure is still very low and their participation is mostly stressed by political parties, more as elements of their own publicity and proof of democratization, than as a real interest and need.

This chapter analysis the decision-making process of married women on household and in FP method use in the area of study.

6.1 Decision on Mate Selection

The right to choose a spouse and to enter marriage with 'free and full consent' is one of the key rights of women articulated in the United Nations Convention on the Elimination of All Forms of Discrimination against Women (United Nations, 1979). Moreover, young women's (and young men's) ability to exercise this right is viewed as a marker of a successful transition to adulthood (Lloyd, 2005). Despite the importance of spouse selection practices from both a women's rights perspective and the perspective of enabling young people to make a successful transition to adulthood, the topic remains under-researched in most developing countries.

Table 6.1: Respondents Decision of Marriage by Education

S.N	Education	Frequency							
		Self		Parents		Joint		Total	
		No.	%	No.	%	No.	%	No.	%
1	Illiterate	-	-	4	57.14	3	42.85	7	5.30
2	Under Primary	2	18.18	5	45.45	4	36.36	11	8.33
3	Primary Completed	1	5.26	5	26.31	13	68.42	19	14.39
4	Secondary Completed	3	8.82	12	35.29	19	55.88	34	25.75
5	Intermediate	1	2.63	4	10.52	33	86.84	38	28.78
6	Bachelor and above	-	-	1	4.34	22	95.65	23	17.42
	Total	**7**	**5.30**	**31**	**23.48**	**94**	**71.21**	**132**	**100.00**

Source: Fieldwork, 2021

Table 6.1 shows the distribution of decision of respondent's marriage according to their education. Here, the majority of the respondents have joint decision on their marriage. They decided their marriage affair by the discussion with their parents. The data in the table depicts that both the educated and undereducated women took the decision of marriage with the support of their parents. Among all respondents, it has been seen from the data that there is an increasing rate of taking marriage decision in collaboration with the family members with the increase in their education level.

Table 6.2 : Respondents Decision of Marriage by Caste

S.N	Ethnicity/Caste	Frequency							
		Self		Parents		Joint		Total	
		No.	%	No.	%	No.	%	No.	%
1	Brahmin	-	-	11	25.58	32	74.41	43	32.57
2	Chettri	1	2.56	9	23.07	29	74.35	39	29.54

3	Janajati	2	6.45	4	12.90	25	80.64	31	23.48
4	Dalit	4	21.05	7	36.84	8	42.10	19	14.39
	Total	**7**	**5.30**	**31**	**23.48**	**94**	**71.21**	**132**	**100.00**

Source: Fieldwork, 2021

Table 6.2 shows the distribution of decision of respondent marriage on the basis of ethnicity/caste. Most of the Janajati, Brahmin and Chettri take their decision of marriage jointly. While in all of the caste most Dalit takes their marriage decision by self.

Nowadays an adult individual can take their marriage decision by themselves once they turn 18 years but this may be influence by the culture and traditional norms of the family. But, previously this self-decision on marriage by women is almost negligible, however there may some exception because of education level of the bride, love affair which is against their family decision. In some family only parents and other elder guardians use to choose the partner for marriage. Similar to this scenario here also most respondents went through their family decision.

6.2 Age at Marriage

Marriage age is the minimum age at which a person is allowed by law to marry, either as a right or subject to parental, judicial or other forms of approval. Age and other prerequisites to marriage vary between jurisdictions, but in the vast majority of jurisdictions, the marriage age as a right is set at the age of majority. The average age at marriage of women has risen relatively rapidly in the last two decades and has reached a fairly reasonable level in recent years.

Table 6.3 : Respondent Age at Marriage by Caste

S.N	**Ethnicity/Caste**	**Frequency (Years)**							
		Below 20		**20-30**		**30 Above**		**Total**	
		No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
1	Brahmin	17	39.53	26	60.46	-	-	43	32.57
2	Chettri	12	30.76	27	69.23	-	-	39	29.54
3	Janajati	4	12.90	26	83.87	1	3.22	31	23.48
4	Dalit	8	42.10	11	57.89	-	-	19	14.39

	Total	**41**	**31.06**	**90**	**68.18**	**1**	**0.75**	**132**	**100.00**

Source: Fieldwork, 2021

Table 6.3 shows, most of the respondent married on the age between 20-30 years. Regarding marriage on ideal age most of the Janajati respondent married on the age of 20-30 years. On the basis of caste, most of the Dalit (8 out of 19) respondents are found to married below 20 years.

Until 80s in our society child marriage is normal trend but nowadays government set the ideal age of marriage is over 20 years. But in some cases due to their parent force some may marry early. In the study area also most of the women who married between 15-20 years belong to the older age. With increase in education and social level most of the parents also nowadays marry their daughter after they became mature or they accomplished their education. Here may be due to the city area most of the family is educated so they give free to their daughter to marry to take decision on their marriage age. So, the most of the respondents are married at the age between 20-25 years.

6.3 Type of Marriage

Marriage is an immemorial institution which, in some form, is found everywhere. Mating patterns are closely associated with marriage, more so with the social structure. Love marriages still do not enjoy the same respect and position in the society as arranged marriages; parents are becoming thoughtful of their children's feelings. The biggest reason for opposing a love marriage is caste or religion difference. This is because people are skeptical in marrying their kids in an alien cultural setting. In addition, there are other issues like economic standard, horoscope compatibility, that also hinder the process of love marriage.

Table 6.4: Respondents Type of Marriage by Education

Education	Frequency							
	Love marriage		Arrange marriage		Love-cum-Arrange marriage		Total	
	No.	%	No.	%	No.	%	No.	%
Illiterate	-	-	7	100.00	-	-	7	5.30
Under Primary	2	18.18	9	81.81	-	-	11	8.33
Primary Completed	1	5.26	13	68.42	5	26.31	19	14.39
Secondary Completed	3	8.82	27	79.41	4	11.76	34	25.75
Intermediate	1	2.63	29	76.31	8	21.05	38	28.78
Bachelor and above	-	-	18	78.26	5	21.73	23	17.42
Total(N)		**5.30**	**103**	**78.03**	**22**	**16.66**	**132**	**100.00**

Source: Fieldwork, 2021

The Table 6.4 shows the data of different types of marriage of the respondents in the study area. Here, 78.03% respondents did the arrange marriage which is followed by love-cum-arrange and love marriage respectively. All out of 7 illiterate respondents did the arrange marriage.

Arranged marriage is a type of marital union where the bride and groom are selected by individuals other than the couple themselves, particularly by family members such as the parents. This type of marriage is still very high in our country. So the situation of the study area is similar to this. Nowadays Love marriages were quite common and welcomed by the society. However, in rural and remote areas, the scene is still pretty traditional, partially due to lack of education and awareness. Thought the study area is urban this kind of tradition is still can be observed.

6.4 Child Related Decision

The birth of a child is a pivotal time in the life of a mother and her family. The health and well-being of a mother and child at birth largely determines the future health and wellness of the entire family. The outcome of childbirth, however, is not the only factor of importance in a mother's well-being. Some research suggests that the way in which a woman experiences pregnancy and childbirth is also vitally

important for a mother's relationship with her child and her future childbearing experiences.

Parents tend to invest in their children's education based on their children's academic abilities, allocating more educational resources to higher-performing children in the belief that the returns to education are greater for students who are more likely to succeed.

Table 6.5 : Respondents Child Related Decision

S. No.	Decider	Child Birth		Child Education	
		No.	%	No.	%
1	Husband	21	18.42	20	20.6
2	Wife	7	6.14	8	8.24
3	Both	83	72.8	69	71.13
4	Other	3	2.63	-	-
	Total	**114**	**100.00**	**97**	**100.00**

Source: Fieldwork, 2021

Table 6.5 gives the data of respondent on their child related decision like child birth and child education. This figure shows that in the study area, most of the respondent together with their husband use to decide about the child birth and child education. Compare to the husband, lesser number of wife decides the child birth and child education. However, child birth only in some household was decided by other like parents' wishes.

The birth of a child is a pivotal time in the life of a mother and her family. For child birth most prominent factor includes the choice in decision making. In most of the family, the child birth decision is taken by the shared discussion of the partner while these things can be affected by the education level, thought, and the tradition of the family. Though it should be solely depending upon the partner, in some society the parents of the partner also play significant role on the decision making for example the parents can force their son for the baby. The area of the study is the urban area and educated area so the most of the child birth decision is taken by mutual understanding between husband and wife. But our society is still patriarchal society so the husband use to dominate this type of decision. Similarly, child education is also the important thing to decide by their parents which makes their child's better future.

So most of the parent use to take their child education seriously and decide after the discussion with partner. Our society is the male dominated society still, so in the research area also these two important decisions are very less taken by the wife alone.

6.5 Involvement in Household Decision Making

Women play a crucial role in the economic welfare of the family. Women perform different tasks depending on their Socio-economic structure, number of people in the family, the nature of professions they are involved in and many other factors. Decisions made in home management ranges in importance from major once in a lifetime. Women are traditionally less involved in decision making at all levels. Their important role is not recognized and, therefore, still not accepted in decision-making. The share of women in community decision-making structures still very low and their participation is mostly stressed by political parties, more as elements of their own publicity and proof of democratization, than as a real interest and need.

Table 6.6: Respondents Household Decision Making by Occupation

S.N	Occupation	Frequency									
		Always		Mostly		Sometimes		Never		Total	
		No.	%	No.	%	No.	%	No.	%	No.	%
1	Self employed	26	78.78	7	21.21	-	-	-	-	33	25.00
2	Government service	1	50.00	1	50.00	-	-	-	-	2	1.51
3	House wife	22	33.33	31	46.96	11	16.66	2	3.03	66	50.00
4	Private Service	13	68.42	5	26.31	1	5.26	-	-	19	14.39
5	Other	4	33.33	6	50.00	2	16.66	-	-	12	9.09
	Total(N)	**66**	**50.00**	**50**	**37.87**	**14**	**10.60**	**2**	**1.51**	**132**	**100.00**

Source: Fieldwork, 2021

Table 6.6 shows 50% respondent's always take the household decision while 36.36% respondents took their household decision most of the times, and 10.60% respondent's took household decision only sometimes. In some instances, 1.51% respondents never took their household decision. Here we found that the respondents who never takes the household decision are only housewives. While most of the self-employed respondents always do their household decisions. Self-employed women

are economically strong and independent so in most of the household decision they are always participated.

Table 6.7: Respondents Household Decision making by Education

S. N	Education	Frequency									
		Always		Mostly		Sometimes		Never		Total	
		No.	%	No.	%	No.	%	No.	%	No.	%
1	Illiterate	-	-	2	28.57	4	57.14	1	14.28	7	5.30
2	Under Primary	3	27.27	5	45.45	2	18.18	1	9.09	11	8.33
3	Primary Completed	5	26.31	8	42.10	6	31.57	-	-	19	14.39
4	Secondary Completed	16	47.05	18	52.94	-	-	-	-	34	25.75
5	Intermediate	23	60.52	13	34.21	2	5.26	-	-	38	28.78
6.	Bachelor and Above	19	82.60	4	17.39	-	-	-	-	23	17.42
	Total	**66**	**50.00**	**50**	**37.87**	**14**	**10.60**	**2**	**1.51**	**132**	**100.00**

Source: Fieldwork, 2021

Table 6.7 shows 82.60% bachelor and above studied respondents always take the household decisions. Whereas, only illiterate and under primary respondents never take the household decisions.

Same as the national data most of the married women use to stay home as a house wife in the study area also. So they take the most of the household decisions like what to buy, where to buy, how to decorate home and so on. Even the society is male dominated most of the husband use to discuss with their wife for such kinds of household decisions. There may be some exceptions depending upon the type of family, behavior of the husband and parents, education level of the wife, and so on.

6.6 Decision Making on Using FP Devices

Family planning method use can help ensure healthiest timing and spacing of pregnancy, hence, regulating fertility. As fertility falls, so do infant, child, and maternal mortality. Women spend decreasing proportions of their lifetimes giving birth and caring for young children. Contraception plays a key role in decreasing maternal mortality. They provide significant protection for women by preventing unintended pregnancies, which often end in unsafe abortions. Decisions about contraceptive use and childbearing may be confounded by unequal power relations, especially in more patriarchal societies.

Table 6.8 : Respondents Decision Making on FP Method Use by Education

S. N	Education	Frequency							
		Husband		Wife		Both		Total	
		No.	%	No.	%	No.	%	No.	%
1	Illiterate	3	75.00	-	-	1	25.00	4	3.12
2	Under Primary	3	33.33	1	11.11	5	55.55	9	7.08
3	Primary Completed	2	10.52	1	5.26	16	84.21	19	14.96
4	Secondary Completed	4	11.76	2	5.88	28	82.35	34	26.77
5	Intermediate	1	2.63	-	-	37	97.36	38	19.92
6	Bachelor and above	1	4.34	-	-	22	95.65	23	18.11
	Total(N)	**14**	**11.02**	**4**	**3.14**	**109**	**85.82**	**127**	**100**

Source: Fieldwork, 2021

Table 6.8 shows the distribution of the respondent on the basis of decision making on FP methods use. Majority of the decision on the use of FP methods are taken by both husband and wife together while 4 respondents only take the decision of using FP methods and only 14 respondent's husband take the decision of the FP method use. Here majority of the illiterate husband take the decision of FP method use. While most of the Intermediate and bachelor studied respondents use to decide together with husband.

Table 6.9: Respondents Decision Making on FP Method Use by Occupation

S.N	Education	Frequency							
		Husband		Wife		Both		Total	
		No.	%	No.	%	No.	%	No.	%
1	Self employed	2	6.06	3	9.09	28	84.84	33	25.95
2	Government service	-	-	-	-	2	100.00	2	1.57
3	House wife	7	10.60	1	1.51	58	87.87	66	51.96
4	Private Service	1	5.26	-	-	16	84.21	19	14.96
5	Other	4	33.33	-	-	8	66.66	12	9.44
	Total	**14**	**11.02**	**4**	**3.14**	**109**	**85.82**	**127**	**100**

Source: Fieldwork, 2021

Table 6.9 shows, all respondents doing government service decided FP methods jointly. Likewise, all the respondents having job takes the decision of FP methods jointly with husband.

It is expected that women contraceptive decision-making power to be less in a rural community where women's literacy status is very low and economic dependence is high. But the study area is the urban and literate area of the Kaski district so the most of the decision use to be taken by mutual discussion with the partner. If the partner are not open to discuss or if they feel shy taking about these things the decision can be taken by husband and wife solely. The above data shows the little higher on decision making by wife, this may be because women’s contraceptives and pills is common nowadays and is reliable for the birth control.

6.7 Respondent Attitude towards Use of FP Method

Couples are being provided with the information and services needed to protect women’s and children’s health, and families have been educated effectively about fertility. Using FP methods prevents young and old age pregnancies and high fertility, and as the spacing between births increases, the number of high-risk pregnancies decreases and the maternal death rate also drops. However, Education may influence men’s and women’s desired family size.

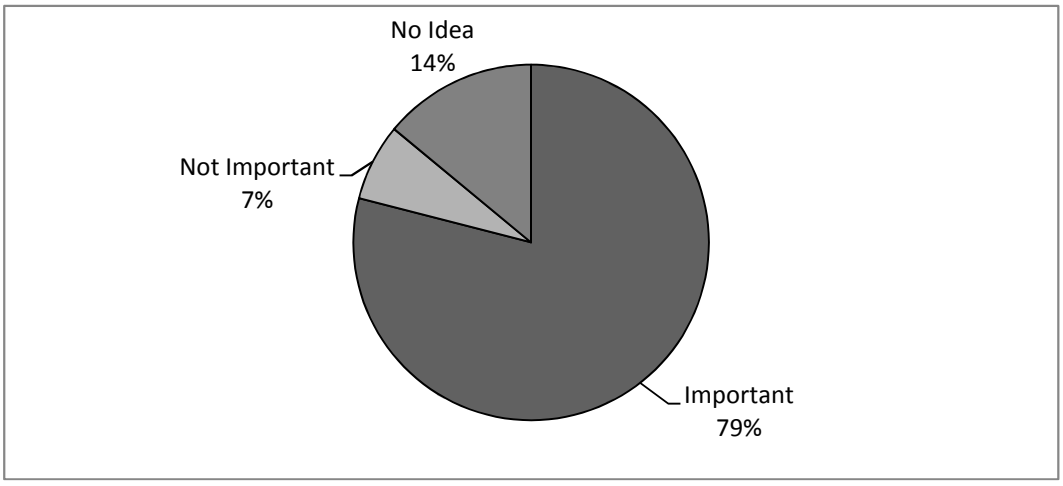


Figure 6.1 Respondents Attitude towards Use of FP Method

Source: Fieldwork, 2021

Figure 6.1 shows the data of respondents thought towards the use of FP methods. 79% of respondents thought the FP methods is important to use. In contrast, 7% respondents thought FP methods is not important while 14% respondents have no idea on its importance.

Family planning provides many benefits to mother, children, father and the family. FP education and awareness is common nowadays so most of the women knows about the benefits of using. Here in the study area also most of the respondents know the importance of FP methods.

6.8 Distribution of respondent currently using FP method

Family planning involves the use of all techniques, practices, and medical devices that help a couple to plan their family including deciding the number of children they want to have and spacing their births. Family planning can be categorized as temporary and permanent. People use the FP methods only when they are sexually active.

Table No. 6.10 Respondents FP Methods Users

S.N	User	No. of Respondent	Percent
1	Previous user	28	22.04
2	Current user	99	77.95

	Total	**127**	**100**

Source: Fieldwork, 2021

Above Table 6.10 suggest that out of total 127 FP methods users 77.95% are currently using while 22.04% were previous users.

Family planning allows people to attain their desired number of children and determine the spacing of pregnancies. It is achieved through use of contraceptive methods and the treatment of infertility. In the study area some of the respondents are previous users because some respondents are older age and sexually inactive whereas some respondent's husband are far from the home for earnings.

6.9 Reason for Using FP Devices

Ability of a woman to start a successful, continuous and appropriate contraceptive method is influenced by many different factors; e.g. access to the health care, community, cultural attitudes and personal attitude can all be considered as obstacles to apply correct use and effective method of the women to family planning objectives. In developing countries, where women are dependent upon old traditions and social constraints, knowledge and awareness about family planning acceptance would not be the only decisive factor as well as reduction in reproductive rate.

Table 6.11: Respondents Reason for Using FP Methods

S. No.	Reason	Number of Respondents	Percentage
1	Birth Spacing	56	44.09
2	Better Health of Mother and Child	38	29.92
3	Want no more Children	21	16.53
4	Can't Explain	12	9.44
	Total	**127**	**100.00**

Source: Fieldwork, 2021

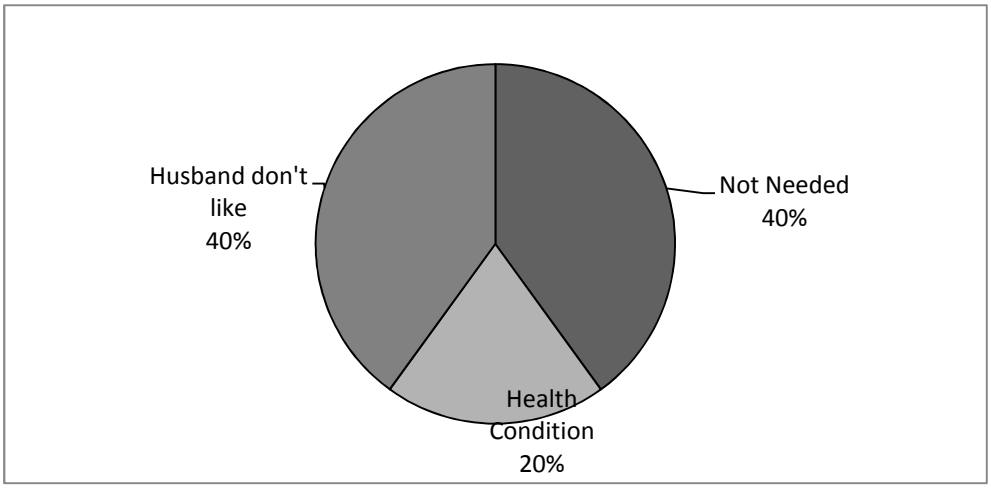
Table 6.11 shows the reason behind using FP methods. Out of 127 FP methods users 44.09% respondents use FP methods for birth spacing and 29.92% respondents use FP methods for better health of mother and child. Similarly, 16.53% respondents use FP methods to avoid more children while 9.44% users have no exact reason for using the methods.

Encouragement of FP in countries with high birth rates has the potential to reduce poverty and hunger and to prevent 32% of maternal deaths and approximately 10% of child deaths. In addition to its importance even for women who do not work outside of the home; better reproductive health services benefit the economy and contribute to sustainable development by allowing women to complete their education, join the workforce, be more productive at work and obtain a higher income. Moreover, married women also prefer FP methods use for birth spacing, better health of mother and child and to avoid more children. This reason may vary on each individual perception, condition and education.

6.10 Reasons for Not Using FP Devices

The decision to use birth control and the method of choice is a personal one. A healthcare provider or birth control clinic can guide the decision and advise which method may be best for each individual to safely and effectively prevent pregnancy. While most methods of birth control are highly effective when used correctly, there is always a chance that any method will fail. Weighing the options with a doctor and partner is an important part of the decision-making process. But due to some reasons some couples don't use the FP methods. Family planning programs have been directed more toward increasing availability of services than toward increasing motivation for their use. Also efforts have been directed more toward women than men. Some may tend to have stronger concerns about side effects and may oppose contraceptive use more frequently. The figure below shows the data related to it:

Figure 6.2 Respondents Reason for Not Using FP Methods



Source: Fieldwork, 2021

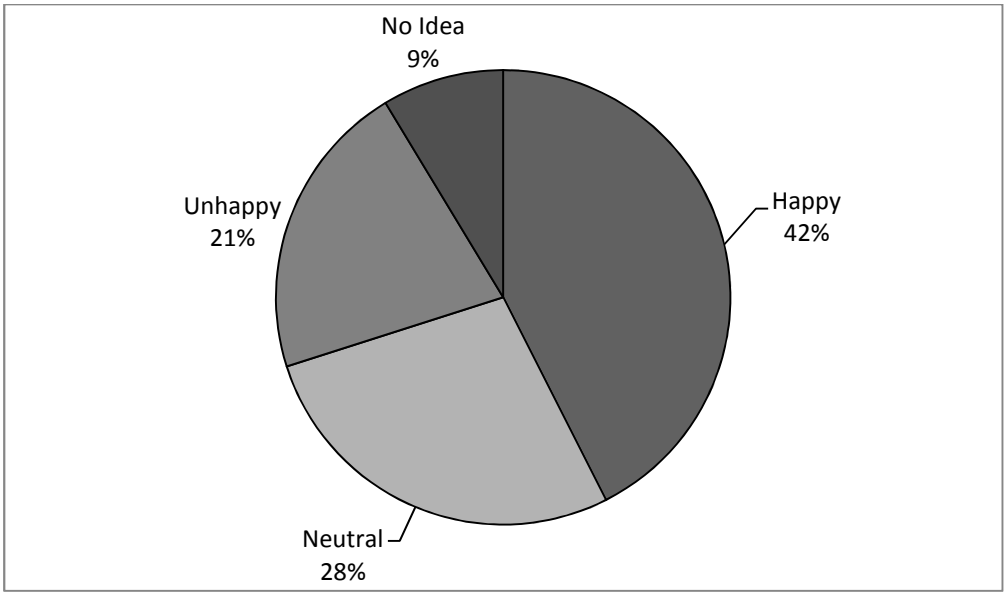
Figure 6.2 shows the reasons for not using FP methods. Among 5 non users 40% of respondents don't like to use because of husband or they think the methods is not important while 20% respondents have neglected due to their health condition.

Despite of the several beneficial reasons FP methods may show side effects to some users. In some context, some people think the FP methods is not needed, may be economic burden and due to disfavor from the husband they may don't use the FP use for themselves. Here is the research area also the reasons for not using FP methods is due to health condition, disapproval from husband and they think it is not needed.

6.11 Satisfaction of using Family Planning Devices

Although use of effective contraception is growing in many parts of the world, lesser women of reproductive age in developing countries use a modern contraceptive. Unmet need for contraception is the percentage of women of reproductive age who want to stop or postpone childbearing but who report that they are not using a method to prevent pregnancy, and is used as an indicator of the gap between the demand for contraceptives and contraceptive use. Women's expectations of and experiences with side effects may lead to satisfaction with their method and continuation with using it or dissatisfaction and discontinuation of their method.

Figure 6.3: Respondents Satisfaction of using FP Method



Source: Fieldwork, 2021

Figure. 6.3 shows, 42% respondents are happy while 21% respondents are unhappy with their decision on using FP methods. However, 21% have neutral view and 9% have no idea about using FP methods.

Table 6.12: Respondents Reason behind Unhappy

S. No.	Reason	Number of Respondents	Percentage
1	Economic Burden	3	11.11
2	Negative effect on Health	9	33.33
3	Troublesome	4	14.81
4	Don't know	11	40.74
	Total	**27**	**100.00**

Source: Fieldwork, 2021

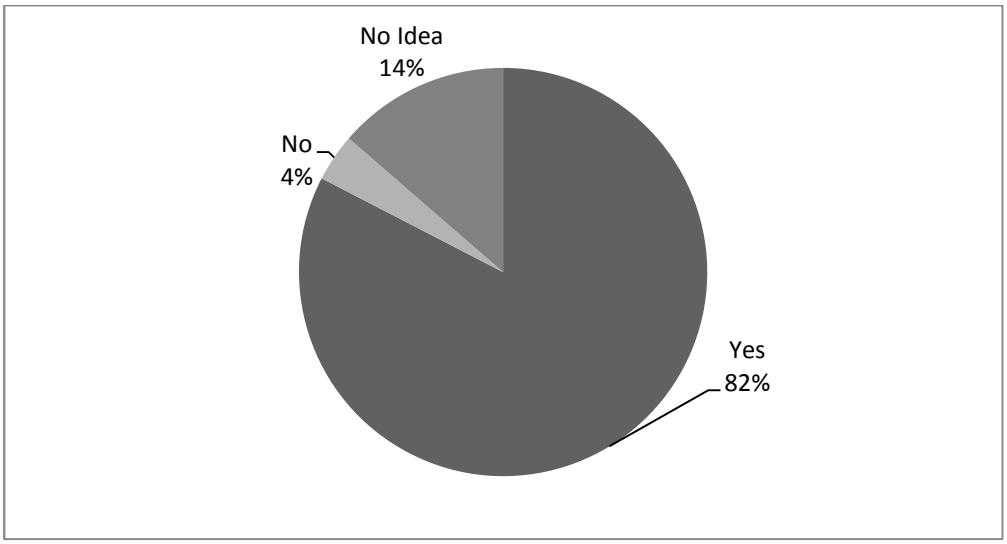
Table 6.12 shows the reason behind unhappiness on using FP methods. Among, unhappy 21% of FP methods users 9 of them have negative effects on health, 4 of them feel troublesome on using, 3 is due to economic burden and rest don't know the exact reason.

The users of FP methods may also feel unhappy with their decision. May be due to lack of complete knowledge, economic burden, and negative effect on health and may find troublesome for using. Here in the study area also we observed the mixed view of the FP methods users.

6.12 Respondent Recommendation for FP Devices Use

Increasing contraceptive use is one way to encourage reduction of maternal mortality and improve both maternal and child health. It also gives women more decision-making power, empowers women, and this could have positive effects in sexually transmitted infections (STI) and HIV/AIDS prevention. The choice of a contraceptive method is a complex decision; medical providers have an important role in providing information and supporting patients' decision making about contraceptive methods through contraceptive counseling. Similarly, encouraging new adopters of contraceptive methods by the experienced one is important, but so too is understanding consistency of use among existing users. Family planning programs, however, are in place to ensure that those who want family planning services can get it. But still, encouraging the new users remains a challenge.

Figure 6.4 Respondents Recommendation FP Method to Others



Source: Fieldwork, 2021

Figure 6.4 shows 82% of respondents would like to suggest other married women to use FP methods. In contrast to this 4% respondents would not suggest while remaining 14% have no idea on suggesting others to use the FP methods.

Family planning is essential to promoting the well-being and autonomy of women, their families and their communities. Quality of care in family planning is paramount for ensuring progress towards achieving high standards of health for all. Lack of knowledge of where to obtain correct family planning (FP) information and methods can be a critical barrier to eventual uptake of FP services. The side effects of the different methods should be kept in mind because they may discourage users. The preferences of the individual or couple are often founded on subjective factors, and cultural, religious, or customary factors in the community may influence the overall demand for each method. The marital status, frequency of sexual relations, stage of family formation, number of partners, and stability of individuals or couples should also be considered in choosing a method. This suggestions for using the FP methods to the new users will be more effective through the experienced users. They can be the good counselor to the new users by sharing the proper way to use FP methods and some good and side effects.

CHAPTER VII

SUMMARY, FINDINGS, AND CONCLUSION

This chapter includes the summary of the study, major findings, conclusion and recommendations for further related research. Summary includes the knowledge and practice of decision making related to our study and major findings includes the key findings of the study and are listed in the bullets. Similarly, Conclusion includes the study conclusion and compared with the previous studies results. The recommendation in this chapter includes the area which the researcher left and guidance for the further related research.

7.1 Summary

The present study entitled “Decision Making on Use of Family Planning Devices among the Married Women” has addressed the current situation of the married women on knowledge and practice of family planning. The study has analyzed the household and family planning decision making process of married women over variable like age, ethnicity, education and occupation.

The study specifically deals with the knowledge and practice of family planning and use of family planning methods by married women of the age group 15 to 49 years. The study deals about the current and previous use and non-use of family planning methods. The study also addresses the reason for using and not using the family planning methods and the view of study population.

Since the using family planning methods are affected by several factors like socioeconomic, sociocultural, location, age, education, gender, occupation and decision-making ability (Nazli et al, 2018). The study attempts to investigate the relation between these factors on the decision-making process on use of family planning methods. The study also tried to find out the correlation between the household decision making ability and decision on use of family planning methods by married women.

The sampling was done by descriptive method and data were collected by the help of interview schedule. This study includes 132 sample population from age 15 to 49 years old out of total 195 married women. The area of study was Pokhara Metropolitan City Ward No. 4, Gairapatan Tole where diversified population in terms

of ethnicity, religion and culture were settled. The data obtained were analyzed using simple statistical process and procedure i.e. percentage, frequency, tables and interpretation was done by comparing the findings with the national average and on the basis of findings; conclusion and appropriate recommendations were made and a descriptive report has been prepared.

7.2 Major Findings

In the study area, married women of age group up to 49 years had different economic and demographic characteristics. In addition, they had different perception about the family planning methods. The following results were obtained through the collection and analysis of data.

Social Background of the Informants

- It was found that 29.54% of married women are 30 to 34 years and followed by 23.48% of age 25 to 29 years.
- Majority of respondents were Hindu which is 92% of the total.
- It was found that 94.69% of the respondents were literate and only 5.30% were illiterate. So, the educational status of women in the area is very good in comparison to the national average i.e., 53.1% female literacy rate.
- Out of 132 respondents, 38 of them have intermediate level of education.
- About 50% of the respondents were house wife.
- Regarding ethnicity, 32.57% of the respondents were Brahmin.
- Among 132 total respondent's husbands, 41 have education bachelor and above and 45 of them are self-employed.
- 79% of respondents live in nuclear family and business is the main source of family income. Other main source of income are job, agriculture and pension.

Knowledge and Practice of Family Planning

- Television is the main source of information for family planning among the respondents followed by husband, friends, social media and health workers.
- 81.06% of respondents have good knowledge on the ideal age of child bearing age. 100% of respondent with bachelor and above education know about the ideal age of child birth.
- Out of total, 36.36% of respondents thinks birth spacing between two children

should be 2 years. However, 18.39% of respondent have done less than 2 years birth spacing. This may be the results of factors like pressure from relatives, forced from husband, economic condition and unwanted pregnancy.

- The study indicates that 71.21% of the respondents have not participated in any kind of formal family planning awareness program. Likewise, most of the Janajati respondents did not participate in the family planning awareness program.
- 85.6% women discuss /communicate with their husband about family planning while only 71% of husband give the positive response towards the use of family planning methods. Most of the Chettri respondents use to discuss about family planning with their husband.
- 89.39% respondents use the temporary family planning methods while only 3.78% are non-users.
- 57% of family planning methods users have experienced side effects and 44.44% of side effects are irregular mensuration.

Decision Making and Family Planning

- Out of total respondents, 71.21% respondents jointly discussed about their marriage with family members, where most have bachelor and above education. Most of the Janjati respondents took joint decision on their marriage with their family members.
- 68.18% of respondents married on the age between 20-30 years. Compared to other ethnic group, most of the Dalit respondents married below 20 years of age.
- 78.03% of respondents did the arrange marriage. 100% illiterate respondents did arrange marriage.
- In most of the respondent's family, husband and wife jointly decides the child birth and their child education.
- I found that 50% of respondents always take the household decision. Most of the respondent who are self-employed found to take always their household decision. And most of the bachelor and above studied respondents always take the household decision.
- The study indicates that most of the respondents jointly decides the use of family planning methods with their husband. Most of the respondents with

bachelor and above jointly decides the use of FP methods with their husband. And most of the respondent from all occupations jointly decides the use of FP methods.

- Among 127 FP methods user, 77.95 are currently using while 28% are previous user. Previous users are older age and sexually inactive and some respondent's husband are far from the home.
- 44.09% of respondent use FP methods for birth spacing. While, reason for not using is due to husband, health condition and they think FP methods is need.
- 42% of respondents are happy with their decision of using FP methods while 21% are unhappy and most of them don't know the reason of dissatisfaction.
- Among, 132 respondents, only 82% of respondents would like to suggest other married women to use FP methods.

7.3 Conclusions

The study demonstrates that the area has very high literacy rate as compared to national average of female literacy rate and more than one-third of the respondents have above intermediate level of education. This may be due to the study was done in urban area and the study area is near to the Prithvi Narayan Campus. In contrast to the research done in developing countries lesser number of women have participated in the family planning awareness program. Although more than two-third of the respondents have not participated in the formal family planning awareness program, most of the respondents have good knowledge of family planning. Another study done in Nuwakot (Sushmita, 2016) showed similar finding as the study results. Similar results as our study were obtained from previous studies, In Ethiopia (Ujuju, 2011) and in the slums area of Vanarasi (Gupta, 2014) majority of women have good knowledge about family planning. The study found that the main sources of information are television, followed by husband, friends, social media and health workers. The study done in Nuwakot also showed that majority of married women heard family planning from radio/T.V. (Sushmita, 2016) and another study from Pakistan also showed the major source as television (Irma, 1999). Though the sources of information about FP are similar, a survey done in rural Uganda showed the main source of information is from health workers (Stephen et al, 2016). This result may be due to lack of television accessibility in the rural village of Uganda.

Despite of good knowledge on ideal birth spacing duration some of them haven't practiced in their life. Similar results were obtained from eastern Nepal (Uprety et al, 2016) and Nuwakot district (Sushmita, 2016). So, we can suggest that the practice of family planning methods may be affected by other factors like family, husband support, education, etc. Majority of the married women prefer to use temporary FP methods which is similar to the results from Nuwakot (Sushmita, 2016) and eastern Nepal (Uprety, 2016). Similar result was obtained from the study done in Uganda (Stephen et al, 2016). Majority of married women use to discuss about FP methods with their husband and most of husband give positive response. This result corroborates with the finding of previous study done in Chad (Laurie, 2004). In contrast to these results, a study in Ethiopia showed more than half partners do not discuss on FP and use of FP methods is also low (Ogunjuyigbe, 2002). These findings can suggest that if women discussed with their husband there is less chances of disapproval of using FP methods. Despite of some side effects the majority of the married women suggests other to use the benefits of family planning methods. The reason for not-use of family planning method is 'not need', health condition and husband will.

I found that higher educated women always participated in the household decision making. A similar finding was obtained in the previous study however, they have also suggested other factors like economic status, husband wife relations and number of children affects the household decision making (Dev, 2010). Previous study done in Nepal reported that decision making of the women is positively associated with the employment and number of children (Dev, 2010). However, we only analyze the association between the household decision making and occupation in our study. We found that most of the married women always participate in the household decision and most of them are self-employed. As of previous study carried out by Mona Sharan, 80% of couple jointly decides on FP methods use (Mona, 2002), most of the married women in the study area decides jointly on the use of family planning methods. Study has demonstrated that joint decision of family planning between spouses is the most effective (Namuunda, 2014). In our study, most of the women having higher education takes the joint decision on FP methods while in majority of home where women is illiterate, husband take the decision of FP methods. A similar trend was found in the study done in Nuwakot where most of the

respondents are illiterate and joint decision FP methods use is low (Sushmita, 2016). Education of the married women directly affects the decision making on household and use of family planning methods. The study revealed that most of the women with all occupations use to decide FP methods jointly with their husband. According to Marie et al (2006) study husband occupation significantly affects the joint decision making on FP methods use but not wife occupation. Similar type of non-significant data was obtained in another study from India (Vijayasree, 2017).

There is strong evidence to conclude that education status of women has strong power to raise decision making ability on their marriage, household and use of FP methods. In contrast, occupation of the married women only affects the household decision making not the joint decision on using family planning methods.

The most popular feminist theory liberal feminism also focuses on the equality and practices of individual freedom and rights in to the lives of women. Some feminists also argue that women should have the similar rights related to property and decision making as their male counterpart and they believe changes in equal opportunities and education policies will end patriarchy (Trueman, 2019). Our society is also the male dominant society. Similar to the context of liberal feminism theory, our findings also suggests that the level of education hugely affects the decision-making process of married women. Higher the education of the married women higher the active participation on household discussion and more capacity to take the decision on family planning.

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ANNEX I
INTERVIEW SCHEDULE

This questionnaire is developed for the research work entitled “Decision Making on Use of Family Planning among the Married Women in Urban Area”. The provided information will be used only on research work.

A. Individual Profile

S.N	Questions	Response
1	Age	……years
2	Academic Qualification	1. Illiterate. 2.Literate only 3.Under Primary 4.Primary complete 5.Secondary completed 6. Intermediate 7.Bachelor and above
3	Religion	1.Hindu 2.Buddhist 3.Christian 4. Other …….
4	Caste/Ethnicity	1. Brahman. 2.Chhetri 3.Janajati 4.Dalit 5.Others
5	Family Structure	1.Nuclear Family 2.Joint Family
7	Occupation	1.Self-employed 2.Government services 3.House wife 4.Private services 5.Foreign Employment 6. Other ……
8	Husband's Academic Qualification	1. Illiterate. 2.Literate only 3.Under Primary 4.Primary complete

		5.Secondary completed 6. Intermediate 7.Bachelor and above
10	Husband's Occupation	1.Self-employed 2.Government services 3.Private services 4.Foreign Employment 5. Other ……
11	Main Income source of family	1.Bussiness 2.Agriculture 3.Job 4.Pension 5. Other ……..

B. Knowledge and Practice of Family Planning

No	Questions	Response	skip
12	Do you know about family planning?	1.Yes 2.No	
13	From where do you know about family Planning?	1. Television 2. Radio 3. Social Media 4. Husband 5. Friends 6. Newspaper 7. Others	
14	How many children you have?	1. One 2. Two 3. More than two 4. No	
15	If more than one children, what is the age gap between your first and second child?	1. 1-2 2. 2 years 3. 3 years 4. 4 years 5. More than 4 years	
16	Do you know the ideal age for child bearing?	1. 20-30 2. Doesn't matter 3. Don't know	
17	Do you know the ideal birth spacing duration?	1. 2 years 2. 3 years 3. 4 years 4. More than 4 years	

18	Have your couple used family planning methods?	1. Yes 2. No	
19	Do you discuss your husband about family planning methods?	1. Yes 2. No	
20	Response of husband on using family planning method?	1. Positive 2. Negative 3. Neutral 4. Don't know	
21	What type of family planning method you used?	1. Temporary 2. Permanent	
22	Do you have any known side effects?	1. Yes 2. No	
23	If yes, what type of side effects you feel?	1. Irregular mensuration 2. Bleeding 3. Weakness 4. Others	
24	Have you got family planning awareness training services?	1. Yes 2. No	

C. Household Decision Making Related

S.N	Questions	Response	Skip
25	Who keeps the money of earing?	1. Husband 2. Wife 3. Both 4. Others	
26	Who decides on household expenditure?	1. Husband 2. Wife 3. Both 4. Others	
27	Who take the final decision on investment for the family?	1. Husband 2. Wife 3. Both 4. Others	
28	Do you have any fixed assert on your name?	1. Yes 2. No	
29	Do your husband allow your participation in household decision?	1. Always 2. Mostly 3. Sometime 4. Never	

D. Family Planning Decision Making Related

S.N	Questions	Response	Skip
30	What type of marriage you did?	1. Arrange 2. Love 3. Love-cum-arrange	
31	What was your age at marriage?	……..	
32	Did somebody forced you for the marriage?	1. Yes 2. No 3. Can't say	
33	Who took the final decision for your marriage?	1. Self 2. Parents 3. Joint	
34	Have you planned for your first child?	1. Yes 2. No 3. Can't say	
35	If yes, who took the final decision?	1. Husband 2. Wife 3. Both 4. Others	
36	Are you forced to give birth?	1. Yes 2. No 3. Can't say	
37	If forced, who?	1. Husband 2. In laws 3. Parents	
38	Who decided the total number of children?	1. Husband 2. Wife 3. Both 4. parents	
39	Have you sent all your children school?	1. Yes 2. No	
40	Who decides for children's education?	1. Husband 2. Wife 3. Both 4. Others	
41	Have your couple used family planning methods?	1. Yes 2. No	
42	If used, are you currently using?	1. Yes 2. No	
43	Who decides to use family planning method?	1. Husband 2. Wife 3. Both	
44	What is your view towards use	1. Important	

	of FP method?	2. Not important 3. No idea	
45	Why you use the FP method for?	1. Birth spacing 2. Better health of mother and child 3. Want no more children 4. Can't explain	
46	If you don't use FP methods, why?	1. Husband don't like 2. Not needed 3. Health condition	
47	Are you happy with your decision of using FP methods?	1. Happy 2. Unhappy 3. Neutral 4. No idea	
48	If not, why?	1. Economic burden 2. Negative effect on health 3. Troublesome 4. Don't know	
49	Would you like to recommend other women to used FP methods?	1. Yes 2. No 3. No idea	
50	What is your opinion towards FP methods?	…… ……..	
51	Would you like to say anything else?	…… …… …… …… ……	

'Thank you for your kind cooperation'