

**AWARENESS AND PRACTICES OF THARU WOMEN
ON DEPO-PROVERA INJECTION IN
KATAHARI VDC, MORANG**

By

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RECOMMENDATION

This thesis entitled "**Awareness and Practices of Tharu Women on Depo-Provera Injection In Katahari VDC**" Morang, Nepal carried out by **Kusum Khatiwada** in partial fulfillment of requirements for the Master's Degree in Health Education under my supervision. To the best of my knowledge, this study is original and her independent work. I recommend and forward it for final evaluation to the thesis committee.

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ABSTRACT

This is a field base study which is conducted to find out the awareness and practices of Tharu women on Depo-Provera injection in Katahari VDC Morang Districts. 60 respondents (15-49 years) married Tharu women were selected. The main objective of this study is to analyze the level of awareness and practices of the Tharu women. However, the followings are the specific objectives of the study: to analyze the KAP of married Tharu women about Depo-Provera, to identify the problems related to the use of family planning methods, and to find out access of Depo-Provera to Tharu community of Katahari VDC.

Interview schedule was formulated to collect the information of the respondent. Data were carefully checked and analyzed according to the objectives of the study. Nepal is a kaleidoscope of a number of communities. Here live many different different castes, races, and ethnic groups. They have special beliefs, identities and behaviors. Therefore, health related practices differ across communities. So far, there is no specific study on Tharus regarding family planning. Likewise GOs and NGOs are working in this field but there is no concrete evidence of effectiveness or achievement in practice of family planning in the context of Tharu women. Therefore, the problem is stated as "Awareness and Practices of Tharu women on Depo-Provera Injection in Katahari VDC of Morang District".

Males are more educated in comparison to their female counterparts. Compared to 27.27 percent of male population have received primary and 29.09 percent secondary level of education- only 12.28 percent and 14.04 percent women have received primary and secondary education respectively. Similarly, Compared to male illiteracy of 21.82 percentage; 63.16 percent women had not received any formal education. And 18.18 percent of male have received higher level of education but only 3.51 percent of women have received higher level of education. This indicates a gender bias in educational status. More respondents (68.33) percent of total have got married between 13-18 years. Among them 13.33 percent, 11.67 percent and 3.33 percent have got married between the age of 19-21 years, 10-12 years and 22-24 years respectively. 46.67 percent of husbands of the respondents were married between the ages of 16-18 years, followed by 19-21 years 21.67 percent, 13-15 years 16.67

percent and 10-12 years and 22-24 years 8.33 percent and 6.67 percent respectively which is low as the average age at marriage for male is 23.6 years and 20.3 years for female.

In this study, most of the respondents were informed about the devices through health workers because reaching health facility in the Tarai is easy due to favorable geographic condition. It may be attributed to the low literacy rate; very few percent of the respondents were well-versed through their spouses. Among the respondents 66.67 percent are found practicing injection Depo-Provera to delay pregnancy and 33.33 percent never practiced this contraceptive. Of all the respondents who were using injection Depo-Provera have the willingness to continue it, and 25 percent of the respondents who were not using, reported that they intend to use this device in upcoming days. On the other hand, 75 percent of the non-user respondents said that they would not use any of the contraceptive methods in future.

The public sector is the predominant source of the Depo-Provera. Majority of the respondents (87.5 percent) named health post as the main source of Depo-Provera supply where as 12.5 percent named Private clinics as the source. It also indicates that nobody named NGOS/INGOS as their source of the devices. Among users nobody had the side effect of Depo-Provera, they said. Respondents don't know how the injection works to delay pregnancy. Respondents don't know about the hormone's name that is in the Depo-Provera. All 66.67 percent respondents, who were used Depo-Provera knew if they used Depo-Provera, they would be free from the unwanted pregnancy.

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ABBREVIATIONS

AIDS	=	Acquired Immune-Deficiency Syndrome
BS	=	Bikram Sambat
CBS	=	Central Bureau of Statistics
CDC	=	Curriculum Development Centre
DPHO	=	District Public Health Office
DOHS		Department Of Health Service
FCHV	=	Female Community Health Volunteer
FDA	=	Food and Drug Administration
FP	=	Family Planning
FPAN	=	Family Planning Association of Nepal
IUCD	=	Intrauterine Contraceptive Device
INGO	=	International Non Governmental Organization
KAP	=	Knowledge, Attitude and Practice
MCH	=	Maternal and Child Health
MMR	=	Maternal Mortality Rate
MoH	=	Ministry of Health
NGO	=	Non- Governmental Organisation
NPC	=	National Planning Commission
OCP	=	Oral Contraceptive Pills
PGR	=	Population Growth Rate
TU	=	Tribhuvan University
VDC	=	Village Development Committee
WHO	=	World Health Organization

CHAPTER-I

INTRODUCTION

1.1 General Background of the Study

Our country Nepal is one of the most beautiful country in the world. It is located between 80°04' to 88°12' east longitudes and 26°22' to 30°27' north latitudes. Nepal is bordered with People's Republic of China in the north and Republic of India in the east, south and west. The total land area of the country is 1, 47,181 square kilometers that is 0.03 percentage of the world's total land.

Nepal is divided into three ecological/geographical regions: namely mountain, hilly and the Terai. Politically it is divided into different divisions and sub divisions such as 5 development regions, 14 zones, 75 districts, 240 electoral areas; and 9 Illakas of each district. Village Development Committees (VDCs) and Municipalities are the lower administrative units in a district.

However, Nepal never came under claws of prolonged war, mentionable natural calamities for a long period of history. But it is feeling some non-tolerable pains according to the point of view of health such as malnutrition, high maternity-and-child mortality rate, illiteracy, poverty, racial isolation, over population growth and its several adverse consequences as crowd, deforestation, environmental pollution, unsafe drinking water and prevalence of communicable diseases etc.

Population growth is one of the world's most continuing environmental concerns. It was the major topic at the International Conference on Population and Development in Cairo in 1994. Women's reproductive health and population control are linked to the issue of RPG throughout the world. Moreover, the status of women in society pervades all aspects of reproductive health. No society treats women and men equally; and often the health and well being of women are compromised by a combination of negligence and abuse.

In this context, health becomes and is being a most important and highly used term, which is heard and mentioned, everywhere in the renowned literatures: even in street board, in the voice of political leaders, or doctors and teachers. The meaning of health is being contextual and relative. Here, it will not be the matter of debate that “to be healthy is a fundamental human right.” Because of the health of human being starts from the fertilized ovum to death (womb to tomb). Nepal, a small landlocked country sandwiched between giant neighbors China and India has been experiencing the rapid population growth. The total population of Nepal is 23.2 million which is growing at the rate of by 2.2 % and total fertility rate is 3.1 annually (NDHS, 2006).

To control the population growth and to promote the health of people; education, especially population education can play a vital role. Through education all the people can gain knowledge, develop attitudes and practice according to their various context about planning a family. Moreover, population education can play a significant role in reducing child mortality, increasing life expectancy and developing the quality of life of the people.

A large section of the women (47.11%, 2006) are illiterate due to our traditions, beliefs, and poor economic conditions and are ignorant regarding health practices. This cause high fertility and high infant mortality, too. Nepal has a number of communities grouped into different castes, races, and ethnic groups, with special beliefs, identities and behaviors. Therefore, health related practices differ across community.

In this regard, Depo-Provera designed to provide a constellation of methods that reduce fertility, enhance maternal and neonatal health, child survival, and bring about a balance in population growth and socio-economic development, resulting in an environment that will help the Nepalese people to improve their quality of life.

1.2 Statement of the Problem

The development of a country depends upon the level of education of its people. Education determines the knowledge, attitudes and about any principle or process. All the health principles, behaviors, processes, thus are determined mostly by the

education and some other economic, socio-cultural factors. Similarly, their level of education, social, cultural, economic status and availability of facilities and use of Depo-Provera also determine knowledge, attitude, and practice of family planning of any community or family.

It is evident that in our Nepalese context, women are more responsible to be careful for their families and family planning activities. But female literacy rate is very low, i.e., 25 % roughly. Moreover, it is less in adult females (24% roughly). Generally, more than 70% of women are deprived of awareness and practices of depo-provera. Education facilities for girls in have been increasing in developing countries. Participation of girls in education is increasing. A number of research studies have shown that fertility is inversely related to wives' education (education of women). It will have a favorable effect on fertility reduction. While the contraceptive use rate is quite low in Nepal (about 33.4%) in 2006 A.D. it is seen that most couples knows contraceptives and the former resistance to their use has been reduced, especially in urban areas.

On the other hand, population growth rate is high (2.25%). total fertility rate is high (4.1%) and acceptors of contraception are 439,613 (2058/59BS), population per hospital bed is 4,409 and population per doctor is 5870. In spite of investment of money, time, and manpower, these major indicators show that Nepalese people are denying or not valuing the ideal family having one or two children. This is due to our tradition, superstition, and negative attitude towards modern family environment. Our grandparents are still blessing us as "Santanle Dandakanda Dhakun" (may your sons and grandsons cover hills and dales), "Jasko Bhaisi Usko Ban. Jasko Chhora Usko Dhan" (The more the sons the more the wealth) is a strong proverb used by traditionalists against family planning.

Realizing the seriousness of problems of population growth, National Planning Commission (NPC) formulated multi-sectional population strategy in 1993 to achieve the international goal "Health for All by 2000." The total fertility rate 6.3 per women was targeted to reduce to 2.5 by 2000 and population growth rate of 2.66% (1981) was targeted to reduce to 1.2 % by the same year but the achievement of the targeted percentage is low due to the other factors.

The married couple of childbearing age using contraceptives is only 51.6% (Ministry of Health, 2065BS). However, some communities are so frustrated, uneducated, unaware, backward and exploited that they do not know the meaning of right and duties and responsibilities on them. In this regard, family planning service are designed to provide a constellation of methods that reduce fertility, enhance maternal and neonatal health, child survival and bring about a balance in population growth and socio-economic development, resulting in an environment that will help the Nepalese people to improve their quality of life.

The present study is concerned with the Tharu Community of Katahari VDC, Morang district. Although, Tharus are spread all over the Southern Terai belt and Inner Terai of Nepal, there is some peculiarity in socio-economic condition of Tharus in Katahari VDC, Morang than other parts of the Nepal. Although the Tharus of Katahari VDC are living together with other ethnic groups because the population of Katahari VDC consists 14 ethnic groups according to census report of 2058 B.S., most of them cannot speak Nepali language and bear hesitation to take any kinds of health services including family planning. Because of their conservative thinking, most of the women in Tharu community even reject to pronounce their husband's name.

In this situation, there are some NGOs and INGOs working in the VDC in the field of agriculture, sports, income generating, and family planning and so on. Youth clubs and cooperatives are organized in some wards. Let us hope they will do something for Tharus to bring them in mainstream of national development. This study was concentrated in the problem of family planning activities, with awareness (mainly knowledge and attitude) and practices and concerning variables such as educational, cultural, socio-economic and age factors etc. There is no factual study on Tharus regarding family planning. Likewise GOs and NGOs are working in this field but there is no evidence of effectiveness or achievement in practice of family planning in the context of Tharu women. Therefore, the problem is stated as "Awareness and Practices of Tharu women on Family Planning Device Depo-provera Injection in Katahari VDC of Morang District".

Specially, this study will attempt to answer the following questions.

- a) What are the present practices on depo-provera in the community?

- b) What are the factors that are affecting the depo-provera practice?
- c) What are the problems and issues of using depo-provera in that community?
- d) What are the awareness practices of depo-provera in that community?

1.3 Objectives of the Study

The main objective of this study is to analyze the level of awareness and practices of Tharu women. However, the following are the specific objectives of the study:

- a. To analyze the KAP of married Tharu women about depo-provera.
- b. To identify the problems related to the use of Depo-provera.
- c. To find out access of depo-provera in Tharu community of Katahari VDC

1.4 Significance of the Study

The main goal of this study is to find out the level of awareness and practices of depo-provera of Tharus in a limited area. The major significances are listed as follows:

- a) The results of this study will be helpful to give feedback for running MCH/FP programs in Tharu as well as other communities with similar circumstances/characteristics.
- b) It will be helpful to plan and launch new programs in this community related to family planning.
- c) This study will be helpful for curriculum planners to develop or modify curriculum for formal as well as non-formal sectors.
- d) The findings of this study will be a secondary source for further researchers.

1.5 Delimitations of the Study

Every study has its own limitations. Due to the limited time and budget, the present study is limited in the following areas.

- a) This study area is limited within the Tharu community of Katahari VDC, Morang.

This study will be limited within the two aspects of using Depo-Provera i.e. awareness and practices only.

- b) The data and information is collected from the married women of childbearing age group only.
- c) The findings of this study may not be generalized for all other communities nation-wide and in the same manner.

1.6 Definition of Terms Used

Tharu:

Tharu, the fourth major population (6.5%) in Nepal, is a kind of ethnic group in Nepal mainly inhabitant of the Terai region, also called “Dharti Putra” of the Terai.

Awareness:

Knowing something, knowing that something that exists and is important, being interested in something: an awareness of the importance of family planning and its consequences.

Family planning:

The 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 decisions by individuals and couples, in order to promote the health and welfare of the family group and thus contribute effectively to the social development of a country." (Park, I.E. and K. Park, 1991)

Knowledge of family Planning:

The gained understanding and familiarity by formal, non-formal and informal education about family planning is known as knowledge of family planning.

Attitude of family planning:

Way of feeling, thinking or behaving positively or negatively about the family planning.

Practice of family planning:

Ways of performing or habit on application of the method/devices of family planning.

Fertility:

Fertility means the actual (total) child bearing capacity of women during her full reproductive period. (15 to 45 or 49 years)

Contraceptive Method:

Contraceptive methods are, by definition, preventive methods to help women avoid unwanted pregnancies. They include all temporary and permanent measures to prevent pregnancy resulting from coitus.

Depo-provera:

Depo-provera is a hormonal contraceptive birth control device which is injected every 3 months of fecund female.

CHAPTER-II

REVIEW OF RELATED LITERATURE

Depo-provera is an injection given to women every three months in order to prevent pregnancy. Luella was a drug similar to depo-provera, and was injected once a month. However, two short years after the FDA approved its use in 2000, Lunelle was recalled by its manufacturer (Pharmacia), and it is no longer available.

One way depo-provera works is by reducing a woman's chances of ovulating. However, since it changes the lining of the uterus, it also can cause early abortions when breakthrough ovulation occurs. With perfect use the effectiveness of the shot in preventing pregnancy is very high—about 99 percent. But with typical use 3 percent of women become pregnant each year.

Few drugs have a more controversial history than depo-provera. In the 1950s a scientist for the pharmaceutical company Upjohn was experimenting with the hormone progesterone, and he created depomedroxyprogesterone acetate (depo-provera). By 1960 the company received FDA approval for the drug as a treatment for endometriosis and habitual miscarriages. However, ten years later the FDA revoked this approval because there was no evidence that the drug worked. Instead it seemed to cause heart defects in babies.

But while the drug was being tested on women in Brazil, researchers discovered that it was also able to prevent pregnancy. As a result of this finding, Upjohn decided to seek approval for the drug as a contraceptive. Studies began on rats, and results looked promising. The FDA granted the drug Investigative Drug Status. This means that it appeared safe based upon previous animal studies, and so research could continue on other animals—and humans. Despite the fact that the drug was still in the early testing phase, doctors from Jamaica to Los Angeles were already prescribing it to women as the newest contraceptive. Hatcher, et al., *Contraceptive Technology*, Nineteenth Revised Edition

By 1965 the drug was being tested on women in foreign countries. A few years later studies began on dogs, monkeys, and over ten thousand women in Atlanta (a

disproportionate number of whom were poor and black). The dogs developed breast cancer, and the monkeys developed endometrial cancer. But as for the women in Atlanta, no annual reports were given to the FDA, as required. After eleven years investigators went to assess the situation because of “something funny going on.”

What they discovered was that the women were not given adequate information about the side effects, consent forms were absent, and women with medical conditions were given the shot despite the fact that the drug could endanger their health. Some women died of cancer, and others committed suicide (depression is now a well-known side effect of depo-provera). Researchers lost track of most of the women in the study, and the research was disregarded.

Years later researchers studied more women from the same area in Atlanta. However, this time they followed up with the women (again, most of whom were poor and black). The scientists showed that about half of the women quit taking the shot after a year. Their main reason was that they were displeased with the side effects. Nonetheless, the summary of this research was entitled “depo-provera: an excellent contraceptive for those who continue to use it.” Today African-American women continue to be the primary targets of those who promote depo-provera, and they are twice as likely to use the drug as white women. Likewise, the poorer a woman is, the more likely she is to be prescribed depo-provera.

Because depo-provera was found to cause cancer in beagles, veterinarians stopped giving it to dogs, and the animal version of the drug (Promone) was taken off the market. Testing continued on women, however. A member of the FDA’s Bureau of Drugs testified, “Animal data for this drug is more worrisome than any other drug we know of that is being given to well people.” Unfazed, the pharmaceutical company pushed the drug overseas. According to the makers of the drug, they paid government officials, hospital employees, and others more than \$4 million in the early 1970s in order to secure sales of depo-provera internationally.

Despite urgings from those in favor of the shot, the FDA denied approval of depo-provera at least three times because of safety concerns for both mother and child. Meanwhile, the drug was being used on millions of women in over ninety countries, such as Nigeria, Belize, Honduras, El Salvador, Costa Rica, Thailand, India, and other

developing nations. Reports of liver cancer, decreased bone mass, and children born with extra or missing fingers didn't help Upjohn's prospects of legalizing the drug in America.

However, in 1991 the World Health Organization published the most comprehensive research of the time, reporting no increased risk of cancer of the liver, ovaries, or cervix. It even demonstrated a protective effect against endometrial cancer. However, breast cancer risk was doubled in the first five years of use. With this new research Upjohn again asked the FDA to approve the drug in 1992. Numerous groups protested, including the National Women's Health Network, the National Black Women's Health Project, and the National Latina Health Organization. Despite their objections, the FDA approved the drug in October 1992.

At the time, the acting president of Planned Parenthood was ecstatic, calling the approval "a very exciting development that is long overdue." Many women did not share his enthusiasm. Since the approval in 1992, many women's groups have united to request that the FDA impose a moratorium on the use of the shot. While many women do not experience serious side effects from depo, other women have gone off the drug, saying, "This hideous poison should never have made it out of the lab."

Even after the FDA's approval of the drug, many countries were still hesitant to license it. In 1991 Canadian women's groups and various health associations petitioned their government to keep the drug out of the country. They wrote, "We urge the government to stand by their decision of 1988, and to remain committed to protecting the health and safety of Canadian women." Aware of the side effects of depo-provera, advocates of women's health were especially concerned about the fact that the shot was "currently being prescribed to teenagers, the physically and mentally disabled, immigrant, Native and Inuit women without their informed consent." M. R., et al., *Depo-provera: An Excellent Contraceptive for Those Who Continue to Use It*, Primary Care Update for Ob/Gyns 5:4 (July 1, 1998), 172.

Unfortunately, these protests were not heeded, and the drug was approved for use in Canada in 1997. But by 2005 women seeking compensation for their suffering brought a class-action lawsuit of \$700 million against the makers of the drug.

Objections to depo-provera span the globe. Women's groups in India requested a complete ban on the shot, which had been approved for marketing in their country before the necessary safety trials had been completed. They wrote, "In a country where a large percentage of women in the reproductive age suffer from anemia, irregular and heavy bleeding can have catastrophic consequences. Studies have shown that injectable contraceptives like depo-provera can also lead to osteoporosis. This can have grave consequences for poor women with low bone density due to poor nutritional status. The evidence available is already damning and it would be unethical to subject more women to clinical trials with these contraceptives."

One reason the FDA approved depo-provera was that the U.S. was concerned with population control in third world countries, whose governments were hesitant to approve a drug that was not even licensed in the country that created it. Thankfully the women's groups in India won a victory for women's health in 2002, when the Indian government cancelled its plan to introduce depo-provera through the government health services systems.

In September 2004 the makers of depo-provera received more bad news about their drug: it increases a woman's risk of contracting certain STDs. According to the journal *Sexually Transmitted Diseases*, when a woman takes the shot, she triples her chances of being infected with gonorrhea and chlamydia (which can sterilize a woman).

Depo-provera can pass through a mother's breast milk to her child. Most studies do not show adverse effects on the baby. However, one study of women who took the shot two days after the delivery of their baby showed it had substantial consequences. The babies in this group had a 75 percent higher incidence of infectious diseases visits to the doctor in their first year of life. Women on depo-provera tend to experience weight gain according to how long they have been on the drug: five pounds in the first year, eight by the second, fourteen by the fourth, and over sixteen pounds by the sixth year.

The first and most effective study done in the field of family planning was "Nepal Fertility Survey 1976." It provided valuable data on fertility of Nepal and related aspects as knowledge, attitude, practice of FP, breastfeeding and family size

preferences. Its immediate objective was to provide data to evaluate the progress of National Family Planning Program in terms of the level of knowledge and actual practice of contraception.

Nepal Contraceptives Prevalence Survey Report for Dang District mentions, knowledge of specific method in Dang is not too different from the country as a whole. Female sterilization recognized by, 46% is the most familiar method followed by male sterilization 31 % and the oral contraceptive pill 25%. Only 15% recognized the condom. Among ethnic groups, only 2% of Tharu women were using contraceptive methods.

Learning about the contraceptive methods from health worker was the most popular channel of communication in Dang and national surveys. The study shown that 73% of married women preferred health worker, 12% preferred radio and 8% preferred group meeting. The population size and its change is most significant parameter of government expenditure. Consequently, fertility regulation strategies can act also as expenditure regulating expenditure in the end.

The knowledge of family planning has been conveyed to the majority of couple in Bangladesh, the current rate of contraceptive use in Bangladesh is low, i.e. 31.1 percentage. With regards to selected demographic and socio-economic factors related to contraceptive use, the results from the 1989 Bangladesh Fertility Survey (BFS) supports the hypothesis that women's education is the most important factor, it is followed in importance of women's participation in family planning decision making.

Serbanescue, Morish (1995) provided a variety of information from the "1993 Romanian Health Survey on Attitudes, Knowledge and Belief about Child Bearing, Modern Contraception, Abortion, Women's Decision Making and Reproduction Roles". In this study, 54 percent of total respondents correctly reported that the greatest chance of pregnancy occurs midway between menstrual periods. Knowledge of the menstrual cycle is lowest among rural women, women under 20 years and even unmarried ones. Knowledge increases with the level of education and socioeconomic status. Seventy five percent women under 25 years, 38 percent of women aged 35-39

years and 21 percent of women in 40-44 years age group desire more information on the subject. Seventy four percent have trust in an obstetrician for reliable information on contraception. Thirty three percent of women do not know the fact that a women can get pregnancy at the very first sexual intercourse, seventy eight percent agree that it is acceptable for a women not to bear children.

Summary of statistics (Biro Pusat Statistic, 1995) were provided from the analysis of the 1994 "Indonesian Demographic and Health Survey" among 28,168 married women aged 15-49 years. The report showed that the use of contraception was highest among 25-34 years age group, women with 2-3 children, women with some secondary education and women living in urban areas. Place of delivery varies by province, but 90% deliver at home.

Pudasaini, (1994) argued that almost 75 percent of the maternal mortalities and morbidities are preventable by improving care during pregnancy, delivery and postpartum period, enhancing obstetric emergency services, timely referral and increasing women's access to quality family planning services. Women's social, economic, legal and educational status will further enhance the survival chances.

Nepal Fertility, Family Planning and Health Survey, (1991) conducted by Ministry of Health, FP/MCH Division and NIV joint venture examined the 'knowledge, attitude and practices about contraceptive devices, their sources of supply including reasons for nonuse' An overwhelming majority of the currently married women (93%) reported knowledge of at least one family planning method. Almost all of the women who reported such knowledge knew of a modern method. This reflects a tremendous improvement since 1986 when the level of knowledge reported to be 56%.

Similarly, 74 percent of all women knew the source of at last one modern contraceptive, which is equivalent to 80 percent when taken as a proportion of those women who knew of at least one modern method of family planning. Among those women who reported to have been aware of the different temporary methods, about one-third of them said that they did not know the sources where to get these methods. This raises question regarding the 'quality' or 'depth' of the knowledge of family planning as presently measured. Overall permanent methods, which include both male and female sterilization, were the most commonly known contraceptives as indicated by the overall level of knowledge (over 80%) as well as the proportions citing them spontaneously (over 40%). It is interesting to

note that though sterilization/voluntary surgical contraception (VSC) are not widely available in terms of the number of outlets, relatively higher proportions of women reported knowing the source of those methods (over 60%) as compared to the other temporary contraceptives (45% or less). M. R., et al., “*Depo-provera: An Excellent Contraceptive for Those Who Continue to Use It*,” Primary Care Update for Ob/Gyns 5:4 (July 1, 1998), 172.

Likewise, among the temporary contraceptives, an oral pill was the most commonly known method (66%) followed by injectable. Overall, 24 percent of all currently married women reported being aware of IUD and only 15 percent knew where to obtain them. Understandably, very few women know the diaphragm, foam or jelly, which is not a part of the government family planning program. A noticeable general pattern is that, compared to the permanent methods, the temporary contraceptives were less known, and required a higher degree of prompting and their sources were less clearly perceived. Women who revealed that they did not intend to use contraceptives at any time in the future were further asked the reason for their disinclination to use contraceptives. Thirty-eight percent of women said that they did not intend to use contraception since they wanted children. This reason was more pronounced for women aged less than thirty years of age as 7 out of 10 women (69%) said that they did not intend to use because they want more children as compared to only 17 percent for women aged more than thirty years. The other major reason for non-use was side effect (13%) women who were menopausal or had undergone hysterectomy and women who had difficulty in becoming pregnant (11%). In all the three reasons for non-use, majority of women were 30 years of age or above. Surprisingly, few (less than 1%) said that the contraceptives were hard to obtain.

The proportion of new acceptors of different spacing methods recruited in the FY 2065/66 is the total new acceptors about half were depo-provera users followed by Condom (28.85 percent) and Oral Pills (19.23 percent). (DoHS 2065/66)

Literatures reviewed above are similar to the content and methodology of present study, which are considered to provide basic guidelines. Most of the study tried to find out women's awareness and practices on family planning. There are more studies in Magar, Gurung, Tamang and Tharu communities and the like, but no study on awareness and practices of family planning has been made on Tharu community so far. Therefore, the present study aims to bridge this gap in the field of health education study of Nepal.

CHAPTER - III

RESEARCH METHODOLOGY

3.1 Research Design

The present study is descriptive research design in its nature. The study is focused on obtaining information about existing conditions of Depo-Provera awareness, attitudes and practices of Tharu women at Katahari Village Development Committee in Morang District.

3.2 Population of the Study

All the Tharu married women (15-49) of Katahari, wada no 2 and 3 was the population of the study. Where total no of Tharu was 535 among them married tharu women (15-49) were 135. Married Tharu women were selected respectively on the basis of using drawn one name at a time.

3.3 Sources of Data Collection

The study is based mainly on primary source of data. The information was collected from field survey at Katahari Village Development Committee in Morang District. Married Tharu women (15-49) years and Health worker of health post were the source of information. Secondary data were drawn from literatures such as from relevant books, journals and annual report of DOHS etc.

3.4 Sampling Size/Procedure

Sixty respondents were selected from wada no 2 and 3 of Katahari VDC respectively on the basis of simple random sampling eg lottery method.

3.5 Data collection Tools and Instruments

The questionnaire was the main tool for the collection of necessary information. The tool was developed on the basis of related references. The tool was submitted to the

Health Education Department. The main purpose of the questionnaire was to collect information of respondents on awareness and practice in relation to depo-provera.

3.6 Validation of Tools

After developing research tool, a trail test was done on 10 women having same characteristics of Katahari VDC, Morang for establishing its practicability and reducing ambiguity and difficulty. Necessary revisions were done and modified as per feedback. Thus, the tool was finalized as per feedback from the pretest as well as teachers of Health Education Department. Research tool is given in appendix.

3.7 Data Collection Procedure

At first, the researcher visited the VDC office with an authorized request letter and explained the reasons of the study. After this, the researcher prepared the list of villages residing Tharus. For assistance, a friend (An inhabitant of Katahari-6) who could understand local language was selected. Then the researcher visited home to collect the necessary information and data with the assistant. Before asking formal questions, the researcher and his assistant tried to motivate them to answer the questions without any hesitation. After performing informal exchange and explaining about the study, the information was collected on the basis of interview schedule. The questions, which were originally drafted in English and asked in Nepali and in their local language as needed.

3.8 Methodology of Data Analysis and Interpretation

After collecting needed data, that was analyzed and interpreted quantitatively. For this, the raw data was tabulated in a master chart according to the objectives of the study and variables. Gathered data was analyzed and interpreted descriptively with the help of the computer.

CHAPTER - IV

ANALYSIS AND INTERPRETATION OF DATA

This Chapter deals with analysis and interpretation of the data that were collected from field survey. The data were tabulated and kept in sequential order according to the need of the study. Then the data were analyzed with the help of the computer on the basis of percentage and ratio. Tables and figures have been used to make the presentation more clear and meaningful.

4.1 Demographic and Socio-economic Characteristics

The demographic and socio-economic characteristics of the population play a vital role in the life status of the people as well as in the development of the country. The development of a country depends upon its demography natural resources, and socio-economic status of the people, food production and qualitative services. Population growth creates problems of poverty, housing, migration, education, health, environment and lack of health awareness; and this leads to high morbidity and mortality. Therefore, public health depends upon the harmonious relationship between the number of people and family planning devices practices. It is understood that the question of family planning is virtually concerned with demographic and socio-economic status of the population.

The section of the study presents the analysis of age composition of the respondents and their husbands', educational status of respondents' and their family, occupational status of respondents' and their husbands', production from land and their annual income.

4.1.1 Age Composition of the Respondents

The respondents defined for the study were those women who were married aged 15-49 years, and lived together with their husbands ever since.

Table -1
Distribution of Respondents By Age

Age Group	Number of Respondents	Percentage
15-19 Years	10	16.67
20-24 Years	23	38.33
25-29 Years	15	25
30-34 Years	4	6.67
35-39 Years	6	10
40-44 Years	2	3.33
Total	60	100

Source: Field Survey, 2011

Table 1: Shows the distribution of Mother's age in terms of convenient five years interval ranging from 15 years to 44 years. In this study, majority of the respondents (38.33%) belong to the age group of 20-24years followed by respondents of 25-29 years (25%), 30-34 years (6.67%), 15-19 years (16.67%), 35-39 years (10%), and the remaining 40-44 years (3.33%). This is due to early marriage tendency of Tharus as well as other communities. Early marriage, which is not good for health of mothers as far as their offspring, is a practice common in rural communities in South Asia.

4.1.2 Educational status of the study population

The educational level of males and females aged 6 years and above of the sample household's population is shown in Table 2. Of the total population shown in 42.85% had not received any formal education, which is less than census 2001(46.26%).

Table-2
Distribution of Study Population by Educational Status

Education	Male	Percentage	Female	Percentage	Total	Percentage
Illiterate	24	21.82	72	63.16	96	42.86
Non formal	4	3.64	8	7.02	12	5.36
Primary	30	27.27	14	12.28	44	19.64
Secondary	32	29.09	16	14.04	48	21.43
Higher	20	18.18	4	3.51	24	10.71
Total	110	100	114	100	224	100

Source: Field Survey, 2011

Table 2 shows that males are more educated in comparison to their female counterparts. Compared to 27.27% and 29.09 percent of male population had received primary and secondary level of education respectively, only 12.28 and 14.04 percent women had received such level of education respectively. Similarly., Compared to male illiterate 21.82 percent, 63.16 percent women had not received any formal education and 18.18 percent of male had receive higher level of education but only 3.51 percent of women had received higher level of education which is indicates a gender bias in educational status.

4.1.3. Educational Status of Respondents

Education plays great role and prepares required manpower for the development and change in the community as well as for the nation. Educational Condition of a community reflects the level of people's awareness and its solution.

Table – 3
Distribution of Respondents by Educational Status

Education	Number of respondents	Percent
Illiterate	32	53.33
Non-formal	8	13.33
Primary	12	20
Secondary	6	10
Higher	2	3.33
Total	60	100

Source: Field Survey, 2011

Table 3 indicates that the educational status of the respondents is very poor, where 53.33 percent are still illiterate, which appears very high. Only 3.33 percent of the respondents having higher education and 10 percent having secondary education was found. Besides, 13.33 percent of the respondents can read and write with the help of non-formal education and 20 percent of the respondents have passed primary level.

4.1.4 Occupational Status of Respondents and their Husbands.

Occupation leads human beings towards certain direction and it can make their life comfortable as well as enjoyable. Occupational status plays a vital role for promotion and protection of individual's as well as community health. The occupational distribution of all women aged 15-49 and their husbands are given in table 4. The table reveals that 100 percent of the women's main occupations agriculture (including housewifery).

Table 4

Distribution of Respondents and Their Husbands by Occupational Status

Occupation	Husband	Percent	Wife	Percent	Total	Percent
Agriculture	15	25	60	100	75	62.50
Business	2	3.33	-	-	2	1.67
Govt. Service	3	5	-	-	3	2.5
NGO/INGO	2	3.33	-	-	2	1.66
Private/wages	38	63.33	-	-	38	31.66
Total	60	100	60	100	120	100

Source: Field Survey, 2011

The table shows that the most of the male's (63.33%) occupation is private service or daily wage earning where as 25 percent and 3.33 percent male's occupation is agriculture and business respectively. In government service and NGO/INGO, 5 and 3.33 percent, males are engaged. In total, 62.5 percent were engaged in agriculture, which is the back bone of Nepalese economy.

4.1.5. Production of land and annual family income

The main production of the study area is rice, wheat, mustard potato, maize and masuro (a kind of legume) All respondents had some land (ranging from some dhur to some bigaha) to cultivate their food. Among them 36 respondents (60%) said their production was sufficient for family sustenance for the whole the year and 24 respondents (40%) said their production was insufficient.

Table 5
Annual Family Income

Amount (Rs)	Number of respondents	Percent
Up to 20 thousand	4	6.67
21 to 30 thousand	20	33.33
31 to 40 thousand	16	26.67
41 to 50 thousand	15	25
More than 50 thousand	5	8.33
Total	60	100

Source: field Survey,2011

Table no.5 shows that 33.33 percent of the respondent's family income lies between 21 and 30 thousand per year. Likewise 26.67 percent and 25 percent of the respondents' family income lies between 31 and 40 thousand and per year and 41-50 thousand per year respectively. 6.67 percent of the respondents' family income lies below 20 thousand per year and 8.33 percent of them more than 50 thousand per year.

4.2 Marriage and Family Planning Device Practice

A well established inverse relationship exists between a women's age at marriage and her fertility. In Nepal, religious beliefs and practices exert immense pressure on individuals to marry early and to produce at least one male offspring. As a result, marriage is almost universal. Further more as most births occur within marital unions, marriage held the exposure of women to the risk of pregnancy and therefore, is important for the overall understanding of fertility.

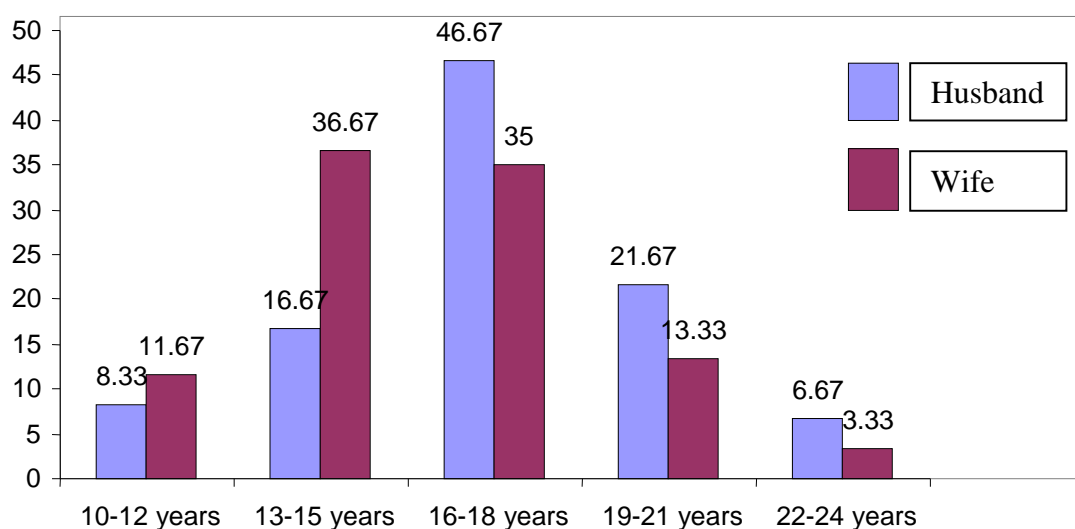
4.2.1 Age at Marriage

Under the existing laws, the minimum age at marriage is 21/18 for boys and girls respectively, with the consent of parents. However, consent is not required if both boy and girl are 21 years or over. It should be noted that marriages take place at an early age in Nepal. This is hazardous for motherhood, their young, and planning their family.

Figure 1 shows that more respondents (68.33%) had got married between 13-18 years. Among them 13.33 percent, 11.67 percent and 3.33 percent had got married between the age of 19-21 years, 10-12 years and 22-24 years respectively.

The figure also shows that 46.67 percent of husbands of the respondents were married between the ages of 16-18 years, followed by 19-21 years 21.67 percent, 13-15 years 16.67 percent and 10-12 years and 22-24 years 8.33 percent and 6.67 percent respectively which is low as the average age at marriage for male is 23.6 years and 20.3 years for female. (MOPE 2060 B.S.)

Figure 1
Age at Marriage



It is revealed that early marriage is prevailing in the Tharu community and mostly females get married earlier than males. This is because of illiteracy as well as lack of awareness about safe motherhood and family planning devices.

4.2.2 Children ever born

A strong negative relationship exists between the level of women's education and fertility. For example, the marital fertility rate among women with some secondary

level of education is lower by two children than among women with no education. (NFHS, 1993)

Table -6
Distribution of Children Ever Born

Total births given		Live	Percent	Died	Percent	Total Percent
Son	48	43	37.07	5	4.31	41.38
Daughter	68	60	51.72	8	6.90	58.62
Total	116	103	88.79	13	11.21	100

Source: Field Survey, 2011

Among the born children of the respondent's life cycle up to the data collection of this study, 37.07 percent son and 51.72 percent daughter are alive but 4.31 percent son and 16.90 percent Daughter had died. Besides this, 1 (1.67%) respondent was pregnant during fieldwork of this study. Her gravid number was 2nd.

4.2.3 Access of Mass Media

Information on women's exposure to mass media (Radio and Television) was also collected in this study. Table 7 gives the distribution of respondents' access to radio and television.

Table -7
Access of Mass Media

Radio/ TV		Percent	Radio	percent	TV	Percent	Both	Percent
Yes	50	83.33	16	32	10	20	24	48
No	10	16.67						
Total	60	100						

Source: Field Survey, 2011

The survey results showed that 83.33 percent households had the facility of mass media where as 16.66 percent had not. Among 83.33 percent, 32 percent respondent had radio only, 20 percent had television only and 48 percent households had radio and television both.

4.2.4 Source of Information about Family Planning Device (Depo-provera)

There are various communication media of inform people about depo-provera: they are health personnel, electronic medias (Audio, Visual and Audio-visual), printed materials etc. To obtain reliable information about this the respondents were asked question about first information on depo-provera. It was found that 100 percent respondents had heard about various methods of family planning devices that a couple can use to delay or prevent pregnancy.

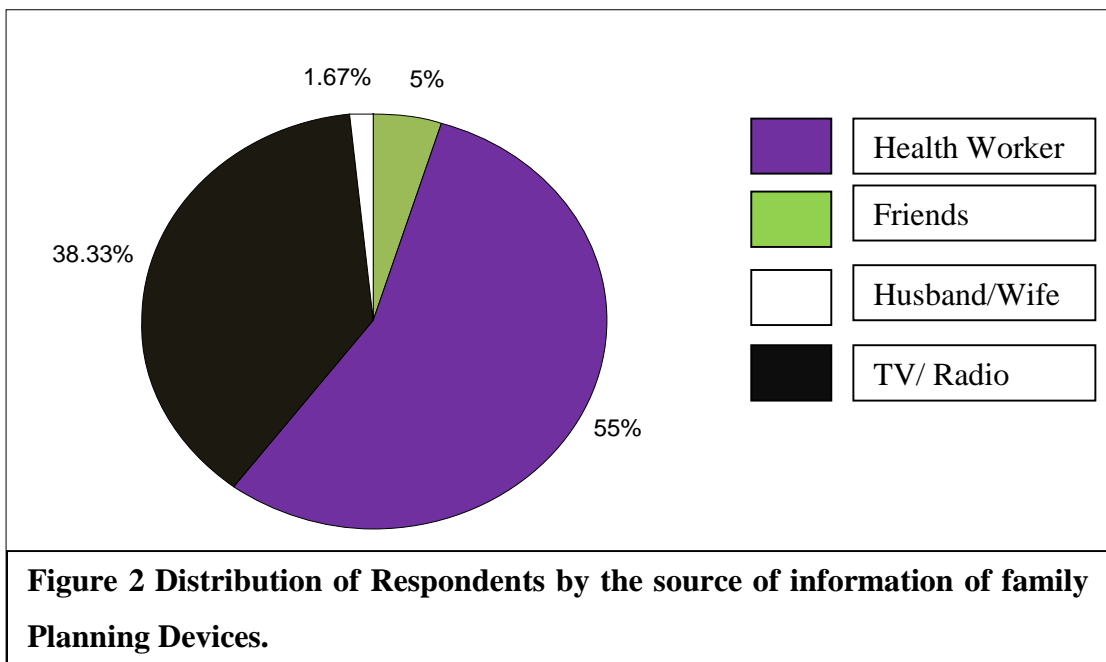
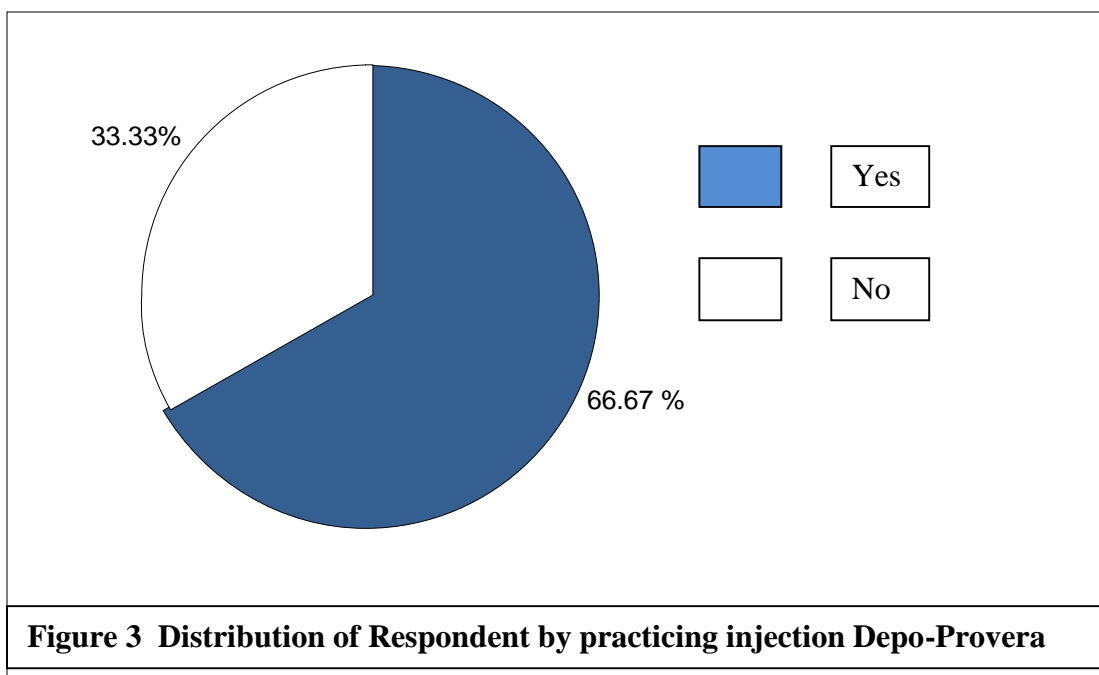


Figure 2 Shows that the majority of the respondents (55%) were informed by health workers and the least (1.67%) respondents were informed by their spouse to each other, 38.33 percent and 5 percent respondents were informed first by television / radio and friends respectively.

4.2.5 Use of Injection Depo-Provera

In order to access the injection Depo-Provera practices each respondents were asked whether they used or not used injection Depo-Provera to delay or prevent pregnancy.



The figure shows among the respondents 66.67 percent practiced injection depo-provera to delay pregnancy and 33.33 percent didn't practice this contraceptive.

4.2.6 Main Reasons for Not Using Depo-provera

According to the obtained data, 33.33 of the respondents were not using depo-provera any time in their life.

Table 8
Reasons for not using injection Depo-provera

Reasons	Number of Respondents	Percent
Ignorance	12	60
Fear of Side effect	4	20
Uneasiness to use	-	-
Religious belief	-	-
Others	4	20
Total	20	100

Source: field Survey, 2011

Table 8 shows that 60 percent of the respondents do not use depo-provera because of their ignorance about family planning. Other stated, 20 percent didn't use because of fear of side effects.

The table indicates that not a single respondent shows uneasiness to use and religious belief as a cause for not using injection Depo-Provera. Likewise 20 percent respondents told that they did not intend to use contraceptives due to several reasons such as want of son, getting newly married, not living together with their husbands, and pregnancy.

It is disclosed that the majority of the Tharu mothers had not practiced injection Depo-Provera due to ignorance that indicates the need for launching effective population education programme in the Tharu community.

4.2.7 Intention to use Depo-Provera in Future

All the respondents who were and weren't using injection at the interview were asked about their intention to use contraceptive in future. The distribution of respondents among users and non-users is presented in table 9.

Table 9
Intention to Adopt Depo-Provera in Future

Intention	Respondents	Percent	Among users	Percent	Among non-users	Percent
Yes	45	75	40	100	5	25
No	15	25	-	-	15	75
Total	60	100	40	100	20	100

Source: field Survey, 2011

Table 9 clearly shows that 100 percent of the respondents who were using injection Depo-Provera have the willingness to continue it and 25 percent of the respondents who were not using, reported that they intend to use this device in upcoming. On the other hand, 75 percent of the non user respondents said that they would not use any contraceptive methods in future.

It is revealed that 75 percent of the mothers are found aware about advantages of injection Depo-Provera and intends to use and give continuity in using in future

4.2.8 Source and Access of Injection Depo-provera

While knowledge on source of different contraceptive is a measure of 'availability' and distance to this source indicated by time required to travel of the source is a measure of 'accessibility'. It is well documented that improvements in the availability and accessibility, of family planning methods lead to its increased use (Ross, 1989).

At the time of data collection, all the Depo-Provera users were asked to report the source for supply of injection it and time of reach the source.

Table 10
Source and Access of injection Depo-provera

Source of Supply	Respondents	Percent	Travel Time to the Source
Sub/Health post	35	87.5	Less than 60 minutes
Private clinic	5	12.5	30 minutes
NGO/INGO Volunteers	-	-	
Total	40	100	

Source: Field Survey, 2011

The data given in table 10 obviously indicates that the public sector is the predominant source of Depo-Provera. The majority of the respondents 87.5 percent named health post as the main source of Depo-Provera supply where as 12.5 percent named Private clinic as the source of Depo-Provera. It also indicates that nobody named NGOs/INGOs as their source of the devices.

However there is a health post as a governmental health facility, the time required to travel from the respondents' home to a health post is less than 60 minutes (one hour). Due to plain and Semi urban area, there are many privates' clinics, which require 30 minutes' walk to reach and obtain the device. It clearly indicates that contraceptives are easily accessible in the study area.

Among the users of Depo-Provera nobody has a side effect. They don't know how the injection works to delay pregnancy and nobody knows about the hormone that contains in the Depo-Provera. On the other hand, all respondents (66.67) who practiced Depo-Provera know that if we use depo-provera we will be free from unwanted pregnancy.

CHAPTER- V

SUMMARY, FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Summary

There is great concern regarding the control of population as a pre-requisite to development of a country. A publication by the National Commission on Population highlighted the acuteness and serious concern and recommended multiple factors such as political, social, economic, cultural be also taken into account. It stressed the need to narrow down the gap between government's concern and individuals' perception regarding the population problem.

The study has been carried out to examine awareness and practices of injection Depo-Provera among Tharus based on primary data. Katahari VDC of Morang District was selected purposively. From the total married women of 15-49 years, 60 respondents were selected with the help of simple random sampling. The detailed study was limited to married Tharu women.

Reviewed many literatures and studies directly and indirectly related to the present study, it was found that the awareness level and practices of injection Depo-Provera is not in due proportion. It is essential to involve men in family planning programs, and for this purpose, special information and training schemes should be organized by concerned organization.

However, the principle objective of this study is to explore the Depo-Provera practices of Tharu community. To fulfill the objectives of this study some selected socio-demographic variables are taken as main influencing variables on marriage and family planning device practices. This study is descriptive in its nature. The questionnaire was the only tool used for the collection of primary data. On the process of collecting information, the respondents were visited door to door. Necessary information was collected from 60 respondent mothers of the Tharu community.

After collecting the necessary information, the data was tabulated in a master chart and later it was analyzed and interpreted with the help of tables and figures.

5.2 Findings

The major findings of this study are as follows:

1. 38.33% of the respondents belonged to 20-24 years. No respondents were found above 44 years.
2. More than Fifty percent of the respondents were illiterate.
3. The males were found more educated in comparison to the females.
4. Total respondents' occupation was agriculture (including housewifery) and among their husbands only 2.5 percent in government service 1.66 percent in NGOs/INGOs and 1.67 percent are engaged in business.
5. All respondent's family had land ranging from some dhur to some bigaha as 60 percent said their production was sufficient for family sustenance for a whole year and 40 percent said their production is insufficient.
6. 33.33 percent respondents' annual family income was in between 21 thousand and 30 thousand rupees.
7. Early marriage was found customary in study population and mostly females got earlier married than males.
8. It was found that 83.33 percent have the facility of mass media.
9. 55% respondents were informed by health workers about Depo-Provera.
10. Higher proportion 66.67 percent of the respondents were using Depo-Provera and 33.33 weren't using it.
11. Since nobody said the religious belief as a cause for non-using Depo-Provera and among the non-users the maximum 60 respondents stated ignorance as a cause.
12. 75% of the mothers are found aware of the advantages of Depo-Provera and intend to use and give continuity on using it in future.
13. The result indicated that the public sector was the predominant source of inj. Depo-Provera. It was revealed that almost 87.5% named health post and only 12.5 named private clinics.
14. Among the users nobody reported the side effect of Depo-Provera.
15. Respondents don't know how the injection works to delay pregnancy.
16. Respondents don't know the hormone's name that contains in the Depo-Provera

17. All respondents who practiced Depo-Provera were aware that if they stop the Depo injection, after some period they can be pregnant again.

5.3 Conclusions

Based on findings of the study the following conclusions are drawn:

This study gives a clear portrait of the situation of injection Depo-Provera practices of the Tharu community of Katahari VDC, Morang. The population of the study area is backward, since the occupation of all respondents is traditional agriculture (including housewifery) and the majority of the respondents' husbands' occupation is private daily wage earning.

Marriage at early age is most prevailing in Tharu community, that is not good from the point of view of health and education about age at marriage must be publicized to eliminate it.

Health workers are the most effective media to spread the information about family Planning Devices. No respondents mention religious belief as a barrier for not using contraception. This is an affirmative characteristic in the context of family planning.

Overall observation of the study indicates that the injection Depo-Provera practices are still influenced by marriage at early age, low socio-economic status, illiteracy gender bias and traditional beliefs. According to my research most of the married female were aware about the Depo-Provera injection and above sixty percent of the married women practice this activity in daily behavior.

5.4 Recommendation

5.4.1 Recommendation for further improvements:

- a. Health education programs should be conducted for mothers group, traditional healers, community leaders and school teachers.
- b. The findings of this study would be helpful for curriculum planned to develop or modify curricula for formal well as no-formal sectors.

- c. Special efforts should be made to improve the real family income through income generating activities and further development of shared responsibility for family planning can be expected. This improves the social status of women.
- d. The findings of this study might be censured to launch new programs in this community.
- e. The findings of this study might be censured as feed back for running MCH/FP programs in the Tharu as well as other communities living in similar circumstances.
- f. Motivation programs for men should be launched in the study area to make them accept male contraceptive devices as well.

5.4.2. Recommendations for further study:

- a. This type of study should be conducted to find out injection Depo-Provera practices in different parts or across different communities of the country.
- b. A relative study should be carried out in injection Depo-Provera practices between regional area, geographical areas, social, cultural and religious groups as well as other multidimensional groups or areas.
- c. The findings of this study might be consulted as a secondary source for further researchers.
- d. Similar types of study should be conducted to explore the relationship between educational attainment and family planning.

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APPENDICES

Appendix A: Questionnaire

Tribhuvan University

Awareness and Practices of Tharu Women's on Depo-provera in Katahari

VDC of Morang District

Questions on General Information

1. Household No.....

Date:.....

Ward No.....

Tole/Gaun:.....

2. Name of the respondent:

Age:

Age of the respondent's husband:

3. Academic qualification of the respondent:

Illiterate.....

Literate: Non-formal.....

Primary level.....

Secondary level.....

Higher level.....

4. Number of family members.....

5. Educational status of family:

Description	Illiterate	Non-formal	Primary level	Secondary Level	Higher level
No of male					
No. of Female					

6. Occupation (Total)

Description (Occupation)	Husband	Wife
Agriculture		
Business		
Government service		
NGO/INGO		
Private/Daily wages		
Others		

7. Is there land property with your family?
 Yes.....No.....
 If yes, mention the area:
 Bigaha.....Kaththa.....Dhur.....
8. What is the annual production from the land? (Amount in quintal)
 Rice..... Wheat..... Mustard.....
 Maize..... Potato..... Others.....
9. Is this production sufficient for family sustenance for the whole the year?
 Yes..... No.....
 If not how many months will it turn?.....Months.
10. What is the amount of income from the occupation? (Whole family)
 Rs...../day, Rs...../Month Rs...../Year
11. Do you have a radio or television? Or both?
 Yes.....No.....
12. At what age were you and your husband got married?
 Husband..... Wife.....
13. Are you pregnant now?
 Yes.....No.....if yes, Gravid number.....
14. Have you ever given birth?
 Yes.....No.....(If no, go to question number 16)
15. Description of the children:
 a) Total number of births given- Son/s.....
 Daughter/s.....
 b) Number of living children- Son/s.....
 Daughter/s.....
16. Have you ever heard about Depo-Provera injection that can delay or prevent pregnancy?
 Yes..... No.....
17. From where/whom, did you get the first information about Depo-Provera?
 i) Posters/pamphlets.....v) Friends.....
 ii) Wife/husband.....VI) Health workers.....
 iii) Radio/television..... vii) NGOs/INGOs
 iv) Volunteers.....

18. Have you ever used Depo-Provera to delay pregnancy?
 Yes.....No.....(If no go to question number 20)
19. What is the main reason why you have not ever used Depo-Provera?
 i) Ignorance.....ii) Religious belief.....(iii) Discomfort.....
 iv) Fear of side effects..... (v) Others.....
20. Do you think that you would like to adopt Depo-Provera in future
 Yes..... No.....
21. How many children are required for an ideal family in your opinion?
 i) Son.....ii) Daughter.....iii) Total.....iv) Don't
 know.....
22. From where do you get Depo-Provera?
 i) Health post/Sub Health Post.....
 ii) NGOs/INGOs volunteers.....iii) Private clinics.....
25. How much time does it take to reach the source of devices?
 i) Half an hour.....ii) One hour.....iii) More than one
 hour.....
23. Do you know the side effect of Depo-Provera injection.
 Yes.....No.....
24. If yes.....
25. Do you know, how does Depo-provera work?
 Yes.....No.....
26. If yes, how
 a) Prevents from Ovulation b) Kills Sperm c) makes vaginal mucus
 more thicker
27. Do you know which hormone does Depo-provera contain?
 a) Yes b) No
28. If yes
 a) Estrogen b) Androgen c) Testosterone d) Progesterone
29. If you are using the Depo-shot, can you get pregnant?
 a) Yes 2) No

Thank you