CHAPTER–I

INTRODUCTION

1.1 Background

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

Nepal is considered to be one of the least developed countries in the world, Nepal's per capita income is only 310$ (WDR, 2004), whereas the annual growth rate of the population is 2.24 and the growth rate of GNP per capita is 2.2 (WB, 2002), and Nepal ranks 142 position in the HDI (2009, HDI) (Human Resource Development Index). Likewise 38 percent of the population lives below the absolute poverty line and 85.8 percent of the population lives in rural areas (CBS, 2001). The main occupation in the rural areas is agricultural (59.6%). IMR of Nepal is 64:34, CMR 92.2 per thousand and data indicate that 42.49 percent female and 65.8 percent male are literate in Nepal. Life expectancy of Nepalese people is 60.8 years (CBS, 2001). In this context, the illiterate people do not have the knowledge and an understanding of the importance of family planning: what it means and why they should practise it.

In the past, the population growth was not considered a serious problem but now it is recognized as one of the most crucial problems that the world is facing. Therefore, a majority of developing countries now realize that a population policy is necessary to meet the challenges of the high population growth.

The population appears to have been growing rapidly during the past four decades in Nepal, due to the continuous decline in the death rates on the one hand and the continuing high fertility rate on the other hand. Nepal is supposed to have experienced one of its highest population growths, at a rate of 2.6 percent per annum, during

1971/1981. It was reduced to 2.08 percent per annum during 1981/91 (CBS, 1991). However, the rate slightly increased up to 2.27 percent per annum during 2001 (CBS 2001). If this growth rate continues, the population of Nepal is certain to be doubled within the next 30 years.

Though migration, fertility and mortality are all responsible for the change in the size of the population, human fertility is the major factor. Like most developing countries, Nepal is suffering from a high-fertility problem. Despite the existence of governmental and non-governmental family-planning programmes, the total fertility rate in Nepal is 4.1 per woman (NPR, 2007) which is higher in comparison with the other developing countries of the world. One of the important and responsible factors for this problem is a low contraceptive prevalence rate of 3 percent in 1976 (NFS, 1976), 7.6 percent in 1981 (NCPS), 15.1 percent in 1986 (NFS, 1986), 25 percent in 1991 (NFAFPS, 1991), 29 percent in 1996 (NFHS) and 38.9 percent in 2001 (MOPE, 2001). The ninth five-year plan emphasized raising the contraceptive prevalence rate up to 30.1 percent by the year 2000 and up to 58.2 percent by the end of the 12^{th} five-year plan.

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

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

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

- Spacing or limiting their children.
- Preventing unwanted pregnancies.
- Promoting adolescent reproductive health and
- Managing infertility. (NPR, 2007).

The status of currently using contraceptive methods among married but non-pregnant women is as follows:. Any modern method – 42.1 percent, sterilization – 24.3 percent, pills 2.8 per cent, Depo-Provera 10.1 per cent, condoms 2.6 percent, Norplant's 1.3 percent and IUCDs 1.1 percent (DoHS, 2006/07).

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

The issues of a rapid population growth, poor socio-economic conditions, worsening of family health and of communicable diseases have all been a challenge to human civilization globally, except for some developed countries. Similarly environmental hazards, low rates of literacy, poor accessibility to physical facilities and to involvement in development opportunities are prominent in those countries where ignorance of FP services still prevails among the population. So to solve problems as

mentioned above FP service could exist as a milestone. Furthermore, attention to review, analysis of the present context, making hypotheses, forecasting possible situations, exploring new dimensions, formulating policy, implementation of planning, the follow-up and evaluation of programmes in the field of family-planning services are all still necessary elements. This means that more and more tasks need to be done in this field. To promote family planning; (FPAN), NGO, INGO, the Ministry of Health and other health institutes have to work more actively in Nepal.

1.2 Statement of the Problem

Most of the Nepalese people depend on agriculture work. They have a very poor socio-economic status and their educational status is even lower. It is calculated that 85. Percent of the total population resides in rural areas (CBS, 2001). In Nepal, the population has been increasing rapidly due to high fertility, low contraceptive prevalence and a continuous decline in the death rate due to modern health technology. In Nepal, for many women marriage and child-bearing will occur at an earlier age than the legal age of marriage, e.g. less than 16 to 18 years, and child-bearing occurs almost exclusively within the confines of marriage. The consequences of child- bearing at an early age are babies with a low birth-weight, congenital complications, maternal and neonatal mortality. Adolescents who become pregnant within two years of menarche have a higher incidence of prenatal complications since their babies are still physiologically and anatomically immature. This implies that the health situation of the Nepalese people is quite serious. Most developing countries are suffering from a high fertility rate and a rapid population growth, including Nepal. Although the level of awareness concerning FP and contraceptive methods has risen since the 1991-96 period, the overall practice of family planning is still very low. Rural and urban differences are great. Most people do not have any knowledge of the importance of FP, what it means and why it should be practiced so, in the rural context, the utilization of FP services is very poor. Use of any modern contraceptive methods in rural Nepal is 24.3 percent as against 45 percent in urban areas (CBS, 2001). Among the *ecological* regions the use of the FP service is lowest in mountain areas (16%) whereas in Terai and in the Hills it is 26.2%. Contraceptive prevalence rate (CPR) is 40 percent (CBS, 2001). According to the Nepal Population Report of 2007, demand for contraception is 67 percent of currently married women. The

current use of contraceptive methods is 48 percent in 2006 (NPR, 2007). This means that currently married women in Nepal have an unmet need for FP services.

According to the Annual Report of the Department of Health of 2005/06, current users of FP throughout the country amount to 2,079,096 including those practising spacing method. 893,548 and permanent method is 1,185,547. The total demand for FP services is 67.1 percent where as the contraceptive prevalence Rate (CPR) is 42.1 percent (DOHS, 2005/06). The present use of contraception among non-pregnant women is as follows: Any modern method 44.2 percent, female sterilization 18.0 percent, male sterilization 6.3 percent, pills 3.5 percent, injectable 10.1 percent, condoms 4.8 percent, Norplant 0.8 percent, and IUCDS 0.7 percent (NPR, 2007). In Nepal the knowledge of family-planning services is not yet satisfactory. In the rural context, the knowledge of FP service is in a pitiable condition. The family-planning programme is a joint-venture programme of many GOs, NGOs and INGOs but they are not well-coordinated. This means that only some institutions are trying to focus on FP service in order to reduce (minimize) the fertility problems.

The programmes of family planning services are not effective therefore. Besides, services are not utilized by the people, because of their lack of awareness, low socio-economic status and the influence of conservative concepts. Problems are moreover created due to the insufficient number and the irregularity and irresponsibility of the assigned health personnel, which has a bad impact upon up on the health institutions. In addition to this, people are deprived of because of their frequent compulsive visits to health institutions, even from distant places. Though the use of family-planning methods has been growing steadily, the rate of growing is still low in view of the present demand and supply of service. The family- planning programme is not a success. So, in order to make FP services more effective, formulation of education, communication and awareness campaigns have to be intensified and FP methods of clients' choice should be provided to the people, even in remote parts of the country whenever they need them. Nepal has 4.1 percent TFR, 37.5 percent of CYP, 2.24 percent of RPG and 40 percent of CPR in the sector of family planning. So, intervention is still badly needed to cover the whole problem of marriage-woman-reproductive age (MWRA) in the country. Where the population growth-rate crosses national limitations, the resources of the country cannot meet the people's demands

with all the resulting problems. Among various problems, the problem of health is significant in the country. Family planning services are directly or indirectly concerned with that problem. The present health status of Nepal is as follows: infant mortality rate (IMR) 64.4/1000, child mortality rate (CMR) 91/1000 and life expectancy 60.8 years. So family planning services can play a vital role in the present situation of poor health. The concept of early marriage, trends of superstitious beliefs concerning health and unhygienic health-care practices have greatly influenced the community. The great number of unplanned children and traditional delivery practices has deep roots in the community, in common with lack of education, lack of awareness of health and of health services. This lack of knowledge of a proper use of family-planning devices is the main reason why the community suffers from large family sizes.

Myagdi is a rural district which lies in the eastern part of Nepal. It consists of 41 VDCs. Health services have been providing help through the network of 1 PHCs, 8 health posts, 31 sub-health posts and 143 ORCs, along with the district hospital at Beni. Myagdi is a remote district as its geographical structure. There are no good hospital facilities so, people must go to Pokhara and Kathmandu modern health service. There are many ethnic groups, in Myagdi. They have their own language, culture and life style. Chhantyal is one of these ethnic groups. They have an unique culture and way of living. They have a very poor educational as well as a socio-economic status. The number of the Chhantyal population is 2865, which represents 2.7 per cent of the total population of Myagdi District of Nepal (CBS, 2001) and all of this them are living in rural areas. The purpose sample is the Chhantyal community is in the Kuinemangle VDC of the Myagdi District. The trend of the family-planning programme in the Myagdi district is as follows: Condom distribution 191110, pills – current users 433, and new 463 Depo-current users 1286 and new 1097, IUCD – current users 532 and new 66, Norplant – current users 46 and new 38, male sterilization current users 4067 and new 90, female sterilization – current users 946 and new 55, where contraceptive prevalence rate (CPR) is 29.5 per cent (Annual Report, DHO, 2064/065).

The above descriptive statistical figures show that the utilization of family-planning services is in a pitiable condition and therefore the quality of life is very poor. The

Chhantyal people, who live at the Kuinemangle VDC, have a very low literacy rate, a low socio-economic status and they are highly influenced by conservative behaviour. Furthermore, Chhantyal people are marginalized and in fact deprived of modern resources. The utilization of FP services and maternal child health is low. For this reason I felt the need to investigate the utilization of family-planning services among the Chantal community in the Myagdi district of Nepal.

1.3 Objectives of the Study

The overall objectives of the study are to examine the status of knowledge, attitude and practice of family-planning services among the Chhantyal community of the Myagdi district. The specific objectives are given below:

- To explore the demographic and socio cultural characteristics of respondents.
- To identify the current trends and knowledge of family planning services and their using practice among the Chhantyal community.
- To identify the reasons for use and non-use of family-planning service among married women of reproductive age.
- To examine effectiveness of family planning

1.4 Significance of the Study

The main aim of the study is to find out about the utilization of FP services provided by governmental institutions. Although a family-planning programme was conducted four decades back, the result does not seem sufficient because of problems, such as high IMR, a high fertility rate and the still low contraceptive prevalence rate (CPR). (In this way, it has been tried to reach the target of family planning programme.) The family health status and traditional believes and practices of family planning are a significant part of the study. The study will attempt to find out about the awareness of family-planning services and about the participation of community people in the health programme, arranged by local public and private institutions. It will provide the actual national figures by generalizing the municipality level study, especially where family planning is concerned. Furthermore, the study seeks to find out barriers of, knowledge and practices of FP services in rural areas among the Chhantyal

community. This research will be helpful for other scholars who wish to get more information on Chhantyal ethnicity and the area. The study may also be useful for local governmental organizations and policymakers. NGO's and INGOs as a baseline study in the field of family planning.

1.5 Limitation of the Study

Every study has its own limitations: no study can cover whole areas or issues. The following issues are the delimitation of the study.

i. The study will be based on the Kuinemangle VDC in the Myagdi district.

ii. The respondents are exclusively Chhantyal married women of reproductive age (15 - 44 years).

iii. Thirty percent of the houses will be selected from Kuinemangle for the interview.

1.6 Definition of Terms Used

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

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

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

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

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

Infant: Child under five years of age

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

Laparoscopy: Female sterilization as a permanent family planning method.

Menarche: First incidence of menstruation cycle in a female.

Pills: Oral tablet of temporary contraception.

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

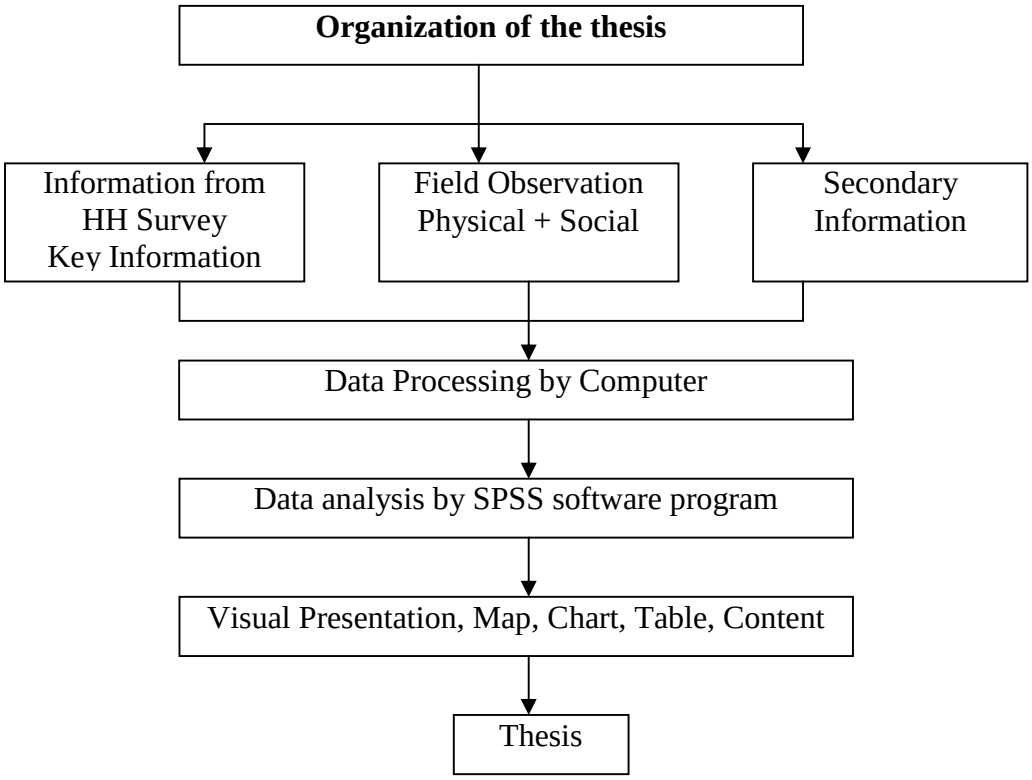
Prevalence: Frequency of incidence.

Sterilization: Permanent method of contraception.

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

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

1.7 Organization of the Thesis



CHAPTER - II

REVIEW OF RELATED LITERATURE

The research attempts to review the extensive list of past studies relevant to family-planning services in Nepal as well as the world. Research is not possible without a review of the literature. It provides a reference and the tools to formulate a proper guideline and the idea for a conceptual framework.

2.1 Theoretical Literature

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

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

NDHS stated that awareness is lacking of how to convert the need especially for temporary family-planning methods into a demand. Due to the rough training and lack of social support, women, children and marginalized ethnic groups are deprived of utilizing the health services that are offered at present. They mainly live in isolated communities, so that the villagers must sometimes walk a distance of 8 km. to access primary health services (DHO Myagdi report 2064/065).

Due to the lack of family-planning services, the population is growing rapidly and, if this gets beyond control on a national level, it will play a key role in health problems. Nepal, a small country, has many problems concerning health and health services. Part of the major health problems are high TFR and RPG, low CPR and low CYP, a low nutritional status, lack of awareness of family-planning services and communicable diseases . Similarly, the poor quality and the inequitable distribution of health services, the poor accessibility of health services, defective decisions especially on the policy and planning level in the health sector, contribute to a poor status of Nepalese health. Poor management and an almost total lack of coordination, support and supervision in the health services are responsible for ruining the people's health. Poor management resources coupled with their scarcity, a poor transport and communication system, the increasing commercialization at the expense of deprived people are some of the ugly features deeply rooted in the health-care system (PSI 2005).

Research in rural Nepal has also shown that there is a huge gap between the knowledge of mothers regarding family-planning methods and family health, and its practice, indicating a lack of access to health services. There is a similar gap between those who do not want more children and those who are actually using a method to alert or to avoid new births (PSI 2005).

2.2 Empirical Literature

Kafle (8: 2000) attempted the "Study on Family Health of Danuwar Community" at Panchkhal VDC of Kavre. He found that most of the women had heard about family planning. The effective communication medium was the radio. Male persons had undergone permanent sterilization more often than females, whereas females had used temporary devices. Depo-Provera use was higher than that of other devices. Most of the couples had undergone sterilization after more than four children. However, most

of the women had preferred two children of either sex. A majority of the Danuwar people had obtained family-planning services through hospitals (DHO Myagdi report 2063/64). So, it shows that strong cultural practices and gender equality has been playing major roles for adoption of family planning devices.

The socio-economic impact on RH in the Tharu Community of Semlar VDC Rupandehi found that most of the people had got their information about FP through radio and television. Only 36.5 percent of the people had any knowledge of family planning, 20 percent of the people aspired to have two children for an ideal family. Among the people as a whole 30.4 percent used family-planning methods whereas almost all of the people with a secondary or higher level of education used FP methods. A majority of family-planning users applied temporary methods, nearly 40.00 percent of the people performed the birth spacing for more than two years. A majority of the people were ignorant of reproductive health methods (Poudel 2001).

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

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

New Era (1990), has done an "Impact study on maternal child health and family planning project in Kavre district." It was found that the infant mortality rate had significantly declined between 1986 and 1990. The contraceptive prevalence rate had also significantly increased from 16.3 to 21.3 percent. The medical check-up rate of pregnant women had increased almost three-fold over four years due to the programme of JICA. Through the JICA programme, about one-third of the women had received TT during pregnancy. The JICA programme made the women aware of

the need of using boiled (sterilized) tools for umbilical cord cutting, of feeding colostrum and of practicing breastfeeding. These practices were very high (90%) in the area where the programme had been conducted (New Era 1990).

S.R. (2004), "A study on married women's knowledge, attitude and practices of family planning methods" in Bakrang VDC of the Gorkha district, the researcher found that 61.7 percent of the respondents had knowledge of family planning methods, however, only 42.6 percent of the respondents were practising them. In regard to ethnic groups, the knowledge of contraceptives was found the highest in Chhetri, lower cast people using contraceptives were the lowest in number in comparison with their ethnic groups (Aryal, S.R. 1994: 3).

Gurung, Newar and Magar people have a negative attitude towards the family-planning programme. Fear of side-effects of using family-planning methods was found as the main cause of this negative attitude. The reasons for not using family-planning methods were the desire of a son (40.5%), effects on health (37.9%) , and the religion (41.2%) of respondents (Shrestha 2000).

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

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

followed by service holders (3.2%) and mothers married after 26 years of age (3.5%). (Panta, I 1995: 26).

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

A studied "Effectiveness of contraceptive devices in Gitanagar VDC of Chitwan" found that (34.38%) of contraceptive users were from low economic households, (45.2%) were from middle and (36.36%) from high groups. In this VDC he found that a higher level of contraceptive users was found in the middle income group Poudel, (20: 1999).

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

The international conference on population and development (ICPD) Cairo, represented the shift in focus in the population field as critical Before ICPD, the concern lay with achieving demographic targets, largely through the provision of family-planning services whereas afterwards the focus shifted towards the broadly defined reproductive health services, which recognized women's reproductive rights

and their need for empowerment. Human rights, human development and individual well-being became the centre of programme policies, since it was realized that for the individual health and well-being of both women and men, to have a small family size is a prerequisite. The new thinking endorsed in Cairo was also that population growth can be established and development efforts can be enhanced particularly through the development of women and by improving their reproductive health (ICPD 1994).

A study revealed that in Nepal, more so than in most other countries of the SAARC region, women have a shorter life expectancy than men. This was primarily due to the risk of child-birth. Almost 40 percent of Nepalese women have their first child between the age of 15 to 19 years. Most births take place at home and an estimated 85 percent were attended by a traditional birth attendant, whose skill and qualities vary across different ethnic groups. Most of their lives are spent in pregnancy or with five or six births, each accompanied by one or two years of breastfeeding. UNICEF stated that 8 percent of the couples were not using contraceptive devices due to the fear of side effects. About 36 percent of women and 31 percent of men had undergone sterilization, 59 percent of the women were using pills, 45 percent of them taking injectable and 36 percent of those using IUCDS UNICEF, (1987 pp. 168-171).

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

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

Concluding Remarks

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

CHAPTER - III

RESERCH METHODOLOGY

3.1 Research Design

The research was conducted in order to establish the utilization of family planning services among the Chhantyal community in the Myagdi district. The research is designed as a descriptive and purposive random sampling in the study. The study will observe facts, conditions and events regarding the utilization of family planning services among married reproductive age groups of women who reside Kuinemangle Village Development Committee in Myagdi district.

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

3.2 Population and the Sample of the Study

The study area accommodates mainly Chhantyal ethnicity. The study population is the Chhantyal community of the Kuinemangle VDC, in the Myagdi district. Altogether there were 1043 Chhantyal population in Kuinemangle VDC. Reproductive age (15 - 44 yrs) women were the study population of this study. For the basis of time and resources twenty per cent of the population has been selected for sample of the study and it is believed that this will be enough for generalization of the result of this study.

3.3 Sampling Procedure

This study was descriptive. There was total 1043 Chhantyal population in Kuinemangle VDC of Mygadi District. Reproductive age population consists of 44.26 percent (census, 2001) of the total population. Thus the reproductive age (15-44 yrs) total population was 462 (1043*44.22% = 461.63) and this was study population. The purposive cum convenience sampling technique was applied to select

the sample size. So, the present study was cover the 20 percent of the study population (462*20% = 92.4) and the sample size covered 93 respondents. Only those women are eligible for response, who are within the 15-44 years of age.

3.4 Data Collection Tools

The study was used scheduled structural and semi-structural close ended questionnaire and interview method. The questionnaire was developed with the consultation of reference materials, magazine, books, reports, and supervisor.

3.5 Data Collection Procedure

First of all an interview schedule was translated into Nepali from English. After the researcher has properly managed to set up an interview schedule, researcher went to the Health Post incharge of Kuinemangle Health Post to seek permission. The researcher gave her introduction, her purpose of research and the persons that were relevant to the research. After obtaining permission from the municipality and suggestions of the HP incharge, the researcher visited different areas for collecting information. According to the suggestions, the researcher makes door-to-door visits to the respondents' houses at a suitable (morning/evening) time to draw up the questionnaire schedule. The researcher continued this work, until information is not be completely collected.

3.6 Validation of Tools

After preparing the research tools the first draft were shown to the supervisor and improved according to the supervisor's suggestions, then the tools were administered to 10 respondents as a pilot study. The research tools were modified according to the feedback obtained from results of the pilot study and suggestions provided by the supervisor.

3.7 Analysis and Interpretation of Data

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

CHEPTER - IV

SOCIO-CULTURAL CARACTERISTICS OF RESPONDETS

This chapter has defined information on demographic socio-cultural and economic characteristics, knowledge, attitude and practice on family planning of the respondents. The demographic, socio-cultural and economic characteristics consist of respondents according to age, district, marital status, race and ethnicity, religion, occupation, education, and economic status.

The chapter deals with the result of the study. The findings are analyzed with reference to relevant national and international data.

4.1 Demographic and Socio-cultural Characteristics

In this research, all respondents are called population. In this study there are some other character of population like age, district, martial status, race or ethnicity, socio-culture, education, occupation and economic status. The findings are analyzed with the reference to relevant national and international data.

Table No 4.1 Ward wise Distributions of respondents

Ward of respondents	Frequency (n=93)	Percentage
1	10	10.8 %
2	22	23.7 %
3	12	12.9 %
5	14	15.1 %
6	11	11.8 %
7	9	9.7 %
8	2	9.2 %
9	13	14.0 %
Total	**93**	**100%**

The above table shows that 23.7 percent of respondents are the representative from ward no? and 9.2 percent of respondents are from ward no?.

4.2 Type of Family

In the context of Nepali, society there are two kinds of family namely as joint family and nuclear family. The following table shows existing family types of the concerned village.

Table No 4.2 Distribution of respondent by family type

Family Type	Frequency (n=93)	Percentage
Nuclear	59	63.4 %
Joint	34	36.6 %
Total	**93**	**100%**

The above table shows that most of the respondents (63.4 percent) are from nuclear family and we could show that couple would allow talking on family planning issues freely in their house.

4.3 Age of Respondent:

This study is concentrated on the women between 15-45 of age group. They are categorized in four sub-groups**. Table 4.3 shows the age distribution of respondents.**

Table No 4.3 Distribution of respondents by age

Age of respondents	Frequency (n=93)	Percentage
Less than 20	43	46.2 %
20 – 29	46	49.5 %
30 – 39	3	3.2 %
Over 40	1	1.1 %
Total	**93**	**100%**

The above table shows that majorities (49.5 percent) of the respondents were between 20 – 29 age groups and 1.1 percent was from over 40 years of age. This age group seems to be more aware of the reproductive health.

4.4 Husband Age

The respective village males get married around 20-29 years of their age**.** This table shows that most of the respondents seem flexible to tell their husband's age.

Table No 4.4 Distribution of respondent by their husband age

Age	Frequency (n=93)	Percentage
Less than 20	14	15.0 %
20 – 29	58	62.4 %
30 – 39	16	17.2 %
Over 40	4	4.3 %
Did not response	1	1.1 %
Total	**93**	**100%**

The above table shows that 62.4 percent of respondents' husbands were married when the respondents were 20-29 of age group and 1.1 per cent did not response.

4.5 Age of Marriage

In Nepali society, marriage is taken as blessing. Early marriage is common in Nepalese society. In context of this village most of them prefer marrying in their twenties.

Table No.4. 5 Distribution of respondents by appropriate age of marriage

Age	Frequency (n=93)	Percentage
Less than 20	10	10.8 %
Over 20	83	89.2 %
Total	**93**	**100%**

The above table shows that 89.2 percent of respondents responded that the appropriate age of marriage is over 20 year of age. And 10.8% respondents responded that the appropriate age of marriage is less than 20.

4.6 Age of first Pregnancy

Generally, married women want to be mother right after their marriage so that they could have better understanding and love in the new family of their husband. The following table shows the tendency of first pregnancy.

Table No. 4.6 Distribution of respondents by age at first pregnancy

Age of respondents	Frequency (n=93)	Percentage
Less than 20	25	26.9 %
20 – 29	51	54.8 %
30 – 39	5	5.4 %
Did not response	12	12.9 %
Total	**93**	**100%**

The above table shows that 54. 8 percent of respondent married when they were 20 to 29 years of age group and 5.4 percent were belonging to 30 – 39 of age groups.

4.7 Occupation

The respective village is also not an exception to mainstream country's occupation. Most of the respondents follow the traditional farming occupation. Only few people are involved in other occupation.

Table 4.7 Distribution of respondents by occupation

Occupation of respondents	Frequency (n=93)	Percentage
Agriculture	85	91.4 %
Government Service	7	1.1 %
Business	1	7.5 %
Total	**93**	**100%**

The above table shows that 91.4 per cent of respondent depended on agriculture and 1.1 percent depended on government services.

4.8 Priority of Child Sex

In most of the communities, they generally prefer male child as their future heir, but respondents in this village are found quite democratic to the sex of the child. This shows that there is good power balance between male and female.

Table No 4. 8 Distribution of respondents by priority of child sex

Sex of child	Frequency (n=93)	Percentage
Male	11	11.8 %
Female	5	5.4 %
Either	77	82.8 %
Total	**93**	**100%**

The above table shows that 82. 8 percent of respondent were reported that they did not have sex selection and they wanted either male or female and 5.4 percent had female priority. We do not see much male dominance in the society there.

4.9 Education

Education level plays key role for the success of family planning program and more educated people well understand the advantage of family planning. The following are the education level of the respondents.

Table 4.9 Distribution of respondents by education

Occupation of respondents	Frequency (n=93)	Percentage
Illiterate	69	75.0 %
Primary	21	22.8 %
Secondary	2	2.2%
Total	**93**	**100%**

The above table shows that 75 percent of respondent were reported that they did not have education and 22.8 percent had primary level of education and only 2.2 percent respondents have secondary level of education. It indicates that there were very less people who were educated and so they had low level of family planning knowledge.

CHAPTER - V

KNOWLEDGE AND PRACTICE OF FAMILY PLANNING

Most of the population has knowledge on family planning. They have been hearing this issue by the various sources in the community. Most of the government health institutes have their activities in the community level. The following tables shows that the present status of knowledge and practices of family planning in the study areas.

5.1 Respondents knowledge on Family Planning

Most of the respondents had knowledge on family planning. They were aware of the family planning issues.

Table No 5.1 Distribution of respondent by knowledge on Family Planning

Knowledge on FP	Frequency (n=93)	Percentage
Yes	80	86 %
No	13	14 %
Total	**93**	**100%**

The above table shows the 86 percent of respondent have knowledge on family planning. Only 14 percent have no knowledge of family planning. In spite of being one of the remotest villages of Myagdi, the respondents seemed well known about the knowledge of family planning.

5.2 Respondent Knowledge on Birth Spacing

Most of the respondents had knowledge about birth spacing which a common in this society. Table 5 .2 shows the knowledge of respondent on birth spacing.

Table No 5.2 : Distribution of respondents by birth spacing

Spacing	Frequency (n=93)	Percentage
Yes	74	80%
No	19	20%
Total	**93**	**100%**

The above table shows that 80 percent of respondent were reported that they were aware of birth spacing. In general they meant family planning is for birth spacing.

5.3 Respondent's Knowledge About Birth Spacing

Normally rural women are unaware about advantage of birth spacing, but the concerned respondents seemed to be aware of the birth spacing while bearing children. Table 5.3 shows the knowledge of respondents on the merit of birth spacing.

Table No 5.3 Distribution of respondents by merit of birth spacing

Merit of birth spacing?	Frequency (n=93)	Percentage
Good Health	70	75.3 %
Education	23	24.7 %
Total	**93**	**100%**

The above table shows that 75.3 percent of respondent were reported that merit of birth spacing is good health. They do not want to bear children immediately after the first one simply because they health will degrade.

5.4 Respondent’s Knowledge About the Family Planning Measure:

In traditional family concept family planning measure were not applied since people were unknown about it. Thanks go to the modern technology and community awareness programs through which the respondents have gained good knowledge about family planning measures.

Table No 5.4: Distribution of respondent by knowledge of family planning measure

FP measure	Knowledge	
	Yes	No
Modern	75 (81.5%)	17 (18.5%)
Natural	2 (100%)	
Total	**77**	**17**

The above table shows that 77 of respondents have heard about modern family planning methods but they did not hear about natural family planning measures. This shows that there is still a lot to do for giving them knowledge about Natural family planning methods.

5.5 Respondent's Knowledge on Permanent Method of Family Planning:

Most of the people still have wrong conception about permanent family planning method**s** simply because of their religious belief and ignorance. Now the awareness of people is gradually increasing. The respondents have heard about the permanent family planning methods. The table 5.5 shows, the respondent knowledge about the permanent family planning measure.

Table No 5.5 Distribution of Respondent's Knowledge on Permanent Method of Family Planning.

Permanent methods of FP	Frequency (n=93)	Percentage
Vasectomy	1	1.1 %
Minilap	69	74.2 %
Laparoscopy	7	7.5 %
Don't know	16	17.2 %
Total all ma	93	100%

The above table shows that 74.2 percent of respondent reported that minilap is a permanent method of family planning.1.1 respondent reported vasectomy is permanent method of family planning, 7.5 percent respondent reported laparoscopy is permanent method of family planning and 17.2 percent respondent has not knowledge of permanent family planning.

5.6 Source of Family Planning Information

The respondents are able to get information about different subject matters including family planning from various sources such as mainly radio/TV, friends, health workers and husband. The table 5.6 shows the source of family planning information of respondent.

Table No 5.6 Distribution of respondents by source of family planning information

Source of FP information	Frequency (n=93)	Percentage
Radio/TV	11	11.8 %
Friends	6	6.5 %
Health workers	64	68.8 %
Husband	2	2.2 %
Did not response	10	10.8 %
Total	**93**	**100%**

The above table shows that 68.8 percent respondents were reported that health workers were the main source of information for family planning.11.8 percent respondent reported that Radio/TV were main source for family planning.6.5 percent respondent reported that friends were the main source of information of the family planning . 10.8 percent respondents did not respond. It also shows that people are rigid and hesitant among and between their friends and partners in context of communication.

5.7 Responsibility of Family Planning

Normally people want family planning to create happy and healthy family so that they could acquire social prestige and prosperous life .The table 5.7 shows that the respondents believe family planning is for different propose.

Table No 5.7: Distribution of respondents by Responsibility of family planning

For whom FP	Frequency (n=93)	Percentage
Family	56	60.2 %
Individual himself/herself	29	31.2 %
Community	2	2.2 %
Unknown	6	6.5 %
Total	**93**	**100%**

The above table shows that 60. 2 percent of respondents were reported that family planning issue is important for family.31 percent respondents were reported family planning issue is important for person. 2.2 percent respondents were reported that family planning issue is important for community.6.5 percent respondent were unknown.

5.8 Knowledge On Side Effect Of Family Planning Measure

People are conscious about the side effect of the family planning which is also been seen and experienced by them in reality. Table 5.8 shows the knowledge of respondents about the side effect of family planning measure.

Table No 5.8 Distribution of respondents by side effect of family planning

Harm of FP	Frequency (n=93)	Percentage
Yes	11	11.8 %
No	53	57.0 %
Unknown	29	31.2 %
Total	**93**	**100%**

The above table shows that 57 percent of respondent were reported that family planning did not harm for their health. Only 11.8 percent respondent were reported family planning is harm for their health.31.2 percent respondent were unknown. It means more then one quarter of the respondents do not have idea on side effect of planning and it might be lack of education.

5.9 First Use Of Family Planning Measure

Generally People either do not know about contraceptive or they do not want to use on purpose simply because they feel shy at their first use .Even then the maturity of respondents (67.7%) responded about the first use of family planning devices. Table 5.9 suggests the response of respondents about their first use.

Table No 5.9 Distribution of respondents by age while first use of family planning materials

Age first use of FP	Frequency (n=93)	Percentage
Less than 20	12	12.9 %
Over 20	51	54.8 %
Did not response	30	32.3 %
Total	**93**	**100%**

The above table shows that 54.8 percent of respondents were over 20 years of age when they used family planning measures first time. 12.9 percent of respondents were less than 20 when they used it first time. 32.3 percent of respondents did not respond

5.10 Favorable Family Planning Measure

The respondents reported that they favor both permanent and temporary method of family planning. Table 5.10 shows the distribution of respondents according to their favorable measure of family planning.

Table No 5.10 Distribution of respondents by most like family planning measure

Methods Most like	Frequency (n=93)	Percentage
Contraceptive	29	31.2 %
Permanent	61	65.6 %
Did not response	3	3.2 %
Total	**93**	**100%**

The above table shows that 65. 6 percent of respondent were reported that they favor permanent family planning method, 31.2 percent of family planning method 3.2 percent did not respond.

5.11 Reason of Family Planning

Previously people did not want to use contraceptive because they wanted to have bigger family so that they could spread elsewhere .But now due to the economic burden, poor health and lack of education, People prefer family planning measure.

Table No 5.11 Distribution of respondents by reason in use of family planning devices.

Reason to adopt FP devices	Frequency (n=93)	Percentage
Economic	43	46.2 %
Education	18	19.4 %
Food	1	1.1 %
Health	26	28.0 %
Others	2	2.2 %
Did not response	3	3.2 %
Total	**93**	**100%**

The above table shows that 46. 2 percent of respondents were reported that they used family planning methods for economic aspect.28 percent respondents were reported that they used family planning method for health aspect. 19.4 percent respondents were reported that they used family planning method for education aspect.

5.12 Birth Spacing

Thanks to the health awareness programme and availability of contraceptive there is positive change about age for birth spacing between first and second child and so on.

Table No 5.12 Distribution of respondents by age for birth spacing

Better years for Birth spacing	Percentage
2 Years	24.7 %
3 Years	17.2 %
3 – 5 Years	55.9 %
Did not response	2.2 %

The above table shows that 55.9 percent of respondent were reported that 3 to 5 years was a better years for birth spacing.24.7 percent of respondent were reported that 2 years was a better years for birth spacing. 2.2 percent were not response.

CHEPTER-VI

EFFECTICENESS OF FAMILY PROGRAM

Most of the people in Nepal have viewed that they like family planning but families have some of the side effects and they thought that due to the some side effects they do not use it. The following are the status of side effects after using the family planning devices.

6.1 Respondents by Effectiveness of Family Planning

Most of respondent replied that they were well understood about the effectiveness of family planning.

Table No 6.1 Distribution of respondents by effectiveness of family planning

Effectiveness of FP service	Frequency (n=93)	Percentage
Well	71	76.3 %
Better	14	15.1 %
No	3	3.2 %
Did not response	5	5.4 %
Total	**93**	**100%**

The above table shows that 76.3 percent of respondents were reported that family planning is well effectiveness.3.2 percent of respondents were reported that family planning is not effectiveness.

6.2 Side Effect of Family Planning

In these study most of the respondents are experienced side effect of contraceptive. Table 6.2 shows the respondent's remark on the side effect of contraceptive and permanent family planning devices.

Table No 6.2 Distribution of respondents by side effect after use of family planning device.

Side effect after FP use	Frequency (n=93)	Percentage
Yes	20	21.5 %
No	44	47.3 %
Did not response	29	31.2 %
Total	**93**	**100%**

The above table shows that 21.5 percent of respondents were reported that they had experienced of some side effect after use of family planning devices. 47.3 percent of respondents reported that that had not experienced of side effect after use family planning.31.2 percent did not respond.

6.3 Respondent Problem After Using Family Planning Device

It is reality to seem some side effect after using family planning device. The respondents of this study reported that they faced different problems after using family planning devices both permanent and temporary contraceptive.

Table No 6.3 Distribution of respondents by problems after use of family planning device

Problem	Frequency (n=20*)	Percentage
Dizziness	5	25 %
Lower Abdomen Pain	3	15 %
Can't feeding baby	1	5 %
Uterus Problem	1	5 %
Weakness	13	65 %
Appetite Loss	1	5 %
Total	**93**	**100%**

The above table shows that 65 percent of respondents had experienced of weakness after use of family planning devices. 25 percent of respondent had experienced of dizziness. 15 percent of respondents had experienced of lower abdominal pain. 5 percent experienced of appetite loss, 5 percent experienced of uterus problem,5 percent experienced can't feeding baby.

6.4 Adoption of Family Planning in Community

The communiny people do not addopt family plannigndevice because they want son .Some have health problem and some have not been allowed by family. Table 6.4 shows the reasons for not addopting the family planning in community .

Table No 6.4 Distribution of respondents by not adopting family planning in community.

Reason for not adopting FP in community	Frequency (n=65)	Percentage
Want of son	35	53.8 %
Not allowed by family	20	30.8 %
Health problem	10	15.4 %
Total	**65**	**100%**

The above table shows that 53.8 percent of people reported that community people do not adopt family planning because they want son. 30.8 percent of then reported that community people do not adopt family planning because they are not allowed by family. 15.4 percent of them reported that community people do not adopt family planning because they have health problem.

6. 5 Accessibility of FP Services

Accessibility of family planning services in the remote area is still a problem in the community. Despite of the government and other non government organization working on the family planning many people does not have access of these services. The status of accessibility of family planning services in the study population as is follows.

Table No 6.5 Distribution of respondents by accessibility of family planning services

FP services available at any time	Frequency (n=93)	Percentage
Yes	90	96.8 %
No	3	3.2 %
Total	**93**	**100%**

The above table shows that 96.8 percent of respondents were reported that family planning services are available in their community.

6.6 Supporting organization for family planning:

VDC,Club and women's groups are supported organization of family planning in Koinemangale VDC. The women's groups are major supportive organization. This table shows details.

Table No 6.6 Distribution of respondents by organization for supporting family planning program

Support organization for FP program	Frequency (n=93)	Percentage
VDC	1	1.1 %
Club	2	2.2 %
Women's group	55	59.1 %
Other	35	37.6 %
Total	**93**	**100%**

The above table shows that 59.1 percent of respondents were reported women's groups were supported to the family planning program in the study areas.

6.7 Distance of Health Intuitions

Distance of health institution is far from respondents .They need to go by foot more than 1 hour. Table 6.7 shows the distance of health institution.

Table No 6.7 Distribution of respondents by distance of health institution

Health Institution by foot	Frequency (n=93)	Percentage
About 10 minute	19	20.4 %
About ½ hours	20	21.5 %
About 1 hour	7	7.5 %
More than 1 hour	40	43.0 %
Did not response	7	7.5 %
Total	**93**	**100%**

The above table shows that 43 percent of respondents were reported that they had more than 1 hrs walking distance for nearest health institute.

6.8 Traditional Values of Family Planning.

In Nepal, traditional values are playing important roles for adopting or not adopting family planning methods. Many individuals and couple have strong belief on traditional values of family planning in the rural areas. The status of traditional values of family planning methods are as follow.

Table No 6.8 Distribution of respondents by traditional restriction of family planning methods

Traditional restriction	Frequency (n=93)	Percentage
Yes	7	7.5 %
No	82	88.2 %
Did not respond	4	4.3 %
Total	**93**	**100%**

The above table shows that 88.2 per cent of respondent were reported that they did not have any traditional restriction of adoption of family planning. Only 7.5 per cent have traditional restriction of family planning methods.

6.9 Respondents Perception on Pre marital Birth

This study is based on rural community of Nepal. In rural areas people are value bound .Their traditional values and norms restrict various practices related to sexual behavior .That is why respondents of this study are reluctant to respond about the premarital birth of a child. They did not like to have pre marital birth of a child .Table 6.9 shows the view of respondent regarding such matter.

Table No 6.9 Distribution of respondents by view of child birth before marriage

Child birth before marriage	Frequency (n=93)	Percentage
No	89	95.7 %
Did not respond	4	4.3 %
Total	93	100%

The above table shows that 95.7 per cent of respondents were reported that they do not like to have child birth before marriage.

6.10 Respondent's Views on Polygyny

Most of respondents did not prefer polygene. Table 6.10 shows the views of respondents regarding polygene.

Table No 6.10 Distribution of respondents by views on polygyny

Polygamy	Frequency (n=93)	Percentage
Yes	34	36.6 %
No	55	59.1 %
Did not respond	4	4.3 %
Total	**93**	**100%**

The above table shows that 59. 1 per cent of respondents were reported that they did not prefer polygamy.

CHAPTER -VII

SUMMARY, FINDINGS, CONCLUSION AND RECOMMENDATIONS

7.1 Summary

In Nepal, the sub-health post is the most peripheral health facility in the health system, with three designated service providers: Auxiliary Health Workers (AHWs), Village Health Workers (VHWs) and Maternal and Child Health Workers (MCHWs). AHWs provide primary health care including clinical services, integrated management of childhood illnesses (IMCI), FP counseling and services (condoms, pills and Depo), infectious disease control and overall management of the SHP as an In-Charge. Family planning services have been available in Nepal for over 50 years, most extensively from the public sector health system, with nongovernmental agencies involved from the very beginning. Social marketing of contraceptives started in 1978. Over the past three decades, FP use has increased dramatically from three percent in 1976 to 44 percent in 2006. Concomitantly, access to FP services has improved tremendously, especially in rural areas through public sector service delivery. Seven modern methods are available, with female and male sterilization (55% of current users) being the most popular followed by Depo Provera® inject able (23% of current us rs). By and large, the inject able is the most popular temporary contraceptive in Nepal s use as doubled in the last 10 years from 4.5% (among all currently married women) in 1996 to 10.1% in 2006 and has the potential to continue to increase given significant unmet need for family planning in Nepal.

This study has analyzed on utilization of family planning services and its effects in health among women in Chhantyal Community of Myagdi District. To study the purposive cum convenience sampling technique was applied to select the sample size and data was collected using structured interview questionnaire. The questionnaire was designed to obtain information on family planning and its effects in health among women and related issues. It is based on primary data gathered from ninety three respondents through structured questionnaire and interview on Feb. and March 2009.
After the collection of data, they were checked, edited and coded. Following that, the data were interred in tabulation and analyzed the collected data by using simple

statistical tools like number, percentage, mean and presented them in table, bar diagram, pie chart and line graph in different topics.

7.2 Findings

The study of "Utilization of Family planning services in Chhantyal Community of Myagdi District" has found some information about the knowledge, experience and practice on family planning in the study population. The major findings are as follows:

1. Most of the study population has nuclear family status. It indicated that they were able to discuss their family planning issues openly among the couples.
2. Almost all respondents were belonged to less than 30 years of age groups.
3. It has also indicated that most of women become mother in their early age and husband age were higher than their partners' age.
4. Most the respondents depended on agriculture for their income in the study population.
5. Over 80 per cent of respondents were told that they were given equally importance of both sexes.
6. Most of the respondents have greater knowledge about the family planning services and methods in the community.
7. They have knowledge about advantages of family planning services as well as they had knowledge of verities of family planning devices which were available in the study areas.
8. The health workers have been played key roles as they were source of family planning services to the community people in the study areas.
9. It has some knowledge about the importance of family planning services in the community.
10. Despite the knowledge and advantage of family planning services, the study population had experienced some of side effects after adopting the family planning devices. They had dizziness, lower abdomen pain and weakness etc.
11. Accessibility of family planning services in the study population is another important factor of this service in the study population. Over 95% of population has accessibility of this service in the community. It indicated that those couple who had need of this services they would get it. Most of the

mothers groups were supporting this program in the community so females' access to this service was appreciable.

12. Due to the geographical location of the study population half of the respondents reported that they needed to walk one hr or more than one hr to get the health facility for family planning services in the study population.
13. Traditional beliefs on family planning services did not have any negative impact in the study population. Most of the respondents did not have any traditional restriction for adopting family planning services in the study areas.

7.3 Conclusion

From the analysis of data on utilization of family planning services and its effects in health among women chhantyal community, we concluded that the level of knowledge and awareness about utilization of family planning services in the study population should be promoted. Most of the women know the family planning services at local level. Similarly large portion of women did not know side effects after adopting the family planning devices and its consequences in health. It may be common in every areas in the developing countries.

The findings show that the family planning service is satisfactory in the study population. Most of the women do not hesitate to report and ask about family planning issues and their health problems even they have a little knowledge towards it and are living in traditionally domination by male.

7.4 Recommendations

This study has drawn conclusion that there is high knowledge on family planning services in the study. However their utilization rate should be increased to maintain their family size and their overall development. It helps them for the further management of their children schools. In relation to this study, there were some limitation, quality of the family planning services is a great concern and male involvement of the family planning services especially for decision making process are main concern of this study. Thus ministry of Health and Population, Department of Health Services and Local DHO should take initiative for the improvement of family planning services in the local level. There were some limitations and it should be addressed in the further research.

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Appendix –A

Tribhuvan University

Faculty of ……..

Department of ……

…….. Pokhara

Utilization of Family Planning Services in Chhantyal Community of Myagdi District.

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

These questions will be asked to married women of 15-44 years only.

District: Myagdi Household No.

VDC: Kuinemangle Ward No.:

Family: (i) Nuclear ☐ (ii) Joint ☐

A. Household Information

S.N.	Name of family	Relation of HHs	Sex	Age	literate illiterate	Educational status	Marital Status	Occupation
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

B. Individual Questionnaire.

1. How old are you ? …….Years

2. How old were you when you got married? ……..years

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

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

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

6. What is your occupation?

a. Agriculture ☐ b. Government service ☐

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

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

a. Male ☐ b. Female ☐ c. Either ☐

C. Knowledge and practices of family planning.

8. Do you know about family planning?

a. Yes ☐ b. No ☐

9. If yes, what is family planning ?

a. Spacing ☐ b. Limitation ☐ c. Others ☐

11. What is the significant merit of birth spacing

a. Good health ☐ b. Education ☐

c. Finance ☐ d. Others ☐

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

a. Modern ☐ b. Natural ☐ c. Unknown ☐

13. What types of permanent methods do you know ?

a. Vasectomy ☐ b. Minilap ☐ c. Laproscopy ☐

14. What are your sources of information about FP devices?

a. Radio/TV ☐ b. Friends ☐

c. Health workers ☐ d. Husband ☐ e. Others ☐

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

a. Family ☐ b. Person ☐ c. People ☐

d. Social respect ☐ e. Unknown ☐

16. Does family planning ham the family?

a. Yes ☐ b. No ☐ c. Unknown ☐

17. At what age did you first use FP services?

a. Below 20 ☐ b. Above 20 ☐

18. Which methods do you like most ?

a. Spacing ☐ b. Permanent ☐ c. Natural ☐

19. From what aspect do you adopt FP devices?

a. Economic ☐ b. Education ☐ c. Food ☐

d. Health ☐ e. Others ☐

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

a. All ☐ b. Partial ☐ c. Not at all ☐

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

a. 1 yrs. ☐ b. 2 yrs ☐ c. 3 yrs ☐

d. 3 to 5 yrs. ☐

D. Side Effects after Using FP Devices.

22. Your using of FP devices is ?

a. Interest ☐ b. Obligation ☐ c. Need ☐

23. How are FP Services as to effectiveness ?

a. Well ☐ b. Better ☐ c. Best ☐

d. No ☐

24. Do you have any side effects after taking family planning device?

a. Yes ☐ b. No. ☐

25. If yes, what are the problems?

a. ……. b. …….. c. ……..

d. ……. e. Others .

26. Is family planning needed for a happy life?

a. Yes ☐ b. No ☐ c. Unknown ☐

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

a. Want of son ☐ b. Not allowed by family ☐

c. Health Problem ☐ e. Others ☐

28. What is the criticism passed on FP users?

a. Unsocial ☐ b. Irreligious ☐

c. Undisciplined ☐ d. Unknown ☐

E. Accessibility of FP Services.

29. Are FP services available at any time?

a. Yes ☐ b. No ☐

30. If no, why?

a. Too far ☐ b. No full-time service ☐

c. Lack of Service centre ☐ d.. Unknown ☐

31. What are the organizations that support the FP programme in the communit?

a. VDC ☐ b. Club ☐ c. Women's group ☐

d. Red cross ☐ e. Others ☐

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

a. Yes ☐ b. No ☐ c. Unknown ☐

33. How far is the health institutions from here on foot?.

a. About 10m. ☐ b.. About ½ Hours ☐

c. About 1 hour ☐ d. More than 1 hour ☐

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

a. On foot ☐ b. Animal back ☐

c. Vehicle ☐ d. Others (please specify).…

F. Traditional Values of Family planning.

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

a. Yes ☐ b. No ☐

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

a. Yes ☐ b. No ☐

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

a. Yes ☐ b. No ☐

39. Does your tradition have a system of polygamy?

a. Yes ☐ b. No ☐