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THE ROLE OF HUSBAND AND WIFE COMMUNICATION IN WELL-PLANNED FAMILY DECISION-MAKING: A CASE STUDY AMONG COUPLES IN A CARPET FACTORY IN LALITPUR, NEPAL

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The Role of Husband and Wife Communication In Well-Planned Family Decision-Making: A Case Study among Couples in a Carpet Factory in Lalitpur, Nepal

Dr. Asha Pun

A thesis submitted for the
degree of Master in Public Health
of the University of Otago, Dunedin, New Zealand

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Abstract

The national family planning programme was introduced in Nepal three decades ago. Although significant increases in contraceptive prevalence rates (CPR) were realised early in the programme, the rates have leveled off for the last six or seven years, despite involvement from government, non-government international non-government organisations and donor agencies. In 1996, the contraceptive prevalence rate was 29 percent among married women of reproductive age and the unmet need for contraception was estimated to be 31 percent (NFHS, 1996). The total fertility rate was 4.6 birth per women (NFHS, 1996).

Lack of knowledge of contraceptive methods, low socio-economic status, low literacy rate, desire for more children, and poor communication between husband and wife are among the documented reasons in Nepal for not using contraception. Husband and wife communication plays an important role in increasing prevalence of contraceptive use. By increasing the communication skills among couples about joint decision-making regarding the well-planned family, the possibility of influencing contraceptive behaviour can be enhanced. The communication between husband and wife can be stimulated by both interpersonal as well as mass media communication methods.

A health communication intervention was developed based on a conceptual framework that was constructed from core elements of several relevant theoretical and communication models. The intervention was pilot tested among the workers in a carpet factory in Lalitpur, Nepal. The carpet factory was selected because it used wool from New Zealand, located in Lalitpur, and was close to the Central Family Planning Clinic. Women were eligible for the intervention if they were; married, aged between 15-39 years, from the rural parts of Nepal, and if the husband and wife were both working and living in the rooms provided by the factory. Women were excluded *if they were; unmarried, widowed, sterilised or the husband was sterilised, aged* below 15 and above 39 years, and not living with husband at the time of the intervention.

This study was carried out as evaluation research and was designed to assess the effectiveness

of the health communication intervention that included a uniquely designed husband and wife communication model called KURAKANI, meaning, 'to talk'. This study took place in four phases. During the first phase the health communication intervention was developed and is presented as a curriculum. The second phase involved the administration of the pre-intervention questionnaire. The implementation of the three-part intervention took place as the third phase of the study and the fourth phase was the administration of the post intervention questionnaire. The intervention itself was made up of three different components. Two workshops focused on knowledge and attitudes about contraception and the third workshop focused on developing husband and wife communication skills using the KURAKANI husband and wife communication model. Important changes in contraceptive knowledge, attitudes, skills, practices, and social norms were demonstrated as a result of the carpet factory workers' participation in the all three phases of the health communication intervention.

The intervention resulted in increased of knowledge of the different contraceptive methods, increased understanding that the man is responsible for the sex of the baby, and also increased knowledge among participants of the places where different contraceptive methods can be obtained. The intervention also resulted in a measurable shift towards more positive attitudes about contraceptive methods, the users of contraceptives, son preference, the well–planned family, and husband and wife communication.

KURAKANI proved to be an effective tool for enabling couples to communicate with each other about the well-planned family, contraceptive decision making, and potentially about other domestic issues. Following the intervention, the participants' understanding of the well-planned family moved beyond the traditional thinking of having few children to a much broader notion of the well-planned family, i.e. planning the number of children desired, the timing of the birth, sharing equal responsibility and opportunity between husband and wife, and demonstrating comfortable communication between husband and wife on all topics.

This study has found that the KURAKANI husband and wife communication model was an effective model in teaching couples how to communicate with each other and to make a joint decision to use effective contraceptive methods.

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List of Abbreviations

ADRA	Adventist Development Relief Agency
ALT	Adult Learning Theory
CBS	Central Bureau of Statistics
CCIA	Central Carpet Industries Association
CEDPA	Centre for Development and Population Activities
CPS	Centre for Policy Studies
CPR	Contraceptive Prevalence Rate
CRC	Convention on Rights of the Child
CWDB	Carpet and Wool Development Board
DHS	Demographic Health Survey
DK	Don't know
FPAN	Family Planning Association of Nepal
FPIs	Family Planning Inspectors
FPICS	Family Planning Communication Impact Survey
FP/MCH	Family Planning and Maternal-Child Health project
FS	Female Sterilisation
FWAs	Family Welfare Assistants
ICHSDP	Integrated Community Health Services Development Project

ICPD	International Conference on Population and Development
IEC	Information Education and Communication
IPC	Interpersonal Communication
IUD	Intrauterine Devise
JHU/PCS	Johns Hopkins University Population Communication Services
LAM	Lactational Amenorrhea Method
MS	Male Sterilisation
MWRA	Married Women of Reproductive Age
NCRSC	Nepal Contraceptive Retail Sales Company
NFPC	Nepal Family Planning Clinic
NFHS	Nepal Family Health Survey
NHEICC	National Health Education, Information and Communication Centre
ODA	Official Development Assistance
PRI	Pre Intervention Interview
PTI	Post Intervention Interview
RCP	Radio Communication Project
RMF	Rug Mark Foundation
SAARC	South Asian Association for Regional Co-operation
SDM	Spiral Design Model
SLT	Social Learning Theory

TFR	Total Fertility Rate
UMN	United Mission of Nepal
WPF	Well-Planned Family

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Chapter 1

Introduction

Mohi magne dhungro lukanune.

' A person is interested in the issue, but feels shy to talk about it or speak out.'

1.1 INTRODUCTION

Nepal is a landlocked country that lies between two neighbouring countries, India on the west, south and east, and the People's Republic of China to the north. Geographically it is divided into three ecological regions: the plains region along the southern border, the hill region through the middle, and the mountain region along the northern border. Administratively the country is divided into five development regions, 14 zones, 75 districts, 4,000 village development committees, and 36,000 wards. Figure 1 is a map of Nepal showing the study area.

Nepal is a developing country with an estimated population of 24.3 million and an annual growth rate of 2.5 annual percent (PRB, 1999). It has one of the highest maternal mortality rates in the world (539 per 100,000) (Annual Report, Department of Health, 1996/1997). The total fertility rate is 4.6 birth per woman (NFHS, 1996), with women of child bearing age (15-49 years) making up 47 percent of the female population. Among them, only 15 percent practise family planning or are sterilised. In 1996, the contraceptive prevalence rate (CPR) was 29 percent among the married women of reproductive age, and the unmet need for contraceptive was estimated at 31 percent (NFHS, 1996).

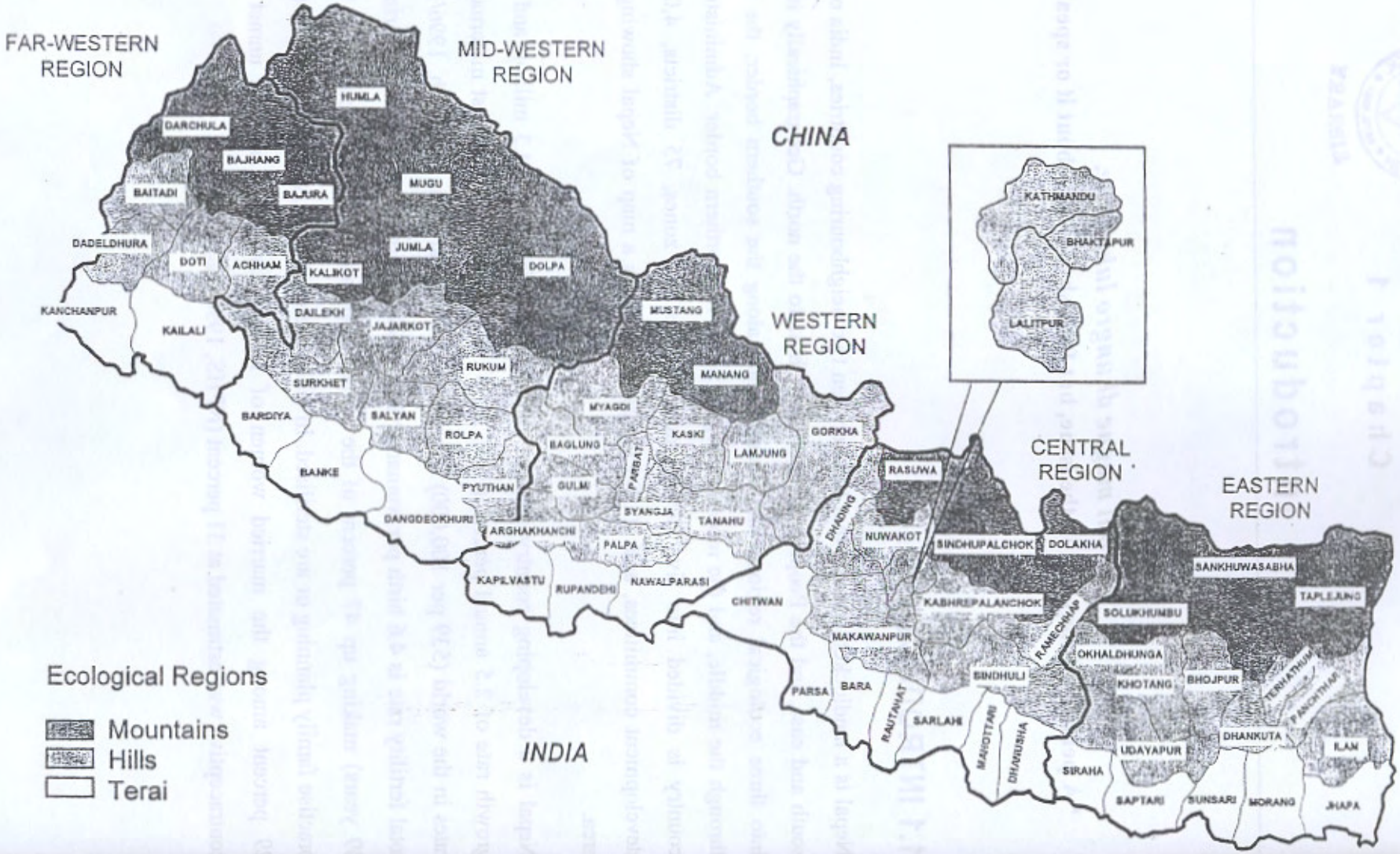


Figure 1 : Map of Nepal.

Population growth is an important global issue because of its implication for health status. Rapid population growth places an enormous burden on the environment, economy, health care and other services of the country. Nepal is faced with this population problem. Despite the implementation of extensive family planning programmes in Nepal (NFHS, 1996), the decrease in the fertility rate has been slow (Retherford and Thapa, 1998). Various studies conducted in Nepal on family planning status have identified lack of knowledge of contraceptive methods, poor communication between husband and wife, low socio-economic status and low literacy rate of Nepali females as the main barriers to effective family planning in Nepal (Tuladhar, 1989; Thapa, 1989; Shrestha et. al., 1988; NFHS, 1996; Aryal, 1996).

Studies showing the important role of communication between husband and wife on acceptance of contraceptive methods have been reported both in Nepal (Storey et. al., 1996; Banjade, 1994; New Era, 1993) and in other parts of the world (Mitchell, 1972; Olson-Prather, 1976; De Silva, 1994). In Nepal, such studies were done either by dissemination of information by mass media (radio) in certain areas of Nepal (Storey et. al., 1996; New Era, 1993) or by analysing the interviews from the Nepal Family Health Survey (NFHS), 1996 (Banjade, 1994). To date, there have been no intervention studies conducted in Nepal examining the influence of communication between husband and wife on acceptance of contraceptive methods.

The 1996 Nepal Family Health Survey (NFHS) is the most recent and is a national representative survey conducted under the Family Health Division of the Department of Health Services, Ministry of Health of His Majesty's Government of Nepal. Interview was conducted with 8,429 ever-married women aged 15 to 49 years from different parts of Nepal. NFHS is the fifth in a series of demographic and health survey conducted in Nepal since 1976. The NFHS is comparable to Demographic and Health Survey (DHS) conducted in other developing countries. The main purpose of the NFHS was to provide detailed information on fertility, family planning, infant and child mortality, maternal and child health and nutrition, and knowledge about Acquired Immune Deficiency Syndrome (AIDS).

This research attempts to test whether a well-designed health communication intervention can have a positive effect on husband and wife communication in relation to contraceptive decision making. The primary research question was does the intervention improve knowledge,

attitudes, and skills required for effective husband and wife communication resulting in increasing: 1) couples' aiming towards a mutually agreed contraceptive decision or 2) couples' joint intentions to choose a contraceptive method, or 3) couples actually seeking and obtaining a contraceptive method.

This research was conducted with the carpet factory workers because the carpet industry is one of the leading foreign exchange earning sectors in Nepal. Moreover, more than 55 percent of the carpet factory workers are women and the majority of these workers are illiterate and from families of low socio-economic status (CPS, 1999). The health of women workers in Nepalese carpet factories reflects the health of the Nepalese carpet industry, and potentially the economy of Nepal.

This research project, therefore, aimed to study the influence of a health communication intervention on knowledge and attitudes of contraceptive methods, and communication skills between husband and wife for well-planned family decision making. The specific research objectives were as follows;

1.2 OBJECTIVES

1. To carry out a health communication intervention with women carpet factory workers and their husbands.
2. To influence positive changes in couples' attitudes towards contraception.
3. To increase husbands' approval of contraceptive use.
4. To positively influence the joint well-planned family and contraceptive decision-making and practises among married couples.

A brief introduction of the study area and the significance of the research are described in Chapter 1. Chapter 2 presents the history and current situation of family planning and the carpet industry in Nepal. The literature on health communication and the different factors

influencing husband and wife communication is reviewed and summarised in Chapter 3.

The models and theories that comprise the conceptual framework which influenced the design of the health communication intervention and guided thesis research are presented in Chapter 4. This chapter explains how the theories and models support each other to build the framework and how the key features of the framework influenced the design of the health communication intervention. Chapter 5 describes the data collection methods, the intervention design, and the data analysis procedures.

The results of the pre and post intervention interviews, the interaction checklist for KURAKANI, and observational notes are presented in Chapter 6. This chapter also includes couples' case studies compiled from both the qualitative and quantitative results in order to bring the data alive and show a few 'faces' of the enthusiastic participants. The findings of this research in relation to the literature are discussed in Chapter 7. The conclusions, lesson learned and implication for future action are summarised in Chapter 8.

The health communication intervention design was written up in full detail according to a training curriculum format. It would have been inappropriate to include this in the thesis text. However, the intervention design is very important to the thesis discussion. The complete intervention design is included in the Appendix 1. Also included in the appendix are a large number of results presented in tables. A large amount of data was generated from the pre and the post intervention interviews. While Chapter 6 presents the detail of these results in summary fashion, only a selection of data graphs and tables are included in the text to maintain a reasonable length. All other data tables appear in Appendix 5 and are referenced in Chapter 6.

Chapter 2

Background

Youta bhaya thika, dherai bhaya dekhya

'Two is ideal, but many is a problem'

2.1 FAMILY PLANNING IN NEPAL

2.1.1 Introduction

The population of Nepal increased from 11.6 million in 1979 to 18.5 million in 1991 (CBS, 1996) and to 24.3 million by 1999 (PRB, 1999). As of 1991, the annual population growth rate was 2.1 percent (CBS, 1996). This rate had climbed to 2.5 by 1999 (PRB, 1999). Ninety-one percent of the population resides in rural areas and only nine percent in the urban environment. The total fertility rate (TFR) in Nepal in 1996 was 4.6 births per woman (NFHS, 1996). According to the 1996 Nepal Family Health Survey (NFHS) the contraceptive prevalence rate was 29 percent in Nepal. The NFHS reported that 31 percent of currently married women of reproductive age (approximately 1.3 million women) desire to space or limit their childbearing but are not using any form of contraception. These women represent the unmet need for family planning in Nepal.

This chapter will introduce the programmes and organisations providing family planning services in Nepal. Fertility and related determinants and factors affecting unmet need for family planning among Nepali couples will also be discussed. The carpet industry in Nepal and demographic characteristics of the carpet factory workers are also described.

2.1.2 Family Planning Programmes in Nepal

The government of Nepal recognised the important role of family planning in national development and family welfare nearly three decades ago. Before the government provided family planning services, the Family Planning Association of Nepal (FPAN) had begun disseminating information and creating awareness about family planning as early as 1958. However, FPAN did not offer any family planning services at that time (Thapa, 1989; NFHS, 1996). In 1965 the government adopted a family planning policy for the Third Five-year Development Plan 1965-1970, to help maintain a balance between population growth and the economic growth (Thapa, 1989). In 1968, with the implementation of the Third Five-year Development Plan, the Nepal government established the Family Planning and Maternal-Child Health project (FP/MCH project), to deliver national family planning services (NFHS, 1996). Currently, family planning services are provided through four main agencies:

a) The Family Planning /Maternal Child Health Project (FP/MCH)

b) The integrated Community Health Services Development Project (ICHSDP)

c) Family Planning Association of Nepal (FPAN), and

d) Nepal Contraceptive Retail Sales Company (NCRSC).

a) The FP/MCH project:

The semi-autonomous FP/MCH project was established in 1968 by the government to deliver family planning services. This project provides the majority of the family planning services in the country. During its initial years, FH/MCH project focused exclusively on training personnel, establishing clinics and gaining experience in operating the programme. Initially the clinics were limited to the urban areas of Kathmandu valley but they gradually expanded to other areas in the country. Different approaches to service delivery were adopted such as mobile clinics, an outreach programme and community based programmes (Thapa, 1989).

b) The Integrated Community Health Services Development Project (ICHSDP):

The ICHSDP is a semi-autonomous organisation under the Ministry of Health (MOH). It is the second largest family planning service provider in the country. The project provides services through 1500 village health workers and 350 community health leaders, who are in turn supported by auxiliary health workers located in 745 ICHSDP rural health posts (Thapa, 1989).

c) Family Planning Association of Nepal (FPAN):

FPAN, a non-governmental organisation, was the first family planning organisation in Nepal. FPAN started offering family planning services in 1958, and is currently active in providing family planning services in 32 districts (out of 75 districts) in Nepal. FPAN also provides sterilisation in selected clinics and organises mobile sterilisation camps in different districts. Besides providing family planning services, FPAN is involved in training and Information Education and Communication (IEC) activities in reproductive health (NFHS, 1996).

d) Nepal Contraceptive Retail Sales Company (NCRSC):

The NCRSC, a non-governmental organisation was established in 1978. NCRSC provides oral contraceptives and vaginal foaming tablets through pharmacies and condoms through retail shops, (e.g. general shops, *paan* shops, hotels, etc.). Currently NCRSC supplies contraceptives to more than 12,000 retailers in all 75 districts of Nepal. The project also markets injectable contraceptives, the IUD and Norplant in the Kathmandu valley and in eight other districts where services are available through trained personnel and certified private practitioners (NFHS 1996).

The above mentioned agencies play an important role in providing family planning services in Nepal. Planning, supervision and implementation of family planning activities are carried out at the central level by the Family Health Division in the Department of Health Services, MOH. Training in reproductive health services takes place at the National Health Training and Regional Training Centres for field workers. The National Health Education, Information and Communication Centre (NHEICC) in the Department of Health Services is responsible for all IEC activities related to reproductive health (NFHS, 1996).

In addition to the governmental programmes and FPAN, several other non-governmental and

international non-governmental organisations are involved in the delivery of family planning services at the grass roots level. These organisations include the Nepal Red Cross Society, Save the Children Fund (UK and USA), Adventist Development Relief Agency (ADRA), United Mission of Nepal (UMN), Centre for Development and Population Activities (CEDPA), the Asia Foundation, and CARE International (NFHS, 1996). The services provided by these organisations are limited to delivery and supply of temporary contraceptive methods, mostly pills, condoms and injectables. These organisations are also involved in educational activities in order to increase family planning awareness and knowledge among the general population (NFHS, 1996).

2.1.2 Fertility rates

The current total fertility rate (TFR) in Nepal is 4.6 births per woman (NFHS, 1996). The NFHS 1996 findings suggest that the fertility rate has declined steadily from six births per woman in the mid 1970s to 4.6 during 1994-1996. Several studies in Nepal have shown a gradual decline in fertility over the last several years (Tuladhar, 1989; Retherford and Thapa, 1998; Acharya, 1998). These studies also show that fertility is lower for urban women than for rural women. The fertility rate reported in the NFHS in 1996 for the urban women was 2.9 births per woman while the fertility rate was 4.5 births per woman for the rural women. The lower urban fertility rate can be attributed to the higher literacy levels, greater accessibility to contraceptive methods, and the steady increase in age at marriage among urban women (NFHS, 1996; Tuladhar, 1989).

2.1.3 Proximate determinants of fertility

By analysing 41 various sample populations, Bongaarts concluded that 96 percent of the total fertility behaviour could be explained by using four primary variables. These variables are; 1) proportion of married females, 2) lactational infecundability (lactational amenorrhea or LAM), 3) incidence of induced abortion, and 4) prevalence of contraceptive use (Bongaarts, 1983 in Risal and Shrestha, 1989). In a traditional society where the fertility level is expected to be close to the natural fertility (e.g. the fertility rate without using any form of contraception),

the two proximate determinants, marriage and lactational infecundibility play an important role. In modern societies where fertility is regulated or controlled, the other two proximate determinants, incidence of induced abortion and prevalence of contraceptive use exert a strong influence.

The three major determinants, 1) social and cultural factors (i.e. age at marriage and number of sons), 2) breast feeding, and 3) prevalence of contraceptive use can be used to explain fertility in Nepal (Risal and Shrestha, 1989; Dahal, 1992). Induced abortion is culturally unacceptable and considered sinful in both the Hindu and Buddhist religions. Furthermore, abortion is illegal in Nepal. However, induced abortion does occur in Nepal. Twenty-four percent of the women participants were reported to have had an induced abortion in a study conducted in three urban districts, Kathmandu, Lalitpur and Bhaktapur of Nepal (Shrestha et. al., 1994). Nepal's maternal mortality ratio is still very high at 539 per 100,000 live births (Annual Report, Department of Health, 1996/1997). A hospital based study in Kathmandu, Nepal, reported fifty percent of maternal deaths were caused by consequences of induced abortion (Padhye, 1996). There are also occasional reports in the local papers about women being jailed for committing illegal abortion (Uprety, 2000). Despite this evidence, induced abortion is not officially recognised as a determining factor for fertility in Nepal (Dahal, 1992; Tuladhar, 1989).

a) Social and cultural factors

Age at marriage

By the age of 30-34 years, 95.6 percent of females in Nepal are married (NFHS 1996). In a society like Nepal, where premarital sexual activity is not condoned, first marriage marks the point in a woman's life at which child bearing becomes socially accepted. A woman who enters into marriage at a younger age is more likely to become pregnant and give birth at a younger age. This in turn contributes to higher fertility levels (NFHS, 1996).

In Nepal the first age at marriage for women varies according to the socio-economic status, cultural values, religion and other demographic characteristics of the woman. The mean age at marriage for women in Nepal was reported at 14.8 years for Muslims and 18.9 years among Buddhists (Risal and Shrestha, 1989).

Under the existing marriage law, the minimum age for marriage is sixteen for girls and eighteen for boys, with the requirement that the consent of the parents or legal guardians must be obtained. If the girl is 18 and the boy is 21 years old no consent is required. Despite the law, marriage at a younger age is fairly common, especially in rural areas (Tuladhar, 1989; Acharya, 1998). In the age group 15-19 years, the proportion of never married women in 1961 was 25.7 percent, increasing to 56 percent in 1996. This indicates that women are getting married at an older age in Nepal. This is one of the important factors in reducing the fertility rate in Nepal (NFHS, 1996).

Importance of son

Nepal is the only Hindu kingdom in the world. Eighty-seven percent of the population is Hindu, 7.8 percent are Buddhists and 3.5 percent are Muslims (CBS, 1996). In Nepal, to have a son is very important. According to Hindu religion, the son is the person who carries out his parents' funeral ceremonies and only a son can perform the *Sraddha* ceremony for his deceased parents. Other cultural reasons for wanting a son are that only a son ensures the continuation of the family name and a son is expected to provide economic security to his parents in their old age. It is well documented that couples in Nepal have more than their desired number of children because they want sons (Karki, 1988; Schuler et. al., 1985; NFHS, 1996; Glennon and Fegan, 1993). This strong religious and culturally based preference directly affects the fertility rate of the country.

b) Breast-feeding

Breast-feeding is practised widely in Nepal. Ninety-eight percent of children are breastfed (NFHS, 1996). In Nepal women tend to breast feed their children longer, an average of 28 months, and they tend to have a long period of postpartum amenorrhoea, an average of 13 months (NFHS 1996). Exclusive breast-feeding lengthens the period of postpartum amenorrhoea and can extend the birth interval thereby reducing fertility (Risal and Shrestha, 1989). Breast-feeding can be a very effective contraceptive method if the following three conditions are met: The baby is less than six months; the mother has not started her period after delivery; and the mother is breast feeding at least six times a day, including night feeds, and is not supplementing with other food. Breast-feeding delays ovulation, thereby preventing

pregnancy. Breast-feeding is a less effective contraceptive after the baby is six months old, after the baby is given solid food, and after the woman recommences her periods. A study conducted in Nepal showed that there is a direct positive association between breast-feeding and increased birth interval, thereby influencing the fertility rate in the country (Shrestha, 1984 in Risal and Shrestha, 1989).

c) Use of family planning in Nepal

Modern contraceptive use among Nepali couples has increased considerably in the last three decades. According to the NFHS, 29 percent of Nepali couples currently use contraceptives (NFHS, 1996). Usage of contraceptive methods has increased from three percent in 1976 to 15 percent in 1986 to 29 percent in 1996 (NFHS, 1996). Although there has been an increase in the current use of contraception, there is still a large number of couples whose contraceptive needs have not been meet. According to NFHS, the most preferred method is female sterilisation (13.3 percent), accounting for 46 percent of the total contraceptive prevalence (NFHS, 1996). Male sterilisation (6 percent) was the next most common method, accounting for 21 percent of the total prevalence. Injectables (5 percent) were the most popular among the spacing methods, accounting for 21 percent of the total prevalence.

Although female sterilisation and male sterilisation have been the most popular methods in the last three decades, there was only a one percent increase in the use of female sterilisation, from 45 to 46 percent in the last decade. However, the use of male sterilisation decreased by 50 percent from 41 to 21 percent over the same time period (see Table 1). In the last decade, the use of spacing methods has increased by 19 percent from 14 to 33 percent. This indicates that women are using contraception to space their pregnancies rather than to limit the number of pregnancies (NFHS, 1996).

Table 1: Percentage of currently married non-pregnant women age 15-49 who are using modern contraceptive methods, Nepal 1976-1996

Method	1976 NFS (percent)	1981 NCPS (percent)	1986 NFFS (percent)	1991 NFHS (percent)	1996 NFHS (percent)
Any modern method	2.9	7.6	15.1	24.1	28.8
	0.1	2.6	6.8	12.1	13.3
Female sterilisation	1.9	3.2	6.2	7.5	6.0
Male sterilisation	0.5	1.2	0.9	1.1	1.5
Pill	0.0	0.1	0.5	2.3	5.0
Injectables	0.3	0.4	0.6	0.6	2.1
Condom	NA	NA	NA	0.3	0.5
Norplant	0.1	0.1	0.1	0.2	0.3
IUD					

NA= not applicable (method not available) Source: Nepal Family Health Survey, 1996

The low use of contraceptives can be explained by the different reasons for unmet need. (These reasons are explained in detail in the section on unmet need on page 27) Practice of contraception varies with the age of the woman, education, place of residence, desire for children, and parity (NFHS 1996; Aryal, 1996; Thapa, 1989). The 1996 NFHS showed that current contraceptive use was twice as high in the urban areas (50 percent) than in rural areas (27 percent). The higher proportion of contraceptive method use in urban areas is most likely due to easy access to the family planning service and women are more educated than in rural area (Thapa, 1989; NFHS, 1996). The 1996 NFHS and a survey of Kathmandu conducted by Aryal in 1996 showed that the use of contraception was lowest among the age group 15-19 years and highest among the 25-39 age group, then decreased in the 40-49 age group. Aryal reported that women in Kathmandu who wanted more children were less likely to use contraceptives. Current use of contraception has positive association with parity of the women (Aryal, 1996). In the 1996 NFHS, the use rate of contraceptives was higher among women with three children and lesser among women with no children or less then two children. Current use of contraception increases with the increasing level of education of the woman (Tuladhar, 1989; Aryal, 1996; NFHS, 1996). The 1996 NFHS showed that 26 percent of currently married women with no formal education were using contraception compared to 52 percent of

women who had completed the school leaving certificate (SLC). The situation in Nepal with a 25 percent literacy rate for women (CBS, 1996), 96 percent of the population living in rural areas, women marrying at a young age and the importance of having son, does not support an increase in contraception use.

2.2.4 Factors affecting unmet need for contraception

Knowledge of contraception among currently married women of reproductive age (MWRA) has increased drastically in the last three decades, from 21.3 percent in 1976 to 55.9 percent in 1986 and to 98.3 percent in 1996 (NFHS 1996). Although 98 percent of currently married women of reproductive age could name at least one method, only 29 percent women were currently using a method. Although there has been a steady increase in use of contraception among currently married Nepali couples, the unmet need for contraception remains high. The 1996 NFHS reported that 31 percent of currently married women of reproductive age (approximately 1.3 million women) desire to space or limit their childbearing but are not using any form of contraception. Of the 31 percent unmet need, 14 percent was unmet need for spacing and 17 percent was unmet need for limiting birth. Currently married women of reproductive age who are fecund, not pregnant and who want to delay or avoid child bearing, but are not using any form of contraception, are said to have an unmet need for family planning (Westoff and Pebley, 1981).

Unmet need is categorised into two sub-groups: those who wish to space births and those who need to limit birth. Unmet need for spacing includes currently pregnant women whose pregnancies were mistimed, amenorrheic women whose last birth was mistimed, and women who are not pregnant or amenorrheic and are not using any contraceptive methods but say that they want to wait for two or more years for the next birth. Unmet need for limiting births includes currently pregnant women whose pregnancies were unwanted, amenorrheic women whose last birth was unwanted, and women who are not pregnant or amenorrheic and are not using any methods of family planning but say that they do not want any more children (Westoff, 1988; Westoff and Bankole, 1996).

The major reasons for unmet need for contraception reported in Nepal are;

1. health related side effects
2. socio-economic reason
3. family planning service related
4. demographic variables
5. desire for number of children
6. husband and wife communication regarding family size (Shrestha et.al., 1988; Tuladhar, 1989; Aryal, 1996; NFHS, 1996; Thapa, 1989)

Studies conducted in Nepal have reported that lack of husband and wife communication is one of the main reasons for not using contraception. This research study focuses on the important role of husband and wife communication and on increasing the knowledge and practice of contraception among carpet factory workers. Husband and wife communication is described in detail in the Chapter 3, pages 27 to 40.

Women in Nepal believe that contraception has adverse side effects. This is the most often reported reason for not using contraception (Tuladhar, 1989; Thapa, 1989; Shrestha et. al., 1988; NFHS, 1996; Aryal, 1996). In part, this may result from inadequate counselling and follow-up care to understand which side effects are serious and which are 'normal'. For certain ethnic groups (Brahmin and Chettri), when a woman has her menses she must remain isolated from her family. She is not to do any housework until her bleeding stops. If she experiences a prolonged menstrual period then she stays away longer from the housework. This might affect her family. If a woman experiences side effects and has to seek help frequently from the hospital this might prove to be costly and sometimes adequate help may not be available. These reasons might make a woman hesitant to use contraception.

Nepali couples are often reluctant to adopt contraception because it might make a person weak and unable to work (Glennon and Fegan, 1993; Schuler et. al., 1985). In 1985, Schuler et. al., surveyed three neighbourhoods in the city of Kathmandu. Survey results showed many low

caste and lower-class couples believed contraception was for wealthy people but unsuitable for people like themselves who had to earn their livelihood by means of physical labour. They believed that contraception would weaken a person so they could not do the hard work and that they would not be able to afford nutritious food to build up their strength in case they become weak.

There are certain demographic factors e.g. age of women, education, number of sons born to the couple, place of residence, which have been shown to contribute to the reasons for not using contraception (importance of son, age at marriage is described in detail in pages 22-23). Younger women of age group 15-19 years and the older women of age group 35-49 years are the two groups of women who are not using contraception. These are the women in Nepal who have an unmet need for contraception (NFHS, 1996; Schuler et. al., 1985; Tuladhar, 1989). Women with no formal education and women living in the rural part of the country are also groups of women who are not using contraception. They too are the women who have an unmet need for contraception.

The 1996 NFHS reported that majority of the women considered three or less to be the desired number of children. Thirty-five percent of women considered two children and another 35 percent women considered three children as their desired number of children (NFHS, 1996). Couples who have not reached their desired number of children tend not to use contraception and tend to postpone the use of contraception until after they have given birth to the desired number of children. In comparison, couples who have given birth to the desired number of children tend to use contraception (NFHS, 1996; Schuler et. al., 1985; Tuladhar, 1989; Aryal, 1996).

Access issues are also important for explaining contraceptive use in Nepal. Three main factors:

1. the length of time a family planning programme has been in place,
2. the geographic distribution of outlets, and
3. the quality of service play an important role in contraceptive prevalence among women who know an outlet for obtaining a method (Brackett, 1980 in Tuladhar, 1989).

Lack of access to a family planning service outlet and non-availability of a chosen or preferred method are the crucial limitations to the wider use of contraception (Tuladhar, 1989; Thapa and Friedman, 1998). As mentioned before, contraception use in Nepal has increased from 2.9 percent in 1976 to 28.8 percent in 1996. The proportion of women who knew a family planning outlet (a measure of availability) increased from 6 percent in 1976 to 36 percent in 1986. Accessibility measured as perceived travel time to the nearest family planning outlet, increased drastically (Tuladhar, 1989). In 1976, twenty-four percent of women perceived the travel time to an outlet to be less than an hour whereas in 1986 it increased to 84 percent (Tuladhar, 1989; Thapa, 1989).

Although there has been an increase in availability and accessibility since the family planning programme started, there is still much to be done before the service is easily accessible in the rural parts of Nepal. Family planning outlets are often difficult to reach in the rural areas of Nepal because of the topography and terrain of the country. The grass roots level service outlets provide only temporary methods, such as condoms and pills, which are demanded by less than one-fourth of the current users. Clinical methods such as male and female sterilisation, Norplant, IUD, Depo-Provera are available only in the hospitals. Therefore the majority of the population is unable to access their method of choice. This is one of the main reasons for the high rate of unmet need in Nepal.

In addition to the availability and accessibility of contraceptive methods, the quality of the service also plays an important role. Studies in Nepal showed that family planning services are of poor quality. Clients are not treated well and are not given correct information and advice on different methods, especially if they are from low and lower caste group (Schuler et. al., 1985; Baker et. al., 1994).

Although it is more then three decades since the family planning service has been available in Nepal, the overall decrease in fertility rate is slow. The unmet need for contraceptive methods remain high. To bring changes in the fertility rate the different factors contributing to unmet need for contraceptive methods should be carefully considered and addressed to reduce unmet need, thereby increasing the contraceptive prevalence rates.

2.2 CARPET INDUSTRY IN NEPAL

2.2.1 Introduction

Rug weaving has been a long tradition in the Himalayan and mountain regions of Nepal. The weaving of *radhi* (carpets) and *pakhi* (blankets) for local consumption or trade is still continued in these regions. The Nepalese carpet industry, on the other hand, has rather a short history of about forty years. The carpet industry in Nepal began as a resettlement programme in the early 1960s for Tibetan refugees who settled in the Kathmandu Valley in late 1950s (Rai, 1999).

The characteristic of Nepali carpet is that the whole production process is done by hand, a tradition which the Tibetan refugees brought with them. The entire process of carpet making from raw wool sorting, washing, yarn spinning, dyeing of yarn and carpet weaving is all done manually. No aspect of carpet weaving in Nepal is mechanised. Figure 2 shows carpet factory workers weaving carpet.

Figure 2: Carpet workers weaving carpet (Source: Dr. Asha Pun)



The early carpet weaving activity was confined to the refugee settlement areas of the Kathmandu Valley. The first commercial shipment of "Tibetan carpets" to Europe was made in 1964 (Rai, 1999; Maskey, 1999). When some European entrepreneurs decided to have the weavers to use European instead of Tibetan designs, the carpet export industry started taking shape. The industry started growing substantially from the early 1980s and experienced growth rates as high as 45 percent per year (Rai, 1999). The industry quickly outgrew the refugee resettlement areas.

The carpet industry has played a vital role in improving the economic development of Nepal. By early 1990s the carpet industry had become the number one exporter in the country, accounting for 50 to 60 percent of the total foreign currency earnings from overseas exports (Rai, 1999). In the fiscal year 1993/94, carpet exports reached a peak, an all time high of 3.3 million square meters of carpets valued at approximately Rs 9.6 billion or US $ 148 million (Rai, 1999; Maskey, 1999; CWDB, 1999). Since then carpet export have been declining. A critical factor in the set back in carpet exports is believed to be the involvement of child labour and quality factors, e.g. the factories started using short, recycled wool to manufacture their carpets. Despite recent trends, the carpet industry has helped generate employment opportunities for people from a low socio-economic background, who are often illiterate.

2.2.2 Current status of the carpet industry

The total number of carpet factories currently registered under the Central Carpet Industries Association (CCIA) is 1,192 (CCIA, 1999). These include all the small and large factories, whether with five or 500 workers. Although there are 1,192 factories registered with the CCIA, not all these factories are necessarily operating. No accurate figure for the number of operating factories in Nepal was available at the time of this study. The Rug Mark Foundation (RMF) conducted a census of carpet factories in 1999 in 14 selected districts to find out the total number and geographical concentration of the carpet factories in the country. The census estimated that the total number of carpet factories was 973. Out of those only 885 factories were in operation at the time of the survey.

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a) Geographical concentration

The geographical concentration of the carpet factories is heaviest in Kathmandu Valley wh 97 percent of the factories in the country are located (CPS, 1999). The highest concentration carpet factories is in Kathmandu district (66.3 percent) followed by Lalitpur district (1 percent) and Bhaktapur district (13.1 percent). The factories are concentrated in areas wh transport is easy and cheap, and the availability of all facilities and public service is better.

b) Classification of factory by activity and size

The main activity in the carpet production process is weaving. Besides weaving other activi involved in a factory are rolling (92 percent of total factories), cutting (54 percent of t factories), spinning (10 percent of total factories), and washing (9 percent of total factor (Bhattarai, 2000). Activities like carding, dyeing, trimming, finishing and packing are o done in the main factories of exporters. For the census, the factories were divided into th categories according to the loom number; 1) less than 20 looms, 2) 20-49 looms, and 3) 5 more looms, which may be considered respectively as "small", "medium" and "large" factor (CPS, 1999). Out of the 787 weaving factories, 46.5 percent were small factories, 34.9 per were medium and 18.6 percent we re large factories (CPS, 1999). According to the ce findings, out of the 885 carpet factories, 787 factories (89 percent) were engaged in wea and other activities. The remaining 98 factories (11 percent) were engaged in other si activities, such as carding, spinning, rolling, dyeing, washing and cutting (CPS, 1999).

c) Employment

The carpet industry has generated the highest level of work opportunities in Nepal. It is als only industry which enables the poor and the illiterate to acquire jobs (Joshi, 1999). The su showed that 47,463 people were employed in the 885 factories. At the time of the census, majority of the factories were found operating below their capacity owing to market constr or stagnation in demand from the importers. Among the total number of production wor females constitute 55.4 percent and males 44.6 percent (CPS, 1999). A survey done by the Mark Foundation in 2000 among their 311 registered carpet factories showed that the ra female to male workers was 54:46 (Bhattarai, 2000). Females are generally preferred i carpet factories probably because of their perceived docile nature and the fact that they c

be employed at lower wages than men (CPS, 1999).

2.2.3 Demographic characteristics of carpet factory workers

a) Age distribution

The majority (64.8 percent) of adult labourers are in the age group of 15-24 years, and 26 percent are in the age group 25-34 years. Thus, 91 percent of total labourers were between the age group of 15 and 34 years (CPS, 1999).

b) Caste and ethnicity

The majority of the workers in the carpet industry are from the Tamang ethnic group. Tamang people live in the districts surrounding Kathmandu Valley. The majority of the carpet factories are located in Kathmandu valley. Tamang people migrate to the Valley in search of work and because it is comparatively easy to get a job in carpet factories. This may be the reason for Tamang ethnic group being the majority in the work force. Recently other ethnic groups have also joined this work force.

c) Family size

Nepal practices an extended family system. When a person is asked hihe/sher family size it is usually large because all family members living in the household are reported. Whereas the labourers living on the factory's premises report having a smaller family size than an average Nepali household. The main reason for reporting a small family may be because they live in a small room provided by the factory and only the husband, wife and their children are allowed to live in these rooms. When reporting their family size they report only members living together and do not report their parents and other siblings.

d) Marital status

Of the total 47,463 workers, 56.2 percent are married 42.2 percent are unmarried, and only a small proportion, 1.6 percent are separated/divorced or widowed (CPS, 1999). The factory provides a room for a couple if both the husband and wife work in the same factory. If they are unmarried then four to five female/male workers have to share a room. Most of them migrate

from remote villages. It would be expensive to rent a room outside the factory premises. Usually a couple tends to work in the same factory. This might be the reason for the higher percentage of married workers in carpet factories. The other reason might be that because the workers spend most of their time in the factory weaving, unmarried workers meet each other at work and get married.

e) Literacy status

The literacy rate among the carpet factory workers is low. According to the survey conducted by the RMF the literacy rate was found to be 59.7 percent which is still significantly higher than the national rate of 39.6 percent. This might be because the 353 participants interviewed were predominantly men (CPS, 1999). The overall national literacy rate is 39.6 percent, but the rate among men is higher, more than twice as high, (54.5 percent) than among women (25 percent) (CBS, 1996).

f) District of origin

The adult labourers working in the surveyed factories came from 41 of the 75 districts of the country. Twelve districts; Jhapa, Morang, Sindhupalchok, Kaverepalanchok, Makwanpur, Ramechhap, Dolakha, Kathmandu, Lalitpur, Udhayapur, Sindhuli and Sarlahi account for 68.5 percent of the total adult carpet workers. The remaining 29 districts account for 31 percent (see Figure 1 for Nepal map).

In Lalitpur the largest proportion of workers (23.6 percent) come from the district itself, followed by Makwanpur (20 percent) (CPS, 1999). The pattern of labourers' migration shows that the workers in the three districts of the valley have largely come from the adjoining mountain and hill district and also from some of the terai districts.

g) Reasons for working in a carpet factory

The largest proportion of the workers (61.1 percent) reported financial problems as the main reason for working in a carpet factory. 'City attraction' was reported by 18.6 percent and 12.2 percent reported 'lack of alternative job' as the reason for joining a carpet factory (CPS, 1999).

2.2.4 Child Labour in the carpet factories

The United Nations declared the Convention on Rights of the Child (CRC) in 1989. The CRC was ratified by 191 national governments around the world including His Majesty's Government of Nepal in 1992. The Children Act-1992 prohibits children under 14 years of age from working as labourers. The Act allows children aged 14 to 16 to work as minor workers in specific conditions (Regmi, 2000).

The major factor for the decline in carpet exports is believed to be the involvement of child labour. The issue of child labour has drawn international attention, alerting government and the non-government organisations. It became a highly charged issue in Nepal after the airing of a documentary on Nepali children working in carpet factories by the Germany's Panorama television in April 1994 (CPS, 1999). Germany is one of the main Western countries where Nepalese carpets are exported. This severely affected the demand for Nepalese carpets, as Germany started cancelling orders to boycott the products of child labour. This event prompted the government to step in and enforce the child labour laws, conduct surprise inspection of factories, and take prompt action with factories in violation of the law. Only then did factory owners begin to address the problem.

Various studies have resulted in different estimates of the percentage of child labour in the carpet industry. The estimates range from 1.6 to 50 percent. The study conducted by the Rugmark Foundation in 1999 arrived at the figure of 3.6 percent of child labour present in the carpet industry. Child labour was prevalent in carpet factories in 7 of the 13 districts (CPS, 1999). It was found that the child labour ratio was higher in the cities compared to the outlying areas. The reason might be because there are more factories in the cities and they have more job opportunities in the cities. But surprisingly the study also found that within the Kathmandu Valley the child labour ratio is higher in the peripheral districts and lower in metropolitan Kathmandu. This may be attributed to the higher frequency of factory inspections by the government and non-governmental organisations in the city.

In Nepal it is common for children to be engaged in household activities from a very early age, such as taking care of their younger siblings and helping with household chores. In some

cases they leave home in search of jobs after they are eight years of age. Studies have shov that children below ten years of age are working in the factories but the percentage is low (percent). About 67 percent of the child labourers were from the age group of 13-14 and 3 percent from the age group of 11-12 (CPS, 1999; Shrestha, 1999). The ratio of male to femal child labourers was 3:2 in the census study conducted by the Centre for Policy Studies an 2.12:1 in the study conducted by Shrestha (CPS, 1999; Shrestha, 1999). The reason for a large proportion of boys being child labourers might be because boys have greater tendency to run away from home. In addition, when families consider the question of sending children outside the home for jobs, boys are more likely to be sent, because girls are considered more vulnerable to external circumstances.

Child labourers in carpet factories come from more than 30 ethnic groups. The majority (43.3 percent) belong to the Tamang ethnic group, according to CPS, 1999. Shrestha's study also showed that majority of the child labourers belonged to the Tamang ethnic group (53 percent) (Shrestha, 1999). The main reasons for the high percentage of Tamang ethnic group involved in the carpet industry are likely to be that this community is relatively poor, the majority of the adult workers in the carpet industry are Tamang and they live in the neighbouring districts of Kathmandu. The main factor influencing the migration of children is poverty. The other factors are the search for a job, when another family member migrates to the city, the attraction of the cities and through contractors. The literacy rate among the child labourers in the carpet factories is low. The census study showed that 57 percent of the child labourers were illiterate (CPS, 1999).

2.2.5 Organisations involved in the carpet industry

a) Carpet and Wool Development Board (CWDB)

In 1993 the Development Act 2013 established the Carpet and Wool Development Board. The main objectives of this organisation is to: produce carpets from all over Nepal, improve the quality control of the carpets, import raw wool, and promote the exportation of carpets (Joshi 1999).

CWDB has organised many activities for the benefits of carpet workers. They have opened childcare centres in some of the factories and made arrangements for the schooling of children to discourage the child labour problem (Joshi, 1999). CWDB have also opened free clinics in some areas for the carpet workers. In the year 1998/99 approximately 10,000 workers used these health facilities (Joshi, 1999).

b) Nepal RugMark Foundation (NRF)

The Nepal RugMark Foundation was established in December 1995 as a result of a joint initiative by the carpet industry, child rights NGOs and the donor organisations. It is registered with the government as a non-profit private organisation (Rai, 2000). The main objectives of NRF are to prevent use of child labour by having carpet produces/exporters abide by the legal and social responsibilities through licensing of RUGMARK, to rehabilitate displaced carpet children with education and training, and to promote a good working environment for the workers (Rai, 2000).

NRF started rescuing carpet child labourers in mid 1996 from the NRF licensed carpet factories. NRF runs four rehabilitation centres to accommodate these rescued children. To date, 347 children have been rescued from different carpet factories. One hundred and fifty children have been reunited with their families and the remaining 188 children live in these four rehabilitation centres run by the NRF. These 188 children are studying from kindergarten to class 8 in these centres. NRF have also started a community based rehabilitation programme for these rescued children (Regmi, 2000).

c) Step Foundation

The Step Foundation is another INGO involved in the welfare of the carpet industry and the workers. The Step Foundation was established in 1995. The main objectives of the Step Foundation are to increase market opportunities for responsible and transparent carpet business, to create better working conditions and remuneration for adult workers, to eliminate abusive child labour, and to support educational programmes, both for children and for illiterate adults working in the carpet factories (Step Foundation, 1999).

The Step Foundation plays a key role between the importers and the exporters/producers.

The Step Foundation makes sure that the importers pay a fair price to the exporter so that th exporters are enabled to pay fair wages, and ensure proper working conditions, and ecologi production methods. The foundation also provides non-formal adult education for the work (women). It also delivers awareness messages to the workers on health and sanitation, safe motherhood, childcare, child right, family planning and the handling of the waste products i the carpet industry. Such classes are conducted at various carpet factories with the initiation and support from the workers and the producers. The Step Foundation has established day childcare centres at various carpet factories (Step Foundation, 1999).

Chapter 3

Husband and Wife Communication

Youta hathle tali bajdaine
'You cannot clap with one hand'

3.1 COMMUNICATION

The literature on family planning and health communication offers several different definitions of communication. The definition chosen for this research emanates from the international work in family planning by the Johns Hopkins University /Population Communication Services (JHU/PCS), which has operated in more than fifty countries world-wide for almost twenty years.

In the early days of family planning, the use of communication was not very effective because it was used far too narrowly. In those days communication was conceptualised as a simple one-way transmission of a message from the source to the receiver, with the intention of producing some effect. In the late 1970s, "communication was defined as a two way, interactive process involving two or more individuals or groups in which all the participants both encode (create and share) and decode (perceive and interpret) information until the goals of each are adequately achieved" (Piotrow et. al., 1997). The practice of communication shifted from monologue to dialogue. Thus communication was redefined as "a process in which the participants create and share information with one another in order to reach a mutual understanding" (Kincaid, 1979 in Piotrow et.al. 1997). Berger and Bradac defined communication as a concept which involves the exchange of a message which may or may not be spoken and which is linguistic in form (Berger and Bradac, 1982 in Gudykunst and

Toomey, 1988).

Communication involves transmitting information and thoughts through words, actions signs. Piotrow et. al., define communication as the key process for bringing changes in;

1. knowledge of contraception,
2. attitudes toward fertility control and use of contraceptives,
3. norms regarding ideal family size,
4. the openness of local cultures to new ideas and aspirations, and
5. new health behaviour (Piotrow et.al., 1994).

Knowledge about contraceptives and the well-planned family can also spread throu communication.

Diffusion of family planning knowledge takes place in two ways, one through interperson communication and the other through mass media (Piotrow et. al., 1994; Robey et.al., 1994). I interpersonal communication the message is transmitted from person to person and in ma media the message is shared directly with an entire audience or population. The strength of th mass media is that it can convey new information and ideas to a large audience all at once. Th use of motivational messages in the mass media can help people change their attitudes an reinforce what they already know, but may not influence behaviour change.

The strength of interpersonal communication is that it allows people to share the informatio they know with others. Interpersonal communication is person-to-person, two way verbal o non-verbal interaction that includes the sharing of information and feelings betwee individuals. Client-provider interaction and husband and wife communication are differen forms of interpersonal communication (Piotrow et. al., 1994). Judith Bruce, in her "quality o care framework" has identified six elements that affect the quality of the service. Interpersona relations is one of the key factors (Bruce, 1990). Counselling is a special form of interpersona communication. The relationship between the client and the provider plays an important role i encouraging clients to seek help to manage their fertility by making the right decision.

Counselling is an important step in a person's decision-making process about family planning.

The combination of mass media and interpersonal communication is a more effective means of family planning communication in South Asia then either method alone (Mullick, 1973 in Pathak, 1997). Mass media channels are the fastest and most efficient means of promoting awareness of an innovation while interpersonal channels more successfully promote its adoption. A study conducted in 1977 in West Bengal, India, revealed that mass media increased awareness of what family planning programmes had to offer, but that interpersonal communication was better able to convey knowledge of contraceptive use (Saha, 1977).

Husband and wife communication plays an important role in increasing prevalence of use of family planning methods (Rimon II and Lediard, 1993; Banjade, 1994; Tuladhar, 1989; NFHS, 1996; Aryal, 1996). One of the conclusion made by Rimon II and Lediard, in the assessment of the Information, Education and Communication (IEC) sector in family planning in Nepal was that special attention to husband and wife communication could contribute to increased prevalence of contraceptive use (Rimon II and Lediard, 1993). They recommended inclusion of messages in the mass media that would stimulate couples to discuss family planning. The percentage of married women of reproductive age (MWRA) who reported discussing family planning with their husband at least once a year has increased since 1991. The 1996 NFHS data reported that 45 percent of MWRA discussed family planning with their husband at least once a year whereas only 30 percent of MWRA reported doing so in the 1991 NFHS. By increasing the percentage of couples communicating about family planning, the possibility of influencing contraceptive behaviour change can be enhanced. The communication between husband and wife can be stimulated by both interpersonal and mass media method (Rimon II and Lediard, 1993; Storey et. al., 1999; New Era, 1993).

In 1993, a study was conducted by New Era in Nepal to assess the strengths and weaknesses of the existing Family Planning and Maternal and Child Health (FP/MCH) related radio programmes. The study found that there was an association between listening to FH/MCH programmes and a higher level of communication between husband and wife on issues related to FP/MCH. Storey et. al. reported that there was a strong association between exposure to the Radio Communication Project (RCP) serials and high husband and wife communication in

Nepal (Storey et. al., 1999).

There is a Nepali proverb *youta hathle tali bajdaine* meaning 'you cannot clap with one hand'. Husband and wife communication is a process in which both the husband and the wife need to participate in order to be heard and in order to be effective. When both the husband and wife participate in the communication, then the couple can arrive at a mutual decision. Communication between partners is crucial for the achievement of effective birth planning. Communication enables husbands and wives to know each other's attitudes and feelings toward family planning and contraceptive use. It allows them to voice their concerns about reproductive health issues such as worries about undesired pregnancy. Communication also can encourage shared decision-making and more equitable gender roles.

Nepal is a patriarchal society in which the husband is the primary agent of family responsibility. Many women feel that decision and discussion, especially about sex, should be made only by their husbands. Most people have difficulty talking about sex and issues related to sex because the subject is still quite taboo in Nepal. In Nepali society it is generally unacceptable to speak openly about sex even with the spouse. Thus while it is very important to encourage couples to communicate with each other, it may be difficult. It is important to emphasise to the couple that through good communication they can be successful in attaining their ideal family size and the practice and continuation of their chosen family planning method. A recent study conducted in Nepal by the Ministry of Health with technical support from the Johns Hopkins University/Population Communication Services (JHU/PCS) showed that women who both discussed family planning with their spouse and thought that their spouse approved of family planning were 39 times more likely to use family planning than women who had neither of those factors (Storey et. al., 1996).

At the 1994 International Conference on Population and Development (ICPD) held in Cairo, Egypt, representatives from more then 180 countries (Nepal among them) formally recognised the importance of men in women's reproductive health and also recognised the importance of men's own reproductive health. The ICPD Programme of Action encourages reproductive health care programmes to move away from considering men and women separately and to

adopt a more holistic approach that includes men with a focus on couple (Drennan, 1998).

Although husband and wife communication has been identified as an important factor in the process of decision making about family size and the adoption of family planning practice in Nepal and other countries, few surveys have included the responses of both husbands and wives. The NFHS, for example, has always collected data entirely from women. Family planning programmes in the past have focused on women instead of men for several reasons. Women bear the risks and burdens of pregnancy and childbearing. Most modern contraceptive methods are for women. Many providers have assumed that women have the greatest stake and interest in protecting their own reproductive health. Studies have found that spousal communication about family planning is uncommon (McGinn et. al., 1989). A growing number of family planning and other reproductive health care programmes and providers are recognising that men deserve more attention for their own sake, for their women's sake and for the health of their families and communities (Drennan, 1998). Card has pointed to the importance of collecting and analysing data from husbands, if one is to understand fertility related behaviour, particularly in those cultures where couple communication is low and marital relationships are characterised by husband dominance (Card, 1978).

Increasingly, health care providers and researchers are realising that the most appropriate client for reproductive health information and services may be the couple rather than the individual (Becker, 1996; Becker and Robinson, 1998; Keller, 1996). Recently, several projects have demonstrated increased use of contraception by facilitating communication between husbands and wives. One good example is the Jiggasha project in Bangladesh. Since 1994, a unique interpersonal communication intervention has been implemented in the thirty villages where Jiggasha, a Bangla term meaning " to inquire", was administered. The Jiggasha approach centres on the establishment of discussion groups of village women in order to extend the reach of the Family Welfare Assistants (FWAs) and increase the social acceptance of family planning. Led by FWAs, the monthly group meetings are hosted on a rotating basis by "link persons", contraceptive-using opinion leaders who are identified by the FWAs among the existing women's communication networks (Pathak, 1997). The meetings provide women with opportunities to obtain family planning and maternal and child health information,

contraceptive supplies and social support for adopting healthier behaviours.

In the villages where women's groups meet, men are likewise encouraged to form Jiggashas t address their own concerns and increase male support for family planning. Male Jiggashas ar led by the male Family Planning Inspectors (FPIs), government workers who supervise th FWAs. The Jiggasha project was formed with two purposes in mind. First, the gathering o women at one site enables each FWA to reach many clients without shouldering the burden o door-to-door visits. Secondly, Jiggasha strives to establish family planning as a communit norm transforming contraceptive use from a taboo to an advisable socially recognise behaviour. Data collected prior to and after the pilot project in Trishal Thana, demonstrate that the mean rate of modern contraceptive use among eligible married women increased b 11.4 percent in the Jiggasha villages, but only by 5.3 percent in the control villages. The da collected in 1994 to 1996 in Zakiganj, Daulatkhan and Barura Thanas showed that women wh had participated in Jiggashas were 11 times more likely to use modern contraceptives the women who had not participated nor been visited at home by an FWAs. This difference i twice as large as that (5.3) observed among women who had only been visited at home by FWA (1996 Annual Report JHU/PCS Project, 1997 in Pathak, 1997).

Even though there have been very few Nepali studies on husband and wife communicatio there is sufficient evidence from studies conducted in other countries to show the importa role of husband and wife communication in contraceptive decision-making. The few studie conducted in Nepal show that husband and wife communication is an important factor fo practising family planning (Storey et. al., 1999; Banjade, 1994; New Era, 1993). Husband an wife communication may affect the possibility of the husband and wife jointly deciding t practice family planning. In many countries traditional male and female gender roles dete couples from discussing sexual matters, condone risky sexual behaviour and ultimatel contribute to poor reproductive health among both men and women.

3.2 BARRIERS TO AND FACILITATING FACTORS FOR HUSBAND AND WIFE COMMUNICATION

Several studies conducted in a number of countries have documented a variety of different factors and barriers affecting husband and wife communication. The factors that are most widely supported by this research are discussed below.

3.2.1. Demographic factors

a) Type of marriage:

The type of marriage affects a woman's influence over her husband and her power in communicating with her husband (Gage, 1995; Meekers and Oladosu, 1996). If a woman can choose her husband, she usually has more influence within her marriage than if her family chooses her husband (Gage, 1995). Women who choose their husbands have higher levels of inter spousal communication on family planning than those who have an arranged marriage (De Silva, 1994; Gage, 1995). Both members of couples whose marriage are arranged are strangers to each other and perhaps have not yet developed the kind of intimacy in which a discussion on family planning would be likely. Thus they might be embarrassed to discuss family planning among themselves.

b) Age at marriage:

Age at marriage plays an important role in husband and wife communication. Women who get married at younger age and women who are young, especially if they are much younger than their husbands have less communication with their spouse (Ezeh, 1993; Gage, 1995; De Silva, 1994; Makomva et. al., 1991). Early marriage continues to be the norm in Nepal, despite laws prohibiting marriage before age of 18 for girls and 21 years for boys (16 for girls and 18 years for boys with parent's consent) (CBS, 1996). A survey conducted among the SAARC (South Asian Association for Regional Co-operation) countries reported that in Nepal 49 percent of girls aged 15-19 years were married (Chaudhary, 1999). In Nepal, when a woman is married she lives with her husband's family (one so-called "joint family"). If the woman has married at

a young age, she might be [illegible]

family. She may have very little to say in any family matters and every decision is made by the elders in her husband's family, usually by her husband's parents.

Apart from age at marriage and age of the women, duration of marriage is another factor that affects husband and wife communication. In most developing countries, couples rarely talk about family size and family planning early in the marriage (Fort, 1989; Banjade, 1994). A study in Nepal reported that women with the shortest duration of married life were relatively more reluctant to discuss family planning than women who had been married longer (Banjade 1994).

c) Residence area:

Place of residence also makes a difference to whether couple can communicate or not with each other. Urban couples are more likely than rural couples to communicate with each other (De Silva, 1994; Banjade, 1994; NFHS, 1996). This may be because urban couples are more educated and are more exposed to family planning programmes then the rural couples. In the rural parts of Nepal, it is still taboo to talk about family planning, even with a spouse.

d) Cultural factors:

A traditional culture often discourages married women from starting discussion about contraception. Nepal is a male dominated country, where women are reluctant to discuss family planning with their husbands. Ethnic group and religion are also influential factors in husband and wife's communication.

As in many societies around the world, both developed and developing, in Nepal too, sex is a taboo subject for men and women to discuss. As with decision making in general, women's inferior status and lack of power can limit couple communication (Daiz, 1997; Dixon-Mueller 1993; Salway, 1994). In the traditional female role in Nepali society, women are made to feel they have little say in sexual matters and lack the status to influence their partners' behaviour (Dixon-Mueller, 1993; Fort, 1989). Traditional cultures often discourage married women from initiating discussion about contraception. In countries like India, Kenya, and Nigeria, the tradition of male dominance in gender roles is a major obstacle to spousal communication

about family planning (Omondi-Odhiambo, 1997)

However, men's control over sexual and reproductive health decision making may be weakening, particularly among younger generations. In many societies, as social, economic, and educational opportunities for women are increasing, traditional gender roles are starting to change. Key global initiatives such as the ICPD Programme of Action, are helping create a safe environment for these changes. As women's equality with men increases, so does their ability to communicate about reproductive health matters and to participate in reproductive decisions (Meekers and Oladosu, 1996).

e) Ethnicity:

Nepal is a multiethnic country. There are 60 different ethnic groups in Nepal (CBS, 1996). Nepali is the official language, but there are 32 other languages are spoken in the country. Each ethnic group has its own cultural values and beliefs. Some ethnic groups are more traditional and conservative than others. For example, Brahmin and Chettri are more conservative than Magar, Tamang, Gurung, and Rai. The existing research findings in Nepal show that different status is given to women within different ethnic groups. Relatively high status is given to women in the mountains for example, where the Sherpa, Bhote and Thakali groups are found. Intermediate status is given to women in the hills, for example where the Newar, Magar, Gurung, Rai, Limbu, Tamang groups are found. Low status is given to women in the Terai region for example where the Tharus and Maithali groups are found (Pradhan, 1989).

f) Religion:

As the status of women varies between religious groups, inter spousal discussion of family planning also differs. In Nepal spousal communication was reported to be higher among Hindu and Buddhist people compared to Muslims (Banjade, 1994). In Sri Lanka it was found that inter-spousal communication was greater among Christian couples than among Muslim couples (De Silva, 1994). The reasons are that Christian wives are more modernised and Muslim wives usually have a lower status than their counter-parts from other religious group in Sri Lanka (De Silva, 1994).

3.2.2 Socio-economic factors

a) Education:

Education of both husband and wife plays an important role in increasing husband and communication. A number of studies in different parts of the world have documented better educated women are able to communicate more easily with their husbands (Meeker Oladosu, 1996; Coombs and Fernandez, 1978; Gage, 1995; De Silva, 1994). Studies in N also report a strong association between education level and husband and wife communic (Banjade, 1994; NFHS 1996; Tuladhar, 1989). More educated women are better infor better able to gather information from newspapers and other media. The closer a man women are in their levels of education and the more education they have, the more likely are to discuss and use family planning (Coombs and Fernandez, 1978; De Silva, 1994; Mee and Oladosu, 1996). A study conducted among Nigerian couples demonstrated that when b husband and wife had secondary or higher education, 61 percent of the couples repo discussing family planning. However, when neither spouse was educated only 15 perc reported discussing family planning (Meekers and Oladosu, 1996). Studies in many countr report that men with more schooling are more likely to approve of family planning then m with primary or no education (Gbolahan and McCarthy, 1991; Turner, 1991; Campbell, 19 Drennan, 1998).

b) Economic power:

A woman who has some economic power may be more likely to discuss family planning wi her husband (Gage, 1995). In Nepal most of the male members of the Magar, Rai, Gurun ethnic groups tend to work in the Nepal, Indian and British Army. They are away from hom most of the year and the economic power to run the house is given to their wives. This may b one of the reasons why more communication between the couples is found among these ethni groups. High levels of communication with their spouse among woman with more economi power is reported in other developing countries too. A study conducted among women in Tog reported women working for cash and investing some of it in credit or savings plans reporte the highest level of communication with their husband about family planning (Gage, 1995).

High levels of husband and wife communication is a characteristic of high income and highly educated couples (Gbolahan and McCarthy, 1991; Mitchell, 1972). Banjade reported that in Nepal, more working women and men discussed family planning with their spouses compared to the ones in agricultural sector (Banjade, 1994). Working women in Nepal have at least a school leaving certificate. If a woman is educated and is bringing home some income then her voice is more likely to be heard in the family.

3.2.3 Relationship between husband and wife

a) Decision maker in the family:

The person making the decisions in the family is another factor influencing husband and wife communication. As mentioned above, in Nepal, living in joint families is still practised. It is usually the in-laws who make the decisions in the family. In a conservative family the husband decides whether to use contraception or not and the number of children the couple should have. In many developing countries husbands are the sole decision-makers in all family and reproductive matters (Isiugo-Abanihe, 1994; Ezeh, 1993; Gbolahan and McCarthy, 1991; Mitchell, 1972; Makomvo et. al., 1991). Decision-making regarding childbearing was examined in the Egypt Demographic Health Survey of 1992. Spouses were asked their opinion as to who should have the last word in various household decisions, including having another child and using family planning methods. Among husbands, 41 percent said that the husband had the last word about having another child and 52 percent reported that both partners decide. Among wives, 37 percent said that the husband had the last word and 56 percent reported that both partners decide (Becker, 1996). Women who have higher levels of influence over general family matters are more likely to practice family planning (Mitchell, 1972).

b) Number of children present and the desired number of children:

The number of children wanted or desired by a couple is another factor influencing husband and wife communication. Couples who have not reached their ideal number of children do not want to practice contraception. Therefore they do not think it is necessary to discuss contraception with their spouse. However, women who do not want any more children appear to communicate more with their spouse and use family planning methods regardless of how

many children they have (NFHS, 1996; Mitchell, 1972). Couples who have smaller id family sizes, and who desire small numbers of children are found to be communicating be with each other (Isiugo-Abanihe, 1994).

c) Decision maker for use of contraceptive method:

The decision-maker for use of contraceptive method plays an important role in influenci husband and wife communication. Peruvian women fear their husbands' disapproval if th use methods of contraception, because family planning is associated with infidelity and havi many children is considered being faithful (Fort, 1989). In another study carried out amon Nigerian students, one out of every five women who were not using a contraceptive metho gave husband's objection as the reason for non use (Gbolahan and McCarthy, 1991). In th same study, Nigerian men reported that they should have a major role in the decision to limi fertility but the responsibility for actual use of contraceptives lies predominantly with women.

3.3 IMPORTANCE OF HUSBAND WIFE COMMUNICATION

3.3.1 Communication is the key to accurate perceptions

Studies in developing countries have demonstrated that because women and their husbands often do not communicate about family planning, many wives perceive that their husbands oppose family planning when, in fact, their husbands approve (Biddlecom et. al., 1997; McGinn et. al., 1989; Oni and McCarthy, 1991; Salway, 1994). Studies in Nepal have shown that women using contraceptives are more likely than the non users to either perceive or actually know that their husbands approve of family planning (Schuler et. al., 1985; Schuler and Goldstein, 1986; Stash, 1996). A survey conducted in the Dominican Republic illustrated the extent of wives' misperceptions of the approval of their husbands (Drennan, 1998). This survey reported that 14 percent of women thought their husbands disapproved when in fact they approved. Another eight percent said they did not know their husband's attitudes, but the husband actually approved of family planning. These findings suggest that women's unmet need for family planning could be reduced if communication between husbands and wives

could be improved.

One of the main reasons reported for unmet need in family planning in Nepal as well as in other countries, is husbands' opposition to using family planning methods (Tuladhar, 1989; NFHS, 1996; Schuler et. al., 1985). Sometimes it may be true that husbands truly oppose using family planning methods. However, sometimes wives assume that their husbands will oppose or get angry if they use a method, when in fact they approve. For example, among couples surveyed in the 1991-92 Tanzania Demographic Health Survey (DHS), 63 percent of the wives reported that their husband disapproved of family planning when this was not the case. In fact, in 59 percent of the cases both husband and wife approved (Robey et. al., 1996). Often, a wife does not know her husband's views about reproductive matters because the couple rarely or never discuss family planning. Therefore husband and wife communication plays an important role in helping couples know the perceptions of their partners about family planning.

3.3.2 Husband Wife communication increases the use of contraceptive methods and better continuity

When the husband supports the wife in contraceptive choice there is more effective use of the contraceptive and better continuity of use. A study in Nepal showed that women who discussed family planning with their husbands and thought their husbands approved of family planning were 39 times more likely to use contraceptives than women who had not discussed family planning and whose husbands disapproved (Storey and Sood, 1997). Another study in Nepal also showed that husband and wife communication played a major role in adoption of family planning among the study group (Banjade, 1994). A study carried out in Nigeria showed that the use of contraceptive methods is dramatically higher among couples who have discussed family planning with each other, across all categories of socio-economic and education (Gbolahan and McCarthy, 1991)

3.3.3 Communication leads to correct information and knowledge about contraceptives

Information and knowledge about choices and options for contraception increase the chance adoption and continuing use of contraception. Women in families with high levels contraceptive knowledge and high levels of husband and wife communication are most lik to make a decision to act on their desire to limit and/or space their pregnancies. They there have fewer unwanted pregnancies (Mitchell, 1972). Many couples miss out on usi contraception, although they have already reached their desired number of children, because limited and incorrect knowledge about contraceptive methods. If husband and wi communicate and learn together, rumours and misconceptions can be reduced, and they sha the same knowledge about how the methods works. A study of couples and family planni was conducted in Bangladesh. The intervention was given to three groups, in one group fami planning education was directed to wives, in the second group it was directed to husbands a in the third, at husbands and wives. The increase in practising contraception between t baseline and the follow-up, in the three groups were: wives only 11 percent, husbands onl percent and both wives and husbands 22 percent. The education aimed at both husbands a wives effected the greatest increase in use of contraceptives (Green et. al., 1972 in Beck 1996).

3.3.4 Increased communication leads to increased agreement in family planning attitudes among couples

Unless couples talk to each other about contraceptive methods and their attitudes towa family planning it will be difficult to know their spouse's attitude towards family planni Increased communication leads to increased agreement in attitude to family planning, beca couples would develop similar attitudes as they discussed their attitudes and ideas with ea other (Olson-Prather, 1976). If the couple is in agreement regarding family planning attitud there is an increase chance in the use of contraceptive methods and in the continuity of meth use over time.

Chapter 4

Conceptual Framework

Dhungako bher mato, mato ko bher dhunga

'When building a house, stone supports mud and mud supports stone.'

4.1 INTRODUCTION

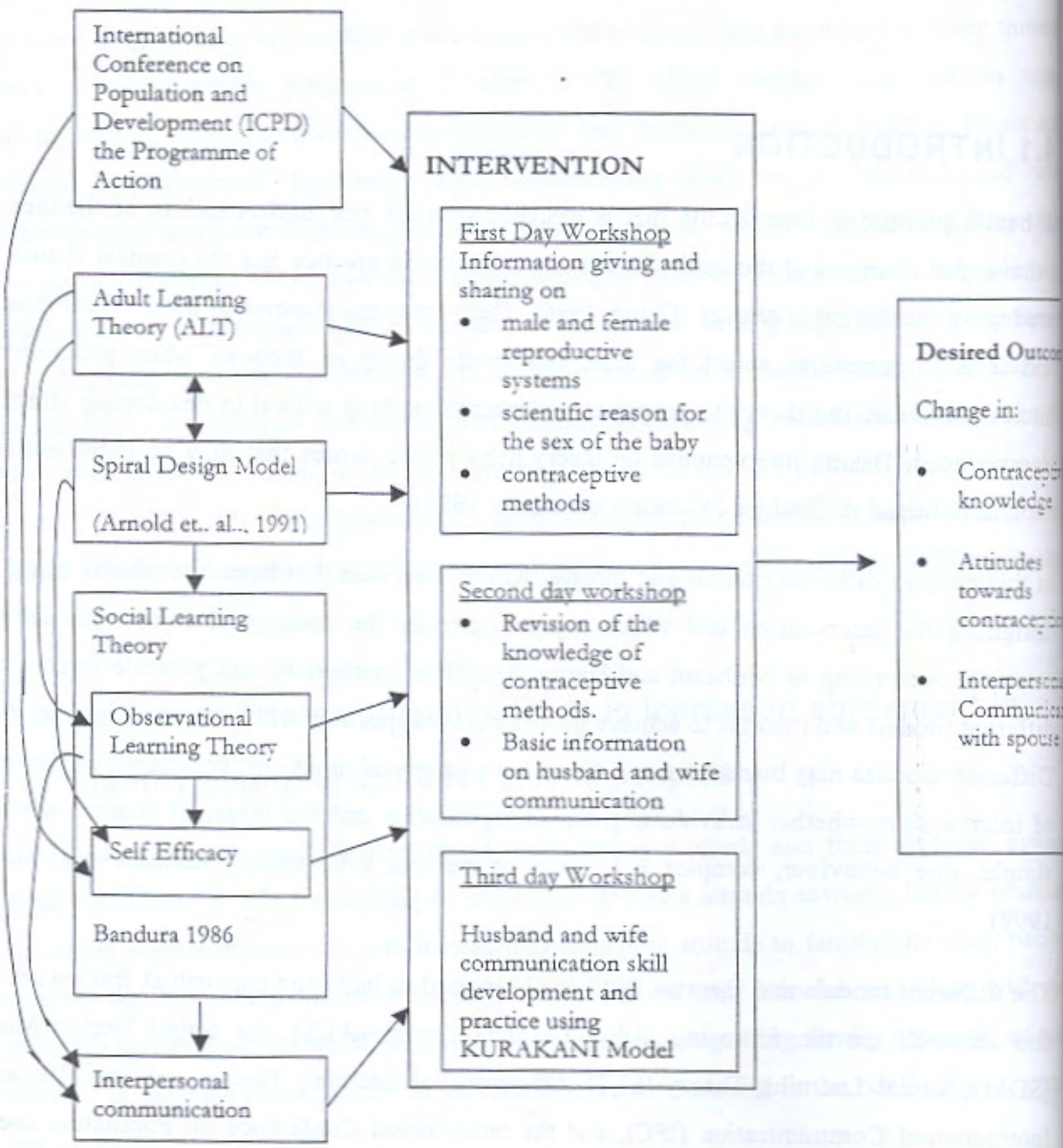
A health promotion intervention that is designed with the best understanding of theories of behavioural change and the ability to use them skilfully in practice has the greatest chance of producing the desirable change (Glanz, 1996). There are many theories of behavioural change and it is important to select the most appropriate theory or theories when planning an intervention. Linking theory to programme planning models is critical in developing effective interventions. Basing interventions on theory helps predict issues that may be important and explain potential difficulties (Nutbeam and Harris, 1999).

In this chapter different models and theories will be discussed that have been found useful in designing the intervention and which together, provide the conceptual framework for the research. According to Nutbeam and Harris, it is often appropriate and possible to combine different models and theories to achieve goals across the spectrum of health promotion actions. Different theories may be relevant and fit well in a variety of situations, depending on the level of intervention, whether individual, group or organisation and the target of change, whether simple, one behaviour, complex behaviour, or multiple behaviours (Nutbeam and Harris, 1999).

The different models and theories that have been used to build the conceptual framework for this research are the following; Adult Learning Theory (ALT), the Spiral Design Model (SDM), Social Learning Theory (SLT) (Observational Learning Theory and Self Efficacy), Interpersonal Communication (IPC), and the International Conference on Population and

Development (ICPD) Programme of Action. Figure 3 provides a diagrammatic representation of the conceptual framework and the component models and theories that have had a combined influence on the research design and the intervention trialed. The key features of these theories and models and reasons for choosing them are articulated in details following the diagram.

Figure 3: Conceptual Framework for Health Communication Intervention with Carpet Factory Workers in Kathmandu, Nepal



4.2 THE INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT (ICPD)

The International Conference on Population and Development (ICPD) was held in Cairo, Egypt, in 1994. ICPD was a United Nations conference organised by the United Nations Population Fund and the Population Division of the UN Department for Economic and Social Information and Policy Analysis. The ICPD programme of action focused on important population and development objectives and goals. One of the main issues covered during the ICPD was gender in relation to health (Johnson, 1995). For the first time in an international forum sponsored by the United Nations, gender-based discrimination was formally recognised as the root of the persistent neglect of woman's sexual and reproductive rights. Women are subordinate and less empowered then men in all areas of public and private life throughout the world because of gender-based discrimination (Alcala, 1995). However, according to the ICPD Programme of Action, men can and must contribute to achieving gender equality, because in most societies men exercise the dominant power in nearly every sphere of life, from personal and family decision making to the policy and programme decisions taken at all levels of government.

The ICDP Programme of Action proposed to address the issues of gender equity, equality and empowerment of women by setting sub-goals for male responsibilities and participation. These are;

1. To promote changes in both men's and women's knowledge, attitude and behaviour to achieve a harmonious partnership between men and women and enable women to realise their full potentials.
2. To improve communication between men and women on issues of sexuality and reproductive health and the understanding of their joint responsibilities, so that they are equal partners in public and private life.
3. To encourage men's responsibility for sexual and reproductive behaviour and increase

male participation in family planning (Johnson, 1995).

Family planning programmes have frequently focused exclusively on women. The important role of men in bringing equity and equality among men and women and thereby empowering women has already been mentioned above. Increasingly, health care providers and researchers are realising that the most appropriate client for reproductive health information and services may be the couples rather than the individual (Becker, 1996; Becker and Robinson, 1998; Keller, 1996). Recently, several projects have demonstrated increased use of contraception by facilitating communication between husbands and wives. The empirical evidence and rationale for including both husband and wife in family planning education are strong. Therefore it was important that the educational intervention designed for the carpet factory workers in Kathmandu include husbands. It was very important to include the couples in the educational intervention programme so that the knowledge and information shared during the intervention would be used later in life decision.

4.3 INTERPERSONAL COMMUNICATION (IPC)

The important role of IPC and family planning has already been described in Chapter 4, page 28-29 Several studies have shown that interpersonal communication (IPC) plays a key role in promoting uptake and sustained use of family planning (Bruce, 1990; Schuler et. al., 1985; Storey and Sood, 1997). Bruce described six important elements of her framework for assessing quality of service. Interpersonal relations is one of these. Good interpersonal relations and communication between client and provider enhance client confidence and respect for service providers. Ultimately good client-provider relations result in increased usage of family planning services and consistent use of contraceptive methods. Interpersonal communication is the interaction that takes place at several different levels in many cultures including; between the client and provider, between husband and wife and between couples and in-laws.

4.4 ADULT LEARNING THEORY

4.4.1 Pedagogy and Androgogy

"Pedagogy" is a term derived from the Greek words *paid* meaning 'child' and *agogus* meaning 'leading'. "Pedagogy" literally means the art and science of teaching children (Knowles, 1985). In the traditional pedagogical model, assumptions about learning or teaching include the following.

1. The teacher is responsible for making all the decisions about what must be learned, when and how it should be learned.
2. Learners enter into the field of educational activity with very little experience that is of value as a resource for learning.
3. Students are ready to learn in order to advance to the next grade.
4. The learning is more subject-centred, and
5. Students are motivated primarily by external pressures from parents and teachers, competition for grades, and by the consequences of failure (Knowles, 1985, p 8-9).

"Andragogy" is also a term derived from the Greek language, A*ner* meaning 'man', not boy or adult. This new term was first used by Knowles in his 1968 article on adult leadership. Since then this term has been used frequently in the international literature regarding adult education and adult learning. According to Knowles, andragogy is based on five assumptions that tend to be very different from those assumptions which guide pedagogy. These assumptions are;

1. The learners are self-directing.
2. Past experiences of the person are rich sources for learning.
3. The readiness to learn is closely related to developing the learner's role in the society.
4. The learning is more problem or task or life-centred and

5. Adults are motivated to learn for internal factors rather than external factors (Knowles, 1985, p 9-21).

Although the andragogical approach provides a very effective model for adult learning, a number of limitations have been demonstrated (Knowles, 1985). As mentioned above, the experiences of adults are the main source of learning, however this is not always true. It seems obvious that because adults have lived longer, they have more experience than young learners. However, the added experience may not necessarily have provided them with correct knowledge and information. Family planning research has documented that people with low literacy levels tend to have less knowledge about different family planning methods and lower knowledge levels correlates with low levels of family planning practise (Tuladhar, 1989; Aryal, 1996; NFHS, 1996). In this situation where low literacy levels are a factor, it is possible that the pedagogical model (e.g. teachers as the main source of information), can potentially be more effective when used in combination with the andragogy model.

Carpet factory workers in Nepal tend to have a low level of literacy (Bhattarai, 2000). It was anticipated that the target population's knowledge of family planning and husband and wife communication would be very limited, and that the communication intervention would need to include a fair amount of information sharing and giving. For this intervention research, the strengths of both the pedagogy model and andragogy model were combined to maximise the chance for achieving the best outcome.

Malcolm Knowles in his book, *The Modern Practise of Adult Education: Andragogy versus Pedagogy* describes the two models as dichotomous; one model for children, the other for adults (Knowles, 1977). However, in the ten years of research following the 1970 publication, Knowles's own research and feedback from other researchers and practitioners helped him realise that, in some cases, the andragogy model is not always as effective on its own and that elements of the pedagogy model are sometimes required, especially in the case where basic skills training is one of the learning objectives (Knowles, 1985).

4.5 THE SPIRAL DESIGN MODEL

The Spiral Design Model is a very practical tool based on an understanding of the adult learning process for designing educational interventions for adults with low literacy level. This model incorporates key elements of both the pedogogy and androgogy models. Rick Arnold, Bev Burke, Carl James, D'Arcy Martin and Barb Thomas are social change educators and are based in Southern Ontario, Canada. Burke and Arnold have worked primarily with international solidarity groups. Thomas and James work with anti-racist educators and Martin with the trade union movement. They developed this model while planning a workshop for social workers on "Education for Social Change". This model suggests that:

1. Learning begins with the experience or knowledge of participants.
2. From the experiences shared among the participants they are able to analyse the commonalties and differences among themselves.
3. New information is added by the facilitators to avoid being limited by the knowledge and experience of people in the room new information is added.
4. Participants need to practice what they have learned: to practice new skills, make strategies and plan for action.
5. Later, participants apply what they've learned in the workshop to their daily activities (Arnold et. al., 1991, p 38).

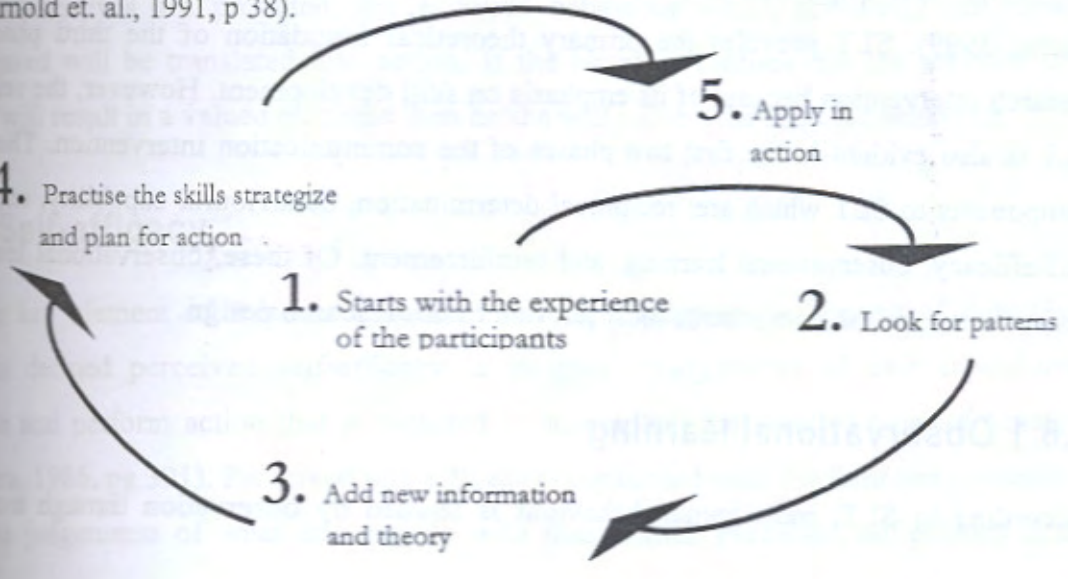


Fig 4 : The Spiral Design Model Source: Arnold et. al., 1991. pg 38

The spiral design model is a practical tool for effective adult education. The spiral model take into account how people learn. If a person only hears new information then he retains only 20 percent. If he/she only sees new information then he retains only 30 percent. If he/she hear and sees the information then he/she retains 50 percent. If he hears, sees and talks about the new information then he/she retains 70 percent and if hears, sees, talks and acts then he/she can retain up to 90 percent of what he/she has learned. The research intervention was designed so that the person would have a chance to listen to others, see what others do and talk to others about how they feel and thereby achieve maximum retention of what he/she has learned. The intervention was designed so that the participants were expected to not only hear and see but to also talk about the new knowledge so that they could retain the most of what is shared during the intervention.

4.6 SOCIAL LEARNING THEORY

Social learning theory (SLT) is considered to be the most complete theory currently applied to the design and implementation of effective health promotion programmes (Nutbeam and Harris, 1999). SLT provides the primary theoretical foundation of the third phase of this research intervention because of its emphasis on skill development. However, the relevance of SLT is also evident in the first two phases of the communication intervention. There are six components to SLT which are: reciprocal determination, behavioural capability, expectations, self-efficacy, observational learning, and reinforcement. Of these, observational learning and self-efficacy are the components most relevant to this research design.

4.6.1 Observational learning

According to SLT, most human behaviour is learned by observation through modelling

(Bandura, 1986). By observing and imitating the behaviour of others, individuals practice new knowledge and skills. Observational learning enables people to expand their knowledge and skills on the basis of information exhibited by others. Observational learning is governed by four processes; attentional process, retention process, production process, and motivation process (Bandura, 1986, pg 51).

Attentional process involves the attention and involvement of the person. To get the most out of observation, people have to attend and accurately perceive the relevant aspects of modelled activities (Bandura, 1986). If a person is present at the moment of modelling but is not observing the act attentively, then that person will learn very little from the process.

Retention process involves two ways of retaining observed information. To be able to make the most out of modelled activities, people have to observe very carefully and remember them. The best way to retain a modelled information is transforming it into symbols. Another way is by rehearsing or practising the modelled information (Bandura, 1986).

Production process involves converting symbolic conceptions into actions. By observing modelled performances, one forms a conception of how information can be combined and used to produce new forms of behaviour. The more accurate the conception, the better the performance (Bandura, 1986).

In the motivational process, incentives play an important role. According to Bandura when positive incentives are provided, the acquired behaviour which previously had remained unexpressed will be translated into action. If the observer realises that the activities of the models will result in a valued outcome then he/she will exhibit the acquired behaviour.

4.6.2 Self-efficacy

Another key element of Bandura's Social Learning Theory is the concept of self-efficacy. Bandura defined perceived self-efficacy as peoples' "judgements of their capabilities to organise and perform action that is required to accomplish the required types of behaviour" (Bandura, 1986, pg 391). Perceived self-efficacy is concerned with the skills one possesses and with the judgements of what one can do with these skills. Perceived self-efficacy is an

important determinant of health promotive behaviour (Bandura, 1995).

According to Bandura, there are four main forms of influence in creating and strengthening self-efficacy; mastery experiences, vicarious experience, verbal persuasion and physiological state (Bandura, 1986, pg 399). In mastery experiences, a person is able to build a strong sense of self-efficacy when he/she overcomes obstacles through persistent effort (Bandura, 1995). When a person succeeds this helps him/her belief in his/her personal efficacy. In a vicarious experience, other people similar to oneself are observed to succeed by persistent effort. This vicariously raises the observer's self-efficacy and belief that he/she is also capable of doing the same kind of activity and succeeding. Conversely, people with low efficacy are readily drawn back from the activities when they observe others failing to succeed. Verbally persuading people who have the capabilities to master the activities is likely to motivate them to try harder and succeed and this will raise their self-efficacy (Bandura, 1986; Bandura, 1995). If a person is emotionally strong then he/she will believe in his/her self-efficacy. When people are equipped with the necessary skill and confident with their self-efficacy, then they are better able to adopt behaviours that promote health and eliminate behaviours that impair health (Bandura, 1995).

4.6.3 Important components of an intervention

According to Bandura there are four essential components to an effective intervention model to develop self-efficacy; information, self regulatory, self management of the skill, and enlisting the desired personal change, (Bandura, 1995). These components are very similar to key elements of the Spiral Design Model and Adult Learning Theory. Both models also emphasise the important role of sharing and listening to experience and knowledge, analysis of experience and knowledge, introduction of new information, practising new skills and new knowledge, and applying it in real life. Figure 4 shows the four important components for an effective intervention model according to Bandura.

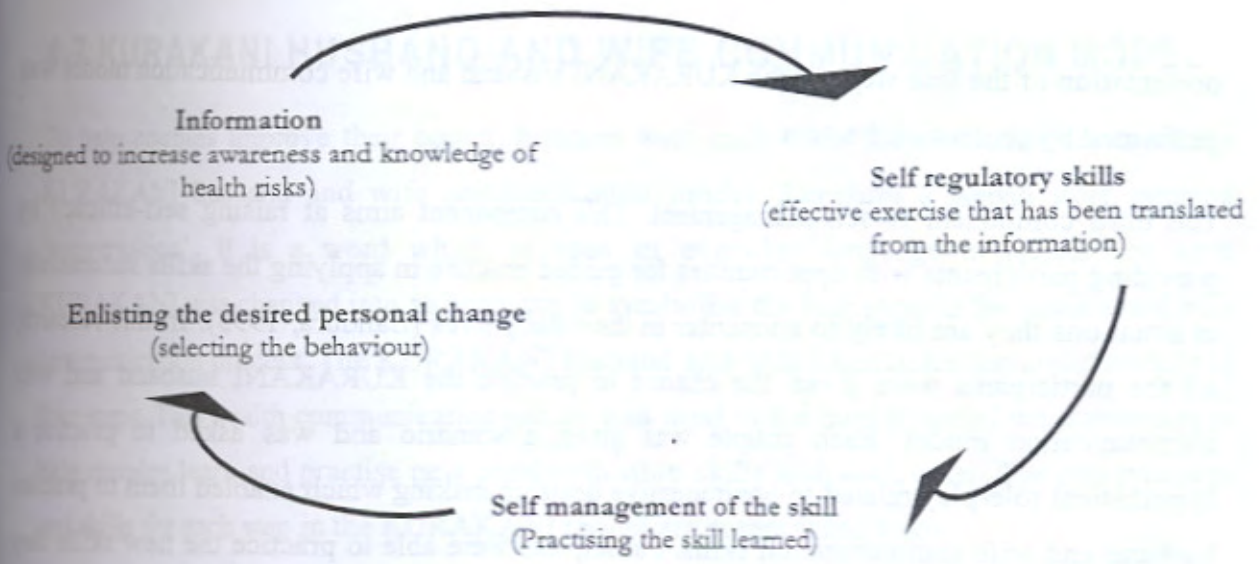


Figure 5: Important components of an effective intervention model
Adopted from Bandura, 1995

The first component is that the intervention should be informative. The intervention should be designed in such a way that it increases awareness and knowledge of the problem and of the possible solution. In this research, the focus was on the influence of husband and wife communication in adopting a family planning method. Therefore the workshop was designed to give the participants information on eight different family planning methods, the importance of husband and wife communication, and key elements in successful husband and wife communication (full details can be found in Chapter 4).

The second component is the development of self-regulatory skills so that one can have control over the habits and the social influences that will promote one's own health. Self-regulatory motivation is very important because if people are not fully convinced of their self-efficacy then they will easily abandon the skills they have learned which in turn will affect behavioural change. In this research, the participants learned the KURAKANI husband and wife communication model and the different communication skills needed for good communication. A role-play demonstrating the KURAKANI husband and wife communication model was shown to the participants which was intended to help them to develop self-regulatory skills by understanding that good husband and wife communication can become an accepted cultural norm, at least accepted among couples who work together in the carpet factory. A theatrical

presentation of the four steps of the KURAKANI husband and wife communication model w performed by professional actors.

The third component is self-management. This component aims at raising self-efficacy providing participants with opportunities for guided practice in applying the skills successfu in situations they are likely to encounter in their daily lives (Bandura, 1995). In this resear all the participants were given the chance to practice the KURAKANI husband and wi communication model. Each couple was given a scenario and was asked to practise hypothetical role-play related to contraceptive decision making which enabled them to practi husband and wife communication skills. Participants were able to practice the new skills th learnt during the workshop. Couples were then invited to record a private conversation in the own room so that they could practice the KURAKANI approach and gain confidence in usi the approach again. Thus the KURAKANI husband and wife communication model w designed with Bandura's SLT in mind as a tool for helping husband and wife communica with each other more easily.

The fourth component of Bandura's theory is enlisting and creating social support for desire personal changes. According to Bandura, personal change occurs within a network of soci influence (Bandura, 1995). Many of the habits that affect health are influenced by soci norms. People will behave in ways which give them self-satisfaction but which will not viola social norms. If there are habits which go against the social norms, people will hesitate to ado them. Following the intervention changes in attitudes and knowledge about contracepti methods as well as improvement in communication skills for making a joint decision abo using a contraceptive methods were expected among the participants. All the participants live within the factory premises. It was expected the participants would share the information the learned from the intervention with their friends who did not participate in the intervention thereby, influencing their peers to practise contraception and desire a well-planned family creating supportive norms in the workplace.

4.7 KURAKANI HUSBAND AND WIFE COMMUNICATION MODEL

To help couples improve their communication with each other the researcher developed the KURAKANI husband and wife communication model. *Kurakani* a Nepali word meaning 'conversation'. It is a word which is used in everyday language in Nepal. The word KURAKANI was changed into an acronym to symbolise the four steps in the husband and wife communication process. The KURAKANI husband and wife communication model consists of four steps. This health communication model was used in the third phase of the intervention to help couples learn and practise new communication skills with each other. The core meanings and skills for each step in the KURAKANI model are summarised below.

4.7.1 KURAKANI (Conversation)

a) KU-Kura (talk)

In Nepali, *kura* means 'to talk'. In the *KU* step couples talk and share information about contraceptive methods and how to achieve a well-planned family. Couples learn how to talk with each other in this step.

b) RA-Raya (opinion)

Raya is a Nepali word meaning 'opinion'. *RA* is the second step of the KURAKANI husband and wife communication model. In this step each member of the couple learns to ask their partner for his/her opinion, such as, about which is the best contraceptive method for the couple to use.

c) KA-Kadar (respect)

Kadar is another Nepali word meaning 'to respect'. *KA,* the third step, teaches the couple to respect each other's opinion and to respect their joint decision.

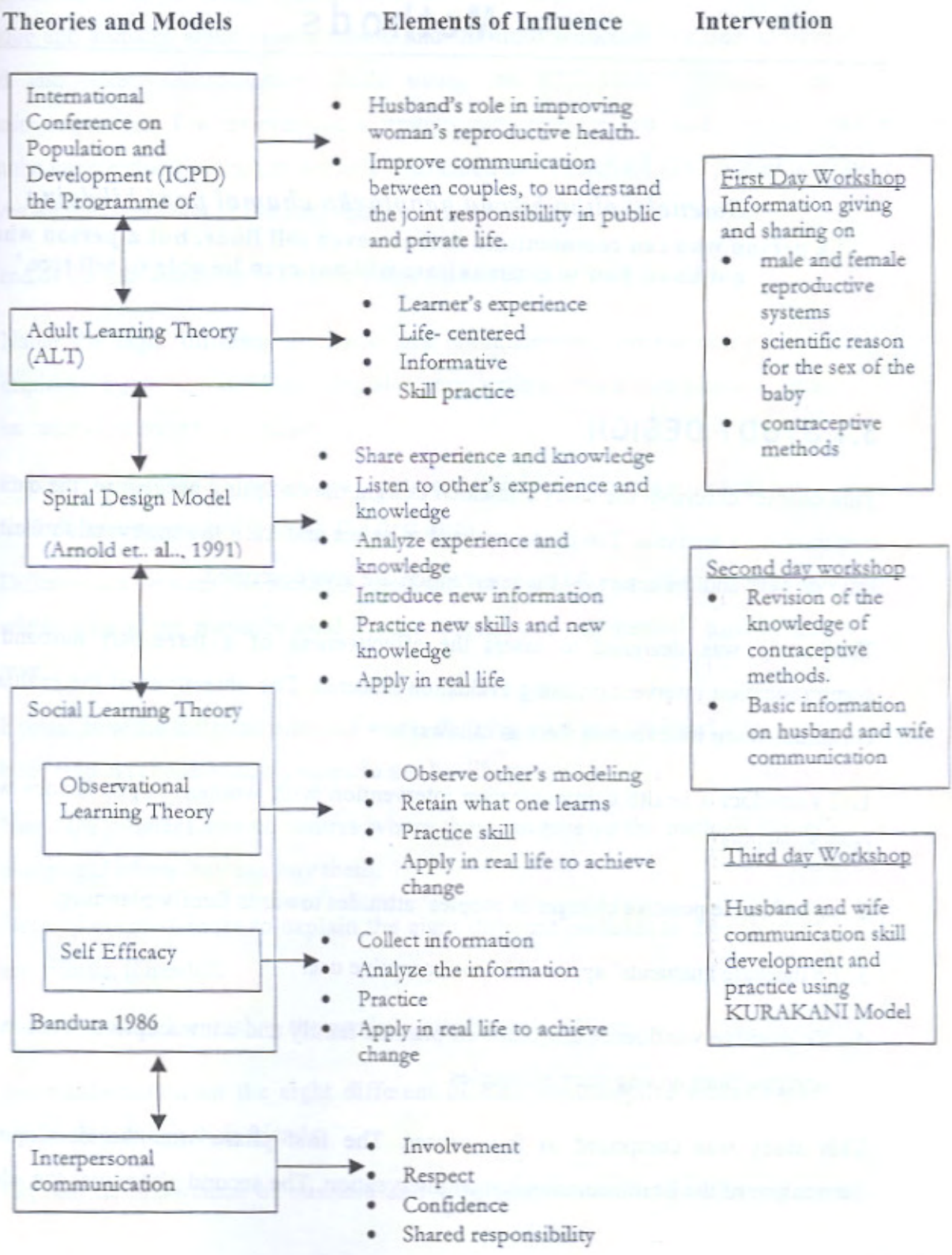
d) NI-Nirnaya (Decision)

In Nepali *nirnaya* means 'decision'. *NI,* the fourth step, teaches couples how to reach a joint decision while selecting a contraceptive method and planning a well-planned family.

Active listening, summarising and paraphrasing, questioning, and praise and encouragement are the four important communication skills. In all four steps of KURAKANI husband and wife communication model, couples are taught the different communication skills which will help them to communicate with each other better. The details of the four steps of the KURAKANI husband and wife communication model are included as Appendix 1.

Figure 5 shows the important influential elements of the theories and models that have been selected to help develop the framework for this research. The framework shows how the important elements of the different theories and models are brought together to bring changes in knowledge, attitudes, and communication. By sharing experience and knowledge, by learning from others, by practising and by improving self-efficacy, the learned action brings changes in knowledge, attitudes, and communication .

Figure 6: Conceptual Framework for Health Communication Intervention with Carpet Factory Workers in Kathmandu, Nepal



Chapter 5

Methods

Boleneko pitho bikcha nabolneko chamal pani bikdaine

'A person who can communicate well can even sell flour, but a person who does not know how to communicate will not even be able to sell rice.'

5.1 STUDY DESIGN

This chapter describes the study's research design, the sampling procedure, the data collecti methods, data analysis. The processes used to select and train the intervention facilitators, t interviewers and the actors for the intervention are also described.

This study was designed to assess the effectiveness of a three-part husband and wi communication intervention using evaluation research. The objectives of the evaluation of t communication intervention were as follows:

1. To conduct a health communication intervention with women carpet factory workers a their husbands.

2. To influence positive changes in couples' attitudes towards family planning.

3. To increase husbands' approval of contraceptive use.

4. To positively influence the joint well-planned family and contraceptive decision-making and practices among married couples.

This study was comprised of four phases. The first phase was the development of t curriculum of the health communication intervention. The second phase was the administrati

of the pre-intervention questionnaire. The third phase was the implementation of the three-part intervention, and the fourth phase was the administration of the post intervention questionnaire. The intervention itself was made up of three different components. Two workshops focused on knowledge and attitudes about contraception and the third workshop focused on developing husband and wife communication skills using the KURAKANI husband and wife communication model. The intervention's strategy activities for this study are described in detail in the intervention curriculum document attached as Appendix 1. The process or strategy objectives for the three parts of the intervention are noted below.

By the end of the first workshop the participants should be able to;

1. Name the eight different methods: oral contraceptive, inter-uterine device, implant, injection, condom, female sterilisation, male sterilisation, and lactational amenorrhea method.
2. Explain the purpose of using contraceptive methods, e.g. to space the next birth, to limit family size, and to delay the first birth.
3. Differentiate between the methods used for spacing birth and limiting birth. In addition name the methods used by the woman and the methods used by the man.
4. Explain how the different methods work, their benefits and drawbacks, how the body responds (side effects), when to see health personnel.
5. Name the different service centres where they can receive the methods free of charge and where they can buy them.
6. Develop the confidence to explain the eight different methods to their relatives and friends, if needed.

By the end of the second workshop the participants should be able to;

1. Share information on the eight different modern contraceptive methods with confidence among their friends.
2. Explain the importance of husband and wife communication in achieving a well-

planned family.

3. Explain at least three benefits of husband and wife communication.
4. Name the obstacles to good husband and wife communication.

By the end of the third workshop the participants should be able to;

1. Define of husband and wife communication.
2. List and explain the four steps of KURAKANI.
3. Use the four steps of KURAKANI to demonstrate good husband and wife communication.

5.2 STUDY POPULATION

The selection process used to identify and recruit the study population involved main tw steps. First, an appropriate factory was identified and secondly the study participants wer identified and recruited within the selected factory.

5.2.1 Selection of factory

The criteria for selecting the factory were: that the factory should be using wool from Ne Zealand, that it should be located in Lalitpur district, and that it should be close to the Centra Family Planning Clinic. As many carpet factories are located in Lalitpur, Lalitpur district wa selected as the site for the research. Lalitpur district has 80 carpet factories (CBS, 199 varying from ten to 500 workers. The intervention factory needed to be close to the Centra Family Planning Clinic so that the participants would have easy access to these services.

The researcher approached three different factories before being able to identify an appropria factory. All the three factories were selected through family connection. The factory that wa first selected had only Tibetan refugee workers. Most of them could not speak Nepali fluentl so an interpreter would have to be recruited to conduct the interviews and the workshop. Usin an interpreter for the interview would take double the time expected and potentially result in

lower quality data. It was then decided that another more suitable factory had to be identified. A suitable carpet factory in Akantakuna, Lalitpur was selected through a family connection which saved a considerable amount of time. According to the Official Development Assistance (ODA) scholarship regulations the researcher could spend only three months in the country where the research was to be conducted, if it was outside New Zealand, limiting the time available to conduct the study. The other reason for using a family connection to select the carpet factory was because the factory owners do not allow anybody to enter their factories for fear the person might be a journalist trying to get information for example, concerning child labour. It helps to have an introduction to the factory, otherwise it is very difficult to gain access.

The second factory chosen met the initial selection criteria. Its full capacity was 120 workers at peak season for weaving carpets. During the time of the research there were no orders for carpets. Only few of the husbands were able to participate, this factory was also eliminated from the selection process. After facing difficulties in finding sufficient numbers of participants in the second factory, the fourth criterion, that the husband and wife should be working in the factory and living in the rooms provided by the factory to the workers, was added to the original selection criteria.

Finally, a third factory with 70 workers, had to be approached. This factory met the selection criteria and there were enough couples to participate in the intervention.

5.2.2 Selection of participants

Women were eligible for the intervention if they met the following criteria; married, aged between 15-39 years, from the rural part of Nepal, and husband and wife should both be working in the factory and living in the rooms provided by the factory. Women were excluded from the study if they were; unmarried, widowed, sterilised or husband was sterilised, aged below 15 and above 39 years, and not living with husband at the time of the intervention.

The rationale for the specific selection criteria used was as follows. The fertile age group in the National Family Health Survey (NFHS, 1996) was defined as 15-49 years of age. For the

NFHS data, all contraceptive methods including sterilisation were taken into account when reporting the prevalence of contraception in the country. In Nepal, women get married at a young age so by their late 20s or early 30s they will have given birth to their desired number of children (NHFS, 1996). Current use of contraception among married women is 29 percent, and sterilisation represents 19.3 percent, of which 69 percent is female sterilisation and 31 percent is male sterilisation (NFHS, 1996). Ninety-five percent of women who had undergone sterilisation were under the age of 39 years, highest in the age group of 25-29 years (35.9 percent) (Thapa and Friedman, 1998). This was the main reason for narrowing the study age group to 15-39 years. The other reason was that workers in carpet factory tend to be from a younger age group (Rai, 1996).

Among the Hindus, pre-marital sexual experience by a woman is not condoned, and her sexual purity is imperative. Arranged marriage continues to be favoured and practised in Nepal. The act of the parents giving away their daughter is called *kanyadan*. *kanya* meaning 'virgin' *dan* meaning 'giving away'. Great importance is attached to the bride being *kanya*. According to Hindu belief a woman can only truly marry while she is pure. A divorced or widowed woman is considered no longer pure so it is believed in Hindu religion that marriage to a widow would pollute the man, decrease his purity and put his next life in jeopardy. According to Hindu religion k*anyadan* earns the parents a great deal of merit. To fail in arranging a daughter's marriage, or to fail to keep the daughter pure until marriage, is a disgrace and can jeopardise the parents in their next life (i.e. reincarnation is a Hindu belief) (Burbank, 1994). If unmarried women and widows were included in the research, it would probably be very difficult to obtain truthful answers from them. Even if they were using a contraceptive method they would never admit it for fear they would be discovered to be having sexual intercourse when this is not accepted by their society. The results of the research would be adversely affected. Because of these cultural and religious beliefs and practices, unmarried women and widows were excluded from the study.

Screening for couples was not carried out in the first factory because it failed to meet the initial selection criteria. The screening process conducted in the second and third factories consisted of a brief interview with individual women to ascertain their status with regard to the

following factors and selection criteria. The women were asked their age, marital status, if the husband or wife had undergone sterilisation, fertility status, and their preference for ideal family size.

In the second factory, twenty-one female workers were present when the selection of the participants took place which was conducted by the researcher herself. In this factory, two of the women approached were unmarried, two had undergone sterilisation and one of the woman worker was not living with her husband at the time of the selection so they were all excluded. Therefore, fifteen workers potentially qualified for the intervention research. However, when the husbands of these women were initiated by the researcher to participate only six of them agreed to participate in the workshop. The reason given for the husbands not being able to participate was that they could not leave their job to participate in the intervention. Some were taxi drivers, some *tampo* drivers (three wheeler), some were builders and some were painters. They were paid daily wages, so if they did not attend work they could not earn. The other reason husbands reported not being able to participate in the intervention was because their employer would not let them take the day off.

In the third factory, thirty-one women workers were screened; fourteen were unmarried girls, two widows and fifteen married women. Most of the workers were living within the factory premises. Fifteen women were eligible according to the initial selection criteria stated above and all fifteen husbands agreed to participate in the intervention research.

5.3 THE THREE-PART HEALTH COMMUNICATION INTERVENTION

An educational intervention was designed for the participants which was comprised of three-parts. The first two workshops focused on knowledge about and attitudes towards contraception and the well-planned family concepts. The third workshop focused on communication skills using the KURAKANI husband and wife communication model. The KURAKANI husband and wife communication model was developed by the researcher who was influenced by similar health communication models for improving client-provider

interaction such as GATHER and NAMASTE models which have been successfully used Nepal (Heckert et. al., 1996; Storey et. al., 1999). The different communication skills need and the procedure for the four different steps of KURAKANI husband and wi communication model are given below.

5.3.1 *Ku-Kura* (Talk):

- The couple should feel free to talk about contraceptive methods with each other.
- Either the husband or wife can initiate the talk. It is not necessary for the husband to initi the talk.
- Both husband and wife should have a chance to speak. There should be a two-w dialogue.
- The wife should also be given chance to have her say in family size.
- When one is talking the other one should listen. They should not interrupt in between.
- The couple should share information with each other about contraceptive methods.
- The couples should discuss the number of children they want, spacing between birt whether the sex of the children makes a difference to their ideal family size? Are the going to keep on trying unless they have a son or they will be happy to have two children?
- Discuss the different contraceptive methods available and which one to choose if the decide to use one.
- Discuss where they can get it. Do they have to go to the health centre for the method or ca they get it from the local medical shops?
- The couples should consider the usefulness and the drawbacks of the method and compa with other methods. This will help them to make a better choice and the chances c continuation of the method will be enhanced.

- Discuss body responses carefully. Many discontinue the method because of misinformation about body responses. If discussion has taken place prior to starting the method, there is a greater chance of coping with it and continuing the method.
- The couple should discuss when they would like to start using contraception, the reason for the use of a contraceptive method, whether for spacing or limiting births.
- It is not necessary for the couple to discuss each and every method and its considerations one by one, but they should try to incorporate other methods in their talks, relating to the topic of the discussion.
- The couple should not hesitate to ask questions when having the discussion.
- The couple should share the rumours and the stories about the methods going around in the community. When the couple talk it will help them to correct the misconceptions they have about the method. If they are still not clear then they can always seek help from the health worker.

5.3.2 *RA-Raya* (opinion)

- Should ask his/her spouse what contraceptive method he/she would like to use.
- Listen actively when his/her spouse is sharing their opinion.
- Restate what the spouse says. This assures the spouse that he/she has heard and understood what he/she has said.
- Ask the reasons why he/she thinks that method is the best for them. Is it because of few drawbacks, easy use, or easily available.
- Ask his/her spouse what he /she thinks about the method.

5.3.3 *Ka-Kadar* (respect)

- Respect their spouse's opinion about the method.
- Make positive statements about his/her opinion. This is a way to show he/she you respe his/her opinion.
- Use appropriate non-verbal communication e.g. facial expressions, nodding etc. This how you can let your partner know that you are listening.
- Do not laugh or immediately disagree. This will discourage the spouse giving an opinion the future. If one of you disagree with the method then don't get worried there is alwa another alternative method they could choose from.
- If the couple does not understand the method or has doubt about the method always go health centres and ask for help. The people in the health post are always happy and ready help clients.

5.3.4 *Ni-Nirnaya* (decision)

- When choosing a contraceptive method try to make a joint decision. When both a involved in deciding the method, it is more effective. If both discuss about the method th will have more information about the method. Partners will be more supportive a understanding about the side effects and continuation is more likely.
- Before making the decision the couple should consider:
  - What their plans and wishes are about having children.
  - Their reason for using the method: spacing or limiting births.
  - Whether there is any medical contraindication to use the method, (if not sure consul health worker before making the decision).

The intervention was carefully designed to take into consideration a number of important

characteristics of the participant group and a number of important features of the context in which the intervention would take place. While designing the intervention the adult learning theory, interpersonal communication and Nepali culture and religion were considered and used carefully. There is a saying in Nepali *Kalo achyar bhaisi barabar* which means a person who cannot read and write, black words are like black buffaloes to him. As a majority of the participants could not read or write, exercises requiring writing and reading were not used for the workshops. Pictorial posters were used rather than posters with lots of words. If written material was used it would be like 'black buffaloes' to the participants who could not read and write. Figure 7 shows the participants participating during the intervention workshop.

Figure 7 (photograph, participants during the workshop) (source: Dr. Asha Pun)



Most of the exercises were developed by the researcher. Only a few were adopted from oth resources; such as the Interpersonal Communication and Counselling for Community Base Distributors and Training for Transformation (Hope, A., and Timmel, S. 1989; Anonymou 1992). Several group exercises were included in the workshop to teach and demonstrate ke messages. The purpose of the group exercises were to help participants know each other bett and share their experience with each other, thereby learning from each others' experience Adult Learning Theory, the Spiral Model and Bandura's Self-Efficacy Theory all reinforce th notion that a person can learn more from observing others and sharing others' experienc Figure 8 shows participants playing the Bean's game during the workshop. The purpose of th beans' game was to make the participants understand the person (husband or wife) responsib for the sex of the baby (Appendix 1).

Figure 8 Participants playing the Beans' game during the first day intervention worksh (source: Dr. Asha Pun)



For the first two workshops, the participants were divided into two groups, wives in one and husbands in the other. Each group met simultaneously, but in different rooms not far from one another at the carpet factory. Most people in Nepal have difficulty talking freely about topics related to sex as the subject is quite taboo. In Nepali society it is considered inappropriate to discuss fertility and sexuality in a mixed gender group. It would be very difficult for the women to express themselves if they were put together with men. Research conducted in thirteen districts of Nepal in 1996 showed that only one out of every five consumers of oral contraceptive pills reported discussion with retailers while purchasing the contraceptive. The major reason for not consulting retailers was shyness or embarrassment (Shrestha et. al., 1990). This finding suggested that women are shy and embarrassed to discuss family planning with others. Women participants would have found it embarrassing to sit with men and listen and share their experiences with the group.

However, men and women were brought together as couples for the third workshop because KURAKANI, the husband and wife communication model, was designed to be introduced and practised by couples. It was presumed that the two separate workshops that preceded KURAKANI would help prepare the women and their husbands for the third joint workshop. (See Appendix 1 for the detailed curriculum for the three-part intervention.)

The intervention curriculum was originally prepared in English. The entire curriculum was translated and written in Nepali by the researcher for the facilitators. The researcher conducted the training of the facilitators, two women facilitators for the women group and two men facilitator for the men group. Each and every step of the intervention was discussed with the facilitators. The first two days workshop had to be done in two groups in two different rooms. The researcher could not run both the workshop simultaneously and if she ran the workshop for one group and someone else did it for the other group, there may be some difference in running the workshop. If new facilitators were trained then there is the possibility that the workshop would run the similar way. The training for the facilitators was conducted at the Nepal Family Planning Clinic (NFPC). Two days prior to each workshop the researcher and the facilitator met once again to discuss and revise the methods and how to conduct the intervention. The third workshop on KURAKANI was conducted by the researcher herself.

The researcher wrote the script for the performance of KURAKANI in the third worksh (Appendix 1). The male actor recruited by the researcher was an experienced street drama The actor recommended the actress. The two actors (one male and one female) and researcher met one month prior to the workshop and discussed how KURAKANI should performed. The script was given to them and they practised it themselves.

Two male facilitators facilitated the first two days workshop for the male participants. On them was a Family Planning Counsellor with ten years experience. The other man was a He Assistant with five years experience. The head of the Nepal Family Planning Clinic (NF recommended them for the work. These two men were also trained to carry out the pre and p intervention interviews with the husbands. It would not have been appropriate for a woma conduct these interviews. The questionnaires were discussed and each interviewer practi while the researcher observed to ensure consistency in obtaining the information from participants. The researcher conducted all interviews with all female participants.

5.4 DATA COLLECTION METHODS

Three different data collection methods were used to evaluate the effectiveness of intervention. These methods were:

1) pre and post intervention face-to-face interviews, with both closed and open-en questions using a structured interview schedule,

2) observational note taking by the researcher and the male observer, who was recruite the researcher, and

3) an intervention checklist for analysing transcripts of husband and wife communica based on KURAKANI, including comments and impressions noted by the researcher as transcribed the audio tapes. These included notes and comments about the conduct of intervention as well as participants' interactions and participation during the series of t workshops.

This combination of data collection methods enabled the collection of both qualitative and quantitative data. According to Denzin and Lincoln in *Handbook of Qualitative Research* "Qualitative methods put emphasis on the qualities of entities and on processes and the meaning that are not experimentally examined or measured in terms of quantity, amount, intensity, or frequency. In contrast, quantitative methods emphasise the measurement and analysis of causal relationships between variables, not the process" (Denzin and Lincoln, 2000). Quantitative methods are suitable for answering 'how many?' 'how much?' and 'how often?', while qualitative methods are suitable for answering 'how does this come to happen?' There were a number of key questions in this research which quantitative methods alone could not answer. Combining qualitative and quantitative methods can be complementary and enrich the other which often helps to understand and appreciate the phenomena under investigation (McKinlay, 1993). For example, qualitative methods may be used to help interpret the findings from quantitative methods. Qualitative methods can also help clarify the issues under investigation, identify gaps and generate questions for further study. The participant group in this research was mostly illiterate or of low literacy levels. Because qualitative methods offer flexibility, they were well suited for this study population, especially for assessing the husband and wife communication or KURAKANI interaction.

A multi-methods approach or triangulation, helps achieve broader and hopefully better results (Fontana and Frey, 2000). Triangulation helps to obtain an in-depth understanding of the phenomenon in question and was used in this study to double check the reliability of the data obtained from different methods, especially the improvement of husband and wife communication.

5.4.1 Pre- and post-intervention questionnaire

Keeping in mind the low level of literacy among the carpet workers, the language in the questionnaires was kept as simple as possible. The pre and post intervention questionnaires consisted of five areas of investigation. For the pre intervention questionnaire (PRI) these were: demographic characteristics, fertility, knowledge and use of contraceptive methods, husband and wife communication, and attitudinal questions on contraception and its users.

The post intervention questionnaire (PTI) did not include the demographic questions but di include a new section which gathered information about the workshop such as: what th participants learned from the workshop, their attendance, and what they found most useful. Th demographic section was excluded mainly to save time in the interview process and these da were collected in the PRI. These questions were selected to measure whether the researc objectives regarding changes in knowledge, attitudes and practise of contraceptive methods an improvement of husband and wife communication would be met or not. The total number o questions in the PRI was 120 and 91 for the PTI. The number of questions and type of questio for each area of investigation are shown in detail in Table 2. Of the 120 questions, 49 of the were borrowed from the Family Planning Communication Impact Survey, (FPICS) (Valle Research Group, 1997a). These questions were considered relevant to the research, had alread been field tested in Nepal and were shown to be reliable and valid.

Table 2: Pre and post intervention questionnaires

Pre intervention questionnaire				Post intervention questionnaire			
Area of investigation	No. of question	Type of question	No. of question from FPICS, 1997	Area of investigation	No. of question	Type of question	No. of question from FPICS, 1997
1)Demographic Characteristic	23	Dic=7 FC=13 O/E=2		1) Fertility	18	Dic=4 FC=11 O/E=3	5
2) Fertility	25	Dic=5 FC=17 O/E=3	5	2)Contraceptive methods	22	Dic=2 FC=13 O/E=7	10
3)Contraceptive methods	27	Dic=3 FC=18 O/E=6	10	3) Husband and wife communication	15	Dic=5 FC=6 O/E=4	5
4) Husband and wife communication	15	Dic=5 FC=6 O/E=4	5	4) Attitudinal questions on contraception and its users	30	L/S=30	19
5) Attitudinal questions on contraception and its users	30	L/S=3	19	5) About the intervention workshop	6	O/E=6	

Note: Dic= dichotomous, FC= forced choice, O/E= open ended, L/S= Likert scale

The questionnaires were originally developed in English then translated into Nepali and ba translated into English for consistency. The researcher translated and back translated herself.

(The English version of the pre intervention questionnaire and the Nepali version of the post intervention questionnaire are attached in Appendix 2.a and 2.b respectively.) The Nepali version had to be typed into Devangiri (Nepali script) which is difficult because it is a script. The researcher had no prior experience typing in Devangiri script and thus spent a great deal of time with the translation and typing. After translating the questionnaire into Nepali, it was double-checked by another native Nepali speaker (a postgraduate student at Lincoln University).

The interview schedule was pre-tested twice, once in Christchurch, New Zealand and a second time in Nepal. The objectives of the pre-tests were: to provide information on the length of the interview and the clarity of the questions, to ascertain respondents' comprehension, and to determine whether the questions on sexuality were acceptable to Nepalese participants. Even though the level of education and socio-economic status of the pre-test participants in Christchurch was higher than that of the potential study participants from the carpet factory; the pre-test was conducted among the most readily available Nepalese, two Nepali student couples. The couples lived in Lincoln. The husbands were postgraduate students at Lincoln University and the wives had Bachelor degrees. As a result of the pre-test the researcher restructured some of the questions for clarity and to avoid duplication. The male respondents were a little reluctant to answer some of the questions on sexuality. A Westerner might not have a problem answering these questions but for Nepali men from a more conservative society, it was awkward to answer some of the sexuality questions posed by the female researcher. The researcher decided the men might find it easier to speak to a male interviewer rather than to a female interviewer. In the same way, the female participants would find it easier to speak with a female interviewer rather then a male. Considering these preliminary findings it was decided that male interviewers would be hired and trained to conduct the interviews with the male participants in Nepal.

On arrival in Nepal, the Nepali translations of the draft pre and post intervention interview schedules were reviewed by Dr. Yagya Bahadhur Karki. At the time of the research Dr. Karki was the Director General of Nepal Family Planning Association, an expert in family planning and communication with many years of experience in this field. The pre-test in Kathmandu

was conducted with two couples from a carpet factory not involved in the study, for the reason stated above. The pre-test in Nepal confirmed that the questions were clear and easy to understand, and no changes were made.

The pre intervention interviews were conducted a week before the intervention workshops. It took three days for the researcher to complete the fifteen interviews. Whereas, the two male interviewers took four afternoons to complete the fifteen interviews with the male participants. On average, one face-to-face interview took approximately an hour to complete. Both male interviewers were employed at the Central Family Planning Association Clinic, one as a counsellor and the other as a health assistant. They worked in the clinic in the morning hours and agreed to do the interviews in the afternoon. The same two men were trained by the researcher to facilitate the first two workshops with the male participants. All interviews were conducted on the factory's premises to make it easier and comfortable for the workers.

The post intervention interviews were conducted two weeks following the last part of the intervention. The same two male interviewers conducted the post intervention interviews with the male participants and the researcher did the interviews with the female participants. Post intervention interviews took approximately an hour.

5.4.2 Observational notes

Observational notes were recorded during the workshops. A male cousin of the researcher was asked to observe and take notes in the men's group. The main reason for selecting a man as an observer was to make the male participants feel at ease, as men would feel embarrassed and reluctant to talk freely about family planning if a woman was present in the group. The researcher made observational notes in the female group. The male observer and the researcher met before the workshop and discussed the points that were to be observed during the workshop. The points to be observed and noted included the interactions between the participants, between participants and facilitators, and the involvement and participation of the participants in different activities during each workshop.

5.4.3 KURAKANI interaction checklist

Six couples were oriented to the use of the audio taping equipment in order to record a conversation between themselves in their own rooms. A KURAKANI interaction checklist includes all skills or desired behaviours for good husband and wife communication from the curriculum (Appendix 3). The checklist was used to assist in analysing the taped conversations. The comments and impressions noted by the researcher as she listened and transcribed every tape, were also used in the analysis. The KURAKANI interaction checklist was modelled after the interaction observation checklist developed by the Johns Hopkins University/ Population Communication Services (JHU/PCS) for a study of client-provider interaction conducted in Nepal (Valley Research Group, 1997b).

5.4.4 Ethical consideration

The researcher approached the Canterbury Ethics Committee for the ethical approval but was told that since the research was to be conducted in Kathmandu, they were not able to give ethical approval. The researcher was told that ethics approval had to be sought in Nepal. The research proposal was submitted to the Nepal Health Research Council, Kathmandu, Nepal two months prior to the beginning of the research. Immediately upon arrival in Nepal, the researcher followed-up with the research council. A few questions were raised by the ethical committee which needed to be clarified. After clarifying the questions raised by the ethical committee, the proposal was approved. (Letter of ethical approval included as Appendix 4).

Each participant was informed individually by the researcher about the research and invited to provide verbal consent to participate. Few carpet factory workers know how to sign their names, thus written consent was not practical. Each participant was told that she/he could cease participation at any time throughout the research without any adverse consequences. All the data and the questionnaires collected during the research were kept confidential and locked in a file cabinet in the researcher's office. All the questionnaires will be destroyed when the research is completed and the thesis has been reviewed and marked.

5.5 DATA ANALYSIS

To protect the identity of the participants when processing the data, code numbers were given to each male participant. The female participants' code number was the same as her husband with a 'w' added at the end of each code. For example if the husband's code number was '1' then wife's code number was '1w'. This made identification of the couple's data easier. The information collected during the research was kept by the researcher in a locked cabinet. As all the data processing was conducted only by the researcher upon her return to New Zealand, the identity of the participants was kept confidential.

Due to the small number of participants, the researcher decided to use descriptive analysis. A large amount of data were collected using the three methods. Due to resource and time constraints, the researcher was unable to utilise all the data that were collected. To aid data analysis, a data analysis plan was developed (Appendix 6). The main questions that were relevant to the research objectives and the key areas of investigation were identified. The relevant questions from the pre and the post intervention interviews for each area of investigation were selected and appropriate computer software was identified for data entry and analysis. Several computer software programmes were used to analyse the pre and post intervention interviews. First, all PRI and PTI data were coded and entered into Epi-Info version 5.0. All responses to the open-ended questions were translated into English and entered into MSWord. These data were used to generate a list of key ideas, words, and phrases that were analysed manually. The participants' ideas were then clustered into various categories that formed the themes of the discussion. Excel was used to produce all the graphs forms and tables generated on Epi-info.

Each of the taped conversations of the six husband and wife couples were first transcribed in Nepali and then translated into English using a literal translation. The transcripts were then retranslated into contemporary conversational English. The KURAKANI interaction checklist was used to analyse couples' use and understanding of the husband and wife communication behaviours and skills. The comments and impressions noted by the researcher as she listened to the tape were also included in the analysis.

The observation notes collected by the male observer and the researcher during the workshop were entered into MS Word and analysed in a manner similar to the method used for the open-ended question of the questionnaire.

Chapter 6

RESULTS

Sapriyako gharko aghee sallaha, bigrako gharko pachi sallaha.

'In an ideal family usually discussion takes place before an incident happens whereas in an unhappy family discussion takes place after the incident has happened.'

6.1. INTRODUCTION

This chapter describes the results of the pre (PRI) and post (PTI) intervention interviews, observational notes and the KURAKANI interaction checklists. The multiple variables of the interview questionnaire are grouped according to five main areas of investigation:

1. Demographic characteristics of the participants.
2. Knowledge of the well-planned family, eight different contraceptive methods, their body responses, benefits, and drawbacks and the knowledge of where to obtain the methods.
3. Attitudes and perceptions regarding contraceptive use, the well-planned family, contraceptive method users and husband wife communication.
4. Use of contraceptive methods among the participants, and
5. Factors influencing husband and wife communication.

To demonstrate changes in knowledge and attitude as well as self-reported contraceptive use, the post intervention data were compared with data from the pre intervention interviews.

For the pre intervention interview 29 participants participated. For the post intervention

interview only 27 participants participated. The reasons for the dropout of two participants were: one started to work outside the carpet factory after the intervention started and one woman returned to her rural village during the intervention. When data showing comparisons between the pre-intervention interview (PRI) and the post-intervention interview (PTI) are presented, only responses from the paired 27 participants are included.

6.2 DEMOGRAPHIC CHARACTERISTICS

The following is a summary of the demographic and socio-economic characteristics of the participants (Table 3). Responses from twenty-nine participants are included in this section. These responses were collected for the pre intervention interview only.

6.2.1 Age and sex composition

Twenty-six of the 29 participants were below the age of 30. Two of the participants were in the 15-19 age group, 14 in the 20-24 age group, 10 in the 25-29 age group and three in the 30-34 age group. The female participants were younger than the male participants.

6.2.2 Area of resident

All participants came from the rural Nepal. They had all moved to Kathmandu in search of work. Of the 29 participants, 24 were from the hill districts and five from the Terai districts of Nepal. Sixteen of the participants came from Makwanpur, four from Sarlahi, three from Kavre, and one each from Ramechap, Morang, Nuwakot, Sindhupalanchok, and Udayapur districts. All these districts are close from Kathmandu except for Morang which in the eastern part of Nepal (map of Nepal in Figure 1).

6.2.3 Education

Thirteen of the participants attended school and 13 had never been to school. The participants who attended school or can read and write are considered literate and those who are not able to

read or write are considered as illiterate (NFHS, 1996).

The majority of the female participants (12) have never been to school compared to only fo of the male participants have never been to school. Ten of the male participants attende school, compared to only three of the women. Ten of the women were illiterate, (a perso unable to read or write is considered to be illiterate) whereas only three of the male participant were illiterate. Of the 12 women who had never been to school, five had learned to read an write in adult learning classes. Eight of the male participants had some primary education an one of them had completed the School Leaving Certificate (SLC). Only two of the femal participants had some primary education and only one had reached secondary school.

6.2.4 Ethnic group

The majority of the participants (27 of the 29) were from the Tamang ethnic group with on participant each from the Rai and Newar ethnic groups.

6.2.5 Religion

A majority of the participants (27 of the 29) were Buddhist and only two participants wer Christian. Tamang people in Nepal are predominantly Buddhists.

6.2.6 Occupation

Fifteen of the female participants and 11 of the male participants were working as carpe weavers, two of the male participants were working in the carpet factory as 'masters' and on male was a gatekeeper of the carpet factory. A 'master' is a person who is in charge o distributing wool and patterns for the carpets and supervises the other workers.

A majority of the participants (27) reported working long shifts, both day and night shifts (1 hours a day). Only two male participants (masters) were working solely during the daytim shift. The carpet weavers work long hours, largely because they are paid per square metre. Th other reason concerns the care of their children. All most all the couples had young childre They started work at 4 o'clock in the morning while the children were sleeping and they

went back to work in the evening after the children went to sleep. The husband and wife took turn in looking after the children and the couples help look after each other's children. The children often sat in the weaving room when the parents are working but the parents worked more efficiently when the children are not present.

Table 3: The demographic characteristics of the participants

Characteristics	Females	Males	Totals
Age			
15-19	2	0	2
20-24	8	6	14
25-29	4	6	10
30-34	1	2	3
Residence			
Urban	0	0	
Rural	15	14	29
Area of residence			
Hills	12	12	24
Terai	3	2	5
Education			
No	12	4	16
Yes	3	10	13
Primary incomplete	1	7	8
Primary complete	1	1	2
Secondary incomplete	1	0	1
Secondary complete	0	1	1
School Leaving Certificate (SLC)	0	1	1
Literacy			
Illiterate	10	3	13
Literate	5	11	16
Religion			
Buddhist	14	13	27
Christian	1	1	2
Ethnic group			
Tamang	14	13	27
Newar	0	1	1
Rai	1	0	1
Occupation			
Carpet weaving	15	11	26
Others	0	3	3
Work shift			
Day shift	0	2	2
Day and night shift	15	12	27

N= 29, 15 females and 14 males

6.3 KNOWLEDGE OF THE WELL-PLANNED FAMILY AND CONTRACEPTIVE METHODS

Knowledge level in these specific areas will be presented:

1. Knowledge of contraceptive methods, their body responses, benefits and drawbacks,
2. Knowledge of the different sources for obtaining contraceptive methods, and
3. Knowledge of the concept and characteristics of the well-planned family.

6.3.1 Participant's knowledge of different contraceptive methods (Appendix 5a)

Responses of 27 participants are included in this section. During both pre and post interventio interviews all the participants were asked to name all the contraceptive methods they knew o had heard of. Each method mentioned was recorded as a spontaneous response. If there wer any methods unmentioned by the participants, the interviewer then read the name an described that method. If the participant recognised the method, it was recorded as a probe response. If the participant had not heard about the method, it was recorded as 'don't know' response.

Figure 9 shows spontaneous and probed knowledge of ten different contraceptives before an after the intervention. Before the intervention the most well known method was the injectio (23 out of 27 participants), then pills (21 out of 27) followed by the implant and the condo respectively (14 and 13). The least well known methods were female and male sterilisation (and 6 respectively). Among all the participants, traditional methods were the least well known either spontaneously or by probing. Lactational amenorrhea method (LAM), rhythm metho and withdrawal are taken to be traditional methods. Twenty-six of the 27 participants did no know about the LAM and 24 participants did not know about the rhythm method an withdrawal method.

Following the intervention, spontaneous knowledge of these methods increased

dramatically. Twenty-one out of the 27 participants could name all the seven modern methods including the male and female sterilisation. Knowledge of traditional methods also increased. Furthermore, as the spontaneous and probed knowledge of methods increased, the number of 'don't know' responses for LAM decreased from 26 to 4 participants; for withdrawal from 24 to 9 and for the rhythm method from 24 to 15.

Knowledge of contraceptive methods after the intervention increased more among the female participants than male participants. For both men and women, a greater number of participants reported knowing a modern method than a traditional method after the intervention.

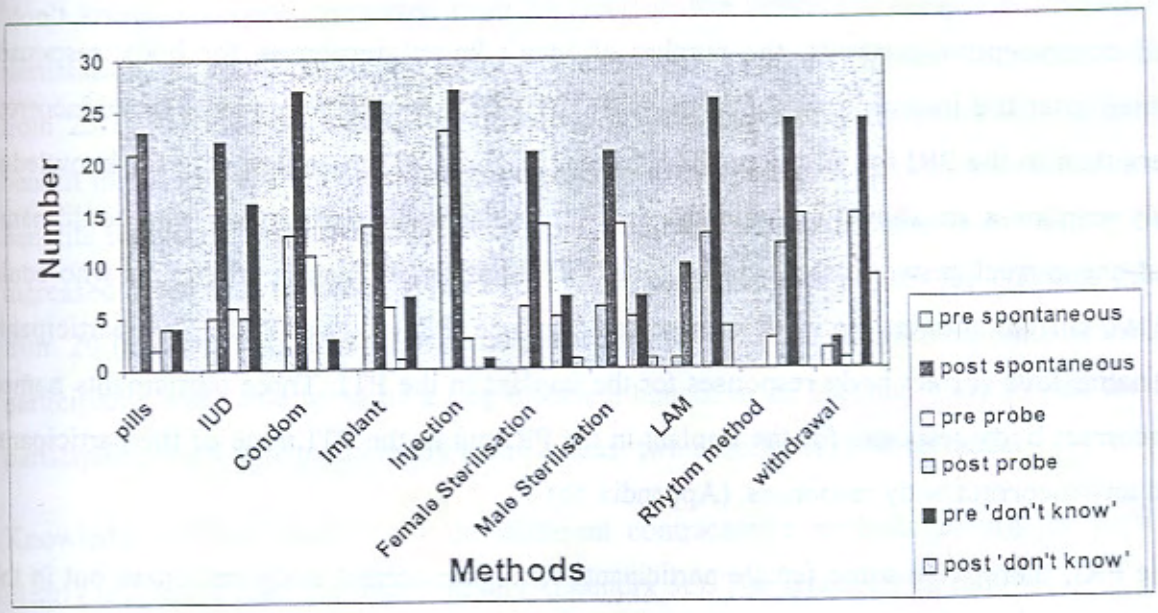


Figure 9: Knowledge of contraceptive methods: Comparison between PRI and PTI (See data tables in Appendix 5a)

Before the intervention participants could, on average name 3.3 methods spontaneously, 2.2 after probing and did not know about 4.4 methods. After the intervention the responses increased to 6.7 methods spontaneously, 2.2 after probing and the average of 'don't know' response decreased to 1.1 methods. (Appendix 5a)

6.3.2 Knowledge of body responses for contraceptive methods (Appendix 5b)

The participants were asked to name the different body responses induced by the differen methods. Body responses are the different side effects produced by the use of differen contraceptive methods. Before the intervention five of 27 participants named at least on correct body response for pills but after the intervention no participants named a single correc body response. Following the intervention there were three participants who could name two correct responses and one participant each who could name three and four correct body responses for pills.

For all contraceptive methods, the number of 'don't know' responses for body responses decreased after the intervention. Surprisingly, in the PTI, the participants gave more incorrect answers than in the PRI for all the methods except implants. (The detailed data for knowledge of body responses are shown in Appendix 5b). For implants, the participants who could name at least one correct answer increased from one (PRI) to eight (PTI) and participants who could name two correct answers for implant increased from one (PRI) to two (PTI). Two participants could name four correct body responses for the implant in the PTI. Three participants named one incorrect body response for the implant in the PRI but in the PTI none of the participants named any incorrect body responses. (Appendix 5b)

For the PRI, there were some female participants who gave correct body responses but in the PTI the number of female participants giving the correct body responses decreased. The number of male participants naming the correct body responses increased in PTI. (see detail Appendix 5b)

6.3.3 Knowledge of benefits of contraceptive methods (Appendix 5c)

Participants were asked to name the benefits of contraceptive methods. For both the PRI and the PTI, none of the participants gave an incorrect response to this question. Therefore

incorrect responses are not noted in this section.

When the participants were asked to name the benefits of pills, only seven could name one correct benefit and one could name two correct benefits in the PRI. Nineteen of the participants did not know any correct benefits. In the PTI, ten could name at least one correct benefit and 11 could name two correct benefits. The 'don't know' responses decreased from 19 (PRI) to six (PTI). For the IUD, female sterilisation and male sterilisation three, two, and two participants respectively could name one correct benefit. After the intervention the number of participants who could name the benefits increased. Following the intervention, for the IUD, two participants could name one benefit, 18 participants could name two benefits and the 'don't know' response decreased from 24 (PRI) to five (PTI). The same was true for female sterilisation, 22 could name two benefits and the number of 'don't know' responses decreased from 25 (PRI) to five (PTI). For the condom the number of participants able to name one benefit in the PRI and PTI was the same (four) but the number of participants able to name two benefits increased from two (PRI) to 16 (PTI) and the participants able to name three benefits increased from one (PRI) to five (PTI). The 'don't know' responses for condom decreased from 20 (PRI) to two (PTI). For female sterilisation and male sterilisation none of the female participants were able to name a single correct benefit in the PRI but in the PTI all the female participants were able to correctly name at least two benefits of these methods.

Knowledge of the benefits for the different contraceptive methods among the participants clearly increased after the intervention (Appendix 5c). The details are as follows.

a) Pills

Before the intervention only eight participants knew a correct benefit. Of the eight participants who knew the correct answer, seven named one correct answer and one named two correct answers. However, at the PTI, of the 27 participants 21 knew the correct benefits. Of the 21 participants who knew correct answers, 10 named one correct answer, 11 named two correct answers. Only six participants did not know any benefits after the intervention.

b) IUD

In the PRI only three of the 27 participants could name one correct benefit. After the

intervention the number of participants able to name the correct answers was 21. Of the 21 participants, two named one correct benefit and 19 named two correct benefits.

c) Condom

In the PRI, seven participants were able to name correct benefits for the condom. Following the intervention 25 participants were able to name the correct benefits of condom. Of these 25 participants four named one correct benefit, 16 named two benefits and five named three benefits.

d) Implant

In the PRI five out of the 27 participants named the correct benefits for implant. After the intervention 24 participants named the correct benefits for implant. Of the 24 participants one named one benefit, 18 named two benefits and five named three benefits.

e) Injection

In the PRI, from the 27 participants 12 participants were able to name correct benefits for injection. Following the intervention 25 participants were able to name the correct benefits of injection. Of the 25 participants two named one correct benefit, 14 named two benefits and nine named three benefits.

f) Female Sterilisation (FS)

In the PRI only two participants were able to name one correct benefit for FS. In the PTI 23 participants could name two correct benefits.

g) Male Sterilisation (MS)

In the PRI only two participants were able to name one correct benefit for MS. In the PTI 21 participant could name two correct benefits and six did not know any correct benefit.

h) Lactational Amenorrhea Method (LAM)

Before the intervention three out the 27 participants named one or two benefits for LAM. After the intervention 11 participants named one or two correct benefits. Nine participants named two correct benefits in the PTI.

Following the intervention, naming of the benefits of the different contraceptive methods increased dramatically among the female participants. There was improvement among the male participants but not as great as for the female participants. (see details Appendix 5c)

6.3.4 Knowledge of drawbacks of contraceptive methods

In the PRI, few participants could correctly name at least one drawback for the different contraceptive methods. The number of participants able to name at least one correct drawback increased in the PTI. (Appendix 5d) Details for each contraceptive method are as follows.

a) Pills

In the PRI of the 27 participants only one participant could name one correct drawback, three named one incorrect drawback. After the intervention 16 correctly named one or two drawbacks. Of these 16, two participants named one correct drawback, one named two correct drawbacks and 13 named three correct drawbacks. Of the eight participants who named incorrect drawbacks, five named one incorrect drawback and three named two incorrect drawbacks.

b) Intrauterine Device (IUD)

In the PRI, only two participants could name one correct drawback for the IUD. After the intervention 14 participants named correct drawbacks for the IUD. Of these 14 participants who could name correct drawbacks, 10 named one correct drawback, three participants named two and one named three correct drawbacks. One participant named two incorrect drawbacks. Twelve participants did not know any drawbacks.

c) Condom

In the PRI, four participants correctly named drawbacks for the condom, one named an incorrect drawback. Of the four participants who could name correct drawback three named one correct drawback and one named two. After the intervention the number of participants who correctly named at least one drawback increased to 19. Of the 19 participants who named correct drawbacks, seven participants named one correct drawback, eight named two and four participants named three drawbacks. Three of the participants who named correct drawbacks

also named incorrect drawback. Eight of the participants did not know any drawbacks.

d) Implant

In the PRI, none of the 27 participants were able to correctly name any drawbacks for the implant. Six participants named incorrect drawbacks, and 22 participants did not know any drawbacks. After the intervention, three participants named correct drawbacks. Of the three participants who named correct drawback, two named one correct drawback and one named two correct drawbacks. Sixteen participants named incorrect drawbacks. Of the 16 participants who named incorrect drawbacks four of the participants also named at least one correct drawback. Of the 16 participants who named incorrect drawbacks 10 named one incorrect drawback, four named two and two participants named three incorrect drawbacks. Ten participants did not know any drawbacks.

e) Injection

In the PRI, none of the 27 participants correctly named any drawback. Six named incorrect drawbacks and 21 did not know any drawbacks for injection. Of the six participants who named incorrect drawbacks, five named one incorrect drawback and one participant named two incorrect drawbacks. In the PTI, three participants named correct drawbacks, 18 named incorrect drawbacks and seven did not know any drawbacks. Of the three participants who named correct drawbacks, one named one correct and two named two correct drawbacks. Of the 18 participants who named incorrect drawbacks, one of the participant also named correct drawbacks. Of the 18 participants who named incorrect drawbacks, seven named one incorrect, nine named two incorrect and two participants named three incorrect drawbacks.

f) Female Sterilisation (FS)

In the PRI, two participants named one correct drawback. In the PTI 11 participants named correct drawbacks, three named incorrect drawbacks and 13 did not know any drawbacks. Of the participants who named correct drawbacks, eight named one correct drawback and three named two correct drawbacks. Three participants named one incorrect drawback in the PTI.

g) Male Sterilisation (MS)

In the PRI of the 27 participants, none was able to name a single correct drawback. One

source in the PRI successfully named at least one source in the PTI. The increase in knowledg from the pre to post intervention among the female participants was greater than for the mal participants.

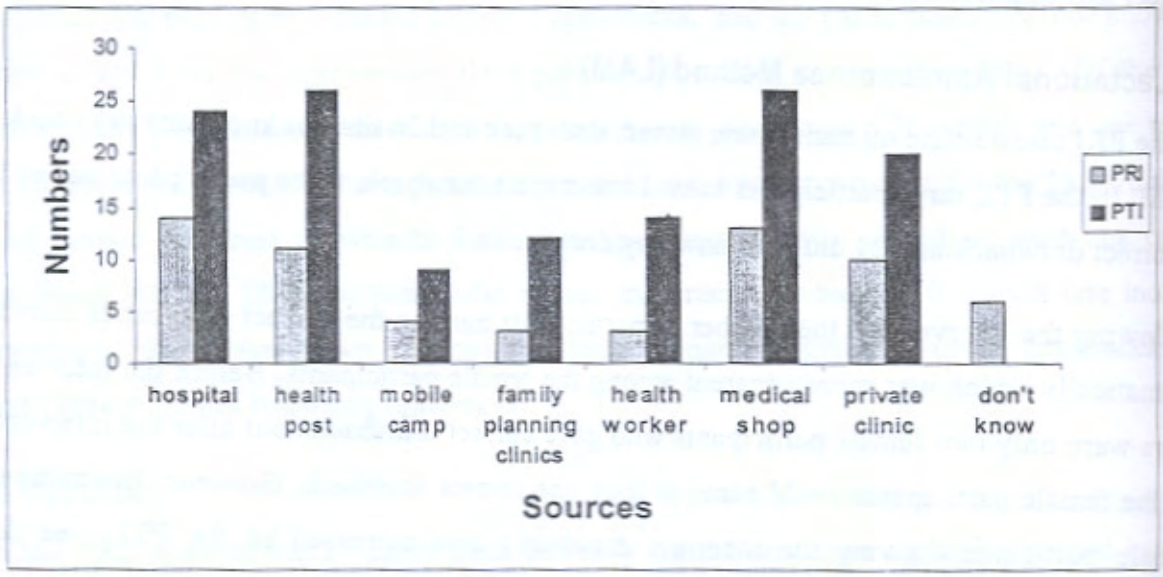


Figure 10: Knowledge of source of contraceptive methods: Comparison between PRI an PTI (See data table Appendix 5e)

6.3.6 Knowledge of well-planned family (WPF)

Participants were asked if they had ever heard of the well-planned family concept. Of the 7 participants, 20 had heard of the WPF and seven had not heard of the WPF for both PRI an PTI. There was no difference between the pre and post intervention responses. Participan were then asked to talk about what the well-planned family concept and terminology, as the understood. The participants' meanings and frequency of mention of WPF can be found in th Appendix 5f. The analysis of the open ended responses to the question 'What do yo understand by the phrase the well-planned family', revealed that most responses fell into one o the eight different categories of meaning. The results of the pre and post interventio interviews to the open-ended question, "What do you understand by a well-planned family" included the following responses.

a) WPF meanings given by the participants in the Pre-intervention interviews

To have one or two children.

To have few children.

To have one son and one daughter.

Small family happy family.

Not to have too many children only 2 children, to have a gap of 2-3 years in between, to be able to educate the children, give them food and clothes to wear, to have only 4 members in the family.

To give birth to few children and the interval between children should be long.

To have family planning operation.

b) WPF meanings given by the participants in the Post-intervention interviews

Small family, happy family.

Healthy family and happy family.

To have 2 children it does not matter what sex.

A family with two children.

Small family with 2 or 3 children, to be able to give them education food and clothes.

To have one son and one daughter, to be able to feed them give clothes and educate them.

To have one or two children, either son or daughter it would not matter, to be able to feed them, give them clothes to wear and educate them, to have a good relation between husband and wives.

To have one son and one daughter only two children, the interval between the two children should be long, to have a good relation between the husband and the wife.

To have two children. To be able to give them good food, clothes and educate them. To have a good relationship between husband and wife. After reaching the desired

number of children plan and decide to use a method which help to have a well-planned family.

6.3.7 Knowledge of husband and wife communication

Although none of the participants could give the full definition (e.g. four meanings)(se Appendix 1) of husband and wife communication, they could state at least one of the fou meanings taught to them during the intervention. The total number of participants able to sta at least one meaning of husband and wife communication in the post intervention intervie increased from 13 (PRI) to 21 (PTI) and the number of participants responding 'don't know decreased from 14 (PRI) to 6 (PTI). The improvement of knowledge among the femal participants was greater than for the males (see details Appendix 5g). Some of the respons given by the participants to the question "What do you understand by husband and wi communication?" are included below.

a) Pre-intervention:

Husband and wife have to talk about the domestic affairs, family affairs and everything.

The talk between husband and wife.

To discuss about how to run the house, to talk about the family.

To talk about how to make the family happy.

To have important discussion, to encourage each other, to decide after discussion.

b) Post-intervention:

Kurakani.

To talk with each other, to tell each other the things in your heart.

The final decision that comes out from the discussion between the husband and wife. It is the discussion between the husband and wife

Only one person's say is not enough, both should be allowed to say, to discuss and

decide, for anything should discuss with each other.

To discuss, get ideas between husband and wife.

Husband and wife should discuss and plan together, should discuss about anything.

Husband and wife should discuss about everything. Should share their happiness and sorrows. Should have good relations between themselves.

6.3.8 Knowledge of communication skills

The number of participants able to name the skills needed for good communication between husband and wife increased from two (PRI) to 11 (PTI). Although there were 11 participants in the PRI who were able to name some skills, their responses were incorrect. Only two out of the 11 named correct skills. In the PTI 20 participants named different skills. Eleven of the 20 participants named correct skills. The different skills named by the participants can be found in Appendix 5h. A sample of the responses is included below

a) Pre-intervention

To have conversation in a friendly manner, husband should love his wife and wife should love her husband.

Both should be in a good mood, both should be like two wheels of a chariot and discuss.

Husband and wife should help each other and love each other.

Both should understand each other's problem, not get angry, scold, not to quarrel, should have faith in each other.

To listen carefully

Both talk in turns and listen.

b) Post-intervention

To listen carefully.

To listen carefully, to repeat what the other says.

Listen carefully, should repeat what the other one has said, if the spouse has done some good job then should praise them.

To obey each others sayings will help for a good communication.

To have good conversation.

6.3.9 Knowledge about who is responsible for the sex of the baby

Figure 11 shows the comparison of knowledge in the pre and the post-intervention interview about the person responsible for the sex of the baby. In the PRI, six (one female and five males) participants correctly said the husband was responsible, one male participant incorrectly said the wife, 17 participants (12 females and five males) incorrectly said both husband and wife were responsible for the sex of the baby and three participants (one female and two males) did not know the answer. In the PTI 19 participants (14 females and five males) correctly said the husband, one male said wife, and seven males said both were responsible for the sex of the baby. All female participants knew the correct answer (i.e. husband is responsible for the sex of the baby) in the PTI, whereas there was no change in correct answer among the male participants.

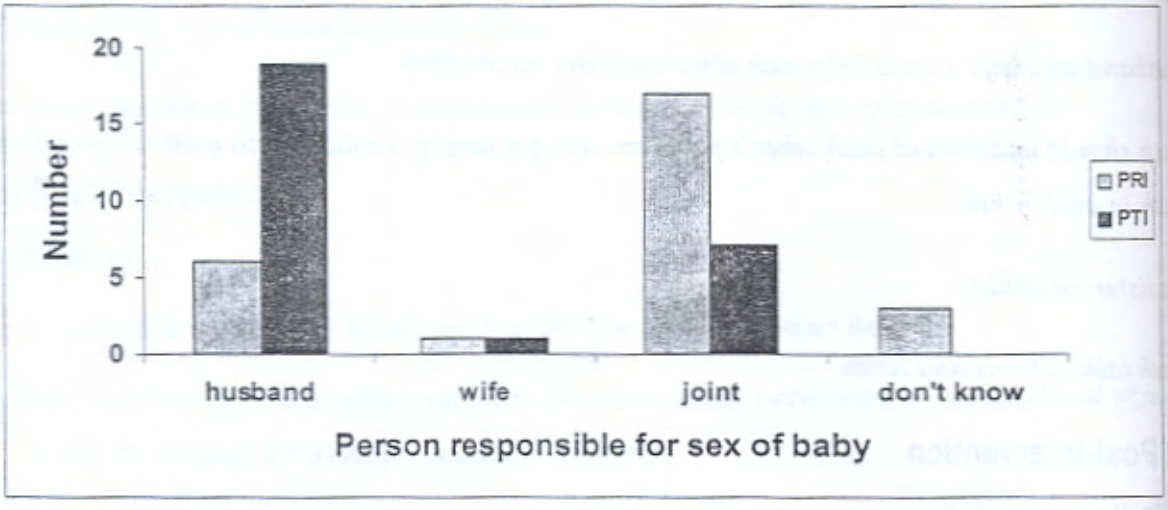


Figure 11: Knowledge of person responsible for the sex of the baby: Comparison between PTI and PTI (see Appendix 5i for data table)

6.4 ATTITUDES AND PERCEPTIONS ABOUT CONTRACEPTIVE USE AND OTHER FAMILY PLANNING CONCEPTS

A total of 30 attitudinal statements were read to the participants, both for the PRI and PTI. Of the 30 questions, the desired answers were 'disagree' for 19 and 'agree' for 11. A positive change was reported when the change was in the direction of the desired response and a negative change was reported when the change was away from the desired response. The change was measured by comparing participant's change of response in the PRI and PTI. If the participant's answer did not change from PRI to PTI then it was reported as ' no change' in attitude whereas if the participant's answer changed in the PTI then it was reported as positive or negative change in attitude. These 30 attitudinal statements are grouped into 5 categories which were as follows;

1) attitudes regarding the benefit of a well-planned family,
2) attitudes regarding the image of family planning users,
3) attitudes associated with the importance of having a son in the family,
4) attitudes regarding perception of contraceptive use,
5) attitudes regarding husband and wife communication

6.4.3 Attitudes regarding the benefits of a well-planned family

There were two attitudinal statements regarding the benefits of a well-planned family; a) 'In a well-planned family, children get better education.' and b) 'People are happier and healthier in a well-planned family.' The desired response was 'agree' for both these statements. For statement (a) all 14 female participants gave the desired response for both PRI and PTI, whereas for the 13 male participants, 12 gave the desired response for both PRI and PTI and only one male participant made a negative change from PRI to PTI.

For statement (b) all 13 male participants gave the desired answer at both PRI and PTI. Of the 14 female participants, 13 gave the desired response both before and after intervention and

one made a positive change from PRI to PTI. Overall the participants had a positive attitude towards the benefits of a well-planned family both before and after the intervention. There was very little change. (Appendix 5k)

6.4.4 Attitudes regarding the image of contraceptive users

Four attitudinal statements were asked to measure the change in attitudes regarding the image of family planning users before and after the intervention;

(a) 'Going to the health post for a contraceptive method is shameful or embarrassing.'

(b) 'When a woman uses a contraceptive method her husband becomes angry.'

(c) 'Contraceptive use is often associated with promiscuity.'

(d) 'A woman is not suppose to talk about contraceptive methods openly in the public.'

For all 4 statements 'disagree' was the desired response.

For question (a) 17 participants (six females and 11 males) gave the desired response for both PRI and PTI. Six participants (five females and one male) gave the undesired response. Three participants (two females and one male) made a change in the positive direction and one female participant made a negative change from PRI to PTI. Overall, the number of participants with positive attitudes increased from 17 (PRI) to 20 (PTI) and participants with a negative attitude increased from 6 (PRI) to 7 (PTI). There were changes in both positive and negative directions following the intervention.

For question (b), 'When a woman uses a contraceptive method her husband becomes angry', 17 participants (six females and 11 males) gave the desired response for both the PRI and PTI. Four participants (three females and one male) gave the undesired response. Three participants (two females and one male) made a change in the positive direction and two females made a negative change. the number of participants with a positive attitude increased from 17 (PRI) to 20 (PTI) and participants with a negative attitude decreased from 6 (PRI) to 4 (PTI). There were changes in both positive and negative directions following the intervention.

Figure 12 shows the change in attitude in associating contraceptive use with promiscuity. The desired response for this question was 'disagree'. Six participants (five females and one male) gave the desired response, seven (one female and six males) gave the undesired response whereas five participants made positive change (two females and three males) and nine made a negative change. Following the intervention there were more participants (17) with a negative attitude in comparison to participants with a positive attitude (11).

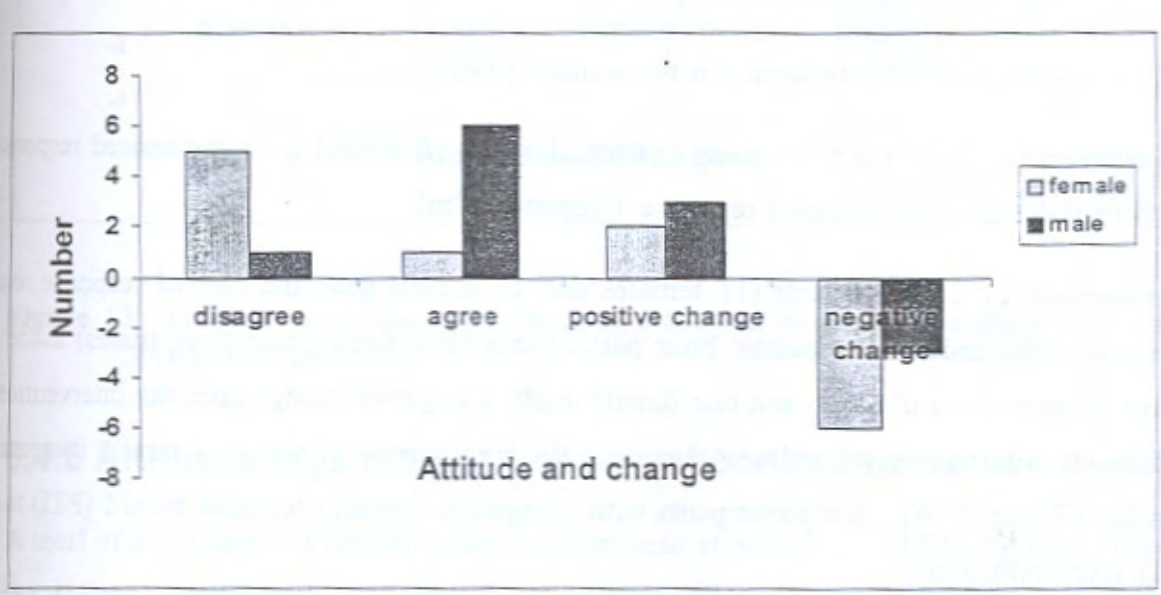


Figure 12: Attitudes associating contraceptive use with promiscuity

The desired response for (d)'When a woman use a contraceptive method her husband becomes angry' was to disagree. Eighteen participants (13 females and five males) gave the desired response, six (five females and one male) gave the undesired response and three participants (two females and one male) made a positive change and one female made a negative change. Following the intervention there were 20 participants with a positive attitude and seven participants with a negative attitudes.

For statements (a), (b) and (d) more positive changes in attitude occurred from PRI to PTI than negative changes. However, for statement (c) change in attitude from PRI to PTI was more often in a negative direction (nine) more than in a positive direction (Appendix 5l).

6.4.5 Attitudes associated with the importance of having a son

Three attitudinal questions associated with the importance of having a son in the family were asked. The desired responses for all statements were 'disagree'. The statements were;

(a) 'It is necessary to keep having children until a boy is born.'

(b) 'If a wife gives birth to daughters only the husband should marry another woman.'

(c) 'If a couple cannot have children it is the woman's fault.'

For statement (a), 24 of the participants (14 females and 10 males) gave the desired response and three males gave the undesired response. (Appendix 5m)

For statement (b), 21 participants (11 females and 10 males) gave the desired response, one female gave the undesired response. Four participants (one female and three males) made a change in the positive direction and one female made a negative change after the intervention. Participants with the desired attitude regarding the importance of son in a family increased from 21 (PRI) to 25 (PTI) and participants with a negative attitude increased from 1 (PTI) to 2 (PRI). (Appendix 5m)

Figure 13 shows the attitudes associated with woman's fault if the couple cannot have children (i.e. cannot conceive). Thirteen participants (five females and eight males) gave the desired response, five (four females and one male) gave the undesired response, nine participants (five females and four males) made a positive change and two females made a negative change after the intervention. Participants with the desired attitude regarding the woman's role in having children increased from 13 (PRI) to 22 (PTI) and the participants with a negative attitude also increased from 5 (PRI) to 7 (PTI).

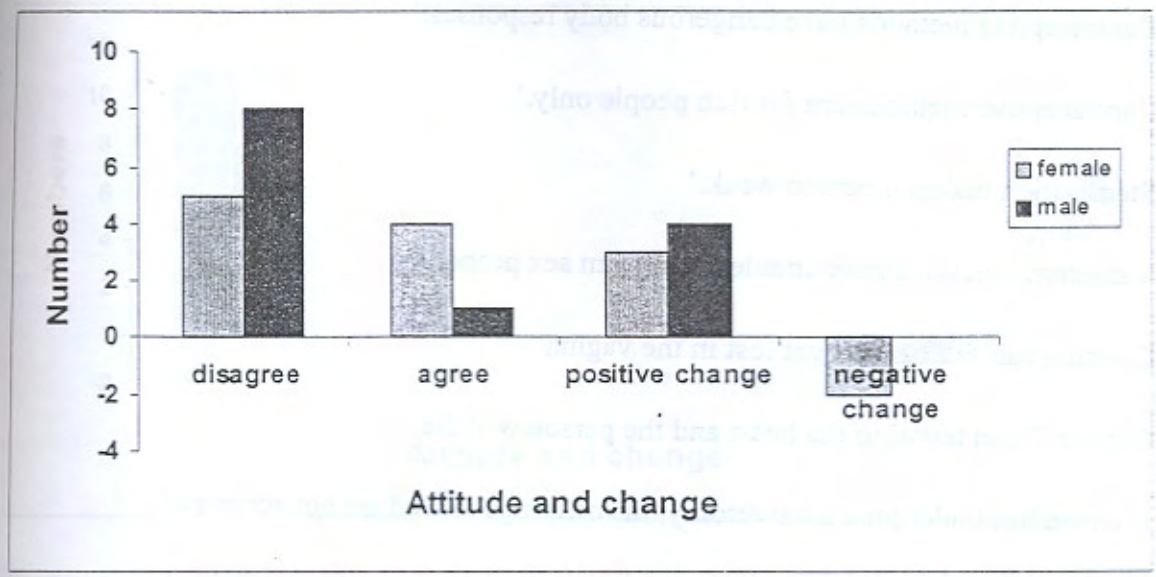


Figure 13: Attitudes associated with woman's fault if the couple cannot have children (Appendix 5m)

6.4.6 Attitudes regarding perception of contraceptive use

A total of 30 different attitudinal questions were read at both PRI and PTI. Of the 30 questions, the desired answers were 'Disagree' for 19 and 'agree' to 11. A positive change was reported when the change was in the direction of the desired response and a negative change was reported when the change was away from the desired response. The change was measured by comparing participant's change of response in the PRI and PTI. If the participant's answer did not change from PRI to PTI then it was reported as 'no change' in attitude whereas if the participant's answer changed in the PTI then it was reported as 'positive' or 'negative' change in attitude.

A total of 11 attitudinal questions regarding the participants' perception of contraceptive use were asked. These statements reflect the correct and incorrect knowledge of contraceptive methods among the participants. These statements were as follows.

(a) 'If a woman uses a temporary contraceptive method she may become sterile.'

(b) 'Religion is against women using contraceptive methods.'

(c) 'Contraceptive methods have dangerous body responses.'

(d) 'Contraceptive methods are for rich people only.'

(e) 'Sterilisation makes a person weak.'

(f) 'Vasectomy makes a man unable to perform sex properly.'

(g) 'Condom can fall off and get lost in the vagina.'

(h) 'Copper-T can travel to the heart and the person will die.'

(i) 'If a man has undergone a vasectomy, his offerings to God are not accepted.'

(j) 'More people would use contraceptives if they were more readily available.'

(k) 'People do not know how contraceptive method works.'

Of these 11 questions, the desired response for the first nine statements (a) through (i) was 'disagree' and the desired response for two questions (j) and (k) was 'agree'. (Appendix 5n)

Figure 14 shows attitudes associated with use of temporary methods and sterility. Nineteen of the participants (11 females and eight males) gave the desired response, one male gave the undesired response. Seven participants (three females and four males) made a positive change from PRI to PTI. Participants with the desired attitude regarding use of temporary methods increased from 19 (PRI) to 26 (PTI). Only one participant made a negative change.

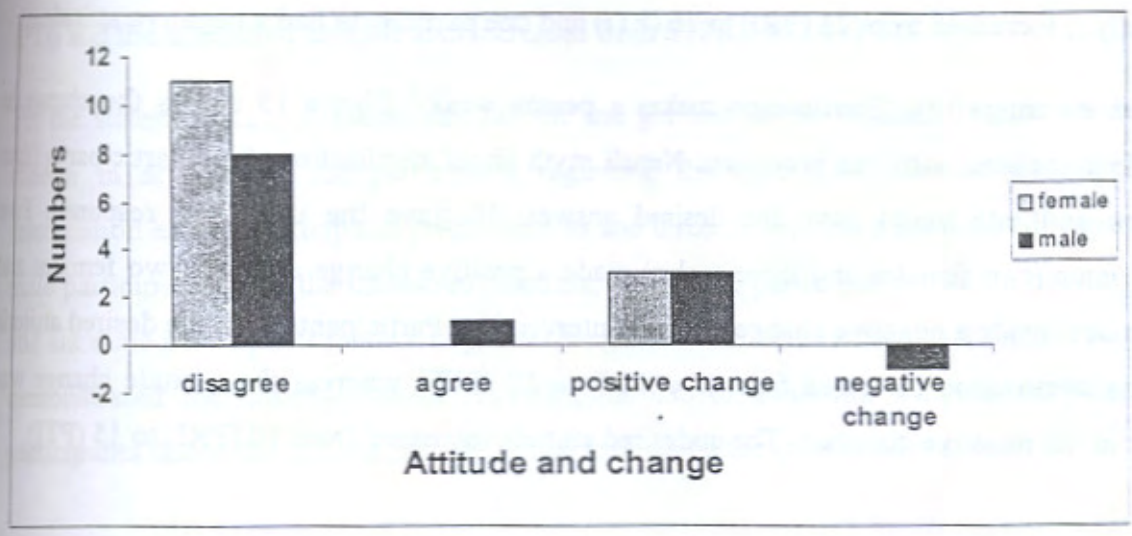


Figure 14: Attitudes regarding use of temporary method and sterility (Appendix 5n)

For statement (b), 22 participants (11 females and 11 males) gave the desired response, one male gave the undesired response. Three participants (two females and one male) made positive change and one female made negative change after the intervention. Among the participants with the desired attitude associated with religion and contraceptive use increased from 22 (PRI) to 25 (PTI) and with a negative attitude, increased from 1 (PRI) to 2 (PTI)

For the statement (c),'Contraceptive methods have dangerous body responses', 18 (nine females and nine males) participants gave the desired response and one female gave the undesired response. Five (three females and two males) made a change in a positive direction and three (one female and two males) made a negative change. The number of participants with desired attitude associated with body response and use of contraceptive increased from 18 (PRI) to 23 (PTI) and with negative attitude increased from one (PRI) to four (PTI).

For statement (d), 'Contraceptive methods are for rich people only.', 23 participants (13 females and 10 males) gave the desired answer, one male gave the undesired answer, three participants (one female and two males) made a positive change between PRI and PTI. Participants with the desired attitude regarding the statement 'Contraceptive use is not for the

rich only.', increased from 23 (PRI) to 26 (PTI) and one participant had a negative attitude.

For the statement (e), 'Sterilisation makes a person weak.' Figure 15 shows the change in attitude associated with this prominent Nepali myth about sterilisation. Five participants (four females and one male) gave the desired answer, 10 gave the undesired response. Five participants (two females and three males) made a positive change and six (two females and four males) made a negative change after the intervention. Participants with the desired attitude towards sterilisation increased from five (PRI) to 10 (PTI), whereas the attitude change was higher in the negative direction. The undesired attitude increased from 10 (PRI) to 15 (PTI).

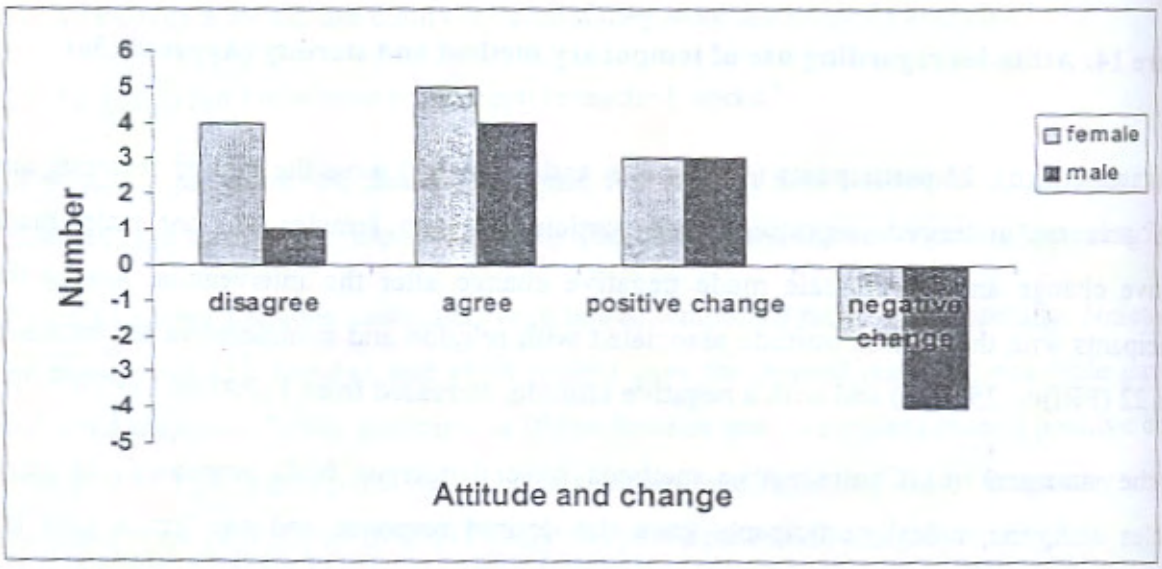


Figure 15: Attitudes associated with the belief that sterilisation makes a person weak (Appendix 5n)

For the statement (f), 'Vasectomy makes a man unable to perform sex properly.' Seven female participants gave the desired response, eight participants (two females and six males) gave the undesired response, six participants (two females and four males) made a positive change and six participants (three females and three males) made negative change after the intervention. The participants with the desired attitude towards vasectomy increased from 7 (PRI) to 13

(PTI) and the undesired attitude also increased from 8 (PRI) to 14 (PTI).

For the statement (g), 'Condom can fall off and get lost in the vagina.' Figure 16 shows the change in attitude of the participants regarding the myths of condom use. Before the intervention eleven participants (eight females and three males) gave the desired response, four male participants gave the undesired response, six female participants made a positive change and six male participants made a negative change after the intervention. All female participants demonstrated the desired attitude regarding the use of condoms whereas only three male participants stated the desired attitude and 10 men stated the undesired attitude.

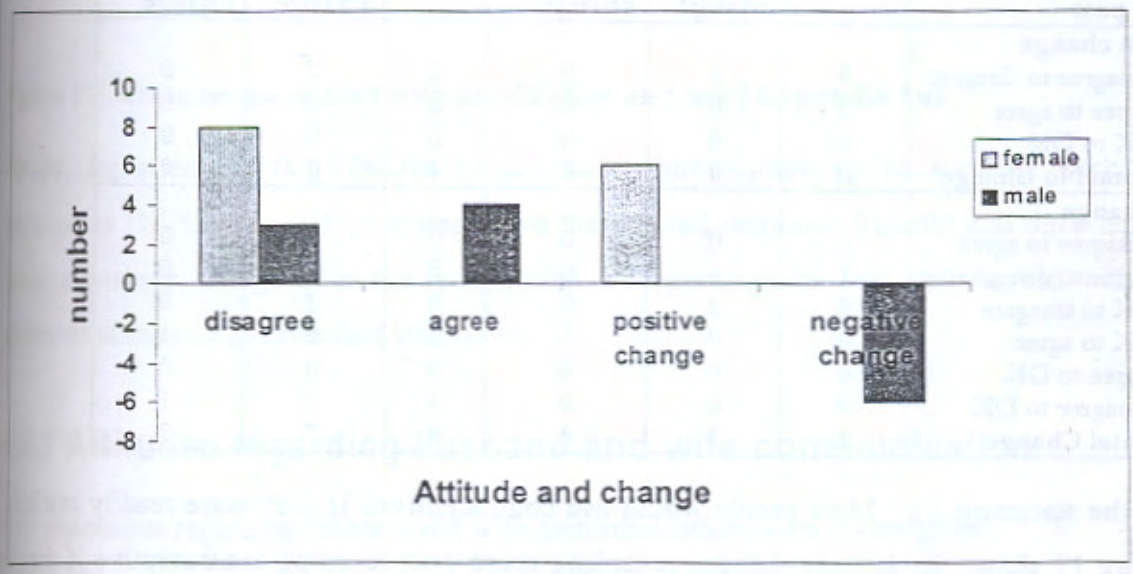


Figure 16: **Attitudes associated with condom use. (Appendix 5n)**

For the statement (h), 'Copper-T can travel to the heart and the person will die.', 15 participants (13 females and two males) gave the desired response, two gave the undesired response and ten participants (one female and nine males) made a positive change after the intervention. The participants with the desired attitude towards the side effects of Copper-T increased from 15 (PRI) to 24 (PTI) and two male participants had the undesired attitude or perception towards the side effect of Copper-T.

For the statement (i) 'A person who has undergone vasectomy, his offerings to God are not accepted.' Table 4 shows the attitudinal changes made by the participants after the intervention. Ten participants (eight female and two male) gave the desired response, five (three females and two males) gave the undesired response. Ten (three females and seven males) made a positive change and two male participants made a negative change after the intervention. Participants with the desired attitude regarding the myths of vasectomy increased from 10 (PRI) to 20 (PTI) and participants with undesired attitude increased from 5 (PRI) to 7 (PTI).

Table 4: Change in attitude associated with misbeliefs related to vasectomy.

Change from pre to post	Female	Positive change	Negative change	Male	Positive change	Negative change
No change						
Disagree to disagree	8	0	0	2	0	0
Agree to agree	2	0	0	2	0	0
DK to DK	1	0	0	0	0	0
Total No Change	**11**	**0**	**0**	**4**	**0**	**0**
Change						
Disagree to agree	0	0	0	0	0	0
Agree to disagree	1	1	0	5	5	0
DK to disagree	2	2	0	2	2	0
DK to agree	0	0	0	1	0	1
Agree to DK	0	0	0	0	0	0
Disagree to DK	0	0	0	1	0	1
Total Change	**3**	**3**	**0**	**9**	**7**	**2**

For the statement (j), ' More people would use contraceptives if they were readily available.' Figure 17 shows the attitude changes regarding more people using contraceptive if they are readily available. Twenty-five participants (13 females and 12 males) provided the desired response, and two (one female and one male) made a positive change after the intervention. Participants with desired attitude towards availability of contraceptive methods and use increased from 25 (PRI) to 27 (PTI).

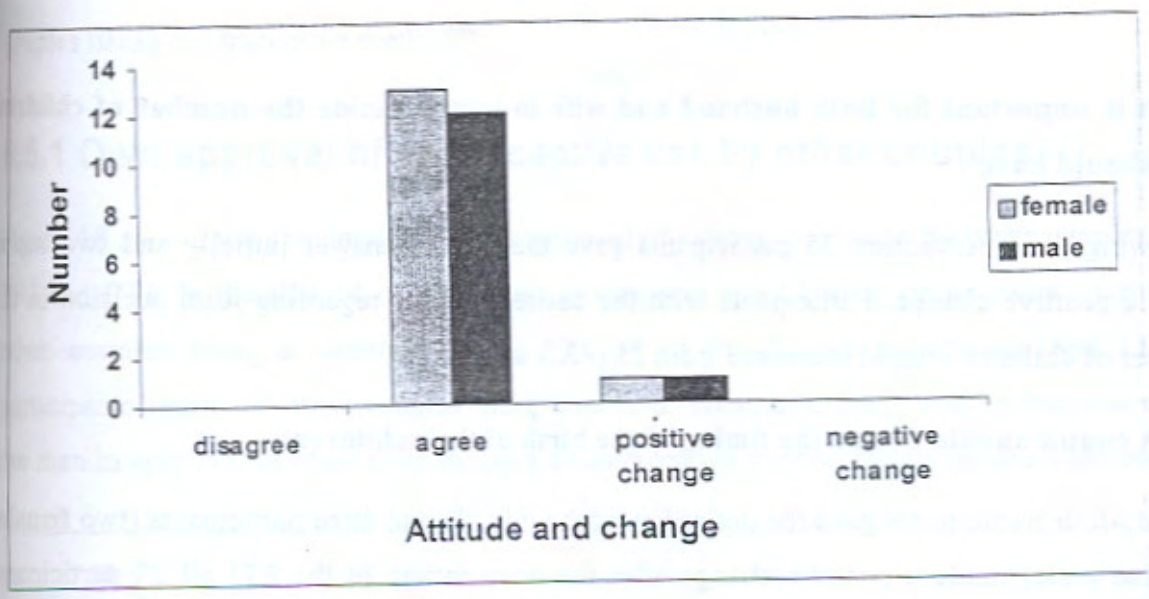


Figure 17: Attitudes associated with availability and use (Appendix 5n)

Finally, for statement (k), 'People do not know how contraceptive methods work.', 24 participants (11 females and 13 males) gave the desired response initially and three females made a positive change after the intervention. All participants said they agreed with this statement at the post intervention interviews.

6.4.7 Attitudes regarding husband and wife communication

Four statements regarding husband and wife communication were investigated.

(a) 'It is important for both husband and wife to jointly decide the number of children they should have.'

(b) 'A couple should decide the timing of the birth of their children.'

(c) 'Husband and wife should discuss contraceptive methods together.'

(d) 'Husband and wife should be able to discuss anything between themselves.'

For all 4 statements the desired response was agree. (Appendix 5o)

(a) 'It is important for both husband and wife to jointly decide the number of children they should have'.

Following the intervention 25 participants gave the desired answer initially and two males made a positive change. Participants with the desired attitude regarding joint decision in the number of children wanted increased from 25 (PRI) to 27 (PTI).

(b) 'A couple should decide the timing of the birth of their children'.

Twenty-four participants gave the desired response initially and three participants (two females and one male) made a positive change after the intervention. In the PTI all 27 participants expressed desired attitude regarding the joint decision for the timing of the birth of their children.

(c) 'Husband and wife should discuss contraceptive methods together'.

Twenty-six participants gave the desired response initially and one made a positive change after the intervention. In the PTI all the 27 participants expressed the desired attitude regarding whether couples should discuss contraceptive methods together.

(d) 'Husband and wife should be able to discuss anything between themselves.'

Twenty-six participants gave the desired response initially and one made a positive change after the intervention so that in the PTI all the 27 participants expressed the desired attitude. In general, the participants initially expressed the desired attitudes towards husband and wife communication in the PRI. The participants who were not sure or had a negative attitude all changed their attitudes in the positive direction following the intervention.

6.5 APPROVAL OF CONTRACEPTIVE METHODS

The following are the results from two open-ended questions, "Do you approve of other couples using contraceptive method?" and "Do you think your spouse approves of other

couples using contraceptive method?"

6.5.1 Own approval of contraceptive use by other couples

Figure 18 shows the comparison of own approval of contraceptive use by other couples in the PRI and PTI. In the PRI 14 of the female participants and 11 male participants approved of other couples using a method. At the PTI, 14 of the female participants and 13 male participants approved other couples using a method. Therefore, there was an increase among the men in approval of other couples using a contraceptive method following the intervention.

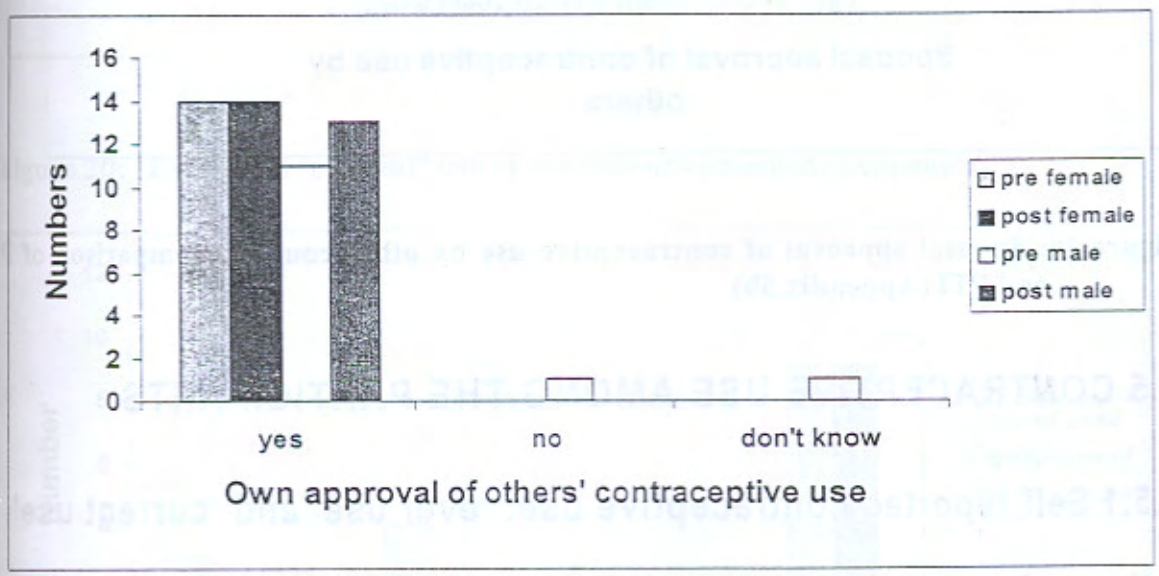


Figure 18: Own approval of others using contraceptive: Comparison between PRI and PTI (Appendix 5j)

6.5.2 Spousal approval of contraceptive use by other couples

Figure 19 shows the perception of spousal approval of contraceptive use by other couples in the PRI and PTI. Twelve of the female participants thought their husbands approved of other couples using a method and 11 male participants thought their wives approved of other couples using a method in the PRI. For the PTI 13 of the female participants and 13 male participants thought their spouse approved of other couples using a method. Therefore there was increase in the correct perception of spousal approval of other couples' contraceptive use following

the intervention.

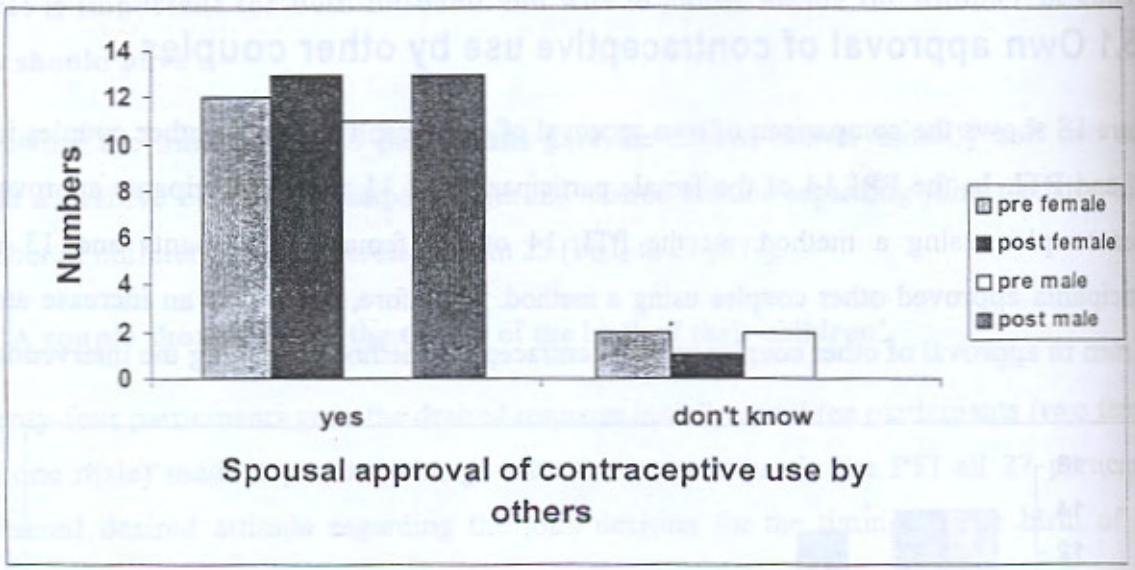


Figure 19: Spousal approval of contraceptive use by other couples: comparison of PRI and PTI (Appendix 5h)

6.5 CONTRACEPTIVE USE AMONG THE PARTICIPANTS

6.5.1 Self reported contraceptive use: 'ever use' and 'current use'

Self reported contraceptive use is shown in Figure 20. Of the 27 participants 17 reported 'ever' using a method. The different methods 'ever' used are shown in Figure 21. The most 'ever' used contraceptive method was the injection (9). The use of condoms was not reported by the female participants either as 'ever' use or 'current' use. In the PRI 12 participants reported currently using a method. Self reported 'current use' increased to 15 participants in the PTI. For both PRI and PTI Injection was the method used currently by most. (Appendix 5p)

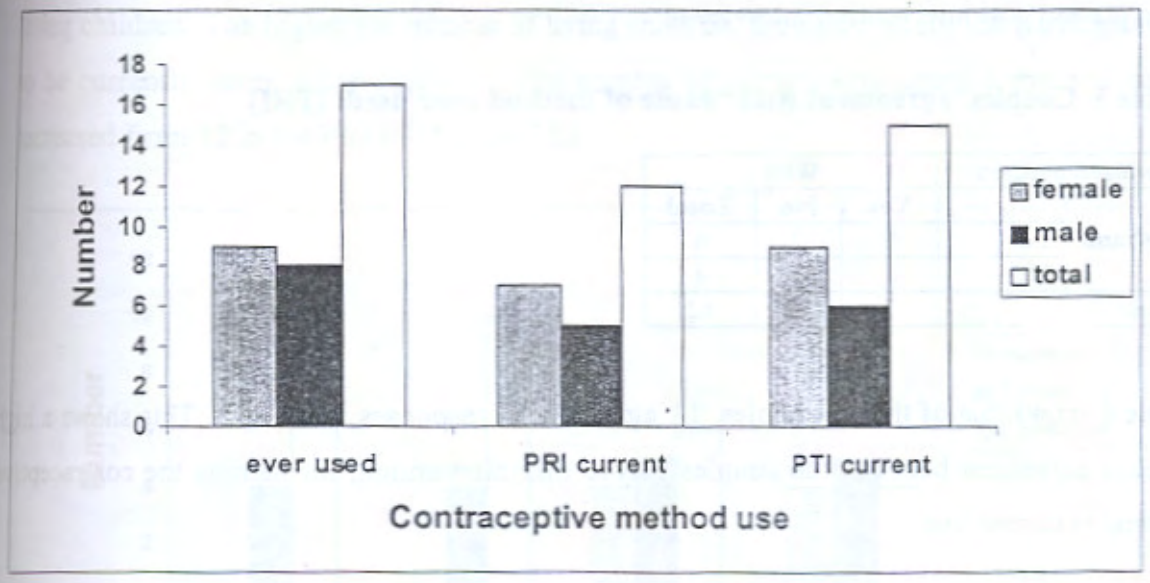


Figure 20: 'Ever' and 'current' use of contraceptive methods (Appendix 5p)

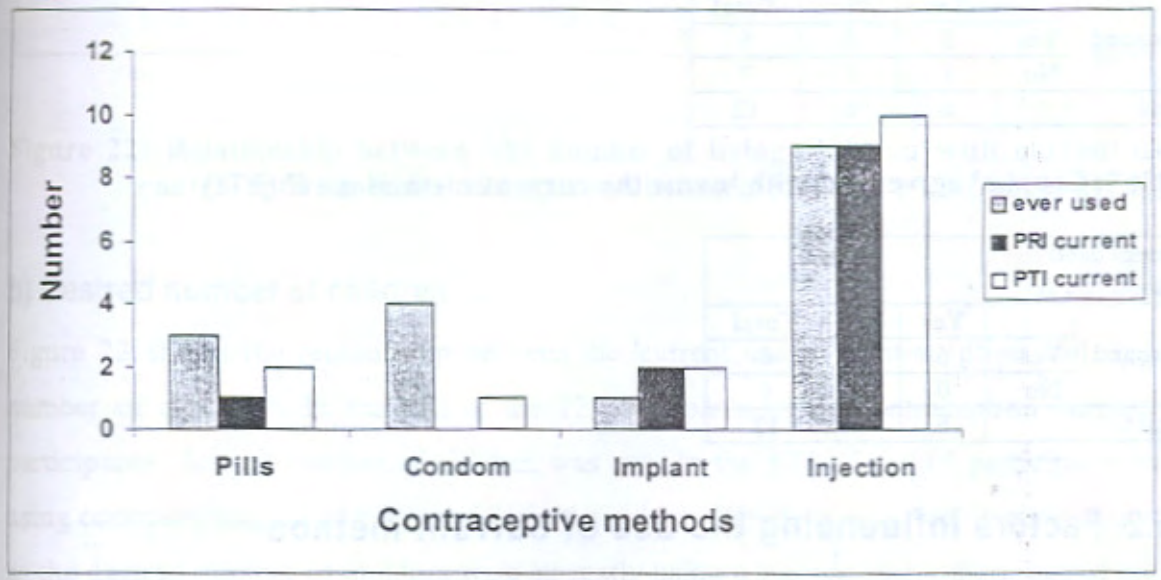


Figure 21: Names of 'Ever' and 'current' used methods. (Appendix 5p)

Table 5 shows that of the 12 couples who participated in all the intervention workshops, nine couples had same responses to the questions on contraceptive use. Agreed response between the couple indicates that communication between husband and wife has taken place. Three participants were not included in this analysis because their partners were unable to take part in

both pre and post intervention interviews.

Table 5: Couples' agreement with 'name of method ever used' (PRI)

Ever used method		Wife		
		Yes	No	Total
Husband	Yes	6	2	8
	No	1	3	4
Total		7	5	12

Table 6 shows that of the 12 couples, 11 agreed with responses in the PRI. This shows a high level of agreement between the couples before the intervention, for naming the contraceptive method in current use.

Table 6: Couples' agreement with 'name the current method used' (PRI)

Current used method (PRI)		Wife		
		Yes	No	Total
Husband	Yes	5	0	5
	No	1	6	7
Total		6	6	12

Table 7: Couples' agreement with 'name the current method used' (PTI)

Current used method (PTI)		Wife		
		Yes	No	Total
Husband	Yes	6	0	6
	No	0	6	6
Total		6	6	12

6.5.2. Factors influencing the use of current method

The three factors mentioned below are considered very important factors for influencing couples' decision to use a method. The three factors are: 1) numbers of living children, 2) desired number of children, and 3) want more children.

a) Number of living children

Figure 22 shows the relationship between the current use of contraception and the number of

living children. The higher the number of living children, the more likely the participants were to be currently using a contraception. The number of participants using a method currently increased from 12 in the PRI to 15 in the PTI.

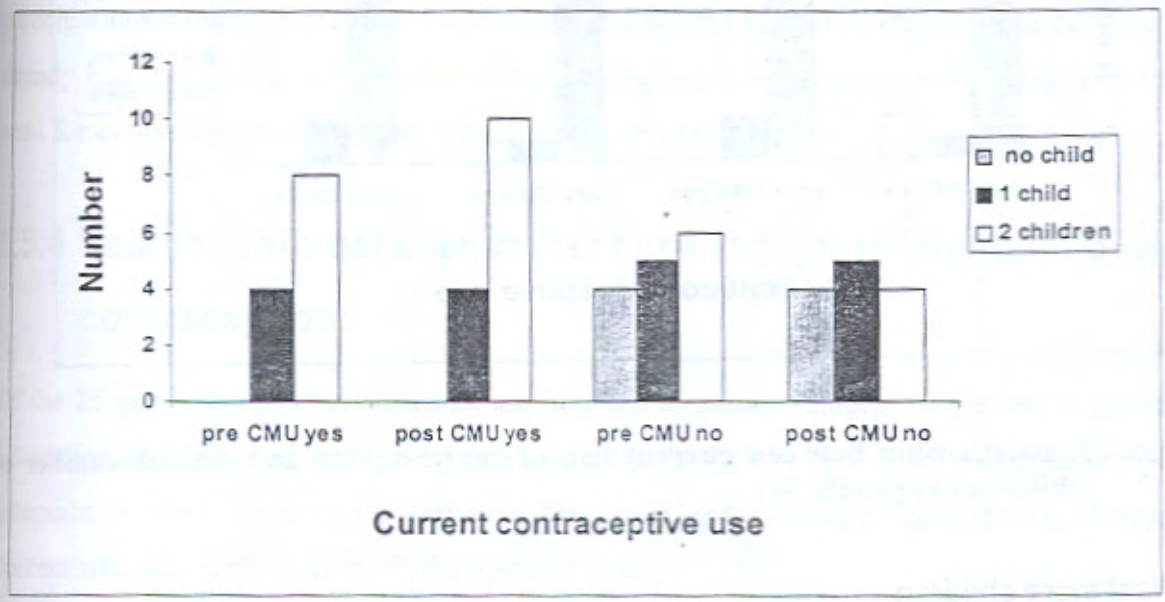


Figure 22: Relationship between 'the number of living children with current use of a contraceptive method': Comparison between PRI and PTI. (Appendix 5q)

b) Desired number of children

Figure 23 shows the relationship between the 'current use of contraception and the desired number of children'. In the PRI of the 12 participants using contraception currently, nine participants' desired number of children was two. In the PTI of the 15 participants currently using contraception, 13 participants' desired number of children was two. Participants with two as the desired number of children were currently using a current method compared with other participants with other number of desired children.

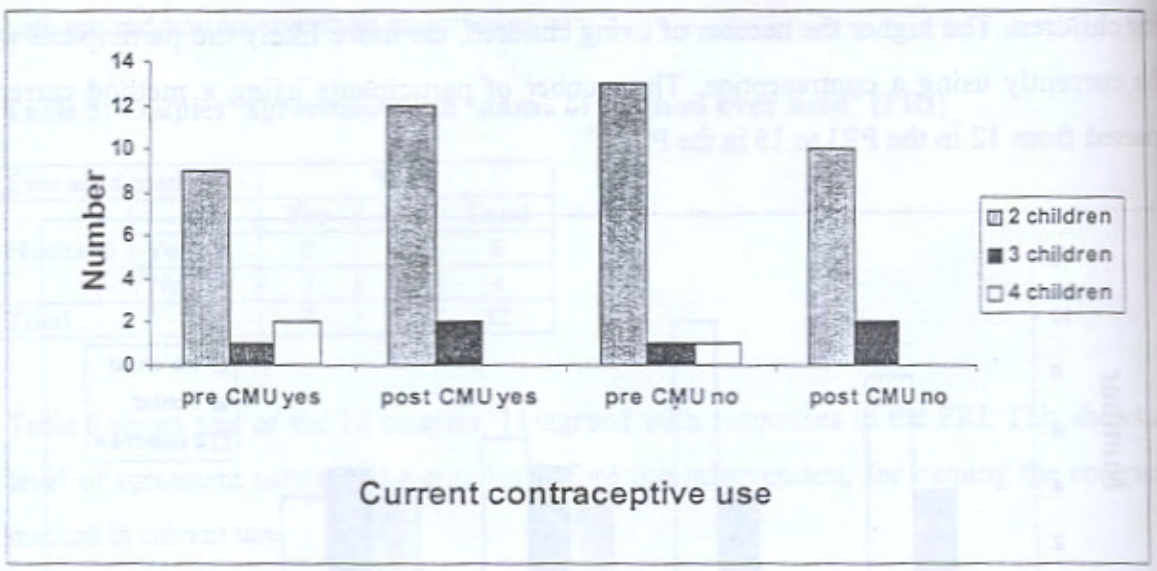


Figure 23: Relationship between current use of contraception and desired number of children (Appendix 5q)

c) Want more children

In the PRI, of the 12 participants currently using contraception, six wanted more children and six did not want more children. In the PTI, of the 15 participants currently using contraception, eight wanted more children and seven did not. Therefore, the major reasons for using contraception both in the PRI and PTI were spacing children (50 percent) and limiting number of children (50 percent). (Appendix 5q).

6.5.3 Relationship between current use of contraception with desired number of children and actual number of living children

Of the 12 participants currently using contraception in the PRI, seven participants' desired number of children was two and they already had two living children. For the 15 participants not using contraception, nine participants' desired number of children was two and they already had two living children. Therefore there were five participants who could be said to

have an unmet need for contraceptives in the PRI.

In the PTI, of the 15 participants who reported currently using contraception, nine participants desired number of children was two and they already had two living children. Of the 12 participants not using a method, four participants desired number of children was two and they already had two living children. After the intervention, the number of participants with unmet need for contraception decreased from five to four. (Appendix 5r)

6.5.4 Relationship between current use and future intention to use contraception.

Of the 25 participants who expressed an intention to use a contraceptive method in the future, 12 participants reported current use of a method in the PRI. In the PTI, 25 participants reported intention to use contraceptive method in the future, and of these 25 participants, 15 reported current use of a method in the PTI. (Appendix 5s)

When asked in the PRI what would be the reason for using a contraceptive method in the future, 15 of the participants gave the reason 'not to have too many children', four said 'spacing' and four 'limiting'. In the PTI, eight gave the reason 'not to have too many children', eight for 'spacing' and seven for 'limiting'. The responses to the question 'What would be the reason to use contraceptive method in the future?' are cited below.

a) Pre-intervention

Because I don't want another baby.

I don't want any more children, it is good for health also.

To space the children. If give birth to children too close it is very difficult, can't go anywhere and the children are too small.

I don't want a baby now.

Not to have too many children.

If I give birth to a baby and I had enough. If I don't use I will have many children.

If I don't use a method I will conceive, if I have too many children then the children will suffer.

Yes, not to have too many children. What is the advantage of having too many children?

To have a small and a happy family.

b) Post intervention

If I have one baby, I will use method not to have another baby.

I have enough children. If I use a method I will not have another baby. I can work. If I have small children I will not be able to go any where.

If we have too many children it will be difficult. We won't be able to educate them, give them food and clothes.

Not to have children, when I have two children I will do permanent operation.

Have to work, if I have too many children can't do anything. If I use a method I will not have children.

For the good health of the child and the mother. Can breast feed the child for longer, if use a method don't have to worry about another baby until one wants.

Will have no fear of having another baby, if don't use then there is the risk of having another baby.

Unless the youngest one has grown big not to have another baby.

To have a good spacing between the children.

Not give birth to a baby too soon. If another baby comes soon it will be difficult.

To have a long interval between the two children.

If I give birth to a baby and I had enough. If I don't use I will have many children.

If I don't use a method I will conceive, if I have too many children then the children will suffer.

Yes, not to have too many children. What is the advantage of having too many children?

To have a small and a happy family.

b) Post intervention

If I have one baby, I will use method not to have another baby.

I have enough children. If I use a method I will not have another baby. I can work. If have small children I will not be able to go any where.

If we have too many children it will be difficult. We won't be able to educate them, gi them food and clothes.

Not to have children, when I have two children I will do permanent operation.

Have to work, if I have too many children can't do anything. If I use a method I will not have children.

For the good health of the child and the mother. Can breast feed the child for longer, use a method don't have to worry about another baby until one wants.

Will have no fear of having another baby, if don't use then there is the risk of having another baby.

Unless the youngest one has grown big not to have another baby.

To have a good spacing between the children.

Not give birth to a baby too soon. If another baby comes soon it will be difficult.

To have a long interval between the two children.

6.6 HUSBAND AND WIFE COMMUNICATION

Figure 24 shows the level of communication between husband and wife in the PRI and PTI. Three questions were asked: a) 'Have you discussed WPF with your spouse?', b) 'Have you discussed the number of children you want with your spouse?', and c) 'Have you discussed contraceptive methods with your spouse?'

The number of participants discussing WPF with their spouse increased from 18 (PRI) to 24 (PTI). The number of participants discussing the number of children wanted with their spouse increased from 15 (PRI) to 24 (PTI). The number of participants discussing contraceptive methods with their spouse increased from 15 (PRI) to 25 (PTI). When asked, 'When was the last time you discussed WPF?' in the PRI, there were only six participants who said 'a few weeks back' whereas in the PTI, there were 16 participants who said they discussed it 'a few weeks back'. The number of participants reporting no discussion with spouse decreased from between husband and wife increased following the intervention, 11 (PRI) to three (PTI). This would support the conclusion that the level of communication between husband and wife was positively influenced by the intervention.

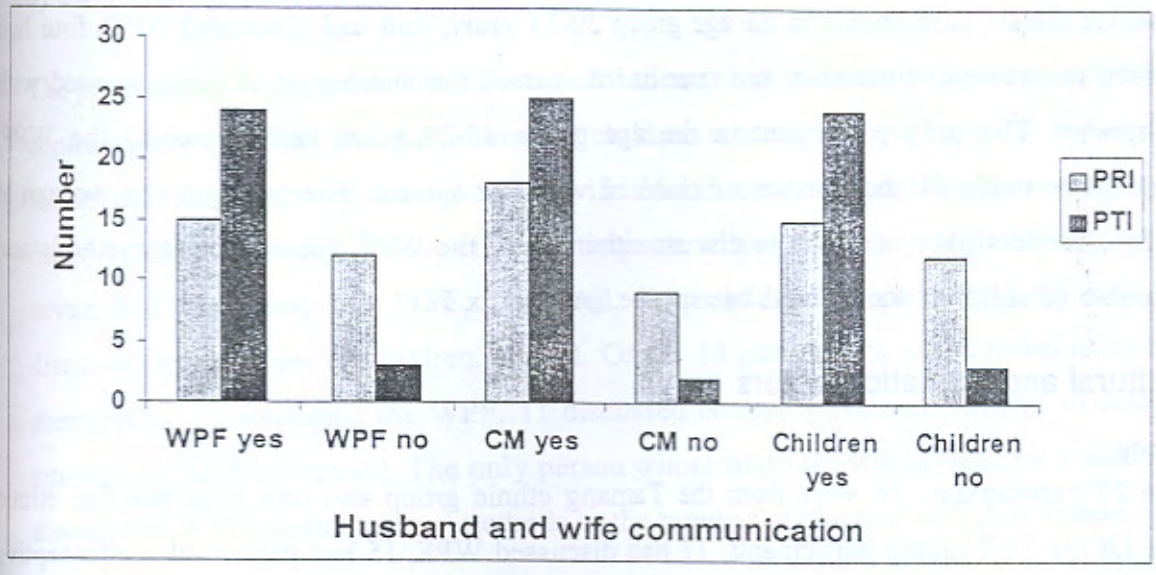


Figure 24: Communication between husband and wife (Appendix 5t)

6.6.1 Factors affecting husband and wife communication

Information on demographic factors, cultural and education factors, decision about marriage and decision in the family was collected in the PRI only and not in the PTI. Therefore the data presented below in a) are from the PRI only.

a) Demographic factors

Age of the wife

The two women in age group 15-19 and 30-35 years did not discuss WPF, contraceptive methods, nor the number of children wanted with their husbands. Of the 12 women in the age group 20-30 years, nine had discussed WPF, seven discussed contraceptive methods and six discussed the number of children wanted with their spouse. Women in the age group 20-25 years were more likely to discuss the WPF with their husbands than they were to discuss contraceptive methods and the number of children wanted. (Appendix 5u)

Age at marriage

Of the three participants in the age group 13-14 years, two had discussed WFP, one had discussed contraceptive methods and one had discussed number of children wanted with their spouse. Of the 17 participants in the age group 15-19 years, 11 had discussed WFP, nine had discussed contraceptive methods and nine had discussed number of children wanted with their spouse. Of the six participants in the age group 20-24 years, four had discussed WFP, four had discussed contraceptive methods and four had discussed the number of children wanted with their spouse. The only participant in the age group 25-29 years had discussed the WPF, contraceptive methods and number of children with her spouse. The younger the woman at marriage, the less likely she was to discuss either the of the WPF, contraceptive methods and the number of children wanted with her spouse. (Appendix 5u)

b) Cultural and education factors

Ethnicity

Of the 27 participants, 26 were from the Tamang ethnic group and one from the Rai ethnic group. Of the 26 Tamang participants, 17 had discussed WPF, 15 had discussed contraceptive methods and 14 had discussed the number of children wanted with their spouse.

The only Rai participant had discussed the WPF and the number of children wanted but had not discussed contraceptive methods with her spouse. (Appendix 5u)

Religion

All the Tamang participants were Buddhist and the one Rai participant was a Christian. The responses to whether or not they had discussed the WPF, contraceptive methods and the number of children wanted with their spouse were the same as for ethnicity. (Appendix 5u)

Education

Participants were more likely to discuss the WPF, contraceptive methods and the number of children with their spouse if they had attended school. Of the 27 participants, 11 had attended school and 16 had not attended school. Of the 11 participants who attended school, nine had discussed the WFP, six had discussed contraceptive methods and eight had discussed the number of children wanted with their spouse. Of the 16 participants who had not attended school, nine had discussed the WFP, nine had discussed contraceptive methods and seven had discussed the number of children wanted with their spouse (Appendix 5u).

6.6.2 Source of decision-making and children factors

a) Decision of marriage

The participants who decided on marriage for themselves were more likely to discuss the WPF, contraceptive methods and the number of children wanted with their spouse. Figure 25 shows the relationship between husband and wife communication and the person who makes the decision about marriage. Of the eight participants whose marriage was decided by the parents, seven had discussed the WPF, four had discussed contraceptive methods and five had discussed the number of children wanted. Of the 18 participants who decided on marriage by themselves, 11 discussed the WPF, 11 discussed contraceptive methods and 10 discussed the number of children wanted. The only person whose marriage was decided by a relative did not discuss the WPF, contraceptive methods or the number of children with their spouse.

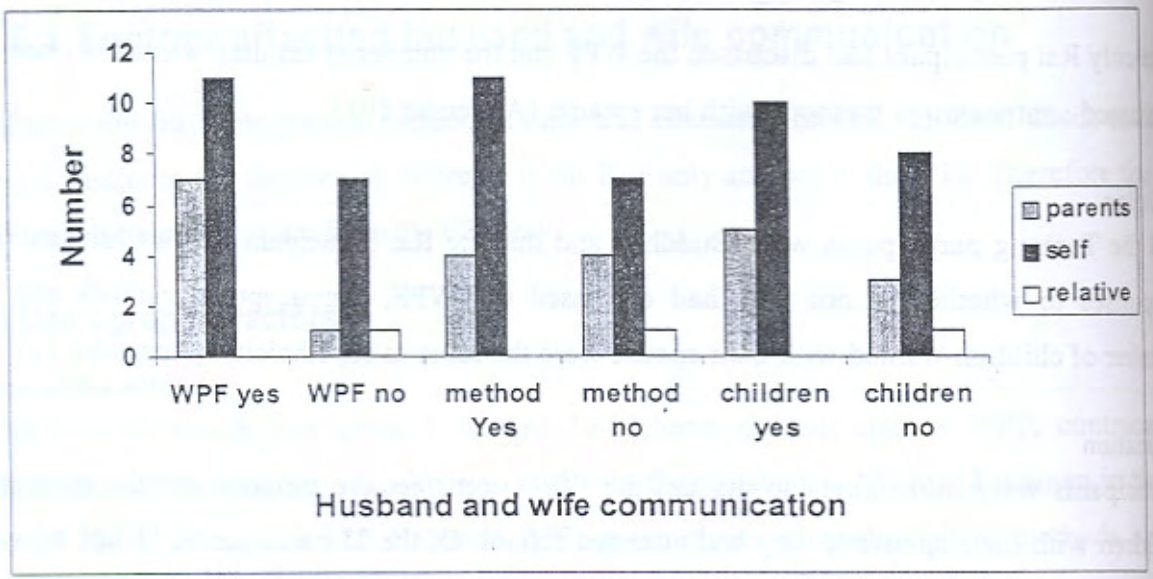


Figure 25: Husband and wife communication and the marriage decision (Appendix 5u)

b) Decision in the family

Figure 26 shows that the person making the decision in the family affects husband and wife communication about contraceptives choices. Of the 16 participants reporting the husband as the decision-maker in the family, 12 had discussed WPF, eight had discussed contraceptive methods and nine had discussed the number of children wanted with the spouse. Of the three participants reporting the wife as the decision-maker in the family, two had discussed the WPF, contraceptive method and the number of children wanted with the spouse. Of the two participants reporting their mother-in-law as the decision-maker in the family, none had discussed the WPF, contraceptive methods or the number of children wanted with their spouse. Of the four participants reporting the father-in-law as the decision-maker in the family, two had discussed the WPF, three had discussed contraceptive methods and two had discussed the number of children wanted with their spouse. Two participants reported joint decision-making in the family by the husband and wife and both of them reported discussing the WPF, contraceptive methods and the number of children wanted with their spouse. (Appendix 5u)

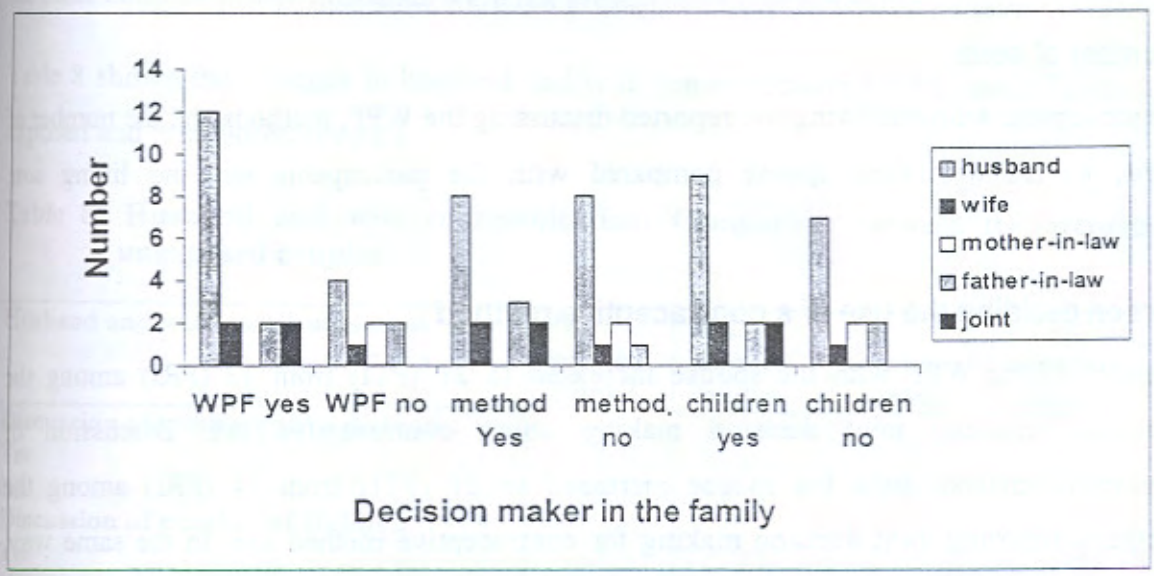


Figure 26: Husband and wife communication and the decision-maker in the family (Appendix 5u)

c) Desired number of children

Of the 22 participants whose desired number of children was two, 16 had discussed the WFP, 14 had discussed contraceptive methods and 13 had discussed the number of children wanted with the spouse in the PRI. That number increased to 19 for discussion of the WFP, 21 for discussion of contraceptive methods and 19 for the number of children wanted in the PTI. (Appendix 5v)

d) Number of living children

Participants with two living children reported more discussion of the WPF, methods and the number of children wanted with their spouse compared with the participants with one or no children. The number of participants discussing the WPF increased to 13 (PTI) from 10 (PRI), participants discussing contraceptive methods increased to 15 (PTI) from 11 (PRI) and participants discussing number of children wanted increased to 14 (PTI) from 7 (PRI). (Appendix 5v)

e) Number of sons

More participants with one living son reported discussing the WPF, methods and the number of children wanted with their spouse compared with the participants with no living son. (Appendix 5v)

f) Person deciding the use of a contraceptive method

Discussion of the WPF with the spouse increased to 21 (PTI) from 13 (PRI) among the participants reporting joint decision making about contraceptive use. Discussion of contraceptive methods with the spouse increased to 21 (PTI) from 14 (PRI) among the participants reporting joint decision making for contraceptive method use. In the same way, discussion of the WPF with the spouse increased to 20 (PTI) from 14 (PRI) among the participants reporting joint decision making in contraceptive use. Therefore communication between husband and wife increased following the intervention as demonstrated by the increase in the number of participants reporting joint decision-making in the use of a method. (Appendix 5v)

6.7 COMPARISON OF COMMUNICATION BETWEEN EXPOSED AND UNEXPOSED COUPLES BEFORE AND AFTER INTERVENTION.

In the first two days of the three days of workshops, 8 different contraceptive methods were discussed along with introductory information about husband and wife communication (see Appendix 1). On the third and last day of the workshops, the KURAKANI husband and wife communication model was taught and practised. All twelve couples were present for the first two days of the workshop. For the third day half or six couples and six women without their husbands were present. The six women whose husbands were not able to be present participated in the KURAKANI activities and practised among themselves. The six couples who participated in the KURAKANI workshop were considered the 'exposed' couples and

the other couples whose husbands were not present were considered the 'unexposed' couples.

Table 8 shows the changes in husband and wife communication for PRI and PTI among the exposed and unexposed couples.

Table 8: **Husband and wife communication: Comparison between the exposed and unexposed couples**

Husband and wife communication	PRI exposed couples	PTI exposed couples	PRI unexposed couples	PTI unexposed couples
Discussion of contraceptive method				
Yes	7	10	7	10
No	5	2	5	2
Discussion of number of children				
Yes	7	10	10	11
No	5	2	2	1
Discussion of WPF				
Yes	6	10	9	11
No	6	2	3	1
The last time WPF discussed				
Few weeks	0	8	1	6
1-six months	4	0	5	2
>1 year	2	2	2	2
DK	1	1	2	1
No discussion	5	1	2	1

Table 9 shows the level of agreement between members of each exposed and unexposed couple regarding the discussion of number of children. Of the six exposed couples only one couple agreed on their response in the PRI, both husband and wife reported having discussed number of children with their spouse. All six exposed couples had the same responses in the PTI. Of those six couples, five couples were in agreement about having discussed the number of children and one couple agreed they had not discussed the number of children.

Table 9 also shows that of the six unexposed couples, three had agreeing responses in the PRI. Two couples agreed on discussing the number of children and one couple agreed they had not discussed the number of children with their spouse. For the PTI, four couples had responses in agreement. Four of the six unexposed couples reported discussing the number of children with their spouse.

Table 9: Couples' agreement with 'discussion of number of children', PRI and PTI (exposed and unexposed)

Discussion of number children PRI and (PTI)(in parenthesis)		Wife (exposed)			Discussion of number children PRI and (PTI)(in parenthesis)		Wife (unexposed)		
Husband (exposed)		yes	no	total	Husband (unexposed		yes	no	total
	yes	1 (5)	4 (0)	5 (5)		yes	2 (4)	2 (2)	4 (6)
	no	1 (0)	0 (1)	1(1)		no	1 (0)	1 (0)	2 (0)
	total	2 (5)	4 (1)	6 (6)		total	3 (4)	3 (2)	6 (6)

Table 10 shows only one exposed couple agreed on their response in the PRI. Members of only one couple reported discussing the WPF with their spouse, whereas, four couples agreed on their responses in the PTI. These four couples reported discussing the WPF with their spouse after the intervention.

Table 10 also shows that four of the unexposed couples had the same responses in the PRI. The husbands and wives of four of the couples reported discussing the WPF with the spouse. Members of these five couples agreed on their responses in the PTI. These five couples all reported discussing the WPF with their spouse.

Table 10: Couples' agreement with 'discussion of WPF', PRI and PTI (exposed and unexposed)

Discussion of WPF PRI and (PTI)(in parenthesis)		Wife (exposed)			Discussion of WFP PRI and (PTI)(in parenthesis		Wife (unexposed)		
Husband (exposed)		yes	no	total	Husband (unexposed		yes	no	total
	yes	1 (2)	3 (3)	4 (5)		yes	4 (5)	2 (1)	6 (6)
	no	2 (1)	0 (0)	2(1)		no	0 (0)	0 (0)	0 (0)
	total	3 (3)	3 (3)	6 (6)		total	4 (5)	2 (1)	6 (6)

Table 11 shows two couples agreed on their responses in the PRI. One couple reported discussing contraceptive methods and the other couples agreed that they had not discussed contraceptive methods. In the PTI, all six exposed couples showed agreement in their responses. Five of the couples reported discussing, whereas one couple agreed they had not discussed contraceptive methods with their spouse.

Table 11 shows that of the six exposed couples, the responses from three sets of husbands and wives were in agreement in the PRI. All three couples reported discussing contraceptive methods with their respective spouse. Of the six unexposed couples, five agreed that they had discussed contraceptive method with their respective spouse.

Table 11: Couples' agreement with 'discussion of contraceptive method', PRI and PTI

Discussion of contraceptive methods PRI and (PTI)(in parenthesis)		Wife (exposed)			Discussion of contraceptive methods PRI and (PTI)(in parenthesis		Wife (unexposed)		
Husband (exposed)		yes	no	total	Husband (unexposed		yes	no	total
	yes	1 (5)	2 (0)	3 (5)		yes	3 (5)	1 (1)	4 (6)
	no	2 (0)	1 (1)	3 (1)		no	2 (0)	0 (0)	2 (0)
	total	3 (5)	3 (1)	6 (6)		total	5 (5)	1 (1)	6 (6)

Table 12 shows that for the six exposed couples, none of the husbands and wives had the same response as their respective spouse in the PRI. For the PTI members of three couples had the same response as their spouse. They all reported having discussed WPF with their respective spouse within the last few weeks

Table 12: Couples agreement with 'last time discussed about WPF with the spouse'. PRI and PTI (exposed)

Last time discussed about WPF at PRI and (PTI)(in parenthesis)		Wife (exposed)					
		Last few weeks	1-six months	> 1 year	DK	No discussion	Total
Husband (exposed)	Last few weeks	0 (3)	0 (0)	0 (0)	0 (0)	0 (0)	0 (3)
	1-six months	0 (0)	0 (0)	0 (0)	0 (0)	2 (0)	2 (0)
	> 1 year	0 (1)	0 (0)	0 (0)	1 (0)	1 (1)	2 (2)
	DK	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
	No discussion	0 (1)	2 (0)	0 (0)	0 (0)	0 (0)	2 (1)
	total	0 (5)	2 (0)	0 (0)	1 (0)	3 (1)	6 (6)

Table 13 shows that only one couple agreed on their response in the PRI. For the PTI also only

one couple agreed on their response as their spouse.

Table 13: Couples agreement on 'last time discussed about WPF with the spouse', PRI and PTI (unexposed)

Last time discussed about WPF in PRI and (PTI)(in parenthesis)		Wife (unexposed)					
		Last few weeks	1-6 months	> 1 year	DK	No discussion	total
Husband (unexposed)	Last few weeks	0 (1)	0 (1)	0 (0) ·	1 (0)	0 (0)	1 (2)
	1-6 months	0 (0)	1 (0)	0 (0)	1 (0)	1 (0)	3 (0)
	> 1 year	0 (2)	1 (0)	0 (0)	0 (0)	1 (0)	2 (2)
	DK	0 (0)	0 (1)	0 (0)	0 (0)	0 (0)	0 (1)
	No discussion	0 (1)	0 (0)	0 (0)	0 (0)	0 (0)	0 (1)
	total	0 (4)	2 (2)	0 (0)	2 (0)	2 (0)	6 (6)

In the PRI, when the six exposed couples were asked 'What do you understand by the phrase husband and wife communication?', seven members of the couples did not know the answer and five participants said it means' to talk to each other'. For the PTI, the number of participants who did not offer an answer decreased to only two. The remaining ten participants provided a correct response to that question. Among the unexposed couples, five did not provide an answer and seven gave a correct response to the question for the PRI. For the PTI, there was no decrease in the number of participants who did not provide an answer.

Among the six exposed couples (twelve participants), four participants could name a husband and wife communication skill, but only one participant named a correct skill needed for good communication between husband and wife. Eight of the participants did not provide an answer at the PRI. In the PTI, the number of participants able to name a correct husband and wife communication skill increased to eight and the number of participants not able to name a skill decreased to three. Although, among the six unexposed couples, five participants named a skill but only one participant named a correct skill needed for a good communication between husband and wife. Seven of the participants did not provide an answer at the PRI. In the PTI, the number of participants naming a skill increased to eight, but only two of those were

able to name a correct skill.

For another open-ended question, 'What do you understand by a well-planned family?' eight participants among the exposed couples expressed their understanding of a WPF as a 'small and a happy family'. Four of the participants did not know the meaning of WPF in the PRI. In the PTI, nine of the participants gave a more defined meaning of WPF and only three said they did not know the meaning. Among the unexposed couples, nine participants were able to give a better-defined meaning of WPF then the exposed couples for the PRI. For the PTI there was no change in the definition or meaning among the unexposed couples.

6.8 INTERACTION CHECKLIST FOR KURAKANI (APPENDIX 3)

6.8.1 *Kura* 'talk'

Of the six couples who participated in the KURAKANI workshop and audio-recorded their discussion in their rooms, four of the husbands initiated the talk. The wife initiated the talk among the other two couples. Wives were all speaking freely with their husbands, except one. All six couples were engaged in a two-way dialogue and husbands and wives were talking in turn. All six husbands and five wives asked both closed and open-ended questions, using verbal cues to make their partners feel they were listening. However, when compared with the husbands, the wives asked fewer closed and opened-ended questions. All six husbands and four of the wives demonstrated reassurance and encouragement and expressed empathy toward each other. The following is one example of how one husband showed reassurance, encouragement and expressed empathy to his wife.

Number 1 couple

Wife: *I am thinking of one two things in my heart Bura. Having it in the heart is also not good. Too much time has gone, many worries have been increasing in my heart. I have given up hope, I have not been able to think about anything else but this problem.*

Husband: *Everything will give worries and sadness. But one should not worry and feel sad. There is no need for any disease, people lose weight, people get sick because of these*

worries and the sadness. But you should not worry. We should take this thing in such a way that it is good for us. Does it help you when you worry? People's life is of blood and meat. Everyone has to die, it is only that, who goes earlier and who goes late. We should not worry and become sad in this short life.

Wife: *Now what to do for this problem?*

Husband: *What to do? If we have, [children] then good, if not then it's alright. We can stay like this, What can we do?... I think this is how we can solve our problem, what can we do? What to say?*

Wife: *It is true what can we do. Even if I want to think I cannot think of it. I cannot console my heart by any means. What should be done? I am deeply hurt when I think about it.*

Husband: *Thinking of the difficult times is not good. There is a saying " in winter don't think of your debts and when you are eating don't think of dirt." I think this is very true. They also say "when going to sleep don't worry". If you worry too much the food we eat will not nourish our body. If you are happy and eat, then the food will nourish you. Even if we have lots of problem we should not think of it. Keep those problem aside, follow those things you believe and make a progress. Let's not talk about children. Some have too many children so they are asked to talk about family planning, day before yesterday sister has told us. We don't have children. Because we don't have children, we might get some help on how to get children from them. You should not worry about that problem."*

Wife: *Let's see, if that is your thinking and you say that then we will do it. I was just telling you what I felt. Nothing happens according to one's thinking, it is not only my life that is going to be spoiled but both of us. But I am very happy you said that.*

Of the six couples, only one husband had some say in the desired number of children. Four of the wives decided the desired number of children. Two of the husbands discussed when to have the next baby with their wives. One wife and five husbands had no say in the desired number of children. Five of the husbands and four of the wives discussed the number of sons and daughters they would like to have. Four of the husbands and three of the wives discussed

with their spouse whether the sex of baby would influence the number of children they would have. Only one of the wives discussed with her spouse when to have the next child. One of the couples did not have any children so their discussion was focused more on how to get help to conceive a child rather then how many they wanted. Two contrasting examples are given below to show the communication between couples when discussing the number of children wanted and how the sex of the baby influences the number of children desired.

Number 3 couple

Husband: *How many children do we want?*

Wife: *For now we have two and it is enough.*

Husband: *Then you don't want a son?*

Wife: *We will see later*

Husband: *There is no difference between son and daughter. So two is enough isn't it?*

Wife: *It is enough. Son and daughter are the same.*

Husband: *That's true, son and daughter are the same. There is no difference between a son and a daughter. Daughter is also a son. What can one do by giving birth to too many children. We cannot take care of them like others, cannot give good things, cannot give them enough to eat and wear. We should also...those people with four five children, if they feed them one day then there is not enough for the next day. It is not good as thought. Because we have two so they will get good care, can give them good food to eat, can give them nice to wear so why? That well-planned family... if those people give birth to too many then they cannot have.*

Number 2 couple

Husband: *In my opinion, for me two daughters are enough. So you have decided to have another son?*

Wife: *Of course we need one son. Only having daughters is not enough. If we had one son and one daughter those two would have been enough. But we have only daughters*

so we have to have one son.

Husband: *So, what will daughter do and what will son do? What can we do with a son and what can you do with a daughter. Both are equal isn't it?*

Wife: *If we have a son when he grows up he will work and take care of his father and mother. When a daughter grows up she will go to some other person's house isn't it? What to do the problem is that.*

Husband: *So you want a son isn't it?*

Wife: *Whether it is a son or a daughter, after having one more we will not have another.*

Five of the husbands and five of the wives discussed contraceptive methods with their respective spouses. However, the information shared among themselves varied widely. Some just mentioned the name of the methods whereas others discussed the methods in detail. The most discussed method by the husbands was the injection (4), followed by male and female sterilisation (3), pills (2), IUD (2), condom (1), and LAM (1). The most discussed method by the wives was injection (4), followed by pills (2), IUD (1) and implant (1). Four of the husbands and four of the wives discussed the benefits of injection. Two of the husbands discussed drawbacks of injection and pills. Two of the wives discussed the drawbacks of the pill and how to use it. One wife discussed the benefits and body responses of the pills with her husband. One of the women did not discuss individual methods but did mention temporary methods and permanent methods. She did not discuss any of the methods in detail.

All six couples completed the KURA step of the KURAKANI. Three couples demonstrated most of the skills of the KURA step, whereas three couples did not utilise all the skills.

6.8.2 Raya 'opinion'

Four of the husbands and three of the wives asked their spouse's opinion about the appropriate contraceptive method to be used. Two husbands and two wives asked why their spouses thought the method was the most appropriate one. Four husbands and two wives stated their opinions about the method. Four of the husbands asked their wife's opinion about having fewer children. Two of the wives discussed the number of child they wanted. Four of the

husbands and four wives used verbal cues to show that they were listening and restated what their spouse was saying. The couple with no children shared their opinions about how to have a well-planned family and discussed other domestic issues.

All the six couples went through the RAYA step of KURAKANI but did not necessarily utilise all of the skills of RAYA.

6.8.3 *Kadar* 'respect'

The multiple communication skills for showing respect between husband and wife were used very well. Five of the husbands and five wives made positive statements in response to their spouse's opinion about the methods. Five of the husbands and five wives used verbal cues to show that they were listening. None of the husbands, nor the wives made fun of their spouse's opinion of the method she/he chose. None of the husbands disagreed with the method the wife chose, but three of the wives disagreed at once with the method the husband chose. Two of the husbands agreed at once to the method the wife chose. Two husbands and one wife agreed with their spouse to have fewer children. Two of the husbands and one wife decided to see the health worker for more information about methods.

All six couples went through the KADAR step of KURAKANI but not all utilised all of the skills for KADAR.

6.8.4 Nirnaya 'decision'

Four couples decided to use a contraceptive method for spacing births. Although four of the wives made the choice of method, the four couples made a joint decision to use the method. Four couples were happy with the method and their decision. Three of the couples decided to have fewer children and said they were happy with the decision.

All six couples completed the NIRNAYA step of KURAKANI. Some reached the decision of how many children they wanted, some reached the decision to use a method and some couples reached a decision on both issues.

Therefore, all the six couples used the four steps of KURAKANI and came to a joint decision about which method to use and how many children to have. Three of the couples covered

the four steps very thoroughly whereas the other three couples covered all four steps and
multiple skills but in less detail.

6.9 CASE STUDIES

Because the sample was small the following couples' case studies were compiled from both
qualitative and quantitative results in order to bring the data alive and show a few 'faces' of
enthusiastic participants. Three couples were selected from among the twelve couples
participated in the workshop. To protect the identity of the participants the names used in
case studies are not the true name of the participants.

No. 1 Couple

Ram Bahadur Tamang is 29 years old and has been married to Sita Maya Tamang who is
years old, for ten years. They used to live in Kisadi village about 180 km from Kathmand
The couple moved to Kathmandu in 1994 in search of employment. Ram and Sita have be
working in the carpet factory since they moved to Kathmandu. Although they have be
married for ten years they have not been able to conceive and have children. They really wa
child and have spent a large sum of money trying to obtain fertility advice.

Ram attended school so is able to read and write but Sita never attended school. She did try
attend the Adult Literacy class in her village but could not continue due to a variety
domestic problems.

Ram took part actively in the workshop. He asked questions and responded to the questio
asked. He showed a great deal of interest in the workshop. He was one of the most acti
participants. In the women's group, Sita was also a very active participant. She asked questio
and responded to the questions asked. Although Ram and Sita do not have any children, th
participated and were very keen to learn. On the third day of the intervention, when practisi
the KURAKANI model, they did an excellent job of performing the role-play. They were n
as shy or reserved as the other couples and were therefore the best couple to do the role-pl

Ram and Sita were one of the six couples who agreed to record their husband and wife conversation. The conversation they recorded was the strongest of the six. They had all the four steps of KURAKANI well put together and had obviously practised ahead of time.

Ram and Sita discussed how to have a well-planned family but had never discussed about the use of contraceptive methods and the number of children they wanted before the intervention. They did not have any children so they thought it was not necessary for them to talk about the topic. But after the intervention they understood it was important to know and discuss about contraceptive methods. Ram and Sita reported discussing about contraceptive methods after the intervention. A segment of the taped conversation between Ram and Sita is provided below.

Wife: *Actually we don't have any children, but if we know about that family planning temporary methods in reality it will be useful for us. We can tell our friends and make them understand.*

Husband: *Yes it is true, we don't have any children. But if we know about this kind of things it will be useful for the village, neighbours, community it is a service to our country 'To provide Service is religion, religion is to work' isn't it? But we don't have any children. Even though we don't have children that doctor sister talked about the temporary family planning methods. She has given us a tape to record. We should record it so let's talk about family planning methods. What are the different methods that will be good for us to use?*

Ram and Sita both found all the three days workshops very interesting and useful. Sita said she heard and understood a lot of things during the workshops which she had never heard before. Sita also learned how to communicate with her husband. She was very confident she would use the KURAKANI model and was certain it would help her to communicate well with her husband. Ram thought he would also use the KURAKANI model in future.

No 2 couple

Bhim Tamang, 28 years old, has been married to Hira Maya Tamang, 24 years old, for six years. They lived in Basambari village about 200 km from Kathmandu. The couple moved

to Kathmandu just five months before this study to look for better opportunities. Bhim and Hira had been working in the carpet factory since they moved to Kathmandu. They have two daughters, the eldest one is four years old and the youngest one 18 months. Although their desired number of children is two, Hira wants to try one more time for a son. Hira herself comes from a family with seven daughters and no sons. Now her parents are old and there is no one to take care of them in their old age. When Hira was asked why she wants a son she said *daughter will get married and go to her husband's home, if I have a son he will take care of us in our old age. Look at my parents, though they had seven daughters there is no one to take care of them in their old age. We, daughters are married and have to take care of our own family, so my poor parents have to take care of themselves*'. If she fails to have a son next time they will not have any more children.

Bhim was another active participant. He showed a lot of interest in learning by asking questions now and then. When the men were asked to share with their group about the methods they had learned Bhim was able to tell his group about the methods. Hira was a quiet person but would speak out if asked. She would not participate if not asked. She was a very keen listener. She attended all three days of the workshop. Bhim and Hira were reluctant to do the role-play during the KURAKANI workshop. However, they did a good job of recording the KURAKANI interactions. One segment of the conversation is provided below:

Husband: *In my opinion, for me two daughters are enough. So you have decided to have another son?*

Wife: *Of course we need one son. Only having daughters is not enough. If we had one son and one daughter those two would have been enough. But we have only daughters so we have to have one son.*

Husband: *So, what will daughter do and what will son do? What can we do with a son and what can you do with a daughter. Both are equal isn't it?*

Wife: *If we have a son when he grows up he will work and take care of his father and mother. When a daughter grows up she will go to some other person's house isn't it? What to do the*

problem is that.

Husband: *So you want a son isn't it?*

Wife: *Whether it is a son or a daughter, after having one more we will not have another.*

Although Hira wants to try one more time for a son she realises that there should be some gap between births. She is using the contraceptive pill to prevent herself from getting pregnant without discussing it with Bhim. When asked why she is using it without discussing with Bhim she said *I have to use, so why ask him?*

Before the intervention, Bhim said he had discussed about the WPF, contraceptive methods and the number of children wanted with his wife. Hira reported discussing about the WPF with Bhim but not discussing about contraceptive methods and the number of children wanted. After attending the intervention she realised it was important to discuss contraceptive methods and the number of children with Bhim to have a well-planned family. She reported having discussed contraceptive methods and the number of children wanted with her Bhim after the KURAKANI intervention.

Bhim and Hira found the three days of workshops interesting and said they would use the knowledge learned during the workshop in the future.

No 3 couple

Lal Bahadhur Tamang, 28 years old, has been married to Maili Maya Tamang, 25 years old, for six years. They lived in Marphu village about 150 km from Kathmandu. Maili came to Kathmandu with her parents ten years ago. Her parents moved to Kathmandu in search of work. Lal Bahadhur moved to Kathmandu eight years back in search of work too. Six years ago, Maili and Lal happened to work in the same factory. It was then that they met each other and got married. They have two daughters. The elder one is five and the younger is one year old. Lal and Maili are happy with these two daughters and have decided not to have any more children.

Lal Bahadhur was a quiet man but a good learner. He attended all three days of the workshop.

Maili was an attentive person. She was not a very active person but took part in the activities along with the group during the workshop. Lal Bahadhur and Maili were also hesitant to do the role-play but the recording of their KURAKANI conversation revealed excellent use of the various communication skills. A segment of the recorded conversation is provided below.

Husband: *If we had to use a temporary method which one would you use?*

Wife: *Depo injection*

Husband: *Depo is the one, which will make three months gap isn't it?*

Wife: *Yes*

Husband: *The gap makes us feel secure. There is no hassle of forgetting and so on*

Wife: *ah*

Husband: *And yesterday, those actors doing the drama, they said very good things isn't it?*

Wife: *They did very well.*

Husband: *If we agree with each other, if work is done in agreement, it is very good.*

Wife: *Yes*

Husband: *Now if we do any work in agreement it is good. The people who quarrel have received knowledge, those husbands and wives who quarrel all the time, they have learnt something. In reality, it is very good to agree with each other.*

Wife: *To be in agreement with each other that is good.*

Husband: *And now how many children do we want?*

Wife: *For now we have two and it is enough.*

Husband: *Then you don't want a son?*

Wife: *We will see later.*

Husband: *There is no difference between son and daughter.*

Wife: *It is enough. Son and daughter are the same.*

Husband: *That's true, son and daughter are the same. There is no difference between a son and a daughter. Daughter is also a son. What can one do by giving birth to too many children. We cannot take care of them like others, cannot give good things, cannot give them enough to eat and wear. We should also...those people with four five children, if they feed them one day then there is not enough for the next day. It is not good as thought. Because we have two so they will get good care, can give them good food to eat, can give them nice to wear so why? That well-planned family. If those people give birth to too many then they cannot have. In between us two, that three monthly... let's use Norplant, is it alright? For five years.*

Although Maili and Lal Bahadhur were very happy with their two daughters and were not planning to try for a son, they were not using any contraceptive method. They were intending to a use contraceptive method in the future.

From the responses Lal Bahadhur and Maili gave for the PRI, it was apparent they had not discussed about the well-planned family and number of children they wanted before the intervention. Their husband and wife communication improved after the intervention.

Discussion

Logne swasni rathako duee pangra jasto ho

'Husband and wife are like the two wheels of a chariot'

7.1 INTRODUCTION

The discussion is organised according to the five main areas of research investigation, simila to the preceding chapter. Data from the PRI and PTI, the observational notes, and the husban and wife interaction checklist are all considered for the purposes of the discussion.

7.2 KNOWLEDGE OF CONTRACEPTIVE METHODS AND COMMUNICATION

7.2.1 Knowledge of methods

The participants' knowledge of contraceptive methods was measured by how many differen contraceptive methods they could name. The average number of methods participants coul name spontaneously increased following the intervention. A greater proportion of th participants reported knowing a modern method than a traditional method. This finding is ver similar to the findings of the Family Health Survey, Nepal (NFHS, 1996). Knowledge o contraceptive methods is nearly universal in Nepal therefore it was not surprising to find a hig number of participants able to name a method (NFHS, 1996). The NFHS reported that 98

percent of both ever-married women and currently married women age 15-49 knew at least one method of family planning. A greater proportion of currently married women reported knowing a modern method (98 percent) than a traditional method (44 percent) (NFHS, 1996). The main reason for low reporting of traditional methods in the PRI in this study may be because the participants were reluctant to report the use of a traditional method even if they knew of one. The participants may have been embarrassed to mention a traditional method since these methods are not widely accepted and it seems to be more private than discussion of modern methods. A survey conducted among couples in Switzerland in 1980 also reported low reporting of traditional methods compared to modern methods. The reason given was embarrassment (Hopflinger and Kuhne, 1984). The high level of modern contraceptive knowledge before the intervention may be the result of the wide dissemination of family planning messages through the mass media in Nepal over the last decade. The participants may have heard the name of the contraceptive methods on the radio, television or from friends or they may have seen posters of the methods which are widely displayed throughout Nepal and made available by the Ministry of Health.

7.2.2 Knowledge of body responses of contraceptive methods

Although the change in knowledge of body responses for different contraceptive methods was not as great as expected, there was some improvement in the knowledge of body responses among the participants after the intervention. One reason for not achieving the expected result may be that the participants were confused about the difference between drawbacks and body responses. When asked about the body responses the participants gave answers which they were expected to be given when asked about the drawbacks of the methods. Therefore the participants' responses were considered incorrect. In Nepal, while sharing information about a method, health providers usually use two Nepali terms, *phaida* (advantage) and *bephaida* (disadvantage). All benefits are *phaida* and the body response and drawbacks are *bephaida*. As the participants have been accustomed to hearing these terms, using the new term *shareerlai ashar parne* (body response) may have been difficult to understand and confusing.

Another reason may be that too much new information was given to them in a very short

time period. One of the objectives of the intervention was to provide the participants with up to date and accurate information to help them in their decision making process. Although the intervention was specifically planned for illiterate people and the information shared was made as simple as possible, the amount of information may have been too much for the participants to absorb fully in the time available.

7.2.3 Knowledge of benefits of contraceptive methods

Knowledge of the benefits of different contraceptive methods improved dramatically between the PRI and PTI. All participants could say which methods was permanent for limiting the number of children and which methods were temporary for spacing children. The majority of participants could accurately state the working duration for all methods.

As mentioned above, it is almost universal in Nepal to know the name of a modern contraceptive methods (NFHS, 1996). However, women do not necessarily know how each method works, for how long, and how each method is used. This study showed that although a majority of the participants were able to name the different contraceptive methods, when asked to name the benefits for these methods, very few could do so in the PRI. However, there was a dramatic change in the knowledge of benefits of contraceptive methods in the PTI. Many could name the benefits for these methods. The improvement of knowledge may be because, as mentioned above, the benefit was expressed as *phaida* which is a very familiar word to the participants. This may have made it easier for the participants to remember. If the participants are able to name the different temporary and permanent methods, their effectiveness and their duration of use, this knowledge will help them to decide which method is the best for them. This information would help them in their contraceptive decision making.

7.2.4 Knowledge of drawbacks of contraceptive methods

Although the improvement of knowledge of drawbacks for the different contraceptive methods was not as great as expected, there was some improvement. When asked 'What are the drawbacks for the different methods?', the participants gave more incorrect answers to this question than for the question about the body responses. Again they seemed to be confused

between the two terms body responses and drawbacks. The minimal change in knowledge of drawbacks may be partially explained by a similar reason as the low level of change for knowledge of body responses provided on page 136-137.

7.2.5 Knowledge of different sources for obtaining contraceptives

The most frequently named source for obtaining contraceptives in the PRI was the hospital, followed by the medical shop, then the health post and the private clinic. The least frequently named sources were mobile camps, the family planning clinic and health workers. In the PTI, the naming of different sources where contraceptive methods are available increased dramatically. In the PRI there were participants who could not name even one source but in the PTI all the participants could name at least one source for obtaining contraceptive. In the PTI the most named sources were the health post and medical shops, followed by hospitals private clinic. The least named sources were mobile camp and family planning clinic. The results of this study were very similar to another study conducted among men of seven districts in Nepal, which reported hospital as the most named source followed by health post, mobile camps. The least named source in the study were the family planning clinic, private clinics, and health workers (Valley Research Group, 1999). In the NFHS the most named sources were hospitals, health posts and mobile camps (NFHS, 1996).

The reason for the low reporting of health posts and mobile camps could be explained by the following reasons. The participants for this study all came from the rural area of Nepal. The health posts are the public health facilities which serve the rural communities. Health posts usually supply pills, the injection, and condoms. Before moving to Kathmandu, the health post would have been the main source of contraceptives for the participant. Medical shops supply pills, the injection, and condoms. In the city, the hospital, medical shops and private clinics are the places where contraceptives are available. Most of the participants have lived in Kathmandu for some time. If a woman wants to use a contraceptive method, the older workers show the newcomers where they can obtain contraceptives. Most of the participants were accessing contraceptives from the district hospital where they pay a registration fee of Rs 5 and where the contraceptives are free of charge. The other main reason for preferring the

hospital may be because of its close proximity to the carpet factory. In addition, some said they used the medical shops although they are much more expensive (Rs. 30-35). The main reason stated by the participants for using the medical shop was because the waiting time was less and the providers were more helpful, compared to the providers in the public hospital.

Mobile camps are operated several times a year by the government and the Nepal Family Planning Association in the rural parts of Nepal in order to provide permanent male and female sterilisation to the local people. Health workers work in the villages. The study participants do not appear to have used the mobile camps and village health workers. This may be the main reason for infrequent mention of the mobile camps and health workers as sources of contraceptives.

If the participants are able to name the various sources where different methods can be obtained and if they express their intention to use a method in the future, they will know where to obtain it. The improvement in knowledge of the different sources where different methods can be obtained is an important factor in increasing contraceptive use.

7.2.6 Knowledge of well-planned family (WPF)

A majority of participants mentioned they had heard of the WPF in the PRI. While the number of participants who had heard of the WPF did not change in the PTI, a larger variety of meanings of the WPF were given in greater detail in the PTI. None of the participants thought good husband and wife communication was an important element for a well-planned family in the PRI. In the PTI there were five participants who mentioned the importance of good husband and wife communication for a well-planned family. An increased understanding of the WPF was also clearly demonstrated after the intervention.

In Nepal when someone talks about a well-planned family they always speak about the number of children in the family. If a family has two children then that family is considered to be a well-planned family. This concept has been accepted by the Nepalese people as the result of the wide dissemination of family planning messages through the mass media. The slogan *sano pariwar shukhee pariwar* 'a small family is a happy family' has been widely disseminated

by the Family Planning Association of Nepal and the government throughout the last three decades. This message has clearly influenced the public's understanding of the well-planned family which is strongly equated with having few children.

The Johns Hopkins University/Population Communication Services and the government of Nepal launched a serial radio drama in Nepal in 1995. The 'Cut Your Coat According to Your Cloth' serial was broadcast nationally on the National Radio Nepal channel and was intended for the general public. The aim of this programme was to shift the publics' attitudes away from the historically narrow association of contraception with sterilisation toward a broader notion of the well-planned family (WPF) (Storey et. al., 1999). Because the majority of participants were able to give the meaning of a well-planned family in the PRI, one might assume that the participants were influenced by the messages from this programme. However, participants were asked in the PRI whether they listened to the programme about WPF on the radio, and as if they knew the name of the programme. Few participants reported having heard the WPF programme on the radio. Even though they had heard about the WPF on the radio, none of them could remember the name of the programme. As mentioned earlier, the majority of the participants have lived in Kathmandu for at least a year. At the carpet factory, the main source of entertainment is listening to the radio. In 1996 a new FM radio station was established in the Kathmandu valley. This station broadcasts all the latest Nepali and Hindi hit songs. People now tend to listen to this station more than to the National Nepal radio. This FM station does not broadcast any health and educational programmes produced by the Ministry of Health and other government offices. Consequently, it is likely that the study participants were not influenced by the WPF message from 'Cut Your Coat According to Your Cloth'.

7.2.7 Knowledge of husband and wife communication

There was some change in knowledge of husband and wife communication following the intervention. The level of change was most dramatically demonstrated by the improvement in husband and wife communication skills shown in the analysis of the audiotapes according to the KURAKANI interaction checklist. However, there were also positive changes from the interview results for the discussion between the husband and wife regarding; 1) the well-

planned family, 2) the number of children wanted, and 3) contraceptive methods. The results from the interaction checklist of KURAKANI clearly showed all couples were able to demonstrate good husband and wife communication.

7.2.8 Knowledge of communication skills

Communication skills are very important for good interpersonal communication. Although from the results of the open ended question in the interviews, the change in knowledge of communication skills was not as well demonstrated as expected, the analysis of the taped husband and wife communication showed that the couples were doing a good job of practising the variety of communication skills. Perhaps the participants had trouble naming the skills, but found it easier to put into action the different communication skills that they had learned from the workshop. There was no difference among the exposed and the unexposed couples in naming the different communication skills after the intervention. The unexposed couples were not asked to tape the conversation therefore, it was difficult to assess whether these couples were also good at practising the communication skills. Therefore it is not entirely clear whether the change in use of communication skills were directly influenced by the intervention or whether these six exposed couples already had strong communication skills prior to the intervention.

7.2.9 Knowledge about the person responsible for the sex of the baby

The change in knowledge about the person responsible for the sex of the baby was much more apparent among the women than for the men. At the PTI all the women knew that the husband is responsible for the sex of the baby, whereas there was no change in the men's knowledge. During the workshop when a game was played to help them understand who was responsible for the sex of the baby, the women seemed to really enjoy the exercise. One of the women made the comment, "*This must be taught to the men also.*" It is common practice in Nepal for women to be blamed for not being able to produce a son. Clearly this woman was suggesting that if the men have the correct biological information then they would stop blaming

women.

Who is responsible for the sex of the baby is important information for couples to understand, especially in a country like Nepal where son preference is very strong. (The importance of sons is explained in detail in Chapter Two, page 23.) If a couple is unable to have a son the parents-in-law on the husband's side encourage the son to go for another marriage (Aryal, 1996). It is always considered to be the woman's fault if the couple is unable to have a son or children. If the couples are aware that the man is responsible for the sex of the baby, then the woman may be given better status in the family and no longer blamed for not being able to give birth to a son. Women may be able to teach their in-laws and convince their husbands in order to avoid multiple marriages and the birth of unwanted children.

7.3 ATTITUDES AND PERCEPTIONS ABOUT CONTRACEPTIVE USE AND OTHER FAMILY PLANNING CONCEPTS

7.3.1 Own approval and spousal approval of others using contraceptives

Own approval of other couples using a contraceptive method increased in the PTI, as did the perception of spousal approval of other couples using contraceptive methods. Although all male participants approved of other couples using a contraceptive method, their wives tended to underestimate the level of approval held by their spouses.

This means that some women who approved of contraceptive methods were not using a method because they incorrectly perceived their spouse opposed contraceptive use. Approval of contraceptive method use by the spouse is one of the most powerful influences for first time use and consistent use of contraceptive methods (Storey and Sood, 1997; Joesoef et. al., 1988). Therefore, by improving communication between the husband and wife, couples will know whether their spouse approves of contraceptive use and this will potentially result in increased use of contraceptive methods.

The thirty attitudinal questions concentrated on the well-planned family, image o contraceptive users, son preference, contraceptive methods and husband and wif communication. This study was only able to assess changes in attitude regarding these factor over a very short time period, the three months duration of the study. The attitudes of some participants showed no change, whereas both positive and negative changes were demonstrated for others.

7.3.2 The well-planned family (WPF)

The results of this study show a very positive attitude towards the concept of the well-planned family. The two participants who had a negative attitude before the intervention changed towards a positive attitude by the post intervention interview. Research has shown that most people in Nepal have a positive attitude towards a well-planned family (Schuler and Goldstein, 1986). Nepali people understand a well-planned family to mean, having few children, no more than two or three.

a) The image of contraceptive users

To measure the change in attitude regarding the personal image of family planning users before and after the intervention, four attitudinal statements were used. In many developing countries the public image of the contraceptive user is negative and Nepal is no exception (Schuler et al., 1994; Koenig et.al., 1984). The most dominant negative attitude towards contraceptive use is the fear of being suspected to be promiscuous (Schuler et. al., 1994). This is a common attitude in Nepal (Schuler and Goldstein, 1986). In Nepal, sex is not supposed to be discussed even between husband and wife. Children are not taught by their parents about the menstrual cycle, sex, or childbirth. Because women grow up in sheltered environment, they are embarrassed to discuss sex with anyone.

Following the intervention the number of participants with positive attitudes increased. Participant attitudes unexpectedly changed in both positive and negative directions. The positive change was seen more among the female participants than among the male participants. The main reason may be because the women had more negative attitude towards

the contraceptive users before the intervention but after the intervention when they understood the different methods they changed to have more positive attitudes

A majority of the female participants disagreed that contraceptive use was often associated with promiscuity in the PRI. But surprisingly there were more female participants changing to a negative direction, than the positive direction in the PTI. A majority of the male participants agreed that contraceptive use was often associated with promiscuity in the PRI. The reason for women changing towards negative direction after the intervention may be because when the participants came to know the effectiveness and benefits of the different methods from the intervention, they may have thought that it was easy to hide things from one's spouse.

b) Son preference

Son preference among Nepali couples is very high (Schuler and Goldstein, 1986; Karki, 1988; Gurung, 1994). There are many reasons for the high level of son preference in Nepal as discussed in Chapter Two, page 11. The results of this study do not fully support the high son preference. Three attitudinal questions were asked to the participants.

The practice of marrying for the second time if the first wife is unable to produce a son is not supported by this study either. Although several participants supported this statement before the intervention, they changed their attitude after the intervention. This may be explained by the demonstrated increase and understanding about who is responsible for the sex of the baby. After the intervention, participants seemed to understand that remarrying would not necessarily give them a son.

Research among male participants in seven districts of Nepal showed men had a preference for son over daughters (Valley Research Group, 1999). Research conducted in Chitwan District of Nepal in 1993, showed that men had a stronger son preference than women (Stash, 1996). A majority of the participants in this study among carpet factory workers did not show a preference for sons, but there were three male participants who did show a strong son preference. Son preference was difficult to assess in this study. Although preference for sons was not demonstrated by most of the responses to the statement 'it is necessary to keep having children until a boy is born', the response to another interview question indicated that more

participants had a clear son preference. When asked, 'How many sons and how many daughters would you like to have?', all participants reported one son and one daughter. This discrepancy might be explained as the participant's realisation of the economic burden of raising too many children. All study participants have migrated to the city from the rural part of Nepal. Living in the city is very expensive. Having experienced this economic change they may be less likely to add to their economic burden by giving birth to many children simply in the hope of having a son.

c) Perception of contraceptive use

In Nepal there is a great deal of misinformation as well as a number of myths or rumours that circulate among the people which prevent people from using a contraceptive method. This misinformation, myths and rumours have helped generate and perpetuate misperception and fear of using contraceptives (Schuler et. al., 1985; Tuladhar, 1987).

Nevertheless, many of the study participants demonstrated the correct perception of contraception use before the intervention. The participants who had an incorrect perception of contraception use in the PRI made a positive change in the PTI. This suggests the intervention had some influence on changing the perception of contraception use among the participants.

However, some perceptions were difficult to change, such as those concerning sterilisation. A survey conducted in 1996 in Nepal showed that Nepali women believed that contraception, especially sterilisation, have unwanted side effects (Storey and Sood, 1997). This study also showed that many of the participants had an incorrect perception of sterilisation before the intervention. A majority of the participants believed that sterilisation made a person weak. After the intervention, there were more participants who made a negative change than a positive change in this study. Several studies in Nepal report that one of the main reasons for not using contraception was the perception that sterilisation makes a person weak and prevents people from carrying out their daily chores (Tuladhar, 1987; Thapa, 1989; Schuler et. al., 1985; Schuler and Goldrein, 1986; Aryal, 1996). Even though the participants were informed that the perception that sterilisation makes a person weak was incorrect, the intervention did not appear to influence a change in attitude among the participants. It may be that the perception is so

strong that it is difficult to change in a short time period.

A majority of the participants were misinformed about the side effects of the various methods such as condoms and Copper-T in the PRI. When discussing the drawbacks of the condom during the workshop, the facilitator may have talked about the risk of a condom slipping off occasionally, if the size was not right. This information may have confused the participants and the other reason may be because the same statement was asked in both PRI and PTI that the participants may have thought they had answered incorrectly and thus they changed their answer in the PTI because they were unsure.

All the participants correctly perceived that more people would use contraceptive methods if they were readily available. They also thought that many people do not know how contraceptive methods work. Studies conducted in different parts of Nepal have shown that one of the main reasons for not using a method is the lack of availability (Schuler and Goldstein, 1986; Shrestha et. al., 1990; Tuladhar, 1987).

d) Husband and wife communication

Four questions were asked to measure attitudes regarding husband and wife communication. A majority of the participants had very positive attitudes toward husband and wife communication even before the intervention, especially the female participants. At the PTI, all participants had positive attitudes. The positive attitude towards husband and wife communication among the participants before the intervention may be partially explained by Tamang tradition. In the Tamang ethnic group females are given more importance in the family compared with other ethnic groups in Nepal. Their opinion is heard in family decisions. Another reason may be that a majority of the participants married for love, i.e. their marriages were not arranged. Couples who marry for love may know each other better and may be more comfortable talking to each other than the couples who had an arranged marriage. The intervention appears to have positively influenced the couples, for there was a 100 percent positive attitude towards husband and wife communication after the intervention.

7.4 CONTRACEPTIVE USE AMONG THE PARTICIPANTS

7.4.1 'Ever' and 'current' method used

There were more participants who reported of 'ever using' a contraceptive method compared to 'currently using' a method. There was a difference in the number of women compared to men who reported 'ever using' a method. Four male participants reported condom use for 'ever use' method but none of the female participants reported condom use. There was underreporting of the use of condoms by the female participants. Women may not have reported condoms use because they were embarrassed or because the condom is used by the male. It may be possible that these men used condoms with partners other then their present wife and unconsciously they were reporting the use of condom outside their marriage. Therefore, it may be true that the women were reporting correctly that they never used condoms. A study in India reported that there has been underreporting of condom use by wives because of the negative taboo attached to the use of condom among the village women (i.e. condom use is often associated with prostitution, as a means of protecting against sexually transmitted disease as well as engaging in extra-marital affairs) (Koenig et. al., 1984).

Even though the wife was using the pill before the intervention, the husband did not report his wife using the pill in the PRI but in the PTI he reported use of pills. This suggests that there was increase in husband and wife communication after the intervention. Increase in the number of participants using contraceptives demonstrated that participants were influenced by the intervention and decided to use contraceptive method.

a) Couples' agreement with 'naming of method ever used'

The results show a high level of agreement between the husband and wife when naming of the method ever used which indicates that communication between husband and wife took place. None of the female participants reported using a condom. Two females reported using the pills and only one male reported using the pill. The reason for the lack of agreement may be because the husband and wife were not communicating. It could be that the wife had not told her husband that she was using the pills, therefore the husband did not know what method the wife

was using for contraception. The other reason may be they had trouble remembering events that took place several years ago and the participants were not able to recall properly.

b) Couples' agreement with 'naming of current method used'

In the PRI, 11 out of 12 couples were in agreement when reporting the current use of a method. One of the women had started using the pills without discussing it with her husband. However, after the intervention the couple discussed the method and all the 12 couples agreed on their use of current method for the PTI. This study shows that husband and wife communication was taking place for a number of couples before the intervention and that husband and wife communication increased after the intervention. The high level of communication between the couples may be explained because these couples come from an ethnic group (Tamang) that is considered more liberal than others. For Tamang, the women are given respect and are heard (Pradhan, 1989). If the study had included participants from more conservative ethnic groups, the positive impact of the intervention on husband and wife communication may have been seen more clearly.

7.4.2 The factors influencing the use of current method

Studies conducted in developing countries around the world show that the main reasons for not using a contraceptive method are those mentioned in Chapter 2, page 15. The NFHS reported that as the number of children increases, the contraceptive use rate increases too (NFHS, 1996). Other studies conducted in Nepal also showed that contraceptive practice is positively related to the number of living children (Aryal, 1996; Schuler and Goldstein, 1986; Tuladhar, 1987). This research also showed a positive association between contraceptive use and number of children. None of the participants with no children reported use of contraception. Of the participants with one child, 50 percent were currently using a method and 72 percent of the participants with two children were using a method in the PTI.

The number of participants reporting having one or two children was not the same in the PRI and PTI. One of the male participants had a stepchild and a child of his own. In the PRI that male participant reported having one child and in the PTI he reported having two children.

The number of participants using a contraceptive method increased in the PTI. In the same way, of the participants not wanting more children who were using a method increased at PTI. The intervention appears to have influenced some of the participants to use a method to control birth. Following the intervention two participants started using a contraceptive method for spacing birth. This demonstrates that the intervention may have helped the participants understand that there are several temporary methods which can prevent pregnancy for certain time period and that sterilisation is not the only method which prevents pregnancy. Studies in Nepal demonstrated that couples use contraceptive methods only to limit birth, when they do not want any more children. Few people use methods to space birth due to the fear of side effects (Tuladhar, 1989; Schuler and Goldstein, 1986; NFHS, 1996). The current use of contraceptive methods by the participants in this study is higher (33%) than the national contraceptive prevalence rate of (29%) by currently married women (NFHS, 1996).

7.4.3 Relationship between current use of method with desired number of children and actual number of living children

The couples who have had their desired number of children are more likely to use a contraceptive method than the couples who have not yet had their desired number of children. Couples with a larger desired number of children do not have to worry about reaching their desired number soon so they use a method later when they come close to their ideal number. The majority of the couples in this study had smaller desired number of children and many of them had already reached their desired number of children. This may be the main reason for the high proportion of women using contraception.

Following the intervention, use of contraceptive method increased among the participants with desired number of children of two and already had two children. The intervention appeared to have had some influence on using a method although there were still few participants who have an unmet need after the intervention.

7.5 FACTORS AFFECTING HUSBAND AND WIFE COMMUNICATION

The three different topics: discussion of well-planned family, discussion of contraceptive method, and discussion of number of children wanted were used to measure the level of communication between husband and wife.

7.5.1 Demographic factors

a) Age of the wife

NFHS showed that young women (age 15-19) and older women (age 40-49) were less likely to discuss family planning than women in the 20-39 year age group (NFHS, 1996). In this study, the women in age 15-19 group and 30-35 group did not discuss the WPF, number of children desired or contraceptive methods with their spouse. The topic most likely to be discussed with their spouse, for the women in the 20-30 years old age group, was the WPF followed by the number of desired children, and then finally the preferred contraceptive method. These results suggests that participants were not discussing contraceptive methods as frequently as other topics. One study in Nepal showed that women 25-34 years old were communicating more with their spouse about family planning and the number of desired children than women under 20 years of age (Banjade, 1994). Studies have shown that the age of the wife influences and determines when husband and wife communication begins. The younger the wife or the older the wife, the less communication there is between the husband and wife (Makomva, et. al., 1991).

b) Age at marriage

Studies show that if the women are young at marriage they communicate less frequently with their spouse. De Silva reported that in Sri Lanka women who married before the age of 20 were the largest group (28%) who had never discussed family planning with their husbands (De Silva, 1994). In this study, participants whose age was below 19 years old showed a high level of communication with their spouse. The topic most discussed was WPF, followed by contraceptive method and number of children. A similar result was reported in a study

conducted in Nepal where a high level of communication of family planning and the desired number of children was reported (Banjare, 1994). More participants reported having discussed the WPF, perhaps because they got married at a very young age. There was less use of a contraceptive method among the young group who did not have children or who had a small family (Aryal, 1996). Because there is less use of a contraceptive method among the young age group, the possibility of a pregnancy is very high. Many of the young couples would have reached their ideal number of children when they were still young, as seen in this study. Because they want fewer children and are still young, they have to start thinking about how to take care of the family. This may be the main reason for couples having discussed the WPF more then the other topics.

c) Ethnicity

Nepal is a country with more than 70 different ethnic groups. Each ethnic group has its own cultural values and beliefs. These ethnic groups can be broadly divided into two groups, the Tibeto-Burman group and Indo-Aryan group (Bista, 1979). The Tibeto-Burman group are known to be more open and liberal. In Tibeto-Burman communities, women enjoy greater autonomy and higher status than in the Indo-Aryan group (Pradhan, 1989). In Tibeto-Burman group a higher level of communication between spouses would be expected. Some of the ethnic groups falling in this group are Magar, Rai, Gurung, and Tamang.

The Indo-Aryan group is a more conservative Hindu group, where women have very little control over the important matters of life such as choice of partner or economic independence, so the status of women is generally low (Pradhan, 1989). The men in this group make all the decisions. Therefore, very little communication between spouses takes place in this group. In this study, the majority of participants belonged to the Tamang ethnic group. The level of communication between husband and wife was comparatively high in this study at baseline. The topic most discussed was the WPF, followed by contraceptive method, and then the number of children desired. Ethnicity can be an important predictor of level in husband and wife communication.

d) Religion

Ethnicity is closely related to religion in Nepal. As ethnicity plays an important role in husband and wife communication, so does religion. Brahmins and Chettri belong to the Hindu religion and the Mongoloid ethnic group i.e. Tamang, Rai, Gurung, Magar are generally Buddhist or Buddhism influenced Hindu religion (Pradhan, 1989). The frequency of spousal communication about family planning differs between different groups. In the conservative Hindu and Muslim religions males are dominant with all the major decisions being made by the male in the family. In the Mongoloid ethnic group, women play a dominant role. A majority of the participants in this study group was Buddhist. There was a high level of communication among the couples in this study. Banjade reported that in Nepal spousal communication was higher among Buddhist region people compared to Muslims (Banjade, 1994). In Sri Lanka it was found that inter-spousal communication was greater among Christian couples then Muslim couples (De Silva, 1994).

e) Education

Education of both husband and wife plays an important role in husband and wife communication. Many studies have reported a positive relationship between level of education and husband and wife communication (Turner, 1991; De Silva 1994; Campbell, 1985; Gbolahan and McCarthy, 1991; Banjade, 1994). This study has also demonstrated a positive relationship between the level of education and husband and wife communication. Participants who did not attend school also had a relatively high level of husband and wife communication. This may be because a majority of the participants who attended school had only some primary schooling. Therefore, there was really no difference in the reporting of husband and wife communication for those who had attended school versus those who had not attended school.

7.5.2 Source of decision-making and number of children factors

a) Decision of marriage

The participants who decided on marriage for themselves were more likely to discuss the WPF, contraceptive methods and the number of children desired with their spouse. The majority of participants whose marriage was decided by their parents, discussed the WPF but few

discussed contraceptive methods and the number of desired children. The type of marriage affects a woman's influence over her husband and the power of communicating with her husband. If a woman can choose her husband, she usually has more influence within her marriage than if her family chooses her husband (Gage, 1995). Women who chose their husband reported a higher level of inter spousal communication on family planning than those who had an arranged marriage (De Silva, 1994). Couples who have an arranged marriage are unknown to each other and perhaps have not yet developed the kind of intimacy required to discuss family planning. Thus they might be embarrassed to discuss of family planning among themselves. In Nepal, in the Tibeto-Burman ethnic group a greater proportion of marriages is either by the couple's own choice or by capture (boy makes the girl his wife by force without her consent). Arranged marriages is a very common form of marriage among the Indo-Aryan ethnic group (Pradhan, 1989).

b) Decision maker in the family

In many developing countries, husbands are the sole decision-makers in family and reproductive matters (Isiugo-Abanihe, 1994; Ezeh, 1993; Gbolahan and McCarthy, 1991; Mitchell, 1972; Makomva et. al., 1991). In this study, the participants who reported the husbands as the decision maker reported discussing the WPF with their spouse, and half reported discussing of the number of children wanted and contraceptive method with their spouse. The high level of communication between spouses may be because the majority of the participants belonged to a liberal ethnic group. The other interesting result is that the participants who reported their mother-in-law was the person to decide in the family did not discuss the WPF, contraceptive method and the number of children in the family. In families where elders make decisions the communication between spouses is likely to be less. Usually in a joint family, where all the family live together, the elderly person is the head of the family. He or she decides everything for the family. In the rural part of Nepal, mothers-in-law still have great influence in deciding the use of contraceptives and the number of children couples should have.

c) Number of children present/desired no of children

The results showed that in spite of the differences in the ideal number of children, the

discussion between the husband and wife about the WPF, number of children and contraceptive method increased dramatically in the PTI. The improvement of communication between spouse was more obvious among the participants whose ideal number of children was two. The results show that there has been improvement in husband and wife communication which may have resulted from the intervention.

In this study, participants with two living children reported more discussion about the WPF, contraceptive method and number of children wanted with their spouse than the participants who had one or no children. The majority of the participants' ideal number of children was two and many of them already had given birth to two. During the workshop they learned the importance of husband and wife communication which may have encouraged them to communicate with their husband. There were more participants who had discussed the three topics with their spouse after the intervention. Women who do not want any more children appear to communicate more with their spouse and use family planning method regardless of how many children they have (Mitchell, 1972).

d) Number of living son

The participants with one living son discussed the WPF, the number of children wanted and the contraceptive method with their spouse than the other participants who did not have a living son both at the PRI and PTI. Among the participants who had no son the least discussed topic was contraceptive method in the PRI but after the intervention the number increased dramatically. Perhaps the participants understood that to have a WPF, the number of children, and spacing between birth is very important. To achieve that there should be understanding between the couple and communication is important in order to reach that understanding.

e) Person deciding the use of a contraceptive method

The majority of the participants who said using a contraceptive method should be a joint decision also reported more discussion with their spouse in the PRI and that increased dramatically in the PTI. Studies have shown that couples with higher education and higher socio-economic status tend to say that decisions about contraceptive use should be joint ones and that there is higher communication between the couples (Turner, 1991; De Silva 1994;

Campbell, 1985). The participants of this study are from a low socio-economic background with very little education. However, the high level of communication may be because they live by themselves, and no other family member except the children live with them in the factory premises. Therefore the couples have to rely on each other to decide anything which may have become the norm of life. The intervention may have reinforced the level of communication as in the PTI there was increase in number of participants who reported of having discussed the three topics with their spouse.

Chapter 8

Conclusions and Implications

Joyi poyi milepachi kasyaiko kehe lagdaine

'If husband and wife are together, no one can do anything'

8.1 CONCLUSION

The conceptual framework for this research proved to be very strong because it was constructed from a number of different well-proven models in health communication. It provided excellent grounding for all of the key elements of the health communication intervention. The important elements of the different theories and models were brought together in the framework to influence the intervention design which resulted in changes in knowledge, attitude, and husband and wife communication among the carpet factory workers. By observing the actors in the role play and practising KURAKANI model themselves, the participants' perceptions of their own self efficacy in communicating with their spouse about the well-planned family and making a joint decision about contraceptive methods have increased.

The first part of the intervention gave the participants the opportunity to learn about different contraceptive methods, how they work, their relative effectiveness, the benefits, drawbacks, and body responses, the reproductive system, and the person responsible for the sex of the baby. The first two workshops of the intervention design were important, but proved less powerful than the third part of the intervention. On the other hand the demonstrated gains

in knowledge and changes in attitudes due to the first workshops should not be underestimated. Clearly certain features of these two workshops could be retained in the redesign of a single workshop in the future. Important changes in contraceptive knowledge, attitudes, skills, practices, and social norms were demonstrated as a result of the carpet factory workers' participation in the all three phases of the health communication intervention.

Both spontaneous and probed naming of the different contraceptive methods and their benefits improved dramatically compared to the naming of drawbacks and body responses following the intervention. In Nepal, due to the huge number of clients the family planning providers have to attend to, they have limited time to spend with each client. It is not possible for the provider to explain each contraceptive method to the client due to time constraints. Therefore, it is important for a person to be well informed about the different contraceptive methods for the couple to make an informed choice. The intervention also resulted in a measurable shift towards more positive attitudes about contraceptive methods, the users of contraceptives, son preference, the well–planned family, and husband and wife communication.

The intervention has helped the participants understand that the man is responsible for the sex of the baby. The male participants have recognised their important role. In Nepal, if more men and women are helped to understand that the father determines the sex of the baby, then perhaps where sons are preferred, this understanding will reduce the blame put upon women when a girl is born to a couple.

The intervention has increased the participants' knowledge about places where different contraceptive methods were available. This finding has important implications for access to services. The study's findings suggest that when the workers know where they can obtain the different methods, the chances of them obtaining and using a contraceptive method will probably increase.

The primary strength of the intervention was the KURAKANI husband and wife communication model used in the third step in the intervention. The couples appear to have understood that husband and wife communication is an important factor for a well-planned family. The understanding of a well- planned family improved after the intervention. The

participants' understanding of well-planned family moved beyond the traditional thinking of having few children to a broader notion of well-planned family, i.e. planning the number of children they want, timing of the birth, sharing equal responsibility and opportunity between husband and wife, and demonstrating comfortable communication between husband and wife on all topics.

Good communication skills are essential for good communication. The four steps of the KURAKANI model provide the couples with a set of new and varied communication skills that they practice and adopt in their every day conversations to improve their couples communication. The intervention clearly had an impact on strengthening the couples' communication skills. The KURAKANI husband and wife model has influenced the participants to communicate more effectively with their spouse. KURAKANI gives couples the tools for knowing how to talk with each other, how to listen to each other, how to discuss options, and how to ultimately make a joint decision, together. KURAKANI proved to be an effective tool for enabling couples to communicate with each other about the well-planned family, contraceptive decision making and potentially about other domestic issues, for example, money issues.

The KURAKANI model enabled the couples to understand that it is very important to communicate with their spouse in order to understand his/her opinion and that they should not feel shy to talk with their spouse. By communicating with each other the couples were able to know their spousal approval of using a method, the desired number of children and spacing of the children. This made it easier for the couples to make a joint decision in choosing a suitable contraceptive method and planning for a well-planned family.

For example, one of the participating couples had two children. The wife did not want any more children, but the husband wanted another child. The woman had been using the injection Depo-Provera as her method for two years. The injection was the first method she had heard of and because her friends told her it is good she started using it. Following the couple's participation in the intervention and KURAKANI, the couple talked with each other about the number of children they wanted and when to have the next child. Both agreed to plan a child in a few years time. The couple made a joint decision to use Norplant and the wife had the

implant a few days following KURAKANI. This is a very good example showing that husband and wife communication is an important factor in decision making of a contraceptive method, however, education about the well-planned family and correct, but targeted information about the methods also play an important role in helping couples make an informed choice.

There are a number of practical lessons learned from the study that should be considered for future intervention research and/or health communication programmes in Nepal and potentially, elsewhere. The strengths of the intervention as well as recommended changes for the redesign of the intervention to further strengthen it are based on the lessons learned from the evaluation results. The key lessons learned are summarised as follows.

The majority of the research participants were from one ethnic group. Each ethnic group has its own cultural and religious beliefs. On the one hand, working with one ethnic group makes it easier to understand and interpret their cultural and religious beliefs. On the other hand, working with one cultural group in a country like Nepal with multiple ethnic groups restricts the generalisability of the intervention and potential results.

Working with a captive audience, who live in one area proved advantageous, but has its limitations as well. All of the couples who participated in the intervention lived in the factory premises. Therefore it was logistically convenient to approach them and bring them together for the workshops. If the couples had come from different geographical areas in the city it would have been more difficult to bring them together for the workshop. However, one potential disadvantage of working with a captive audience is the risk of contaminating the results. Since the participants for this study lived within the factory premises they talked and shared with each other about the things they learned during the workshop. It was impossible to keep the couples who participated in the KURAKANI workshop from talking with their friends. In health promotion practice, however, sharing information and the 'contamination' of the strengths of a health communication or intervention can be highly desirable. In practice, the health promoter would want, 'the good news' about a new way of doing something, in this case the KURAKANI model. The health promoter would be please if many more couples then started using the KURAKANI model to communicate with each other, even those who were

not able to attend the workshop.

8.3 IMPLICATIONS

The following implications can be drawn from the research findings

8.3.1 KURAKANI husband and wife communication model

- Husband and wife communication is one of the main factors influencing the well-planned family and the proper use of contraception. It may not be easy to promote husband and wife communication in Nepal where women are often not included in making important family decisions and where women rarely talk to their husbands about contraceptive methods. Nevertheless, based on the success of KURAKANI, husband and wife communication should be considered a key focus of government's population communication programmes in the future.

- The KURAKANI husband and wife communication model was shown to be an effective model in teaching couples how to communicate with each other to make a joint decision. The KURAKANI workshop was professionally video taped. This video can be edited and used to produce a curriculum for teaching couples how to communicate. The National Health Education, Information and Communication Centre of the Ministry of Health for example, could adopt the KURAKANI model and develop a training program for its health workers to help them learn the KURAKANI techniques for teaching couples' communication. Staff in turn, could use the video to hold small workshops for married couples to teach husband and wife communication skills.

- The KURAKANI husband and wife communication model is not only effective for contraceptive decision making but can also be adopted for other family decision making, for examples, money issues and other domestic issues.

8.3.2 The national well-planned family/family planning programme

- The Ministry of Health, the INGOs, and the NGOs should explore different and more basic approaches for sharing information about the contraceptive methods. The information should be simplified and 'package' to include how the method works, the benefits, drawbacks, body responses, and outlet for the methods. Just knowing the names of different methods does not help couples choose a suitable contraceptive method.

- The Central Carpet Industry Association, RugMark Foundation, and the Step Foundation should be encouraged to provide access to well-planned family planning information and contraceptives for their workers. In this study, improved attitudes towards the well-planned family concept and contraceptive methods as well as the willingness and expressed intentions to use after the intervention strongly suggest probable use of contraceptive methods in the future. Therefore this population is an ideal population for information dissemination about contraceptive methods.

- It is time to move away from the traditional use of the term 'family planning' because of its narrow connotations and to institutionalise the term 'the well-planned family' that provides a much broader view. The Ministry of Health, INGOs, and NGOs should start using well-planned family (*bewasthite pariwar*) rather than family planning (*pariwar niyojan*) in all of their programme work.

- The meaning of the well-planned family shifts throughout our reproductive lives. Well-planned family/family planning providers should talk with their clients about how the notion of the well-planned family changes throughout the life cycle.

- In some health facilities in Nepal, men are not allowed to accompany their wife when they seek help for a contraceptive method. The well-planned family/family planning providers should include husbands in the discussions with the wives about choosing and deciding on a contraceptive method. The chances of method continuation are likely to be higher if it is the couple that makes the decision about the contraceptive method. Chances are also greater that the husband will support and take care of his wife if she experiences any of the

body responses.

- The national well-planned family/family planning programme should give importance to husband and wife communication. The importance of husband and wife communication and the different communication skills to support good husband and wife communication should be disseminated through the mass media, i.e. television, radio, local papers, as well as through interpersonal communication channels, such as well-planned family/family planning providers, family welfare assistants, and volunteer health workers.

- The FM radio is broadcast only in the Kathmandu valley and is very popular. This radio station would be an excellent mass media channel for disseminating the well-planned family messages to the Kathmandu population.

- The service providers should start using specific words *sharirik asar* meaning 'body response' and *Hani* meaning 'drawback' so that the clients understand the differences between body response and drawbacks.

8.4.3 Future research on husband and wife communication in Nepal.

- In the future, this research could be repeated with a larger sample in different carpet factories (captive audience), in local communities (audience not captive), and with different ethnic groups to test the effectiveness of the KURAKANI husband and wife communication model.

The KURAKANI husband and wife communication model has been recognised as a very useful tool by the intervention participants in enabling the couples to communicate more efficiently and effectively with each other. When asked what they thought about the KURAKANI husband and wife communication model and whether they would use it in the future one of the women who participated in the intervention replied, '*Yes. I will teach my children later. This is a good method.*'

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Appendix 1: Intervention Curriculum

COMUNICATION INTERVENTION

TOPIC: THE ROLE OF HUSBAND AND WIFE COMMUNICATION IN FAMILY PLANNING DECISION MAKING AMONG COUPLES IN A CARPET FACTORY IN LALITPUR, NEPAL

SESSION 1: INFORMATION ON FAMILY PLANNING CONTRACEPTIVE METHODS

TIME: 5 hours

OBJECTIVES:

By the end of the workshop the participants will be able to

1. Name the 8 different methods, (e.g. oral contraceptive, intrauterine device, implant, injection, condom, female sterilisation, male sterilisation, and lactational amenorrhea method)
2. Tell the purpose of using contraceptive methods, (i.e., to space the next birth, to limit the family size and to delay the first birth.)
3. Differentiate between the methods used for spacing birth and limiting birth and name the method used by the woman and the methods used by the man.
4. Tell how the different methods work, their benefits and draw backs, how the body responses (side effects), when to see the health personnel.
5. Name the different service centres where they can receive the methods free of charge and where they can buy them.
6. Develop the confidence to explain the 8 different methods to their relatives and friends if needed.

MAIN POINTS:

1. Information on 8 different contraceptive methods 1) Oral contraceptive, 2) Intrauterine device, 3) Implant 4) Injection, 5) Condom, 6) Female sterilisation, 7) Male sterilisation, 8) Lactation amenorrhea method

- What is it?
- How does it work?
- Considerations: it's benefits and draw backs
- How the body response to the method(side effects)
- Where the methods are available
- When to contact the health personnel

MATERIALS:

- Flip chart with the methods
- Family planning posters
- Pamphlets on the 8 different methods
- Picture of a men and a women
- Photocopies of the 8 methods

(Notes: the changes made in the curriculum, after reaching Nepal are given in italic)

CONTENT	METHODS
To become familiar with the group so that they can feel at ease.	**CHINAJANI(introduction)** **Purpose:** 1) To know the facilitators, get some idea what their work is and how they can help the participants during the workshop. 2) Some participants know each other and some don't. This exercise is to introduce participants to each other and to help each participant to know other participants better. Time: 30 minutes Ask the participants to sit in a semi circle so that everyone can see everyone. The researcher will introduce the 4 facilitators, the assistants to the participants. All the 12 couple will be present for the introduction. The researcher will ask each couple to stand up in turns. Ask the husband to introduce his wife and the wife to introduce her husband to the group. Tell them to say the person's name what is the best thing he likes to do. (*Very difficult to make the couples stand up and introduce each other to the group. So requested the husband to say his name and his wife's name,)* Then after the introduction the husbands and the wives will be divided into two groups. The workshop will be conducted in two rooms with the husbands in one and the wives in another group.
Introduction to the structure and function of the female and male reproductive system. **Male reproductive organs and it's functions** **Internal parts** (CEDPA, 1996)	**Body Mapping exercise** Purpose: This will help the participants to understand the structure and function of the

Penis: The male organ for sexual intercourse.

Scrotum: The pouch located behind the penis which contains the testicles, provides protection to the testicles, controls temperature which is necessary for sperm production and survival.

Internal parts

Testis: Two round glands lying in the scrotum that produce and store sperms from puberty onwards. Testis also produces the male hormone responsible for male characteristics and sexual performance.

Vas deferens: a thin and long tube that carries sperms from each testis to the urethra.

Seminal Vesicles: Two sacs like structure lying behind the urinary bladder. It secretes a thick milky fluid that forms part of the semen.

Prostrate gland: A gland located in the male pelvis that secretes a thick milky fluid that forms part of the semen.

Erection of Penis: In response to thoughts, fantasies, temperature, touch or sexual stimulation, the penis fills with blood and becomes hard and erect for sexual intercourse.

Ejaculation: The release of semen from the penis after sexual excitement is called ejaculation. This might occur at night during sleep and is called *Sheet Nindra* in Nepali (meaning wet sleep). But this is a normal phenomenon.

Female reproductive organs and it's functions

External parts consist of (CEDPA, 1996)

male reproductive system.

Time: 20 minutes

The facilitator ask a volunteer to draw a outl of a male body and the visible parts of the bo on a new script

1. eye, nose, mouth, ears
2. the reproductive organs

After the volunteer has finished drawing th facilitator will use the drawing to show th penis and scrotum are the two parts that visible but there are other parts of reproducti parts which cannot be see from outside an those parts are called internal parts.

Using the picture of the male reproductiv organs, the facilitator will explain to th participants the structure and functions of th different parts of the male reproductive organs

Video Show

(*Was not possible due to lack of power point*

Vaginal opening: located between the urethra and the anus opening It is the opening for penetration of penis during intercourse.

Labia Majora and labia Minora: Two sets of folds on either side of the vaginal opening, the outer one is called Labia Majora and the outer one is called labia Minora. It provides protection to the clitoris and the urethra and vaginal openings.

Clitoris: A small round fleshy structure located above the urethra opening, at the point where the labia meet. It is the focal point of sexual stimulation for the female.

Internal parts

Vagina: Passageway extending from the outside of the body to the uterus. Canal through which a baby passes during delivery, passageway for the menstrual flow to the outside and place where intercourse occurs. Capable of expanding during intercourse and childbirth.

Cervix: The opening of the Uterus that protrudes into the uppermost part of the vagina.

Uterus: A pear shaped muscular organ located in the pelvic region. When pregnant baby develops inside the uterus. During each menstrual cycle the inner lining of the uterus sheds away which causes bleeding.

Fallopian tube: Two thin tubular structures arising from the upper part of the uterus and having funnel shaped free ends. It is the passageway for the egg from the ovary to the

instead used Maggie's apron and poster)

Purpose: This will help the participants to understand the structure and function of the female reproductive system .It will also be easier for them to understand how a method works

Time: 20

The video has very good illustration of the female reproductive parts the participants will look and listen to the video.

(Maggie's apron has a window in the front. When a woman wears the apron the window lies just in front of the lower abdomen so it helps the participant to understand the internal position of the internal reproductive parts. The poster used had very good pictorial illustration that also helped the participants to understand better.)

After the video the facilitator will ask the participants if they have any questions, they can ask. The facilitator will answer their questions if they have any.

(After explaining about the different reproductive parts with the help of the Maggie's apron and the poster, the facilitator asked if there were any questions)

uterus .It is the place where fertilisation takes place.

Ovaries: It is an oval shaped structure located on either side of the uterus. It contains many immature egg cells. The numbers of egg cells are determined at birth. It produces female hormones. Maturation and release of egg begins after puberty

Ovulation: It is the release of the mature egg from one of the ovaries into the fallopian tube. It occurs once a month after a girl reaches puberty.

A woman can become pregnant only if she ovulates. Usually only one egg is released ovulation. Sometimes, two eggs are released at the same time. If this happens and both eggs are fertilised twins will be born.

MENSTRUATION also called *Nachune* in Nepali. It is the periodic shedding of the uterine inner lining. *Nachune* begins at puberty (about 13 years of age in Nepal) and continues till menopause (early 50s of age). It occurs every 21 to 35 days and the bleeding lasts 3 to 7 days.

Stages of menstruation:

Getting ready stage (Secreting stage)

: Begins after the ripe female egg is ready to be released from the ovary. The lining of the uterus gets prepared to receive a "guest", the fertilised egg that will form the baby. Blood supply to the womb is greatly increased to provide nourishment for the "expected guest.

Video/poster explanation

(only posters used)

Purpose: to make the participants understand the process of ovulation, different stages of menstruation and the changes occurring in the uterus during these stages and what does fertilisation mean.

Time: 15 minutes

A video clip, which shows the process of ovulation and fertilisation, will be shown to the participants.(*as the video could not be used only the poster was used)*

The facilitator will explain the different stages

Weeping Stage (Menstruation stage)

If the male sperm and the female egg do not meet, the egg will die. The womb will be disappointed, as the "expected guest" will not come. The womb therefore weeps, releasing all it's lining and blood (the nourishment prepared for the expected guest). The lining and the egg are shed, passing out of the body through the vagina. This is called the menstrual period.

Building up stage: (proliferate stage)

Having shed the lining and the blood, the womb begins to prepare for the expected guest again. It does this by building up its lining.

Fertilisation: When a male sperm and a female egg meet that is called fertilisation. Millions of sperm cells are deposited into the vagina during sexual intercourse. The sperm cells swim up through the cervix into the uterus, and reach the fallopian tubes seeking an egg. If an egg is present, fertilisation can take place. Although thousands of sperm may be present, only one sperm cell can penetrate the egg. The fertilised egg moves through the fallopian tube into the womb where it will grow.

Conception

Conception means to become pregnant. It takes place when the sperm cell and the egg fertilise and it grows into a baby.

of menstruation, the different changes seen in the womb during these different stages. He/she will use the drawing to explain these processes.

Sex of the baby:

Sperms (male sex cells) are of two types, one has X chromosome and the other has Y chromosome. An egg (female sex cell) are of one type only, it has X chromosome. When an egg meets a sperm with Y chromosome a male is born (XY) When an egg meets a sperm with X chromosome a female is born (XX). This happens by chance but not by choice. Because the males have two types of sperms, he is responsible for the sex of the baby.

Beans game:

Purpose: to make the participants realise that believe that man is responsible for the sex of the baby but not the woman. Even though men are responsible for the sex of the baby they cannot determine the sex of the baby. This happens by chance but not by choice.

Time: 15 minutes

The facilitator will explain to all the participants that there are two bags, one representing female and one representing male. A green pea represents the X chromosome and a kidney bean represents the Y chromosome. In the female bag there are green peas only and in the male bag there are equal number of green pea and kidney beans. The facilitator will go to each participant and ask him/ her to put his/her hand in the bag and pick up one bean from each bag. Ask all the participants with two green peas to stand in one group and all the participants with one green pea and one kidney bean to stand in another group. Ask the participants, the group with two green pea represent which sex of the baby and why

The facilitator write in the new script paper

Green pea (X chromosome) + Green pea (X chromosome)=Female (this answer should come from the group)

Ask the participants, the group with one green pea and a kidney bean represent which sex of the baby and why? The facilitator write in the

new script paper

Green pea (X chromosome) + Kidney bean (Y chromosome)=male (this answer should come from the group)

The facilitator will reinforce once again that sperms (male sex cells) are of two types, one has X chromosome and the other has Y chromosome. An egg (female sex cell) are of one type only, it has X chromosome. When an egg meets a sperm with Y chromosome a male is born (XY) When an egg meets a sperm with X chromosome a female is born (XX). This happens by chance but not by choice. Because the males have two types of sperms, he is responsible for the sex of the baby.

TEA BREAK (serve tea and snacks for both group in the same room, so that they can talk and discuss what they have learnt)

Discussion and Brainstorm

Purpose: is to find out what the participants know about a well-planned family.

Time: 10 minutes

Ask the participants to choose the person sitting next to her/him. Let them spend 5 minutes learning about one another's opinion on a well-planned family, what is their ideal family size, how many children they have.

The facilitator asks the participants how they

he Well- Planned family

- Plans the number of children they want to have
- Plans the timing of the birth.
- Demonstrates comfortable communication between husband and wife on all topics
- Shares equal responsibility and opportunity between husband and wife

Modern contraceptives are two type

Temporary and permanent. Temporary methods prevent pregnancy for as long as they are used. Couples mostly use it for spacing birth or when postponing births but it can also be used by couple who don't want any more children.

There are 6 temporary methods

- Oral contraceptive
- IUD
- Implant
- Condom
- Injection
- LAM

Couples who are sure they do not want any more children in the future use permanent methods.

There are 2 permanent methods

- Male sterilisation: Vasectomy
- Female sterilisation: Laparoscopy/Mini laparotomy

Will be discussing these methods in full detail later

Contraceptive methods for female are

- Oral contraceptive

can have a well-planned family and note the responses from the participants.

Knowledgeable game

Purpose: is to find out whether the participants can differentiate the methods according to the temporary and permanent method, and the method used by male and the method used by female.

Time: 35 minutes

Ask the two assistants to stand in two corners, one represent temporary methods and the other will represent permanent methods. Tell the participants which corner stands for temporary method and which corner stands for permanent method.

Place one set of photocopies on the floor with the picture facing to the ground. Ask each participant to pick one of the papers and identify whether it's a temporary or a permanent method. Tell them to go and stand in the group where she/he thinks the method belongs to. (temporary and permanent methods). Facilitator checks with the participants to see they have chosen the right group. Note the responses.

The one of the assistance will now represent male methods and another will represent female method. Then ask the participants to choose one

- IUD
- Implant
- Injection
- LAM
- Laparoscopy
- Mini lap

Contraceptive methods for male are

- Condom
- Vasectomy

paper with the method. This time ask them to differentiate the method by who uses the method, male or female? The facilitator will check that they have not made a mistake. Note the responses.

The facilitator will tell the participants, which are the temporary and permanent methods, method for female and method for male. If the participants made a mistake when playing the game, tell the group and tell them the correct answer.

Purpose: Facilitator has to cover eight different contraceptive methods in a short time period. To save time but at the same time to make sure the participants learn about the 8 methods, the group is divided into 2 smaller groups and each group covers 4 methods and later share with the other group.

Time: 10 minutes

Divide the participants into two groups. Make the participants stand in a circle. Ask each participants to say A and B alternately. The facilitator will ask all the participants with A to make one group and all participants with B to form another group. One facilitator will facilitate group A and the other facilitator will facilitate group B. The facilitator for group A will tell his/her group about four contraceptive methods (Oral contraceptive, IUD, vasectomy, and LMA). The other facilitator will tell the

ORAL CONTRACEPTIVES (OC)

(CEDPA, 1996; WHO,1994)

What is Oral contraceptive

It is also known as Pills. The woman takes the pills by mouth.

How it works

The pills stop the egg from leaving the ovary every month. It thickens the cervical mucus, which prevents sperm from entering the uterus.

group B about four contraceptive methods (Condom, Implant, Injection, and Female sterilisation). The two groups will go to the two corner of the room for the discussion.

For Group A

Brainstorm and sharing information

Purpose: to assist the knowledge of participants on OC and add new information and reinforce the knowledge of OC among the participants. If they are well informed about the method, it will be easier for them to choose a method.

Time: 25 minutes

The facilitator will show the sample packet of the oral contraceptive to the participants. Pass it round to the group so that they can see what it looks like. The Facilitator will ask the participants to share with the group what they know and have heard about OC. The facilitator note the responses given by the participants

The facilitator will then tell them about the OC While telling them about OC he will tell the participants what they knew and add the new things which the participants were not able tell If they have any wrong concept about the method the facilitator will correct it (*Very few responses from the participants so the facilitator had to do most of the talking. Facilitator did put questions and asked them question in between to see if they have*

understood.)

The facilitator will show the group, the white pills and the brown pills on the sample packet. Tell the participants that the white pills have hormones and the brown pills don't have the hormones it is a reminder only.

If they forget to take the white pills there is possibility of getting pregnant but if they forget to take the brown pill it does not matter. Tell them to start taking the pills from the white pills. When they decide to start taking the pill, count the day you start bleeding as the first day. Then start to take the pill from the 5th day of your menstruation. When the white pills finishes then take brown pills.

OW TO USE IT

When you start taking the pill, count the day you start bleeding as the first day. Then start to take the pill from the 5th day of your menstruation.

You should take a pill every day, preferably at the same time. Keep the pills where you will see them while doing a daily routine like brushing your hair before going to bed.

If you forget to take a pill, you should take one pill immediately after you remember and the next pill at the usual time.

If two or more pills are missed, you should stop taking them for a week, then start a new pack. A backup method e.g. condom should be used for the week without the pills and for the first week with the new pack.

When the pack is empty, start taking pills from a new packet with out leaving a day.

FFECTIVENESS

The facilitator will tell the participants, the effectiveness of a method will depend on how one use the method so that they can prevent unwanted pregnancy. Effectiveness of a method can be divided into three groups.

The facilitator will draw 10 groups of women; each group has 10 women. Tell the participants there are all together 100 women. When explaining **very effective** the facilitator will tell the participants that when the women are using

e effectiveness of a method depends on the es of unintended pregnancies among users of ious family planning methods in the first 12 nths of using that method. Two rates are orted for each method. One is the pregnancy e for the method as **commonly used** the

average or typical rate. The other is the pregnancy rate when the method is **used correctly and consistently**. This is the best rate that a user can expect from the method.

The effectiveness of a family planning can be divided into 3 groups, **very effective** (0-1 pregnancies per 100 women in the first 12 months of use), **effective** (2-9 pregnancies per 100 women in the first 12 months of use), **somewhat effective** (10-30 pregnancies per 100 women in the first 12 months of use),

When **used correctly and consistently** OC is **very effective** (0-1), when **commonly used** OC is effective (6-8)

a contraceptive method for 12 months and if no or one women from these 100 women g pregnant then that method is considered as ve **effective.** While telling them he/she should al draw and show the participants so that it mak them understand more clearly. The facilitat explains to the participants **effective** th facilitator will tell the participants that when th women are using a contraceptive method for 1 months and if two to nine women from thes 100 women get pregnant then that method i considered as **effective.** The facilitator explain to the participants **somewhat effective** th facilitator will tell the participants that when th women are using a contraceptive method for 1 months and if ten to thirty women from thes 100 women get pregnant then that method i considered as **somewhat effective.** Whil telling them he/she should also draw and sho the participants so that it makes them understand more clearly

When **used correctly and consistently** OC i **very effective** (0-1), when **commonly used** OC is effective (6-8)

Use the picture of the female to explain abou the benefits, draw backs and response of th body to the method. Start from the head then g towards the leg. This will help the participant t remember

BENEFITS

- Very effective when used correctly
- Reduces the risk of breast tumours, ovarian and uterine cancer, pelvic inflammatory

disease, ectopic pregnancy, and ovarian cysts.

- May decrease: pre-menstrual syndrome, acne, bleeding, anaemia,
- Periods are more regular and reduces menstrual blood loss and therefore prevent anaemia
- Does not interfere with lovemaking.
- Mini-pill can be used while breast-feeding.
- Can be used as long as a woman wants to prevent pregnancy, no rest period needed.
- Can be used by any age group from adolescence to menopause.
- Users can stop using pills at any time.

DRAW BACKS

- Does not protect against STD's and AIDS
- Some women think it as a problem, to take the pills daily
- May reduce the quantity of breast milk (the combined pills)
- Return to fertility slightly delayed (2-3 months after stopping using pills)
- Not highly effective unless taken every day.
- New packet of pills must be at hand every 28 days.

Contraindication

- Cannot be used by those with a history of: breast cancer, blood clots or at risk to develop blood clots, liver disease, kidney disease, unexplained uterine bleeding, smokers over age 35, melanoma (a type of skin cancer).

- Should not be used by those with:, high blood pressure, diabetes, migraine headaches, depression, ,

Common body responses include:

Nausea, mild headaches, breast tenderness, mood swings, depression, spotting or bleeding in between periods the first few months, sometimes absence of periods, weight gain, increased appetite, skin problems.

Rare body responses

Cause stroke, blood clots in deep vein of the legs or heart attack.

Routine Follow up

The women should return to the health centre any time before her supply runs out. If she has any concerns or questions should not hesitate to see a health worker.

See a health care provider immediately if

You experience any of the following:

severe headache;

sudden vision changes such as blurred vision or seeing double;

skin or eye jaundice (yellowing);

chest pain; shortness of breath

sudden abdominal,

leg pain or swelling

Where to get it

They are available free at the

- Health post

Use the picture of the women to explain when they need to see health personnel. Start from the head towards the leg. It will be easy for them to remember.

- Sub health post
- Public health centres
- Public hospitals
- Through Volunteer health worker and female volunteer health worker
- Through Non Governmental organisations and community health programs
- be purchased at a low price from
- Medical shops
- Private clinics

ACTATIONAL AMENNORRHOEA ETHOD (LAM) (CEDPA, 1996; WHO,1994)

hat is it

east feeding can be a contraceptive method if following three conditions are met:

- Baby is less then 6 months
- Mother has not started her periods after delivery
- The mother is breast feeding at least six times a day including night feeds and not supplementing with other food.

OW IT WORKS

AM delays the ovulation with fully breast eding mother

FECTIVENESS

AM is very effective if used correctly and

Brainstorm and sharing information

Purpose: to assist the knowledge of participants on LAM and add new information and reinforce the knowledge of LAM among the participants. If they are well informed about the method, it will be easier for them to choose a method.

Time: 25 minutes

The facilitator will ask the participants to share with the group what they know and have heard about LAM. Note the responses given by the participants

The facilitator will tell them about LAM. While telling them about LAM she/he will tell the participants what the group knew and add the new information that the participants were not able to tell. If they have wrong concept about the method the facilitator will correct it (*Very*

consistently 0.5 pregnancy per 100 women in the first 6 months after birth (1 pregnancy in every 200 women). LAM is effective as commonly used, 2 pregnancy per 100 women in the first 6 months after birth (1 in every 50 women). LAM is less effective after the baby is 6 months old, after the baby is given other food to eat, and after the woman has her periods.

few responses from the participants so t facilitator had to do most of the talk Facilitator did put questions and asked th question in between to see if they h understood.)

BENEFITS

- Easy to use ,does not require medication or supplies
- Free of cost,
- Can be used immediately after birth.
- Health benefits
  - For baby
    - Natural immunisation and protection against infectious diseases
    - Best source for nutrition
    - Decreases incidence of allergic
    - Helps develop close relationship between mother and baby
- For mother
  - Promotes uterine involution soon after birth thus prevents haemorrhage after birth.

Use the picture of the female to explain the benefits, draw backs and the be responses. Start from the head then go towa the leg. This will help the participant remember them

DRAW BACKS

- Does not provide protection against STDs and HIV/AIDS

- Difficult for working mothers.
- Effective for limited duration (as long as the baby is fully breast feeding)

Contraindication:

- If the women menstrual period has returned after birth
- If the bay is 6 months old or older then 6 months
- If the bay is not fully breast feeding
- If the women is not breast feeding her baby
- If the mother is HIV positive or has AIDS

Common body responses

May cause some women to develop soreness or infection in their nipple or beast

Rare body responses

None

Routine follow up

- When Baby is less 6 months old or older then 6 months
- Mother has started her periods after delivery
- The mother is not fully breast feeding and the baby has started to eat other food

Then the woman has to see the health worker to start another method.

Need to see a health care provider immediately if

You think you are pregnant

You want to start another method

If you are no longer able to meet the 3 condition

for LAM

INTRAUTERINE DEVICE (IUD) (CEDPA, 1996; WHO,1994)

What is IUD?

It is a small plastic device that comes in different sizes and shape. A doctor or a trained health worker places the IUD in the woman's womb. The most commonly used copper IUD can be left in place for 10 years.

How does it work?

The IUD affects the movement of the sperm and prevents sperm in joining the egg.

How to use it

Inserting the IUD

Only a doctor or a trained health worker can do inserting of the IUD. It has to done under proper sterilised condition. The health personnel will insert a new, pre sterilised IUD the client has to go to the health centre to get the IUD inserted.

Removing the IUD

The client has to go back to the health centre to get the IUD removed. A well-trained health worker will remove the IUD in the health post under good sterilised condition.

The reasons for removal:

- The client requests removal
- A medical reason
  - Pregnancy
  - IUD has come out of place

Brainstorm and sharing information

Purpose: to assist the knowledge
participants on IUD and add new informa
and reinforce the knowledge of IUD among
participants. If they are well informed about
method, it will be easier for them to choose
method.

Time: 25 minutes

The facilitator will show the sample IUD to
participants and pass it round the room so
everyone can see and touch it

The facilitator will ask them to share with
group what they know and have heard abo
IUD. Note the responses given by
participants

The facilitator will tell them about the IUD
While telling them about IUD she/he will
the participants what the group knew and a
the new things, which the participants were
able to tell. If they have wrong concept abo
the method the facilitator will correct (*Very fe
responses from the participants so
facilitator had to do most of the talking
Facilitator did put questions and asked the
question in between to see if they ha
understood.)*

- Acute inflammatory disease
- Abnormal very heavy bleeding, that puts the woman's health at risk

When the effective life span of the IUD has passed

When a woman reaches menopause

Any body response, which makes the client to want her IUD, removed.

FFECTIVENESS

ry effective as commonly used-0.8 pregnancy r 100 women in first year of use (1 in every 25)

ry effective used correctly-0.6 pregnancy per 0 women in first year of use (1 in every 170)

ENEFITS

- Very effective, very little to remember.
- Requires no attention except for monthly checks for the string.
- Fertility returns immediately upon removal.
- Does not interfere with lovemaking.
- Copper IUD needs to be changed only every 10 years; progesterone IUD needs changed yearly.
- Can be used while breast-feeding

RAW BACKS

- Does not protect against STD's
- Must be inserted by a health care professional,

Use the picture of the female to explain about benefits, draw backs and body responses. Start from the head then go towards the leg. This will help the participant to remember better.

- Must check for string after every period –
- May be expelled without knowing it.
- Pelvic inflammatory disease (PID) is more likely to follow STD infection if a woman uses an IUD. PID can lead to infertility
- Client cannot stop IUD use on her own. A trained health worker must remove the IUD.

Common body responses

- heavy periods and cramps,
- backache,
- spotting between periods,
- May have an increase risk for tubal pregnancy, PID, infertility;

Rare body responses

- Perforation of the wall of the uterus
- Sever cramps and pain beyond the first 3 to 5 days after insertion
- Heavy bleeding causing anaemia

Contraindication

Should not be used by women who have: never had children Have allergy to copper; have artificial heart valve; a history of decreased immune problems; multiple sex partners; a history of pelvic inflammatory disease (PID) or tubal pregnancy.

WHERE TO GET IT

They are available free at the

- Some Health post
- Some Public health centres

- Public hospitals
- Family planning clinic in institutionalised Districts

Routine follow up

Should visit the health clinic in 3 to 6 weeks after insertion of IUD for a check up. Ask her to visit the clinic in 3 months for a routine check up. She can visit the clinic at any time if she has any quires or problem.

NEED TO SEE A HEALTH CARE PROVIDER IMMEDIATELY IF

You experience any of the following:

- The string can no longer be felt;
- the end of the IUD can be felt at the cervix;
- a missed or a late period; a very light period;
- severe cramping and/or abdominal pain;
- pain or bleeding with intercourse; fever or chills of no known reason;
- more than one sexual partner
- foul smelling vaginal discharge

Use the picture of the women to explain when they need to see the health personnel. Start from the head towards the leg. It will be easy for them to remember.

VASECTOMY (CEDPA, 1996; WHO,1994)

WHAT IS IT

Vasectomy is a voluntary surgical contraceptive method for men. It is a permanent method. Therefore the couple have to be sure they had enough children.

A doctor does this operation. It has to be done in clinic or hospitals with proper infection

Video/discussion *(video not used instead used poster)*

Purpose: to assist the knowledge of participants on vasectomy and add new information and reinforce the knowledge of vasectomy among the participants. If they are well informed about the method, it will be easier for them to choose a method.

Time: 25 minutes

Show the video to the participants.

prevention procedure. A small incision is made in each side of the man's scrotum. Through the incision the small tubes that carry the sperm are cut and tied.

HOW IT WORKS

The tubes that carry the sperm is cut, the sperm cannot reach the egg. Therefore the woman cannot become pregnant.

EFFECTIVENESS

Very effective and permanent as commonly used- 0.15 pregnancies per 100 men in the first 1 year after the procedure (about 1 in every 700)

Even a bit more effective when used correctly 0.10 pregnancy per 100 men in the first 1 year after the procedure (about 1 in every 1000)

Before the operation the man's body will have some sperm stored in the tube .So after the operation it will take time for the body to get rid of all the sperms. Therefore the man or his partner should use another contraceptive method for 12 weeks or the first 20 times they have intercourse after Vasectomy.

BENEFITS

- Very effective
- A man who has had a successful vasectomy no longer need to worry of getting his wife pregnant
- It is a permanent method.
- No change in his sexual function

After the video the facilitator will ask the participants to share with the group what they know and have heard about vasectomy. Note the responses given by the participants. (*Video was not used instead a poster was used to explain about the method. The poster had a picture showing how the method is done.*)

The facilitator will tell them about vasectomy using the pictures of vasectomy. While telling them about vasectomy she/he will tell the participants what the group knew and add the new things that the participants were not able to say. If they have wrong concept about the method the facilitator will correct it

Use the picture of the male to explain about the benefits, draw backs and the response of the body. Start from the head then go towards the leg. This will help the participant to remember them

DRAW BACKS

- Requires minor surgery by a specially trained provider
- Not immediately effective, requires condom use for up to 20 ejaculations or for 12 weeks
- If a man wants a child after he has done vasectomy it is difficult to reverse
- Does not provide protection against STDs and HIV/AIDS
- Most men have a little pain soreness, bruising or swelling after vasectomy which usually goes away after few days

Common body responses

- pain at the incision site
- pain in the scrotum, swelling and bruising of scrotum
- usually uncomfortable for 2-3 days

Rare body responses

- Bleeding or infection at the incision site or inside the incision.
- bruising of discoloration around incision site
- Blood clots in the scrotum.

WHERE TO GET IT

- Hospitals
- Family planning clinics
- Mobile camps
- Some private clinics and nursing homes.

Routine follow up:

Follow up within 7 days or at least within 2 weeks is strongly recommended. A man may

come back in 3 months to get his semen examined, to make sure his semen contains no sperms, and his vasectomy is successful.

NEED TO SEE A HEALTH CARE PROVIDER IMMEDIATELY IF

- Fever within 1 week after surgery
- Bleeding or pus from the wound
- If the pain or swelling around the wound gets worse
- If your partner ever misses a period of thinks she is pregnant. It may mean the operation has failed and your partner might be pregnant.

INJECTION (CEDPA, 1996; WHO,1994)

What is Injection

It is an injection also called Depo-Provera. It is an injection given in the arm or buttock of a woman every three months to prevent pregnancy. It is a temporary method for females.

HOW IT WORKS

An injection, Depo-Provera; containing a hormone, progesterone, similar to what your body produces, prevents release of the egg from the ovary and thickens in cervical mucus making it difficult for sperm to pass through.

EFFECTIVENESS

The effectiveness of a method depends on the

For group B

Discussion

Purpose: to assist the knowledge of participants on Injection and add new information and reinforce the knowledge of injection among the participants. If they are well informed about the method, it will be easier for them to choose a method.

Time: 25 minutes

Show the sample the injection sample to the participants. Pass it round the room so that everyone can see it Ask them to share with the group what they know and have heard about injection. Note the responses given by the participants

The facilitator will tell them about the Injection

tes of unintended pregnancies among users of rious family planning methods in the first 12 nths of using that method. Two rates are ported for each method. One is the pregnancy te for the method as **commonly used** the erage or typical rate. The other is the pregnancy te when the method is **used correctly and nsistently**. This is the best rate that a user can pect from the method.

The effectiveness of a family planning can be ivided into 3 groups, **very effective** (0-1 pregnancies per 100 women in the first 12 months of use), **effective** (2-9 pregnancies per 100 women in the first 12 months of use), **somewhat effective** (10-30 pregnancies per 100 women in the first 12 months of use),

For injection **Very effective** –0.3 pregnancy per 100 women in first year of use (1 in every 333) when injection are regularly spaced 3 months apart

While telling them about Injection she/he will tell the participants what the group knew and add the new things that the participants were not able to say. If they have wrong concept about the method the facilitator will correct it (*Very few responses from the participants so the facilitator had to do most of the talking. Facilitator did put questions and asked them question in between to see if they have understo*

The facilitator will tell the participants, the effectiveness of a method will depend on how one use the method so that they can prevent unwanted pregnancy. Effectiveness of a method can be divided into three groups.

The facilitator will draw 10 groups of women; each group has 10 women. Tell the participants there are all together 100 women. When explaining **very effective** the facilitator will tell the participants that when the women are using a contraceptive method for 12 months and if no or one women from these 100 women get pregnant then that method is considered as **very effective.** While telling them he/she should also draw and show the participants so that it makes them understand more clearly. The facilitator explains to the participants **effective** the facilitator will tell the participants that when the women are using a contraceptive method for 12 months and if two to nine women from these 100 women get pregnant then that method is considered as **effective.** The facilitator explains

to the participants **somewhat** effective th facilitator will tell the participants that when th women are using a contraceptive method for 1 months and if ten to thirty women from thes 100 women get pregnant then that method i considered as **somewhat** effective. Whil telling them he/she should also draw and show the participants so that it makes them understand more clearly

Use the picture of the female to explain about benefits, draw backs and body responses. Star with the side effects from the head then go towards the leg. This will help the participant to remember

BENEFITS

- Very effective
- One injection every 3 months.
- long-lasting,
- helps protect against uterine cancer, ectopic pregnancy,
- safe after childbirth and while breast-feeding.
- May decrease menstrual cramps.
- Does not interfere with lovemaking
- Private, no one else can tell that a women is using it.

DRAW BACKS

- Does not protect against STD's and HIV/AIDS
- Long-acting: fertility returns 6-24 months after last injection.
- Must get an injection administered by a health care professional every 3 months

Common body responses:

- irregular periods,
- loss of interest in sex,

- bloating/weight gain,
- headaches,
- depression,
- nervousness,
- skin rashes or spotty darkening of the skin, and increased body hair;

Side effects last until the medication is out of your system

Contraindication

- Cannot be used by women with: blood clots, breast cancer, liver problems, unexplained uterine bleeding.
- May not be good for women with: family history of breast cancer, abnormal mammogram, irregular or light periods, high blood pressure, migraine headache's, asthma, epilepsy, diabetes, depression, or daughter's with abnormally shaped uterus.

WHERE TO GET IT

They are available free at the

- Health post
- Sub health post
- Public health centres
- Public hospitals
- Through Non Governmental organisations and community health programs
- Family planning clinics

Routine follow up:

Ask her to come in 3 months for the injection, but

if she has any questions or problem she can come at any time.

NEED TO SEE A HEALTH CARE PROVIDER IMMEDIATELY IF:

You experience any of the following:

- severe headaches;
- skin or eye jaundice (yellowing);
- a period which is longer than normal;
- a period which is heavier than normal;
  frequent urination;
- depression

Use the picture of the women to explain when they need to see health personnel. Start from the head towards the leg. It will be easy for them to remember.

IMPLANTS (CEDPA, 1996; WHO,1994)

What are Norplants

It is temporary modern contraceptive method that a woman uses to prevent pregnancy for up to 5 years. Six small capsules, each about the size of a matchstick, which contains hormones These capsules, are placed in the woman's arm surgically by a doctor or a trained health worker. This procedure has to be done under sterilisation, so it has to be done in the clinic or hospital. When the woman wants to stop using the method she has to go to the clinic to get it removed.

HOW IT WORKS

Small capsules containing progesterone, similar to what your body produce, slowly release small amounts of the hormone preventing release of eggs from the ovaries. No egg - no pregnancy. They also cause changes in the lining of the

Brainstorm and discussion

Purpose: to assist the knowledge of participants on implant and add new information and reinforce the knowledge of implant among the participants. If they are well informed about the method, it will be easier for them to choose a method.

Time: 25 minutes

Show the sample of the Norplant to the participants. Pass it round the room so that everyone can see and touch it Ask them to share with the group what they know and have heard about implant. Note the responses given by the participants

The facilitator will tell them about the Implant While telling them about Implant he/he will tell

rus and thickens cervical mucus which vents sperm from entering the uterus

FECTIVENESS

ry effective 0.1 pregnancies per 100 women in first year of use (1 in every 1000). Over 5 ars, 1.6 pregnancies per 100 women (1 in every).

ENEFITS

- Works up to five years
- Fertility returns immediately upon removal of implants.
- Protection within 24 hours of insertion.
- Helps protect against uterine cancer.
- Can be safely used after childbirth and while breast-feeding.
- Does not interfere with lovemaking
- Prevents anaemia
- Can be removed once the women wishes to stop using it

DRAW BACKS

- Requires a small incision and local anaesthesia for insertion and removal, which should be done by a trained person.
- Not advisable for short contraceptive time (one or two year)
- does not protect from STDs and AIDS
- Certain drugs (rifampin and most anti-

the participants what the group knew and add the new things that the participants were not able to tell. If they have wrong concept about the method the facilitator will correct it (*Very few responses from the participants so the facilitator had to do most of the talking. Facilitator did put questions and asked them question in between to see if they have understood.)*

Use the picture of the female to explain about benefits, draw backs and body responses. Start from the head then go towards the leg. This will help the participant to remember

epilepsy drugs) may reduce the effectiveness of implants

Common body responses:

- irregular bleeding
- prolonged periods, light periods,
- decreased interest in sex,
- prolonged time between periods,
- weight changes,

Rare body responses

- headache
- hair loss,
- depression,
- enlargement of ovaries or enlargement of ovarian cyst

Contraindication:

- Cannot be used by women with liver disease, breast cancer, unexplained uterine bleeding, and blood clots.
- May not be good for women with high blood pressure, gall bladder disease, elevated cholesterol,
  irregular periods, light periods, headaches, heart disease, seizure disorders.
- Cannot be used by women who have a history of certain types of high blood pressure, breast cancer, unexplained vaginal bleeding, liver growths, blood clots in veins, meningioma (a type of brain cancer), possible pregnancy

WHERE TO GET IT

They are available free at the

Use the picture of the women to explain when they need to see health personnel. Start from the head towards the leg. It will be easy for them to remember.

- Some Health post
- Some District Public hospitals
- Family planning clinics

outine follow up

o see the doctor or a health worker within a eek to check the incision. No routine follow-up required until it is time for the implant to be moved. She can always come back if she has ny problem or questions.

EED TO SEE A HEALTH CARE ROVIDER IMMEDIATELY IF

ou experience any of the following:

evere headaches

- blurred vision
- swelling pain or bleeding at the implant site; or pain in the arm or hand after the site wound has healed
- a heavier period than normal;
- a prolonged period; a missed period after having regular periods while using the implants;
- severe abdominal pain;

CONDOM (CEDPA, 1996; WHO,1994)

WHAT IS IT

A condom is a temporary contraceptive method for men. It a thin sheath made of latex.

HOW IT WORKS

It catches and holds the sperm that is released

Brainstorm and discussion

Purpose: to assist the knowledge of participants on condom and add new information and reinforce the knowledge of condom among the participants. If they are well informed about the method, it will be easier for them to choose a method.

Time: 25 minutes

during intercourse, so the sperm cannot enter the uterus. Therefore when sperm doesn't reach the egg, there will no pregnancy

Show the sample packet of the condom to the participants. Use the brainstorm method and ask them to share with the group what they know and have heard about Condom. Note the responses given by the participants

The facilitator will tell them about the condom While telling them about condom he will tell the participants what they knew and add the new things, which the participants were not able tell. If they have any wrong concept about the method the facilitator will correct it. (*Very few responses from the participants so the facilitator had to do most of the talking. Facilitator did put questions and asked them question in between to see if they have understood.)*

How to use it

- Use a new condom every time you have sexual intercourse.
- You or your partner should put the condom on the penis as soon as the penis id erect, before the penis is near the vagina.
- Place the unrolled condom on the tip of the penis; make sure the rolled part is facing outside. Leave about one and half inch of the empty space at the tip. Hold the tip of the condom when putting it on so that it does not fill with air and burst.
- After intercourse hold the condom at the base of the penis as you withdraw from the vagina.

The facilitator will demonstrate how to use a condom on the three-dimensional penis model. *In the male group the facilitator used a three-dimension penis to show them how to use it. But in the women's group it was not done because only one model was available. It was explained using a poster and demonstrating it.)* He/ She reminds them they have to put on their own penis before intercourse. Tell them this story: a health worker went to a village and was telling the men about different contraceptive methods. He wanted to show the villagers how to use a condom. He got a stick and placed it in front of

Remove the penis from the vagina soon after ejaculation, taking care not to spill semen near the opening of the vagina. If you lose your erection, the condom might slip off, and pregnancy may result.

Discard the used condom in the wastebasket or throw it in the toilet or bury it. Do not use it again.

FFECTIVENESS

Somewhat effective as commonly used-14 pregnancies per 100 women in the first year of use.(1 in every 8)

Effective when used correctly every time –3 pregnancies per 100 women in the first year of use.(1 in every 33)

If used correctly it helps to prevent STDs and AIDS

BENIFITE

- It is the only contraceptive method that can protect against STDs and HIV/AIDS.
- No medical contraindication so no need for medical examination necessary nor prescription needed.
- It is free or very inexpensive
- Man can be responsible for family planning.
- No systemic side effects
- Can be used as backup method

them. He took a condom and put it on the stick. He told the villagers after putting the condom that way they can have sexual intercourse, and this will prevent their wife getting pregnant. After 2 months a man came to the health worker very angry and worried. He told the worker, "you told us that condom will prevent my wife getting pregnant, I used it but she is pregnant now". The worker asked him how did you use it. The Villager told him, " I did exacting how you showed us. I put the condom on the stick and placed it beside my bed and had intercourse" The worker told the villager that the condom should be put on his penis not the stick.

Giving this example the facilitator should ask the participants to ask anything if they have not understood.

Use the picture of the male to explain about benefits, draw backs and body responses. Start from the head then go towards the leg. This will help the participant to remember

DRAW BACKS:

- A new condom is required for every time they have intercourse.
- Sometimes tear or leak.
- It needs to be available in advance of intercourse. Putting on a condom may interrupt lovemaking
- May cause allergic reaction to latex.
- Disposal after use may be a problem.

Common body responses

- Some might get allergic to latex
- Decrease in sexual sensitivity

Rare body response

None

WHERE TO GET IT

They are available free at the

- Health post
- Sub health post
- Public health centres
- Public hospitals
- Family planning clinics
- Through Volunteer health worker, female volunteer health worker and trained traditional birth attendant
- Through Non Governmental organisations and community health programs

Can be purchased at a low price from

- Medical shops
- Private clinics

Small shops

rine follow up:

needed, but if wants to change the method or s any information about contraceptive thods can go to see the health worker.

EMALE STERILISATION: (CEDPA, 1996; HO,1994)

APAROSCOPY AND

NI-LAPA ROTOMY

HAT IS IT

This is a voluntary surgical contraceptive method r women. It is a permanent method. After this peration a woman cannot have any more ildren. So a couple should be very sure that ey don't want any more children.

A doctor does the operation. A small incision is made in the lower abdomen and through the cision the fallopian tube (the tube which carry e egg from the ovaries to her uterus) are cut and ied or clipped.

HOW IT WORKS

The tubes are cut and closed so the egg released from the ovaries cannot reach the uterus and the sperms cannot reach the egg. Therefore a women cannot become pregnant.

EFFECTIVENESS

Very effective and permanent –0.5 pregnancies per 100 women in the first year of the operation (1 in every 200)

Video/Brainstorm and discussion

(video not used instead poster used)

Purpose: to assist the knowledge of participants on female sterilisation and add new information and reinforce the knowledge of female sterilisation among the participants. If they are well informed about the method, it will be easier for them to choose a method.

Time: 25 minutes

Show the video how the operation is done.

Ask them to share with the group what they know and have heard about laparoscopy and Mini laparotomy. Note the responses given by the participants.*(video was not show instead a poster showing the method was used)*

The facilitator will tell them about the laparoscopy and minilaparotomy operation. While telling them about laparoscopy and minilaparotomy operation. She/he will tell the participants what the group knew and add the new things which, the participants were not able to tell. If they have wrong concept about the method the facilitator will correct it. (*Very few*

Within 10 years after the procedure: 1.8 pregnancies per 100 women (1 in every 55 women)

responses from the participants so the facilitator had to do most of the talking. Facilitator did put questions and asked them question in between to see if they have understood.)

BENEFITS

- It is very highly effective.
- It's a permanent method so the woman does not need to worry about getting pregnant again.
- Immediately effective after surgery.

Use the picture of the female to explain about the benefits, draw backs and side effects. Start from the head then go towards the leg. This will help the participant to remember them

DRAW BACKS:

- Does not provide protection against STDs and HIV/AIDS
- The operation is not easily reversed
- Little pain after the operation but goes away after a few days
- Requires physical examination and minor surgery by a specially trained provider.

Common body responses:

- Painful for few days

Rare body responses

- Infection or bleeding at the incision
- Internal infection or bleeding
- injury to the internal organs

Use the picture of the women to explain when they need to see health personnel. Start from the head towards the leg. It will be easy for them to remember.

WHERE TO GET IT

- Hospitals

Family planning clinics

Mobile camps

Some private clinics and nursing homes.

outine follow up

ollow-up within 7 days or at least within 2 eeks is strongly recommended. Health worker hecks the site of incision looks for sign of any nfection and removes the stitches if needed. If verything is fine no need for further follow-up ut can come if she has any quires and if she hinks she is pregnant.

NEED TO SEE A HEALTH CARE PROVIDER IMMEDIATELY IF

- Fever within one week after surgery
- Pain in the abdomen that gets worse or does not go away
- If there is bleeding from the incision
- If there is pain round the incision or pus discharge from the wound

To reinforce what they learnt during the workshop an exercise will be practice with them

Give an assignment to each participate .Ask them to discuss with their spouse and select a method, which they think, is the best and draw a picture at home demonstrating the method. They have to show the picture to the group on the following session and tell their group about the method.

END of the workshop

TOPIC: THE ROLE OF HUSBAND AND WIFE COMMUNICATION IN FAMILY PLANNING DECISION MAKING AMONG COUPLES IN A CARPET FACTORY IN LALITPUR, NEPAL

SESSION 2: REINFORCING THE INFORMATION ON FAMILY PLANNING CONTRACEPTIVE METHODS AND BASIC INFORMATION ON COMMUNICATION BETWEEN HUSBAND AND WIFE

TIME: 4 hours

OBJECTIVES:

By the end of the workshop the participants will be able to

1. Share information on the eight different modern contraceptive methods with confidence among their friends.
2. Explain the importance of husband and wife communication in achieving a well-planned family.
3. Explain at least three benefits of husband and wife communication.
4. Name the obstacles to good husband and wife communication.

MAIN POINTS:

Share Information on 8 different contraceptive methods 1) Oral contraceptive, 2) Intra uterine device, 3) Implant 4) Injection, 5) Condom, 6) Female sterilisation, 7) Male sterilisation, 8) Lactation amenorrhea method by the participant with the group.

What is it?

- How does it work?
- It's considerations: it's benefits and draw backs
- How the body respond to the method(side effects)
- Where the methods are available

- When to contact the health personnel

2. Definition of Husband and wife communication, Benefits, obstacles to good husband and wife communication

MATERIALS:

Participant's drawings.

(*Posters, photocopies of the 8 different methods*

CONTENTS

Evaluate and at the same time reinforce the information the participants have about the different methods

METHODS

Lenden (giving and taking)

Purpose: to reinforce the information of contraceptive methods among the participants. If they are well informed about the method, it will be easier for them to choose a method.

Time: 2 hours

The facilitator will ask all the participants to hang their drawings on the wall she/he has made. Ask them to walk around the room and have a look at the other drawings too. Then the facilitator will ask the participants to form into groups according to what contraceptive method's drawing they have made for example all the participants with pills will form a group in the same way all the participants with injection will form a group. Let the group spend 20 minutes together discussing about the method, why they chose the particular method, what kind of method is it, what are the considerations,

what are the side effects, where is it available. Ask the group to choose a group leader who will present the method (chosen by their group) to rest of the group. So each group will present their choice of contraceptive method to the rest of the group. (*Only 2 participants had the drawing made, when asked why they did not bring the drawing some said their child tore the paper, some did not know how to draw some had no time.*

In the female group:

Asked the participants to say which method they consider the best. The facilitator revised each method again. When discussing each method the women who had chosen that particular method was asked to say something about the method.

.In the Male group

The facilitator asked the participants to choose a method from the photocopies and each one was asked to tell the group about the method to the group. The facilitator added if they missed anything.(the method was different in the two group because I did not think there would be no drawings so I had not discussed the alternative method for that)

Role play

Purpose: to make the participant understand the meaning of husband and wife

What is Communication?

Communication is transmitting information and thoughts through words, actions or signs.

Communication can spread knowledge, values, and social norms.

It is a two way, interactive process involving two or more individuals or groups in which all the participants both create and share and perceive and interpret information until the goals of each are adequately achieved.

Communication is redefined as "a process in which the participants create and share information with one another in order to reach a mutual understanding"

Interpersonal communication is person-to-person two way verbal or non-verbal interaction that includes the sharing of information and feeling between individuals.

Husband and wife communication is also an interpersonal communication.

Benefits of husband and wife communication

- Reinforces the concept of equal responsibility and equal sharing between husband and wife with regard to planning the family.
- When the husband supports the wife in contraceptive choice there is more effective use of the contraceptive and better continuity.
- Information and knowledge about choices and options increase the chance for obtaining an improved quality of life
- Communication helps eliminate frustration and disputes related to family

communication and the benefit of communication.

Time: 1 hours

Tell the participants the Nepali Proverb *"bolneko pido bikcha, nabolneko chamal peni bikdaine"* meaning the person who speaks can sell his flour but the person who does not speak will not be able to sell his rice even though rice is considered to be better among the two.

Ask them what they understand by this proverb? Using this proverb explain what is communication, husband and wife communication, what are the benefits of husband and wife communication and what are the barriers and how we can over come it.

The facilitator asks 5 participants to volunteer to act in a role play. Three of them will become the customers and the other two will become sells person. Ask one of the sells person to just seat in front of his shop and say not thing. Ask the other sells person to call each person who passes by his shop, talk to them, tell the customers why his goods are good why they should buy from him. Then ask the participant what was happening? What was the benefit of being able to talk to people. Then using the role play as an example, explain about communication, what

and reproductive issues.

- If husband and wife communicate and learn together, rumours and misconceptions can be reduced, and they share the same knowledge about how method works.

Obstacles to good husband and wife communication

- Traditional female gender roles: means that women have little to say in sexual matters and lack the status to influence their partner's behaviour. But men's control over reproductive decision making may be weakening, particularly among younger generations. In many societies, as social, economic, and educational opportunities for women are increase, traditional gender roles are starting to change.
- Traditional culture: often discourage married women from starting discussion about contraception. Nepal is a male dominated country, so here also women are reluctant to discuss family planning with their husbands.
- Women's status:
  - More the level of education of the women better the communication between spouse
  - Closer the level of education in husband and wife better the

is husband wife's communication. The benefits and the different obstacles to good husband and wife's communication.

communication between spouse

- Women who have economic power they are more likely to discuss family planning with the husband.
- The type of marriage –whether choose by themselves, arranged marriage, or polygynous also affect the affects the relative power a woman has and thus the extent that the couple communicates

Tea and snacks served

End of the second day's workshop

TOPIC: THE ROLE OF HUSBAND AND WIFE COMMUNICATION IN FAMILY PLANNING DECISION MAKING AMONG COUPLES IN A CARPET FACTORY IN LALITPUR, NEPAL

SESSION 3: COMMUNICATION BETWEEN HUSBAND AND WIFE

TIME: 4 hours

OBJECTIVES:

By the end of the workshop the participants will be able to

1. Define of husband and wife communication.
2. List and explain the four steps of KURAKANI.
3. Use the four steps of KURAKANI to demonstrate good husband and wife communication

MAIN POINTS:

- Definition of husband and wife communication
- The 4 parts of KURAKANI
- How to use the 4 parts of KURAKANI
- Role play practice

MATERIALS:

- 8 Pictures of a village
- pencils
- papers
- news sheets
- colour pencils
- drawing sheets
- Dictaphones
- 8 micro tapes
- A marker pen

CONTENTS

Knowing each other in the group

What is communication?

Communication is transmitting information and thoughts through words, actions or signs. Communication can spread knowledge, values, and social norms.

It is a two way, interactive process involving two or more individuals or groups in which all the participants both create and share and perceive and interpret information until the goals of each are adequately achieved. Communication is redefined as "a process in which the participants create and share information with one another in order to reach a mutual understanding"

Interpersonal communication is person-to-person two way verbal or non-verbal interaction that includes the sharing of information and feeling

METHODS

Chinajani

Purpose: to know each other well, which mig help the participants to feel comfortable and ease.

Time: 30 minutes

· The facilitator will ask each couple to stand and ask the husband to introduce his wife and t wife to introduce her husband to the group. Wh introducing tell the group the name where comes from and what work he is doing.

Ask all the couples to be introduced *(difficult make the wife introduce the husband so asked husband to introduce himself and his wife.)*

Drawing

Purpose: to make the participant understand meaning of husband and wife communication a the benefit of communication.

Time: 30 minutes

Ask the couple to group into pair, sitting back back. Provide the wife with a picture (A vill Picture) .The husband should not see the pa and should be ready to draw with a pencil paper. Ask the wife to give the directions to husband to draw the picture. The husband instructed to draw the picture exactly as the w tells him. Tell the husbands they MAY NOT their wives questions or make comments. A

between individuals. Husband and wife communication is also an interpersonal communication.

Interpersonal communication skills (Hope, A., and Timmel, S. 1989; Anonymous, 1992).

- Active listening /attending behaviour

Facial expression body signs, maintain eye contact, nod as your spouse speaks, say "um hmm"

- Summarising and paraphrasing

To restate what the partner has said in your own

finishing the drawing, ask them to hang it on the wall.

Ask the husband and wife to repeat the procedure but this time the husband can ask questions. Compare the two pictures and see which one produced a better result.

Ask the husbands how did they feel when they had to draw without asking questions. Was it easy? Did asking questions make a difference? In what way? What helped to draw an accurate picture?

Role play

Purpose: to make the participants understand the interpersonal communication skills, how they can be used and why it is important to have a good husband and wife communication.

Time: 30 minutes

The facilitator asks two participants to volunteer and come forward. Tell one to speak non-stop about a problem for 2-3 minutes and ask the other participant to listen without saying anything. After the speaker has finished the listener should repeat what the speaker has said.

Ask the speaker how she felt to be able to speak without being interrupted?

Ask the listener what made her difficult to listen?

Ask the group "how do we listen effectively?"

Ask a volunteer to act as a woman who has come to the health post with concern about the method

words. This assures the other partner that you have heard and understood her/him

that she is using. The facilitator will act as the health worker. The facilitator should paraphrase and summarise what the client says to you as much as possible. Ask the group what the facilitator is doing? Explain to them that why paraphrase and summarise is important when having a conversation.

- Questioning

Ask questions when having a conversation, this will encourage them to talk freely. You can use open ended questions or close ended questions

The facilitator will ask the group questions, both open ended and close ended.

Open ended questions:

What type of problem are you having? What do you think of using IUD? Can you explain how pills work?

Closed ended:

Are you having problems? Have you ever thought of using IUD? Do you know how pills work?

The facilitator will explain to the participants when open-ended and close ended questions can be used, open ended questions can be used to get more information.

➢ Praise and encouragement

Praising and encouraging will help your partner feel good about themselves. But don't give false praise.

The facilitator will act as the community health worker (CHW). Ask one participant to volunteer to do a role-play. The participant will act as a client. She will be a person who is very happy with the use of the contraceptive method (Norplant). She is very impressed with the method so she has influenced 3 other women who have already started using the method. When she

meets the CHW she tells him about the story. The CHW will praise her for what she has done and encourages her to keep on the work.

Different research results showing the importance of husband and wife communication

- A survey conducted jointly by Ministry of Health/Department of Health/NHEICC/JHU/PCS in Nepal showed that likelihood of women using family planning methods increases dramatically as spousal communication and approval increase. Women who both discuss family planning with their spouse and say their spouse approves of family planning are 39 times more likely to use family planning then women who had not discuss family planning and whose husbands disapproved (Storey et al 1997).

KURAKANI (Conversation)

KU-Kura **(talk)** Couple **talk** and share information about family planning.

RA-Raya **(opinion)** Ask your partner for his/her **opinion** in which he/she thinks is the best contraceptive method for them to use.

KA-Kadar **(respect)** Respect your partner's opinion

Purpose: to show the participants the importance of husband and wife communication in having a well planned family

Time: 15 minutes

Share with the group, the facts and figures from the research showing how much difference it makes if the husband and wife communicate with each other. Tell them what a good communication is and how it can be done. Use the KURAKANI to teach them how to conduct a good communication. Explain to the group about KURAKANI and tell them the performance by the actors will demonstrate how it can be done.

Two Actors from the Street Drama Organisation will be asked to do role-play or performance.

KURA

Role Play

Purpose: to teach the couples that husbands and wives can talk with each other about family planning. There is no sin in doing so

Time: 40 min

Tholi and Bir Bahadur (Bire) are husband and wife. Bire is sitting on the *agan* (the front

NI-Nirnaya (Decision) Make a joint **decision** while selecting a Family planning method

Scenario: In a village, Dhan Bahadhur and Maya have given birth to their 5th girl child. They already have 4 daughter but no son. They were trying for a son but this time also it's a girl.

Ku-Kura (Talk):

- The couple should feel free to talk about contraceptive methods with each other.
- Either the husband or wife can initiate the talk. It is not necessary for the husband to initiate the talk.
- Both husband and wife should have a chance to speak. There should be a two-way dialogue.
- The wife should also be given chance to have her say in family size.
- When one is talking the other one should listen. They should not interrupt in between.
- The couple should share information with each other about contraceptive methods.
- The couples should discuss the number of children they want, spacing between birth, whether the sex of the children makes a difference to their ideal family size? Are they going to keep on trying unless they have a son or they will be happy to have two children?

courtyard of the house). Bire is drinking tea and Tholi is sweeping the floor.

Tholi: Did you hear Dhan Bahadhur and Maya had their 5th girl this morning? Poor thing, they were trying for a son. This time also it's a girl.

Bire: I don't understand why they are giving birth to so many children. It is already difficult for them to take care of those 4 girls, now another one has come. I think it is time for them to start thinking of doing something. Now adays there are so many contraceptive methods available. (looking at his wife) Why don't you women go and talk to her to do something.

Tholi: (comes and sits next to Bire) Her husband is determined to have a son. Until they get one he is not going to stop. Poor Maya, she does not want any more children but she is afraid to talk to her husband about using family planning.

Bire: By the way how are you feeling? Are you still having those bad headaches? Are you still taking pills?

Tholi: My headache is better now. Yes I am still on pills. (bending her head down and playing with the tip of her sari, feeling shy)But sometime I think I should switch to Dipo injection or go for Norplant.

Bire: Why?

Tholi: (Sometimes looking at her husband and sometime looking down) It is really a problem sometime. Sometime I forget to take the pill. I am scared it will not be safe if I have missed one or

- Discuss the different contraceptive methods available and which one to choose if they decide to use one.
- Discuss where they can get it. Do they have to go to the health centre for the method or can they get it from the local medical shops?
- The couples should consider the usefulness and the drawbacks of the method and compare with other methods. This will help them to make a better choice and the chances of continuation of the method will be enchanced.
- Discuss body responses carefully. Many discontinue the method because of misinformation about body responses. If discussion has taken place prior to starting the method, there is a greater chance of coping with it and continuing the method.
- The couple should discuss when they would like to start using contraception, the reason for the use of a contraceptive method, whether for spacing or limiting births.
- It is not necessary for the couple to discuss each and every method and its considerations one by one, but they should try to incorporate other methods in their talks, relating to the topic of the discussion.
- The couple should not hesitate to ask questions when having the discussion.
- The couple should share the rumours and the stories about the methods going around in the

two days. The health worker told me if I forget to take the pill I should take it as soon as I remember even if it is the next day and I have to take two pills at a time. She also said that to be on safe side we should use a condom when I forget to take the pill. Once a month I have a bad headache but otherwise it is quit well for me. I usually take a Paracetamol and after a while it goes away.

Bire: (Looking around, when he sees there is no one around he pats her on her shoulder) Next time if you forget to take the pill tell me so that we can take precaution. We could do one thing for your problem of forgetting to take the pill. From today you keep the pill's packet on the side table next to your bed. Before you go to bed you take your pill in that way you will not forget to take you pill. I will also remind you to take your pill. Let's try for one month if it works well then you can continue using it otherwise we can think about another method.

Tholi: (She looks around to see no one is looking at them) Yes that sounds fine. If we decide to change the method, we could go to the health worker and talk to her and get some idea. (She stands up to go and finish her work)

Bire: (Pulls her hand and) Can you sit down for a while, you can sweep the floor later. I want to talk to you about something.

Tholi:(Pulling her hand off) Chee, what will other think if they see us like this.(She sits down again)

Bire: (Coming closer to his wife and in a softer

community. When the couple talk it will help them to correct the misconceptions they have about the method. If they are still not clear then they can always seek help from the health worker.

voice) Our little girl Anita will also be three years old next month isn't it? I think we should also start thinking of planning for another baby. What do you think?

Thole: (with a big smile in her face and excited) Anita will be very happy to have a baby brother. She is always playing with Maya's little boy.

How many children do you think we should have? I would like to have two, one daughter and one son.

Bire: I would also want two children but I don't mind if both are girls .I will not keep trying for a son if I don't have one the second time. Son and daughter are the same. I want a happy and well planned family .I want both my children to get good education so that they can have good job and stand on their one feet and support themselves when we are gone. In this expensive world we cannot afford to have more them two children.

Tholi: (playing with the broom) I prefer one son and one daughter but if it is both daughters I will not mind. I will be happy. Yes, we cannot afford to have too many children.

The facilitator will ask the actors to stop the role-play and ask the group what was happening, what were Tholi and Bire doing in the role-play, and what are they trying to tell the group. The facilitator will write the participants responses in the newscript in big letters, e.g. KU=(Kura) Talk

RA-Raya (opinion)

- Should ask his/her spouse what contraceptive method he/she would like to use.
- Listen actively when his/her spouse is sharing their opinion.
- Restate what the spouse says. This assures the spouse that he/she has heard and understood what he/she has said.
- Ask the reasons why he/she thinks that method is the best for them. Is it because of few drawbacks, easy use, or easily available.
- Ask his/her spouse what he /she thinks about the method.

and share

RAYA

Role-play

Purpose: to make the participants understand that listening to the opinion of the spouse is an important factor to have a good husband and wife communication.

Time: 40 min

The facilitator ask the actors to continue the role play

Bire: (looking at her) So do you want to continue with the pills?

Tholi: Yes, for the time being. I have just started to adjust with the pills. The other reason is that if we plan to have another baby soon then I will not change to another method. I can continue using pills. (looks at him)What do you think?

Bire: (nodding his head) I think it is good. As you said you are adjusting to the pills it is a good idea. You should be careful not to forget to take the pills; otherwise it will be fine. As I said before I will remind you to take the pills.

The facilitator will ask the actors to stop the role-play. Ask the participants what are the husband and wife doing? Can they say which step of KURAKANI is this role-play trying to show? See if the participants can come out with the answer RA=RAYA (Opinion)

Ka-Kadar **(respect)**

- Respect their spouse's opinion about the method.
- Make positive statements about his/her opinion. This is a way to show him/her you respect his/her opinion.
- Use appropriate non-verbal communication e.g. facial expressions, nodding etc. This is how you can let your partner know that you are listening.
- Do not laugh or immediately disagree. This will discourage the spouse giving an opinion in the future. If one of you disagree with the method then don't get worried there is always another alternative method they could choose from.
- If the couple does not understand the method or has doubt about the method always go to health centres and ask for help. The people in the health post are always happy and ready to help clients.

KADAR

Role play

Purpose: to make the participants understand that respecting the opinion of the spouse is an important factor to have a good husband and wife communication.

Time: 40 min

The facilitator asks the actors to continue the role play

Tholi: (Looking little concerned) Do you think, I said the right thing?

Bire: (patting her on the back and smiling) Yes, I think you said the right. As we are going to try for another baby very soon why to shift to another method. Norplant is a long-term contraceptive method, it can prevent pregnancy for five years. If you use Dipo it will prevent pregnancy for three months and if you want to try for a baby then it might take two-three months to get pregnant after you stop using it.

Wife: (with a big smile) I am really lucky to have such an understanding husband like you. Some men are so mean they will never listen to what their wife's say. For example Dhan, he will not let his wife use any method and he will also not use himself.

The facilitator will ask the actors to stop the role-play. Ask the participants what are the couple doing, which step of the KURAKANI do you

Ni-Nirnaya **(decision)**

- When choosing a contraceptive method try to make a joint decision. When both are involved in deciding the method, it is more effective. If both discuss about the method they will have more information about the method. Partners will be more supportive and understanding about the side effects and continuation is more likely.
- Before making the decision the couple should consider:
- What their plans and wishes are about having children.
- Their reason for using the method: spacing or limiting births.
- Whether there is any medical contraindication to use the method, (if not sure consult a health worker before making the decision).

So it is very important for a couple to complete the 4 step of KURAKANI to make a good communication between husband and wife. If the husband and wife have good communication between themselves, the use of family planning

think they are now? Note the responses on the newscript.

NIRNAYA

Role play

Purpose: to make the participants understand that to come to a decision both husband and wife has very important role. A good husband and wife communication is a way to reach a joint decision.

Time: 40min

The facilitator will ask the actors to continue the role-play.

Bire: Sita, if you are happy with pills why don't you continue with the pills? Only few months then you won't need any method if we have the second baby.

Tholi: (Looking at her husband and nodding) I think I will continue with pills. After the second baby we can go for a method which can be used for a longer time period. For that we can get help from the health worker.

Bire: It's still a long time for that to happen, so we can talk about it when time come. Let's just decide for now. So it's decided, you will continue with the pills isn't it?

Tholi: Yes (gets up and rushes off to finish her work). Oho I have so much to do.

The facilitator will tell the participants the role play is finished. He/she will ask the participants

method and continuity is very high.

By remembering the word KURAKANI, it will help them to make a good communication between husband and wife.

What did the couple do? Who made the decision? Was it the wife or the husband? Or was it a joint decision?

The facilitator will note the responses from the participants.

At this stage the KURAKANI word should be formed The facilitator will once again reinforce the short description of KURAKANI.

Role play by the participants

Purpose: to let the participants practice the KURAKANI approach and help them to understand how to conduct a communication between husband and wife

Time: 2 hours

Four scenarios will be prepared. Each scenario will be written in a piece of paper. Two sets will be prepared and made into balls The facilitator will ask each couple to choose a ball. (two couples will have the same topic). Ask the couples to do a role-play from the scenario they have chosen. Give them 15 minutes to discuss between themselves (husband and wife). Ask each couple to present a role-play to the group. Give 10 min to each couple to do the role-play.

The facilitator will number each couple from one to eight. Pair the one and three, two and four, five and seven, and six and eight. Ask these paired couples to exchange the scenario e.g. couple

number one will get the scenario the couple number three had role-played and vice versa. The facilitator has to make sure each group has got a new scenario. The facilitator tells the participants, this time the husband will do the wife's role and wife will do the husband's role. Give them 15 minutes to discuss between themselves (husband and wife). Ask each couple to present a role-play to the group. Give 10 min to each couple to do the role-play. *(Only one couple did very well in the role-play. It was very difficult to make the couple do the role-play. The women were too shy. So to make them feel comfortable the researcher let two women do the role play, one acting as a wife the other as the husband. Similarly, two men also did the role-play one acting as a wife and the other as husband.)*

The facilitator will first show the couples how to use the Dictaphone. Then each couple will be asked to show to the facilitator how to use the Dictaphone. The facilitator will ask the eight couples to tape a conversation between husband and wife about Family planning at home in the evening or at their convenience. There are two Dictaphones available. The facilitator will lend a Dictaphone and one micro tape (30 minutes) to a couple (two couples in one day) for one day and collect the machine the next day and give it to the next two couples. Lend it to all the eight couples and ask them to tape the conversation between husband and wife. Ask them to incorporate the

KURAKANI when doing the communication between husband and wife.

CLOSING CEREMONY

Purpose: To thank the participants, facilitators, actors and the assistants for their participation and their valuable time

Time: 40 minutes

Invite all the other eight couples who are watching the video. All the 12 couples will be present

The facilitator (researcher) will give a thank you speech. Give all the participants, facilitators, actors and the assistants the card with KURAKANI. On one side the card will have space to write Name, address and on the other side it will have the short description of KURAKANI. It will be printed in Nepali. All the participants and the assistants will be given a gift as a token of thanks.

Provide tea and snacks.

THE END OF THE WORKSHOP

Scenarios

1.Bir Bahadhur and Ram Maya are leaving in Pokhara. They got married three months ago. Both are still studying. They are not planning to have a baby for two more years. Include these questions in the role-play

- What are the different methods they can use?
- Why they can't use certain methods
- Which one will be the best method to use and why

- Where to get it
- Who will use the method, husband or wife?
- If they want advise on the method they should consult the health worker
- Listen to the partner's opinion on which method to use. Discuss whether it is the best method or not.
- Show respect to her opinion
- Make a joint decision on which method to use

1. Bishnu and Hem Lal is a very hard working couple. Hem Lal's mum is staying with them. They have two daughters and a son. But his mother is forcing them to have one more son. She tells them it is safe to have two sons if something happens to one there will be one left.

Include these questions in the role-play.

- Discuss about the number of children they want.
- Should they listen to his mother or ignore what she suggested.
- What are the methods they can use?
- If they both agree those three children is the right number for them then should they go for limiting method?
- Talk about consulting with the health worker
- Listen to the partner's opinion on which method to use. Discuss whether it is the best method or not.
- Show respect to your partner's opinion
- Make a joint decision on which method to use
-

2. Krishna Kumar and Jamuna have five children, three sons and two daughters. The children all look mal-nourished. The two big daughters have stopped going to school. They have to help other in her housework. The other two younger ones go to the local public school. Father has to work very hard to support the family. He wants more children to help him in the field. But the wife is against having any more children.

Questions to be included in the role-play

- Husband tries to convince the wife if they have more children they will help him in the fields, he can have better days in his old age with children after them
- Wife try to explain the difficulty in raising the five children, they will not be able to support any more.
- She asks him to go for the vasectomy if he does not agree she will go for the laparoscopy operation.
- He takes about all the rumours about sterilisation and tries to avoid the talk.
- She corrects the rumours he heard and tells him that she got the information from the health worker (HW). She suggests him that they go to see the health worker.
- After a talk with the HW the husband is a little motivated. He sits with his wife to talk about family planning again. (Or let them end the conversation without coming to a joint decision, showing that sometimes it might stop in different steps of behaviour change theory.)
- This time he listens to the wife's opinion on which method to use. Discuss whether it is the best method or not.
- Show respect to your partner's opinion
- Make a joint decision on which method to use

3. Basanta and Kanchi have three sons. They both want a daughter. The wife is expecting another baby very soon. They both think daughter will take care of the parents when they get old. Sons will marry and go away with their wives but daughter will come now and then to visit them to make sure they are keeping well.

Questions to be included in the role-play

- What will they do if it is a son again
- Will they use a contraceptive method or try for another girl.
- What are the different methods they can use?
- Which one will be the best method to use and why
- Where to get it
- Who will use the method, husband or wife?
- If they want advise on the method they should consult the health worker

- Listen to the partner's opinion on which method to use. Discuss whether it is the best method or not.
- Show respect to her opinion
- Make a joint decision on which method to use

Appendix 2:

Pre-intervention Questionnaire (English)

Post-Intervention Questionnaire (Nepali)

THE ROLE OF HUSBAND AND WIFE COMMUNICATION IN FAMILY PLANNING DECISION MAKING, 1999

PRE INTERVENTION INTERVIEW QUESTIONNAIRE

CONDUCTED BY MPH STUDENT DR. ASHA PUN,1999

Time interview started: Hour:____ Minute:____

Code Number

Date of interview:

Interviewer:

Place of interview:

Form No:

Participant's Name:

Husband/wife's Name:

Address: District:

Municipality/Village Development Committee

Ward No

Code no:

SECTION I: RESPONDENT'S BACKGROUND

(I would like to ask some questions about you)

1. Gender:
   [ ] Male [ ] Female
2. What is your religion?
   [ ] Hindu [ ] Buddhist [ ] Muslim
   [ ] Christian [ ] Others
3. Where were you born? (Ecological Region)
   [ ] Mountains [ ] Hills [ ] Terai
4. When did you move to the Kathmandu?
5. How old are you now?
6. What is your ethnicity?
   [ ] Brahmin [ ] Chhetri [ ] Magar [ ] Newar [ ] Tamang
   [ ] Gurung[ ] Limbu [ ] Sherpa [ ]Tibetan [ ] Sarki
   [ ] Damai [ ] Kami [ ] Others if any
7. Have you ever-attended school?
   [ ] Yes [ ] No (If no go to question 9)
8. What is the highest class you completed?
   [ ] Primary not completed [ ] Primary completed
   [ ] Secondary not completed [ ] Secondary completed
   [ ] SLC [ ] others
9. Can you read the newspaper?
   [ ] Yes [ ] No [ ] little
10. Can you write a letter by yourself?
    [ ] Yes [ ] No
11. Have you attended the adult literacy class? (don't ask the person who has attend school, go to question no.13)
    [ ] Yes [ ] No
12. If no, why did you not go?
13. Approximately how much money do you spend for your household each month?
14. Is Carpet weaving your main source of income?
    [ ] Yes [ ] No
15. Do you have a side job?
    [ ] Yes [ ] No
    If yes what is the job.....
16. In which work shift do you work?
    [ ] Day shift [ ] Night shift [ ] Mixture of day and night
17. Is your spouse working?
    [ ] Yes [ ] No
18. If yes what is the work?
19. Are your in-laws leaving with you?
    [ ] Yes [ ] No
20. Are your parents leaving with you?
    [ ]Yes [ ] No

Code no.

21. Who has the saying in the family, when decision has to be made.
    [ ] you [ ] your husband [ ] your wife [ ] your mother-in-law
    [ ] your father-in law [ ] your father [ ] your mother
22. When do you and your spouse make a joint decision?
23. How many brothers and sisters do you have?
    [ ] brothers [ ]sisters
24. Do you think any of your brothers or sisters are using any contraceptive method?
    [ ] Yes [ ] No [ ] Don't know

SECTION II: FERTILITY

(To the wife: I would like to ask some questions about your pregnancy and child bearing
To the husband: I would like to ask some questions about your wife's pregnancy and child bearing)

25. How old were you when you first got married?

26. Who made the decision for your marriage?
    [ ] your parents [ ] yourself [ ] friends [ ] relatives
27. Was the marriage arranged with your approval?
    [ ] Yes [ ] No
28. In your opinion, the marriage should be according to the parent's interest or the boy and the girl's interest? Why?

29. After marriage, how many years later did you get your first child?

30. Was your first child planned or unplanned?
    [ ] planned [ ] unplanned [ ] Don't know
31. Work, children and a well planned family ,from these three thing which one do you consider to be the most important? Why?

32. Do you have any children?
    [ ] Yes [ ] No
33. How many daughters and sons have been ever born to you?
    [ ] Total number daughters [ ] Total number sons
34. How old are your children, can you tell their age according to the seniority.

35. Of all the children born, how many sons and daughters are alive now?
    [ ] Sons living [ ] Daughters living [ ] None
36. Are you /your wife pregnant now?
    [ ] Yes [ ] No *(If no go to question number40)*
37. If yes, would you like to have a son or a daughter?
    [ ] Son [ ] Daughter [ ] Either
38. What is your reason for choosing the above-mentioned sex for the baby?

39. Was this pregnancy planned?
    [ ] planned [ ] unplanned

40. In your opinion who is responsible for the sex of the baby, the husband or the wife?
[ ] Husband [ ] Wife [ ] Don't Know
41. Do you plan to have any more children?(if no go to question no.35)
[ ] Yes [ ] No [ ] Don't know
42. If your want more children, how many more do you want? Why? if no, why aren't you planning for more children?

43. When would you like to have another baby?

44. Due to any health reason, have you ever had an abortion?
[ ] Yes [ ] No
45. How many times?
[ ] Once [ ] Twice [ ] Three
46. If you could choose exactly the number of children to have in your whole life, how many would that be?

47. In your opinion how many children would your husband like to have?
48. How many sons and how many of daughters would you like to have?
[ ] daughters [ ] sons
49. In your opinion how may sons and daughters would your husband like to have?
[ ] daughters [ ] sons

SECTION III: CONTRACEPTIVE METHODS

(I would like to ask some questions on contraceptive methods)
50. Have you ever heard of a well-planned family?
[ ] Yes [ ] No [ ] Don't Know
51. What does the term "well-planned family" mean to you?

52. Can you tell me which family planning methods you have heard about?

Methods	Yes(spontaneous)	Yes (probed)	No
Pills			
IUD (copper T)			
Condoms			
Norplant			
Injection (Depo)			
Female sterilisation			
Male Sterilisation			
LAM			
Periodic abstinence			
Withdrawal			

53. From which source did you get the information?
[ ] Husband [ ] Mother [ ] sister [ ] sister-in-law
[ ] Neighbour [ ] friends [ ] mother [ ] mother-in-law
[ ]TV [ ] Health personals [ ] Radio program (cut your coat according to your cloth)

54. Among the above mentioned sources which one do you consider the most reliable?

55. Do you listen to the radio program that broadcast about well planned family?
56. Can you name some of those radio programs?

57. Among the ones you have listened which one is the most knowledgeable radio program?

58. Have you ever used any modern contraceptive method? If yes what is or was it?
59. Are you currently using any methods? If yes what is the method? If not then go to question no. 65)
60. For how long have you been using this method?

Methods	Ever Used Q.58	Currently Using Q.58	(If a method is being currently used)For how long? Q.60
Pills			Months
Condoms			Months
IUD (Cooper T)			Months
Norplant			Months
Injection (Depo)			Months
LAM			Months
Female sterilisation			
Male sterilisation			
Withdrawal			Months
Periodic Abstinence			Months
None			

61. What is the reason for choosing this particular method? (*Was it because someone told you it is a good method or you have understood the method and made the choice)Probe*
62. Where did you get the method that you are currently using?

63. Did anybody tell you the health consideration of the method you are using?
[ ] Yes [ ] No
64. Who was the person?
[ ] husband [ ] mother [ ] Friend [ ] sisters
[ ] sister in laws [ ]neighbours [ ] mother in law [ ] Health personal
[ ] Shopkeeper [ ] Others
What did they say? Probe
65. What was the name of the method you first used? (*Ask this question to the participants who have ever used a method, if the response is None then go to question no.69)*
66. When was the first time you used a method?
[ ] Before the birth of the first child
[ ] After the birth of the first child
[ ] After the 2nd,3rd 4th, child

67. For how many months/years did you use that method?
[ ] Months.....[ ] Years.....

68. You said you have used a method sometimes in the past, what was the reason(s) for discontinuing the method? (*For those who have used*)

	First	Second	Third
Name of Method used in the past			
Not available			
Body Responses			
Health centre too far			
No one at the health facility			
Spouse did not approve			
Want children			
Mother-in-law did not approve			
Confused about the method			
Health concerns			
Religion			
Others			
Don't know			

69. Can you name some of the body responses of these methods

Methods	Body Responses
Pills	
IUD (copper T)	
Implant (Norplant)	
Injection (Depo)	
Female sterilisation	
Male sterilisation	
Condoms	
Lactation ammonerrhoea method	

70. Can you name some of the benefits of these methods
71. Can you name some of the draw backs of these methods

Methods	Benefits Q 70	Draw backs Q 71
Pills		
IUD (copper-T)		
Implant (Norplant)		
Injection (Depo)		
Condom		
LAM		
Female Sterilisation		
Male Sterilisation		

72. Can you name the place where you can go to get a method?
[ ] Government Hospitals [ ] Health Post
[ ] Family Planning Clinic [ ] Mobile Clinic
[ ] Health Worker [ ] Pharmacy/shop
[ ] Private Doctor/hospital/Clinic [ ] Others
[ ] Private Doctor/hospital/clinic [ ] Others
73. How long do you have to walk/travel from home to the clinic?
[ ] <30 minutes [ ] 30 minutes to 1 hour [ ] 1-2 Hours(walk)
[ ] <30 minutes [ ] 30 minutes to 1 hour [ ] 1-2 Hours(travel).
74. Do you intend to use a contraceptive method in the near future?
[ ] Yes [ ] No [ ] Not sure [ ] Don't know
a) If yes, why have you decided to use a method?

b) If no, what is the reason for not wanting to use a method?

75. Would you like to know the considerations (benefits and draw back) of different contraceptive methods?
[ ] Yes [ ] No [ ] Not Sure [ ] Don't know
76. If yes when do you think is the best time to tell you?
[ ] Before using the method [ ] After using the method
[ ] Others

SECTION IV: HUSBAND AND WIFE COMMUNICATION
(I would like to ask some questions on husband and wife communication)

77. Have you and your spouse discussed the number of children you would like to have?
[ ]Yes [ ] No
78. Have you discussed about well-planned family with you spouse?
[ ] Yes [ ] No *(If no go to question no. 80)*
79. If yes, when was the last time you talked about it?
[ ] Days ago [ ] Months ago [ ].Years ago
80. Have you discussed the different contraceptive methods with your spouse?
[ ] Yes [ ] No
81. You said you have never discussed family planning with your spouse, what are the reasons for not discussing family planning with your spouse?

82. If you plan to use a contraceptive method, will you discuss with your spouse about the method before you start using it?
[ ] Yes [ ] No
a) if yes, why?

b)If no, why?

83. Did you discuss with your spouse before you adopted the method or after you had already adopted the method?(*For women who have adopted a method*)
[ ] discussed before adoption [ ] discussed after adoption [ ] Don't know

84. Do you think husband and wife should discuss about the contraceptive method before they start adopting it.
[ ] Yes [ ] No

a) If yes, why?

b)If no, why?

85. Between you and your spouse, who decides whether to use contraception or not?
[ ] husband [ ] wife [ ] jointly [ ] Don't know
86. What do you understand by husband and wife communication? (When husband and wife sit and talk about the household matters, do you think that is communication?) Probe

87. Can you tell some of the skills needed to have a good communication between husband and wife?

88. Do you think your spouse approves or disapproves of couples using a method to avoid pregnancy?
[ ] approve [ ] disapprove [ ] don't know
89. Do you approve or disapprove of couples using a method to avoid pregnancy?
[ ] approve [ ] disapprove [ ] don't know

90. In general, do you agree the decision of using a method should be a joint one?
[ ] Yes [ ] No [ ] Don't know
91. Why do you think it should be a joint decision, can you give some reasons?

SECTION V: ATTITUDES ABOUT CONTRACEPTIVE METHODS

(I will read a statement you tell me whether you agree, strongly agree, disagree or strongly disagree. There is no right or wrong answer, you tell me what you think.)

No.	Statement	Strongly disagree	disagree	Agree	Strongly agree	Don't know
92.	It is necessary to keep having children until a boy is born.					
93.	In a well- planned family, children get a better education.					
94.	Going to a health post for family planning is shameful or embarrassing.					
95.	When a woman uses a contraceptive method her husband becomes angry.					
96.	Wives should get their husband's permission before taking any contraceptives.					
97.	If a woman uses a temporary contraceptive method she may become sterile.					
98.	The health care worker at the health post always encourages men and women to talk openly about their problems related to family planning.					
99.	Religion is against woman using family planning methods.					
100.	Health workers respect the privacy of the client.					
101.	If a client has problem with a method, the heath care worker will offer help.					
102.	Contraceptive methods have dangerous body responses.					
103.	If a wife gives birth to daughters only the husband should marry another woman.					
104.	Family planning methods are for rich people					

105.	More people would use contraceptives if they were more readily available.					
106.	People really do not know how contraceptives work.					
107.	Sterilisation makes a person weak.					
108.	Husband and wife should discuss about well-planned family.					
109.	Contraceptive use is often associated with promiscuity.					
110.	Husband and wife should be able to discus about anything with each other.					
111.	Vasectomy unable man to perform sex properly.					
112.	People are happier and healthier in a well planned family.					
113.	It is important for both husband and wife to jointly decide the number of children they should have.					
114.	If a couple cannot have children it is the woman's fault.					
115.	A couple should decide the timing of the births of their children.					
116.	Husband and wives should discuss contraceptive methods together.					
117.	Condom can fall off and get lost in the vagina.					
118.	Copper-T can travel to the heart and the person will die.					
119.	The offerings made in a religious ceremony by a man who has undergone Vasectomy is not accepted.					
120.	A woman is not supposed to talk about family planning openly in the public.					
121.	Husbands are always against their wives using contraceptive method.					

INTERVIEWER'S CLOSING REMARKS

Thank you. We have come to the end of the questions. You have been very helpful. Once again thank you for your time. Your comments have been very helpful. Namaskar.

Time interview ended: Hours _____Minutes

व्यवस्थित परिवारको निर्णय गर्न श्रीमान र श्रीमती बीचको वार्तालापको भूमिका, २०५६ अन्तरवार्ताका प्रश्नहरु

अनुसन्धनकर्ता डा. आशा पुन,२०५६

अन्तरवार्ता शरु भएको समय: घण्टा मिनेट

कोड नम्बर:

अन्तरवार्ता लिएको मिती:

अन्तरवार्ता लिने व्यक्तिको नाम:

अन्तरवार्ता लिएको ठाउँ:

फारम नम्बर:

सहभागिको नाम:

श्रीमान/श्रीमतीको नाम:

ठेगाना: अञ्चल:

नगरपालिका गाउँ विकास समिती:

वार्ड नम्बर

कोड नम्बर:

भाग एक: प्रजनन दर

(श्रीमतीलाई: म तपाईलाई गर्भधारण र बच्चा जन्माउने सम्बन्धी केही प्रश्नहरु सोध्न चाहन्छु।
श्रीमानलाई: म तपाईलाई तपाईको श्रीमतीको गर्भधारण र बच्चा जन्माउने सम्बन्धी केही प्रश्नहरु सोध्न चाहन्छु)

१) तपाईको बच्चा छन् ?
( ) छ ( ) छैनन्

२) आजसम्म तपाईले कति जना छोराछोरीलाई जन्म दिनु भएको छ?
( )छोराहरु ( ) छोरीहरु

३) तपाईको छोराछोरीहरु कति कति वर्षका छन्,कृपया जेठो देखि कान्छोको उमेर क्रमश भन्नहोस्

४) आजसम्म जन्म दिनु भएको बच्चाहरु मध्ये कति जना छोरा र कति जना छोरी जिउदै छन्:
( ) जिवित छोराहरु ( ) जिवित छोरीहरु ( ) छैन

५) तपाई अहिले गर्भवती हुनु हुन्छ?
( ) छ ( ) छैन (छैन भने ९ नम्बर प्रश्नमा जानस)

६) यदि गर्भवती हुनुहुन्छ भने, यस पाली तपाईलाई छोरा वा छोरी के को चाहान छ?
( ) छोरा ( ) छोरी ( ) जे भए पनि हुन्छ

७) तपाईले किन छोरा वा किन छोरी चाहनु हुन्छ?(केही खास कारण छन?)

८) यसपालीको गर्भधारण तपाईहरुको योजना अनुसार हो?
( ) हो ( ) होईन

९) तपाईको विचारमा, छोरा वा छोरी हुनुमा श्रीमान वा श्रीमती, को जिम्मेवार हुन्छ होला जस्तो लाग्छ?
( ) श्रीमान ( )श्रीमती ( ) थाहा छैन

१०) तपाईले अरु बच्चा जन्माउने विचार गर्नु भएको छ वा छैन?(छैन भने प्रश्न १३ मा जान)
( ) छ ( ) छैन ( ) थाहा छैन

११) अरु बच्चा जन्माउने हो भने, अझै कति जना बच्चा जन्माउन चाहानु हुन्छ? (किन तपाईलाई अझै बच्चा चाहियो? किन चाहिएन?)

१२) अर्को बच्चा कहिले जन्माउन चाहनु हुन्छ?

१३) स्वास्थको कारणले गर्दा तपाईको बच्चा खेर गएको छ की छैन?(छैन भने प्रश्न १५ मा जान)
( ) छ ( ) छैन

१४) कति चोटि बच्चा खेर गएको छ? (आफै भएको की गराउनु भएको?)
( ) एक चोटी ( ) दई चोटी ( ) तिन चोटी

कोड नम्बर:

१५) यदि तपाईको इच्छा मुताबिक हुने हो भने कति वटा बच्चा जन्माउन चाहनु हुन्छ?

१६) तपाईको विचारमा, तपाईको श्रीमान (श्रीमती) लाई कति जना बच्चा जन्माउने चाहना छ होला?

१७) तपाईलाई कति जना छोरा र कति जना छोरी चाहनु हुन्छ?
( ) छोराहरु ( )छोरीहरु

१८) तपाईको विचारमा, तपाईको श्रीमान (श्रीमती) लाई कति जना छोरा र कति जना छोरीको चाहना होला?
( ) छोराहरु ( )छोरीहरु

भाग दुई: बच्चा नजन्माउने साधन

(म तपाईलाई बच्चा नजन्माउने साधन सम्बन्धी केही प्रश्न गर्न चाहन्छु।

१९) तपाईले व्यवस्थित परिवारको बारे सुन्न भएको छ?
( ) छ ( ) छैन ( ) थाहा छैन

२०) व्यवस्थित परिवार भन्नाले के बुझ्नु हुन्छ?

२१) तपाईले अब कुन कुन बच्चा नजन्माउने साधनको नाम भन्न सक्नु हुन्छ?

साधनहरु	सक्छु (आफै भन्ने)	सक्छु (भने पछि भन्ने)	नसक्ने
चक्की			
आई.य.डी.(कपर टी)			
कण्डम			
नरप्लाण्ट			
डिपोप्रोभेरा सुई			
महिला बन्ध्याकरण			
पुरुष बन्ध्याकरण			
आमाको दुध चुसाउने			
प्राकृतिक साधन			
वीर्य बाहिर फाल्ने			

२२) भविष्यमा तपाईले बच्चा नजन्माउने अस्थायी साधन प्रयोग गर्ने विचार गर्नु भएको छ की छैन?
( ) छ ( ) छैन ( )पक्का थाहा छैन

कोड नम्बर

२३) यदि प्रयोग गर्नु भयो भने कुन बच्चा नजन्माउने अस्थायी साधन प्रयोग गर्न चाहनु हुन्छ?

२४) हाल कुनै साधन प्रयोग गर्नु भएको छ की छैन? यदि प्रयोग गर्नु भएको छ भने कुन साधन प्रयोग गर्नु भएको छ? (यदि प्रयोग गर्नु भएको छैन भने प्रश्न नम्बर३३मा जानहोस)

२५) यदि प्रयोग गर्नु भएको छ भने, त्यो साधन प्रयोग गर्नु भएको कति समय भयो?

	प्रश्न २३	प्रश्न २४	प्रश्न २५
साधनहरु	प्रयोग गर्न चाहनु भएको बच्चा नजन्माउने अस्थायी साधन	हाल प्रयोग गरेको बच्चा नजन्माउने अस्थायी साधन	हाल साधन प्रयोग गरेको समय
चक्की			
आई.य.डी.(कपर टी)			
कण्डम			
नरप्लाण्ट			
डिपोप्रोभेरा सुई			
महिला बन्ध्याकरण			
पुरुष बन्ध्याकरण			
आमाको दूध चुसाउने			
प्राकृतिक साधन			
वीर्य बाहिर फाल्ने			
कुनै पनि प्रयोग नगरेको			

२६) अहिले प्रयोग गरि राख्नु भएको साधन बर्कसप पछि शुरु गर्नु भएको हो?
( ) हो ( ) होइन

२७) अहिले प्रयोग गरि राख्नु भएको साधन छाड्नु भएको मुख्य कारण के हो?

२८) अहिले प्रयोग गरि राख्नु भएको साधन कति समय सम्म प्रयोग गर्ने विचार छ? किन?

२९) तपाईले अहिले प्रयोग गरि राख्नु भएको साधन कहाबाट पाउनु भयो?

कोड नम्बर:

२८) अहिले प्रयोग गरि राख्नु भएको साधनको फाईदा र बेफाईदा सम्बधी तपाईलाई कसैले बुझाएको छ?
( ) छ ( ) छैन

२९) बुझाएको छ भने कस्ले बुझायो?
( ) श्रीमान ( )आमा ( ) साथी ( ) दिदी बहिनी
( ) नन्द अमाज्यू ( ) छिमेकी ( ) सासु ( ) स्वास्थ कर्मचारी
( ) दोकानदार

३०) अहिले प्रयोग गरि राख्नु भएको साधन छाड्नु भयो भने के कारणले गर्दा छाड्ने हुन्छ होला?

कारणहरु	आफै भनेको	बताए पछि भनेको
साधन नपाउनाले		
हेल्थ सेन्टर धेरै टाढा हनको कारणले		
साधन लिन जादा हेल्थ सेन्टरमा कोही पनि नहुनाले		
श्रीमानले नचाहेर		
अरु बच्चा चाहिएर		
सासुले नचाहेर		
साधन सम्बधी ज्ञान नभएर		
स्वास्थ सम्बन्धी कारण		
धर्मको कारणले		
अन्य कारण		
थाहा छैन		

कोड नम्बर:

२३) तल उल्लेख गरिएका बच्चा नजन्माउने साधनहरुको असरहरु के के छन् बताउन सक्नु हुन्छ?

साधनहरु	शारिरीक असरहरु
चक्की	
आई.य.डी.(कपर टी)	
कण्डम	
नरप्लाण्ट	
डिपोप्रोभेरा सूई	
महिला वन्ध्याकरण	
पुरुष वन्ध्याकरण	
आमाको दूध चुसाउने	

कोड नम्बर:

तल उल्लेख गरिएका बच्चा नजन्माउने साधनहरुको फाईदाहरु के के हुन्, बताउन सक्नु हुन्छ?

तल उल्लेख गरिएका बच्चा नजन्माउने साधनहरुको फाईदाहरु के के हुन्, बताउन सक्नु हुन्छ?

साधनहरु	फाईदाहरु (३Y)	बेफाईदाहरु (३X)
चक्की		
आई.य.डी.(कपर टी)		
कण्डम		
नरप्लाण्ट		
डिपोप्रोभेरा सुई		
महिला बन्ध्याकरण		
पुरुष बन्ध्याकरण		
आमाको दूध चुसाउने		

३६) बच्चा नजन्माउने साधन कुन कुन ठाउँबाट पाउन सकिन्छ?
( ) सरकारी अस्पताल ( ) हेल्थ पोष्ट ( ) घम्ती शिविर
( ) परिवार नियोजन संघ ( ) स्वास्थ्य कार्यकर्ता
((औषधी पसल ( ) प्राइभेट अस्पताल, क्लिनिक

३७) तपाईको घरबाट हेल्थ सेन्टर पुग्न कति समय हिड्नु पर्छ अथवा मोटरमा कति समय जानु पर्छ?
( ) ३० मिनेट भन्दा कम ( ) ३० मिनेट भन्दा बढी ( ) १ देखि २ घण्टा (हिडेर)
( ) ३० मिनेट भन्दा कम ( ) ३० मिनेट भन्दा बढी ( ) १ देखि २ घण्टा (मोटरमा)

३८) बच्चा नजन्माउने साधन भविष्यमा प्रयोग गर्ने विचार छ की छैन?
( ) छ ( ) छैन् ( ) थाहा छैन

३९) यदि प्रयोग गर्ने विचार छ भने, किन छ?

४०) यदि प्रयोग गर्ने विचार छैन भने, किन छैन?

४१) बच्चा नजन्माउने साधनहरुको फाईदा र बेफाईदाहरु सुन्न चाहनु हुन्छ?
( ) चाहन्छु ( )चाहन्न ( ) थाहा छैन

४२) यदि जान्न चाहनु हुन्छ भने, तपाईलाई कहिले भन्दा राम्रो हुन्छ?
( ) प्रयोग गर्नु अघाडि ( ) प्रयोग गरिसके पछि ( ) अरु समय

भाग तिन: श्रीमान रु श्रीमती बिच वार्तालाप

(म तपाईलाई श्रीमान रु श्रीमती बिच हुने वार्तालाप सम्बन्धी केही प्रश्न सोध्न चहान्छु)

४३) तपाई र तपाईको श्रीमान/श्रीमतीले कति जना बच्चा जन्माउने सम्बन्धी छलफल गर्न भएको छ की छैन?
( ) छ ( ) छैन

४४) व्यवस्थित परिवार सम्बन्धी तपाईले तपाईको श्रीमान/श्रीमतीसंग छलफल गर्नु भएको छ की छैन?
( ) छ ( ) छैन

४५) यदि गर्नु भएको छ भने, अन्तिम पल्टी कुरा कहिले गर्नु भएको थियो?

४६) बच्चा नजन्माउने साधन सम्बन्धी तपाईले आफ्नो श्रीमान श्रीमतीसंग वार्तालाप गर्नु भएको छ?
( ) छ ( ) छैन

४७) तपाईको भनाई अनुसार तपाईले श्रीमान श्रीमतीसंग व्यवस्थित परिवार सम्बन्धी कुरा गर्नु भएको रहेनछ, के कारणले कुरा नगर्नु भएको हो?

कोड नम्बर:

४६) यदि बच्चा नजन्माउने साधन प्रयोग गर्ने विचार गर्नु भयो भने, प्रयोग गर्नु अघि तपाईले श्रीमान्/श्रीमतीसंग त्यो साधन सम्बन्धी छलफल गर्नु हुन्छ की हुन्न?

( )गर्छु ( ) गर्दिन

क) छलफल गर्नु हुन्छ भने किन गर्नु हुन्छ?

ख) छलफल गर्नु हुन्न भने किन गर्नु हुन्न?

४७) तपाईले अहिले प्रयोग गर्नु भएको साधन सम्बन्धी श्रीमानसंग प्रयोग गर्नु अघि वा प्रयोग गरि सकेपछि छलफल गर्नु भयो की भएन?

( ) प्रयोग गर्नु अघि ( ) प्रयोग गरि सकेपछि ( ) छैन

४८) तपाईको विचारमा, बच्चा नजन्माउने साधन प्रयोग गर्नु अघि श्रीमान/श्रीमतीले त्यो साधन बारे छलफल गर्नु पर्छ होला की पर्दैन होला?

( ) पर्छ ( ) पर्दैन

क) पर्छ भने किन पर्छ?

ख) पर्दैन भने किन पर्दैन?

४९) बच्चा नजन्माउने साधन प्रयोग गर्ने कि नगर्ने भन्ने विषयमा तपाई र तपाईको श्रीमान/श्रीमती मध्ये कस्ले निर्णय गर्छ?

( ) श्रीमानले ( ) श्रीमतीले ( ) संयुक्त ( ) थाहा छैन

५०) श्रीमान श्रीमतीको बिचको वार्तालाप भन्दा के बुझ्नु हुन्छ?

५१) कुन कुन गुणले श्रीमान श्रीमती बिचको वार्तालाप सफल गराउछ?

५२) तपाईको विचारमा तपाईको श्रीमान/श्रीमतीले, कुनै दम्पतीले बच्चा नजन्माउने साधन प्रयोग गरेको मन पराउनु हुन्छ की हुदैन?

( ) मन पराउनु हुन्छ ( ) मन पराउनु हुदैन ( ) थाहा छैन

५३) कुनै दम्पतीले बच्चा नजन्माउने साधन प्रयोग गरेको तपाईलाई मन पर्छ की पर्दैन?

( ) मन पर्छ ( ) मन पर्दैन ( ) थाहा छैन

५४) कुनै पनि बच्चा नजन्माउने साधन प्रयोग गर्ने अथवा नगर्ने फैसला श्रीमान र श्रीमतीको संयुक्त निणय हुन पर्छ भन्ने कुरामा तपाईको सहमति छ कि छैन?

( ) छ ( ) छैन ( ) थाहा छैन

५५) तपाईको विचारमा, किन बच्चा नजन्माउने साधन प्रयोग गर्ने फैसला श्रीमान र श्रीमतीको संयुक्त निणर्यमा हुनु पर्छ? केहि कारण दिन सक्नु हुन्छ?

कोड नम्बर:

भाग चार: बच्चा नजन्माउने साधन सम्बधी धरणा

(म तपाईलाई पढेर सुनाउछु,तपाईलाई त्यो कुरा कस्तो लाग्छ बताउनोस जस्तै एकदम सहमति छैन, सहमति छैन, सहमति छ, एकदम सहमति छ यसमा कनै पनि ठीक र बेठीक उत्तर छैन,तपाईलाई जे ठीक लाग्छ त्यही भन्नोस।)

नम्बर	वाक्यहरु	एकदम सहमति छैन	सहमति छैन	सहमति छ	एकदम सहमति छ	थाह छैन
५६)	छोरा नजन्मेसम्म बच्चा जन्माई रहनु जरुरी छ।					
५७)	व्यवस्थित परिवारमा बच्चाहरुले राम्रो शिक्षा पाउछन्।					
५८)	बच्चा नजन्माउने साधन लिनको लागी हेल्थ सेन्टर जान लाज र शरम हुन्छ।					
५९)	यदि श्रीमतीले बच्चा नजन्माउने साधन प्रयोग गरेमा श्रीमान रिसाउछ।					
६०)	कुनै पनि बच्चा नजन्माउने साधन प्रयोग गर्नु अघि श्रीमतीले श्रीमानबाट स्विकृति लिनु पर्छ।					
६१)	कुनै महिलाले बच्चा नजन्माउने अस्थायी साधन प्रयोग गर्‍यो भने उ बाझि हुनसक्छ।					
६२)	स्वास्थ कार्यकर्ताले हेल्थ पोष्टमा आउने सबै महिला र पुरुषहरुलाई बच्चा नजन्माउने साधन सम्बन्धि परेका समस्याहरु मन खोलेर व्यक्त गर्नु सधै प्रोत्साहान दिन्छ।					
६३)	धर्म अनुसार महिलाले बच्चा नजन्माउने साधन प्रयोग गर्नु हुन्न।					
६४)	स्वास्थ कार्यकर्ताले आफु कहा आउने सेवा लिन आउने व्यक्तिको गोप्यताको कदर गर्छ।					
६५)	सेवा लिन आउने व्यक्तिलाई बच्चा नजन्माउने साधन सम्बन्धि समस्या परेमा स्वास्थ कार्यकर्ताले सधै मद्धत गर्छ।					
६६)	बच्चा नजन्माउने साधनहरुको स्वास्थ सम्बन्धी डरलाग्दा असरहरु हुन्छ।					
६७)	यदि कनै परिवारमा छोरी मात्र जन्मियो भने श्रीमानले अर्को विवाह गर्नु पर्छ।					
६८)	बच्चा नजन्माउने साधनहरु धनी व्यक्तीहरुको लागि हो।					
६९)	बच्चा नजन्माउने साधनहरु सजिलैसंग उपलब्ध भएमा, धेरैले प्रयोग गर्ने होला।					

कोड नम्बर:

नं	वाक्यहरु	एकदम सहमति छैन	सहमति छैन	सहमति छ	एकदम सहमति छ	थाहा छैन।
७०)	बच्चा नजन्माउने साधनहरुले कसरी काम गर्छ धेरै जनालाई थाहा छैन।					
७१)	वन्ध्याकरणले मानिसलाई कमजोर बनाउछ।					
७२)	श्रीमान र श्रीमतीले व्यवस्थित परिवार बारे छलफल गर्नु पर्छ।					
७३)	बच्चा नजन्माउने साधन प्रयोग गर्ने व्यक्ती विवाह बाहिर पनि यौन सम्बन्ध राख्न सक्छन भन्ने धेरैको भनाई छ।					
७४)	श्रीमान र श्रीमतीले आपसमा कुनै पनि विषयमा छलफल गर्न सक्नु पर्छ।					
७५)	भेसेक्टोमी गरे पछि पुरुषले राम्रोसंग यौन कार्य गर्न सक्दैन।					
७६)	व्यवस्थित परिवारमा, मानिसहरु खुशी र स्वास्थ रहन्छन्।					
७७)	परिवारमा कति जना बच्चा जन्माउने भन्ने बारे श्रीमान र श्रीमतीको संयक्त निर्णय हुनु पर्छ।					
७८)	यदि कुनै दम्पतिले सन्तान जन्माउन सकेन भने दोष श्रीमतीको हुन्छ।					
७९)	बच्चा कहिले जन्माउने भन्ने बारे दम्पतीले निणय गर्नु पर्छ।					
८०)	श्रीमान र श्रीमतीले बच्चा नजन्माउने साधन सम्बन्धी बारे छलफल गर्नु पर्छ।					
८१)	कण्डम प्रयोग महिलाको पाठेघरमा हराउन सक्छ।					
८२)	कपर टी सरेर मुटुमा पुग्न सक्छ, जस्लेगर्दा मान्छे मर्न सक्छ।					
८३)	भेसेक्टोमी गरेको पुरुषले गरेको दान, धर्म, पुजापाठ लाग्दैन।					
८४)	बच्चा नजन्माउने साधन सम्बन्धी महिलाहरुले खुल्ला रुपमा कुरा गर्दै हिड्नु हुन्न।					
८५)	श्रीमतीले बच्चा नजन्माउने साधन प्रयोग गर्ने बारे श्रीमानहरु सधै विरोध गर्दछन्।					

कोड नम्बर:

तिन दिन वर्कशप सम्बन्धी

८८) तपाईको विचारमा त्यो तिन दिनको वर्कशप कस्तो लाग्यो?

८९) तपाईले त्यो तिन दिनको वर्कशपमा कति दिन भाग लिनु भयो? यदि सबै तिन दिन भाग लिनु भएन भने के कारणले गर्दा भाग लिनु भएन ?

९०) तपाईको विचारमा त्यो तिन दिन मध्य कुन दिन सबभन्दा काम लाग्दो लाग्यो , किन?

९१) तपाईको विचारमा त्यो तिन दिनको वर्कशपबाट कति सिकेको जस्तो लाग्यो? के सिक्नु भयो त?

९२) कुराकानी भन्नाले के बुझ्नु हुन्छ? कुराकानी को माने बताउन सक्नु हुन्छ?

९३) तपाईको विचारमा तपाई श्रीमान र श्रीमती बातचित गर्दा कुराकानी तरिका अपनाउनु हुन्छ की हुन्न?

९४) तपाईलाई धेरै धेरै धन्यवाद। प्रश्नको अन्तयमा आई पुग्यौ। तपाईले धेरै मद्दत गर्नु भयो। एक चोटी फेरी तपाईको समयको लागी धेरै धेरै धन्यवाद। तपाईले दिनु भएका उत्तरहरु मलाई धेरै काम लाग्छ। नमस्कार

अन्तरवार्ता अन्तय भएको समय: घण्टा मिनेट

Appendix 3: KURAKANI Observation Checklist

KURAKANI

INTERACTION OBSERVATION GUIDE FOR KURA (TALK)

Husband (N= 6 husbands)

Communication skills/action	Total	Comments
Wife initiates the talk	2	
Husband initiates the talk	4	
Wife speaks out freely	5	1 of the wives is very shy, not speaking freely
It is a one way dialogue, only husband is talking	.	
It is a one way dialogue, only wife is talking		
It is a two-way dialogue; husband and wife both are talking.	6	For all couples the husband and wife were talking in turns.
Initiates by talking about other people and then focusing on them-selves	2	
Wife decides the number of the desired children in the family	4	
Husband decides the number of the desired children in the family	1	
The wife has no saying in the desired number of children in the family	1	
Discusses how many years apart they want their next child.	2	
Discusses the number of sons and daughters they would like to have.	5	
Discusses whether the sex of the child would influence the number of children they would have.	4	
Asks questions, closed and open ended.	6	
Uses verbal cues to make his partner feel he is listening.	4	
Reassures/encourages/expresses empathy	5	

Husband discusses family planning methods with wife								
Method Content	LAM	Oral pills	IUD	Injection	Norplant	Condom	FS	MS
Discusses how method works	1	2	2	4	3	1	3	3
Discusses how to use it		1						
Discusses who should use it				1				
Discusses the benefits		1		4	1			
Discusses the draw back		2		2				
Discusses the body responses				1				
Discusses rumours, fears and misconceptions								
Discusses where to get the method		1		1				
Does not discuss the method	5	4	4	2	3	5	3	3

INTERACTION OBSERVATION GUIDE FOR RAYA (OPINION)

Husbands

Communication skills/action	Total
Ask wife's opinion about the appropriate method.	4
Uses verbal cues to show that he is listening	4
Restate what his wife says	4
Asks the reasons why she thinks the method is the most appropriate one.	2
Puts his opinion about the method	4
Ask wife's opinion about not having too many children	4

INTERACTION OBSERVATION GUIDE FOR KADAR (RESPECT)

Husbands

Communication skills/action	Total
Makes positive statements to her opinion	5
Uses verbal cues to show that he is listening	5
Disagrees at once to his wife's choice of method.	
Agrees at once to his wife's choice of method.	2
Makes fun of her when she tries to explain	2
Decides to see a health worker for more information about the method	
Agrees to have fewer children	2

INTERACTION OBSERVATION GUIDE FOR NIRNAYA (DECISION)

Husbands

Communication skills/action	Total
The couple decide to use a method for spacing birth	4
The couple decide to use a method for limiting birth	
The husband decides which method to be used	
The wife chooses the method to be used	2
The couple jointly decides on which method to use.	3
Husband is happy with method	3
Wife is happy with method	3
The couple are happy with method	3
The couple decide to have fewer children	3
Couple are happy to have fewer children	3

KURAKANI
INTERACTION OBSERVATION GUIDE FOR KURA (TALK)

Wife (N=6 wives)

Action	Total	Comments
Wife initiates the talk	2	
Husband initiates the talk	4	
Wife is speaking out freely	5	
It is a one way dialogue, only husband is talking		
It is a one way dialogue, only wife is talking		
It is a two-way dialogue; husband and wife both are talking.	6	For all couples the husband and wife were talking in turns.
Initiates by talking about other people and then focusing on them selves.		
Wife decides the number of the desired children in the family	4	
Husband decides the number of the desired children in the family	1	
The wife has no saying in the desired number of children in the family	1	
Discusses how many years apart they want their next child.	1	
Discusses the number of sons and daughters they would like to have.	4	
Discusses whether the sex of the child would influence the number of children they would have.	3	
Asks questions, closed and open-ended.	5	
Uses verbal cues to make her partner feel she is listening.	5	
Reassures/encourages/expresses empathy	4	

Wife discusses family planning methods with husband								
Method Content	LAM	Oral pills	IUD	Injection	Norplant	Condom	FS	MS
Discusses how method works		2	1	4	1			
Discusses how to use it		2						
Discusses who should use it				2				
Discusses the benefits		1		4				
Discusses the draw back		2						
Discusses the body responses		1						
Discusses rumours, fears and misconceptions								
Discusses where to get the method								
Does not discuss the method	1	1	1	1	1	1	1	1

INTERACTION OBSERVATION GUIDE FOR RAYA (OPINION)
Wife

Communication skills/action	Total
Asks husband's opinion about the appropriate method.	3
Uses verbal cues to show that she is listening	4
Restates what her husband says	4
Asks the reasons why he thinks the method is the most appropriate one.	2
Puts her opinion about the method	2
Discusses the number of children to have	2

INTERACTION OBSERVATION GUIDE FOR KADAR (RESPECT)
Wife

Communication skills/action	Total
Makes positive statements to his opinion	5
Uses verbal cues to show that she is listening	5
Disagrees at once to her husband's choice of method.	3
Agrees at once to her husband's choice of method	
Agrees at once to her husband's to have few children	1
Does not listen when he tries to explain	
Decides to see a health worker for more information about the method	1

INTERACTION OBSERVATION GUIDE FOR NIRNAYA (DECISION)
Wife

Action	Total
The couple decided to use a method for spacing birth	4
The couple decided to use a method for limiting birth	
The husband decides which method to be used	
The wife chooses the method to be used	4
The couple jointly decided on which method to use.	4
Husband was happy with method	3
Wife was happy with method	3
The couple were happy with method	3
Couple decides to have few number of children	5

INTERACTION between husband and wife
N=6 couples

Communication skills/action	Total
Frequent interruptions/distraction by outsider	5
Frequent interruptions/distraction among themselves	5
Comfortable, both at ease	5
Neither the husband and the wife dominate	5
Uses of verbal cues	6
Mutually respectful	6
Sounds a friendly conversation	5

Appendix 4: Ethical Approval

Nepal Health Research Council

Estd. 1991

NHRC

1836.

utive Committee

irman
Gopal Prasad Acharya

-Chairman

nber-Secretary
Kamal Gyawali

mbers
Sanu Maiya Dali
Rishi Ram Koirala
Madhu Ghimire
Ram Kewal Shah

presentative
Ministry of Finance
nal Planning Commission
Ministry of Health
Research Committee, IOM
rman, Nepal Medical Council

January 27, 2000

Dr. Asha Punn
GPO 8975, Jawalakhel
Lalitpur.

Subject: Approval of the research proposal entitled "'The Role of Husband and Wife Communication in Family Planning Decision Making: A Case Study among Couples in a Carpet Factory in Lalitpur, Nepal."

Dear Dr. Pun:

We are pleased to inform that the above mentioned proposal submitted by you has been approved by NHRC board on the date January 7, 2000 following the recommendation of the Technical Review Committee (TRC) and Ethical Review Committee (ERC). This also certifies that the proposal is ethically cleared.

As per NHRC regulation you are to follow strictly the protocol stipulated in your proposal finalized after the interaction of TRC and ERC with you. Any change in objectives (s), problem statement, research question or hypothesis, methodology, implementation procedure, data management and budget that may be necessary in course of the implementation of the research proposal can only be made so and implemented after prior approval from this council. You are thus strongly advised to submit to NHRC the details of such changes intended or desired with justification prior to instituting actual change.

You are also to abide by the ethical guidelines of NHRC strictly during the implementation of your research proposal. In addition, in course of investigation of any medical health problem needing immediate care, further investigation, or expert consultation you are obliged to inform the subject-study or control clearly in writing from within seven days of detection. However, during the transmission of such information confidentially must be maintained.

Lastly, you are obliged to submit periodic progress reports every 3 months and submit three copies of the final research report, and financial statement after completion of the research. If an article based upon that research is published, you should submit two copies of that article.
If you have any question, please contact our research officers.

Thank you.

Yours truly,

Dr. Kamal Gyawali
Member-Secretary

Tel. (977-1) 254220, Fax: 977-1-262469. Email: NHRC@healthnet.org. np Ramshah Path, P. O. Box 7626, Kathmandu, Nepal.

Appendix 5: Results

Appendix 5a	Knowledge of contraceptive methods: comparison between PRI and PTI for spontaneous, probed and Don't know
Appendix 5b	Number of correct and incorrect body response; PRI and PTI
Appendix 5c	Number of correct benefits for contraceptive methods; PRI and PTI
Appendix 5d	Drawbacks of contraceptive methods; PRI and PTI
Appendix 5e	Knowledge of source of contraceptive methods; PRI and PTI
Appendix 5f	Ever heard of Well-Planned Family (WPF) concept and knowledge of meaning of the WPF; PRI and PTI
Appendix 5g	Meanings of husband and wife communication; PRI and PTI
Appendix 5h	Different skills for good communication between husband and wife; PRI and PTI
Appendix 5i	Knowledge of person responsible for the sex of the baby; PRI and PTI
Appendix 5j	Approval of contraceptive use; PRI and PTI
Appendix 5k	a) In a well-planned family, children get a better education. b) People are happier and healthier in a well planned family.
Appendix 5l	a) Going to health post for contraceptive method is shameful or embarrassing. b) When a woman uses a contraceptive method her husband becomes angry. c) Contraceptive is often associated with promiscuity. d) A woman is not supposed to talk about contraceptive method openly in the public.
Appendix 5m	a) It is necessary to keep having children until a boy is born. b) If a wife has only girls the husband should marry another woman. c) If a couple cannot have children it is the women's fault.
Appendix 5n	a) If a woman uses a temporary contraceptive method she may become sterile. b) Contraceptive methods have dangerous body responses. c) Religion is against women using contraceptive methods. d) Contraceptive methods are for rich people only. e) Sterilization makes a person weak. f) Vasectomy makes a man unable to perform sex properly.

g) Condom can fall off and get lost in the vagina.
h) Copper-T can travel to the heart and the person will die.
j) More people would use contraceptives if they were more readily available.
k) People do not know how contraceptive method works.

Appendix 5o — a) It is important for both husband and wife to jointly decide the number of children they should have.
b) A couple should decide the timing of the birth of their children.
c) Husband and wife should discuss contraceptive methods together.
d) Husband and wife should be able to discuss anything between themselves.

Appendix 5p — Contraceptive use; 'ever used' and 'current use'

Appendix 5q — Factors affecting the contraceptive use

Appendix 5r — Relation between current use of method with desired number of children and number of living children

Appendix 5s — Relationship between current use and future intention to use
Husband and wife communication

Appendix 5t — Factors affecting husband and wife communication

Appendix 5v — Factors affecting husband and wife communication.

Appendix 5w — Factors affecting husband and wife communication

Appendix 5a

Knowledge of contraceptive methods: comparison between PRI and PTI for spontaneous, probed and Don't know

Methods	Spontaneous		Probed		Don't know	
	PRI	PTI	PRI	PTI	PRI	PTI
Oral Pills	21	23	2	4	4	0
IUD	5	22	6	5	16	0
Condom	13	27	11	0	3	0
Implant	14	26	6	1	7	0
Injection	23	27	3	0	1	0
Female sterilisation (FS)	6	21	14	5	7	1
Male sterilisation (MS)	6	21	14	5	7	1
Lactation Amenorrhea Method	1	10	0	13	26	4
(LAM)	0	0	3	12	24	15
Natural method	2	3	1	15	24	9
Withdrawal						
Average number of methods named	3.4	6.7	2.2	2.2	4.4	1.1

Appendix 5b

Number of correct and incorrect body response; PRI and PTI

Methods	PRI							PTI						
	Correct			Incorrect			DK	Correct				Incorrect		DK
	1	2	3	1	2	3		1	2	3	4	1	2	
Pills														
Female	3	2	0	2	1	0	9	0	0	0	0	0	0	14
Male	2	0	0	0	0	0	11	0	3	1	1	0	0	8
Total	5	2	0	2	1	0	20	0	3	1	1	0	0	22
IUD														
Female	0	0	0	0	0	0	14	1	0	0	0	2	1	10
Male	1	0	0	1	0	0	11	1	0	0	0	5	1	6
Total	1	0	0	1	0	0	26	2	0	0	0	7	2	16
Condom														
Female	0	0	0	0	0	0	14	1	0	0	0	0	0	13
Male	1	0	0	1	1	0	10	0	0	0	0	6	3	4
Total	1	0	0	1	1	0	24	1	0	0	0	6	3	17
Implant														
Female	1	1	0	2	0	0	10	3	2	0	0	0	0	13
Male	0	0	1	1	0	0	11	5	0	0	2	0	0	4
Total	1	1	1	3	0	0	22	8	2	0	2	0	0	17
Injection														
Female	2	5	0	4	0	0	6	0	0	0	0	0	0	14
Male	2	1	0	2	0	0	8	4	1	0	0	1	0	7
Total	4	6	0	6	0	0	14	4	1	0	0	1	0	21
FS														
Female	0	0	0	0	0	0	14	0	0	0	0	0	0	14
Male	1	0	0	0	0	0	12	0	0	0	0	4	1	8
Total	1	0	0	0	0	0	26	0	0	0	0	4	1	22
MS														
Female	0	0	0	0	0	0	14	0	0	0	0	0	0	14
Male	0	1	0	0	0	0	12	1	1	0	0	1	0	7
Total	0	1	0	0	0	0	26	1	0	0	0	1	0	21
LAM														
Female	0	0	0	0	0	0	14	0	0	0	0	0	0	14
Male	1	0	0	0	0	0	12	0	0	0	0	3	0	10
Total	1	0	0	0	0	0	26	0	0	0	0	3	0	24

Appendix 5c

Number of correct benefits for contraceptive methods

Methods	PRI					PTI				
	Correct				DK	Correct				DK
	1	2	3	Total		1	2	3	Total	
Pills										
Female	3	1	0	4	10	9	4	0	13	1
Male	4	0	0	4	9	1	7	0	8	5
Total	7	1	0	8	19	10	11	0	21	6
IUD										
Female	1	0	0	1	13	2	10	0	13	1
Male	2	0	0	2	11	0	8	0	8	5
Total	3	0	0	3	24	2	18	0	21	6
Condom										
Female	1	0	0	1	13	2	11	1	14	0
Male	3	2	1	6	7	2	5	4	11	2
Total	4	2	1	7	20	4	16	5	25	2
Implant										
Female	1	0	1	2	12	0	10	4	14	0
Male	2	1	0	3	10	1	8	1	10	3
Total	3	1	1	5	22	1	18	5	24	3
Injection										
Female	4	1	0	5	9	0	8	6	14	0
Male	6	1	0	7	6	2	6	3	11	2
Total	10	2	0	12	15	2	14	9	25	2
FS										
Female	0	0	0	0	14	0	14	0	14	0
Male	2	0	0	2	11	0	8	0	8	5
Total	2	0	0	2	25	0	22	0	22	5
MS										
Female	0	0	0	0	14	0	14	0	14	0
Male	2	0	0	2	11	0	7	0	7	6
Total	2	0	0	2	25	0	21	0	21	6
LAM										
Female	0	0	0	0	14	0	6	0	6	8
Male	1	2	0	3	10	2	3	0	5	8
Total	1	2	0	3	24	2	9	0	11	16

Appendix 5d
Drawbacks of contraceptive methods; PRI and PTI

Methods	PRI					PTI						
	Correct		Incorrect		DK	Correct			Incorrect			DK
	1	2	1	2		1	2	3	1	2	3	
Pills												
Female	1	0	1	0	12	0	1	13	4	0	0	0
Male	0	0	2	0	11	2	0	0	1	3	0	7
Total	1	0	3	0	23	2	1	13	5	3	0	7
IUD												
Female	0	0	0	0	14	4	1	1	0	1	0	7
Male	2	0	0	0	11	6	2	0	0	0	0	5
Total	2	0	0	0	26	10	3	1	0	1	0	12
Condom												
Female	0	0	0	0	14	0	7	3	0	0	0	4
Male	3	1	1	0	8	7	1	1	3	0	0	4
Total	3	1	1	0	22	7	8	4	3	0	0	8
Implant												
Female	0	0	1	2	11	2	0	0	4	4	2	3
Male	0	0	1	1	11	1	0	0	6	0	0	6
Total	0	0	2	3	22	3	0	0	10	4	2	9
Injection												
Female	0	0	1	0	13	1	1	0	3	8	1	1
Male	0	0	4	1	8	0	1	0	4	1	1	6
Total	0	0	5	1	21	1	2	0	7	9	20	7
FS												
Female	1	0	0	0	13	6	1	0	2	0	0	5
Male	1	0	0	0	12	2	2	0	1	0	0	8
Total	2	0	0	0	25	8	3	0	3	0	0	13
MS												
Female	0	0	0	0	14	6	4	0	0	0	0	4
Male	0	0	0	1	12	4	0	0	2	0	0	7
Total	0	0	0	1	26	10	4	0	2	0	0	11
LAM												
Female	0	0	0	0	14	1	0	0	0	0	0	13
Male	1	0	0	0	12	2	0	0	3	0	0	8
Total	1	0	0	0	26	3	0	0	3	0	0	21

Appendix 5e

Knowledge of source of contraceptive methods; PRI and PTI

Name of place	PRI			PTI		
	Female	Male	Total	Female	Male	Total
Hospital	6	8	14	14	10	24
Health post	4	7	11	14	12	26
Medical shop	3	10	13	14	12	26
Private clinic	3	7	10	10	10	20
Family planning clinic	0	3	3	1	11	12
Health worker	0	3	3	4	10	14
Mobile camp	0	4	4	1	8	9
Don't know	3	3	6	0	0	0

Appendix 5f

Ever heard of Well-Planned Family (WPF) concept and knowledge of meaning of the WPF; PRI and PTI

'Ever heard' and meaning of WPF	PRI	PTI
Ever heard of WPF		
Yes	20	20
No	7	7
Total	27	27
Eight categories of meaning of WPF		
• To have few children	8	6
• Small family and happy family	6	2
• Few children(only 2), good spacing able to feed and educate them	3	3
• Happy and Healthy family	0	3
• To have few children, to be able to feed, educate and cloth the children, husband wife have good relation	0	5
• Few children, good spacing	2	0
• To do family planning operation	1	0
• Everything well planned	0	1
• Don't Know	7	7

Appendix 5g

Meanings of husband and wife communication; PRI and PTI

Meaning	PRI			PTI		
	Female	Male	Total	Female	Male	Total
• Talk and discuss between husband and wife	0	5	5	8	7	15
• To talk about household problem	2	1	3	0	0	0
• To talk about how to make a happy family	1	1	2	0	0	0
• KURAKANI	0	0	0	0	3	3
• Others	1	2	3	2	1	3
Total	4	9	13	10	11	21
• Don't know	10	3	14	4	2	6

Appendix 5h

Skills	PRI	PTI
Skills needed to have a good communication between husband and wife		
• To have conversation in a friendly environment	2	3
• To have conversation in a friendly environment and love each other	1	0
• Help and love each other	3	0
• Understand each other	3	0
• Listen carefully	1	8
• Both talk in turns	1	0
• Listen and repeat what the other says		
• To obey each	0	3
• Others		1
• Don't Know	0	5
	16	7

Appendix 5i

Knowledge of person responsible for the sex of the baby; PRI and PTI

Person responsible for the sex of the baby	PRI			PTI		
	Female	Male	Total	Female	Male	Total
Husband	1	5	6	14	5	19
Wife	0	1	1	0	1	1
Both	12	5	17	0	7	7
DK	1	2	3	0	0	0

Appendix 5j

Approval of contraceptive use; PRI and PTI

	PRI		PTI	
	Female	Male	Female	Male
Own Approval of others using contraceptive method				
Yes	14	11	14	13
No	0	1	0	0
Don't know	0	1	0	0
Spousal approval of others using contraceptive method				
Yes	12	11	13	13
No	0	0	0	0
Don't know	2	2	1	0

Appendix 5k
Attitudes regarding benefits of a WPF
a) In a well-planned family, children get a better education.

Change from pre to post	Female	Positive change	Negative change	Male	Positive change	Negative change
No change						
Disagree to disagree	0	0	0	0	0	0
Agree to agree	14	0	0	12	0	0
DK to DK	0	0	0	0	0	0
Total No Change	**14**	**0**	**0**	**12**	**0**	**0**
Change						
Disagree to agree	0	0	0	0	0	0
Agree to disagree	0	0	0	1	0	1
DK to disagree	0	0	0	0	0	0
DK to agree	0	0	0	0	0	0
Agree to DK	0	0	0	0	0	0
Disagree to DK	0	0	0	0	0	0
Total Change	**0**	**0**	**0**	**1**	**0**	**1**

b) People are happier and healthier in a well planned family.

Change from pre to post	Female	Positive change	Negative change	Male	Positive change	Negative change
No change						
Disagree to disagree	0	0	0	0	0	0
Agree to agree	13	0	0	13	0	0
DK to DK	0	0	0	0	0	0
Total No Change	**13**	**0**	**0**	**13**	**0**	**0**
Change						
Disagree to agree	1	1	0	0	0	0
Agree to disagree	0	0	0	0	0	0
DK to disagree	0	0	0	0	0	0
DK to agree	0	0	0	0	0	0
Agree to DK	0	0	0	0	0	0
Disagree to DK	0	0	0	0	0	0
Total Change	**1**	**1**	**0**	**0**	**0**	**0**

C) Contraceptive is often associated with promiscuity.

Change from pre to post	Female	Positive change	Negative change	Male	Positive change	Negative change
No change						
Disagree to disagree	5	0	0	1	0	0
Agree to agree	1	0	0	6	0	0
DK to DK	0	0	0	0	0	0
Total No Change	**6**	**0**	**0**	**7**	**0**	**0**
Change						
Disagree to agree	6	0	6	2	0	2
Agree to disagree	1	1	0	3	3	0
DK to disagree	1	1	0	0	0	0
DK to agree	0	0	0	1	0	1
Agree to DK	0	0	0	0	0	0
Disagree to DK	0	0	0	0	0	0
Total Change	**8**	**2**	**6**	**6**	**3**	**3**

d) A woman is not supposed to talk about contraceptive method openly in the public.

Change from pre to post	Female	Positive change	Negative change	Male	Positive change	Negative change
No change						
Disagree to disagree	13	0	0	5	0	0
Agree to agree	0	0	0	3	0	0
DK to DK	0	0	0	0	0	0
Total No Change	**13**	**0**	**0**	**8**	**0**	**0**
Change						
Disagree to agree	0	0	0	1	0	1
Agree to disagree	1	1	0	3	3	0
DK to disagree	0	0	0	0	0	0
DK to agree	0	0	0	1	0	1
Agree to DK	0	0	0	0	0	0
Disagree to DK	0	0	0	0	0	0
Total Change	**1**	**1**	**0**	**5**	**3**	**2**

c) If a couple cannot have children it is the women's fault.

Change from pre to post	Female	Positive change	Negative change	Male	Positive change	Negative change
No change						
Disagree to disagree	5	0	0	8	0	0
Agree to agree	4	0	0	1	0	0
DK to DK	0	0	0	0	0	0
Total No Change	**9**	**0**	**0**	**9**	**0**	**0**
Change						
Disagree to agree	2	0	.2	0	0	0
Agree to disagree	3	3	0	3	3	0
DK to disagree	0	0	0	1	1	0
DK to agree	0	0	0	0	0	0
Agree to DK	0	0	0	0	0	0
Disagree to DK	0	0	0	0	0	0
Total Change	**5**	**3**	**2**	**4**	**4**	**0**

Appendix 5n

Attitudes regarding perceptions of contraceptive use

a) If a woman uses a temporary contraceptive method she may become sterile.

Change from pre to post	Female	Positive change	Negative change	Male	Positive change	Negative change
No change						
Disagree to disagree	11	0	0	8	0	0
Agree to agree	0	0	0	1	0	0
DK to DK	0	0	0	0	0	0
Total No Change	**11**	**0**	**0**	**9**	**0**	**0**
Change						
Disagree to agree	0	0	0	0	0	0
Agree to disagree	1	1	0	3	3	0
DK to disagree	2	2	0	1	1	0
DK to agree	0	0	0	0	0	0
Agree to DK	0	0	0	0	0	0
Disagree to DK	0	0	0	0	0	0
Total Change	**3**	**3**	**0**	**4**	**4**	**0**

b) Religion is against women using contraceptive methods.

Change from pre to post	Female	Positive change	Negative change	Male	Positive change	Negative change
No change						
Disagree to disagree	11	0	0	11	0	0
Agree to agree	0	0	0	1	0	0
DK to DK	0	0	0	0	0	0
Total No Change	**11**	**0**	**0**	**12**	**0**	**0**
Change						
Disagree to agree	0	0	0	0	0	0
Agree to disagree	1	1	0	1	1	0
DK to disagree	0	0	0	0	0	0
DK to agree	0	0	0	0	0	0
Agree to DK	1	0	1	0	0	0
Disagree to DK	1	0	1	0	0	0
Total Change	**3**	**2**	**2**	**1**	**1**	**0**

c) Contraceptive methods have dangerous body responses.

Change from pre to post	Female	Positive change	Negative change	Male	Positive change	Negative change
No change						
Disagree to disagree	9	0	0	9	0	0
Agree to agree	1	0	0	0	0	0
DK to DK	0	0	0	0	0	0
Total No Change	**10**	**0**	**0**	**9**	**0**	**0**
Change						
Disagree to agree	1	0	1	2	0	2
Agree to disagree	3	3	.0	2	2	0
DK to disagree	0	0	0	0	0	0
DK to agree	0	0	0	0	0	0
Agree to DK	0	0	0	0	0	0
Disagree to DK	0	0	1	0	0	0
Total Change	**4**	**3**	**2**	**4**	**2**	**2**

d) Contraceptive methods are for rich people only.

Change from pre to post	Female	Positive change	Negative change	Male	Positive change	Negative change
No change						
Disagree to disagree	13	0	0	10	0	0
Agree to agree	0	0	0	1	0	0
DK to DK	0	0	0	0	0	0
Total No Change	**13**	**0**	**0**	**11**	**0**	**0**
Change						
Disagree to agree	0	0	0	0	0	0
Agree to disagree	1	1	0	1	1	0
DK to disagree	0	0	0	1	1	0
DK to agree	0	0	0	0	0	0
Agree to DK	0	0	0	0	0	0
Disagree to DK	0	0	0	0	0	0
Total Change	**1**	**1**	**0**	**2**	**2**	**0**

e) Sterilization makes a person weak.

Change from pre to post	Female	Positive change	Negative change	Male	Positive change	Negative change
No change						
Disagree to disagree	4	0	0	1	0	0
Agree to agree	5	0	0	4	0	0
DK to DK	0	0	0	1	0	0
Total No Change	9	0	0	6	0	0
Change						
Disagree to agree	2	0	2	2	0	2
Agree to disagree	2	2	0	3	3	0
DK to disagree	0	0	0	0	0	0
DK to agree	0	0	0	1	0	1
Agree to DK	0	0	0	1	0	1
Disagree to DK	0	0	0	0	0	0
Total Change	4	2	2	7	3	4

f) Vasectomy makes a man unable to perform sex properly.

Change from pre to post	Female	Positive change	Negative change	Male	Positive change	Negative change
No change						
Disagree to disagree	7	0	0	0	0	0
Agree to agree	1	0	0	5	0	0
DK to DK	1	0	0	1	0	0
Total No Change	9	0	0	6	0	0
Change						
Disagree to agree	0	0	0	1	0	1
Agree to disagree	0	0	0	2	2	0
DK to disagree	2	2	0	1	1	0
DK to agree	1	0	1	1	0	1
Agree to DK	0	0	0	1	1	0
Disagree to DK	2	0	2	1	0	1
Total Change	5	2	3	7	4	3

g) Condom can fall off and get lost in the vagina.

Change from pre to post	Female	Positive change	Negative change	Male	Positive change	Negative change
No change						
Disagree to disagree	8	0	0	3	0	0
Agree to agree	0	0	0	4	0	0
DK to DK	0	0	0	0	0	0
Total No Change	**8**	**0**	**0**	**7**	**0**	**0**
Change						
Disagree to agree	0	0	0	2	0	2
Agree to disagree	4	4	0	0	0	0
DK to disagree	2	2	0	0	0	0
DK to agree	0	0	0	3	0	3
Agree to DK	0	0	0	1	0	1
Disagree to DK	0	0	0	0	0	0
Total Change	**6**	**6**	**0**	**6**	**0**	**6**

h) Copper-T can travel to the heart and the person will die.

Change from pre to post	Female	Positive change	Negative change	Male	Positive change	Negative change
No change						
Disagree to disagree	13	0	0	2	0	0
Agree to agree	0	0	0	2	0	0
DK to DK	0	0	0	0	0	0
Total No Change	**13**	**0**	**0**	**4**	**0**	**0**
Change						
Disagree to agree	0	0	0	0	0	0
Agree to disagree	0	0	0	5	5	0
DK to disagree	1	1	0	4	4	0
DK to agree	0	0	0	0	0	0
Agree to DK	0	0	0	0	0	0
Disagree to DK	0	0	0	0	0	0
Total Change	**1**	**1**	**0**	**9**	**9**	**0**

j) More people would use contraceptives if they were more readily available.

Change from pre to post	Female	Positive change	Negative change	Male	Positive change	Negative change
No change						
Disagree to disagree	0	0	0	0	0	0
Agree to agree	13	0	0	12	0	0
DK to DK	0	0	0	0	0	0
Total No Change	**13**	**0**	**0**	**12**	**0**	**0**
Change						
Disagree to agree	1	1	0	1	1	0
Agree to disagree	0	0	0	0	0	0
DK to disagree	0	0	0	0	0	0
DK to agree	0	0	0	0	0	0
Agree to DK	0	0	0	0	0	0
Disagree to DK	0	0	0	0	0	0
Total Change	**1**	**1**	**0**	**1**	**1**	**0**

k) People do not know how contraceptive method works.

Change from pre to post	Female	Positive change	Negative change	Male	Positive change	Negative change
No change						
Disagree to disagree	0	0	0		0	0
Agree to agree	11	0	0	13	0	0
DK to DK	0	0	0	0	0	0
Total No Change	**11**	**0**	**0**	**13**	**0**	**0**
Change						
Disagree to agree	1	1	0	0	0	0
Agree to disagree	0	0	0	0	0	0
DK to disagree	0	0	0	0	0	0
DK to agree	2	2	0	0	0	0
Agree to DK	0	0	0	0	0	0
Disagree to DK	0	0	0	0	0	0
Total Change	**3**	**3**	**0**	**0**	**0**	**0**

Appendix 5o

Attitudes regarding husband and wife communication

a) It is important for both husband and wife to jointly decide the number of children they should have.

Change from pre to post	Female	Positive change	Negative change	Male	Positive change	Negative change
No change						
Disagree to disagree	0	0	0	0	0	0
Agree to agree	14	0	0	11	0	0
DK to DK	0	0	0	0	0	0
Total No Change	**14**	**0**	**0**	**11**	**0**	**0**
Change						
Disagree to agree	0	0	0	0	0	0
Agree to disagree	0	0	0	0	0	0
DK to disagree	0	0	0	0	0	0
DK to agree	0	0	0	2	2	0
Agree to DK	0	0	0	0	0	0
Disagree to DK	0	0	0	0	0	0
Total Change	**0**	**0**	**0**	**2**	**2**	**0**

b) A couple should decide the timing of the birth of their children.

Change from pre to post	Female	Positive change	Negative change	Male	Positive change	Negative change
No change						
Disagree to disagree	0	0	0	0	0	0
Agree to agree	12	0	0	12	0	0
DK to DK	0	0	0	0	0	0
Total No Change	**12**	**0**	**0**	**12**	**0**	**0**
Change						
Disagree to agree	1	1	0	1	1	0
Agree to disagree	0	0	0	0	0	0
DK to disagree	0	0	0	0	0	0
DK to agree	1	1	0	0	0	0
Agree to DK	0	0	0	0	0	0
Disagree to DK	0	0	0	0	0	0
Total Change	**2**	**2**	**0**	**1**	**1**	**0**

c) Husband and wife should discuss contraceptive methods together.

Change from pre to post	Female	Positive change	Negative change	Male	Positive change	Negative change
No change						
Disagree to disagree	0	0	0	0	0	0
Agree to agree	14	0	0	12	0	0
DK to DK	0	0	0	0	0	0
Total No Change	**14**	**0**	**0**	**12**	**0**	**0**
Change						
Disagree to agree	0	0	0	0	0	0
Agree to disagree	0	0	0	0	0	0
DK to disagree	0	0	0	0	0	0
DK to agree	0	0	0	1	1	0
Agree to DK	0	0	0	0	0	0
Disagree to DK	0	0	0	0	0	0
Total Change	**0**	**0**	**0**	**1**	**1**	**0**

d) Husband and wife should be able to discuss anything between themselves.

Change from pre to post	Female	Positive change	Negative change	Male	Positive change	Negative change
No change						
Disagree to disagree	0	0	0	0	0	0
Agree to agree	14	0	0	12	0	0
DK to DK	0	0	0	0	0	0
Total No Change	**14**	**0**	**0**	**12**	**0**	**0**
Change						
Disagree to agree	0	0	0	1	1	0
Agree to disagree	0	0	0	0	0	0
DK to disagree	0	0	0	0	0	0
DK to agree	0	0	0	0	0	0
Agree to DK	0	0	0	0	0	0
Disagree to DK	0	0	0	0	0	0
Total Change	**0**	**0**	**0**	**1**	**1**	**0**

Appendix 5p
Contraceptive use; 'ever used' and 'current use'

Modern methods	Ever used			Current use					
				PRI			PTI		
	F	M	Total	F	M	Total	F	M	Total
Pill	2	1	3	1	0	1	1	1	2
IUD	0	0	0	0	0	0	0	0	0
Condom	0	4	4	0	0	0	0	1	1
Implant	0	1	1	1	1	2	1	1	2
Injection	7	5	9	5	4	9	6	4	10
Total	9	11	21	7	5	12	8	6	15

Appendix 5q
Factors affecting the contraceptive use

Description	Currently using contraceptive methods			
	PRI		PTI	
No. of children	Yes	No	Yes	No
no children	0	4	0	4
1 child	4	5	4	4
2 children	8	6	11	4
total	12	15	15	12
Desired no of children				
2	9	13	13	10
3	1	2	1	2
4	2	0	1	0
Total	12	15	15	12
Want more children				
Yes	6	9	8	7
No	6	6	7	5
Total	12	15	15	12
No of more children wanted				
1	4	7	7	6
2	1	2	1	1
3	0	0	0	0
4	1	0	0	0
Total	6	9	8	7

Appendix 5r

Relation between current use of method with desired number of children and number of living children

Currently using method, PRI

Number of living children	No. of desired children			Total
	2	3	4	
No child	0	0	0	0
1 child	2	1	1	4
2 children	7	0	1	8
Total	9	1	2	12

Currently not using method, PRI

Number of living children	No. of desired children			Total
	2	3	4	
No child	0	0	0	0
1 child	3	1	0	4
2 children	9	1	1	11
Total	12	2	1	15

Currently using method, PTI

	No. of desired children			Total
	2	3	4	
No child	3	1	0	4
1 child	5	0	0	5
2 children	5	1	0	6
Total	13	2	0	15

Currently not using method, PTI

	No. of desired Children				Total
	1	2	3	4	
No child	1	2	1	0	4
1 child	0	4	0	0	4
2 children	0	4	0	0	4
Total	1	10	1	0	12

Appendix 5s

Relationship between current use and future intention to use

Description	Currently using methods			
	PRI		PTI	
Intention to use in the future	Yes	No	Yes	No
Yes	12	13	14	11
No	0	0	0	1
Not sure	0	1	1	0
Don't know	0	1	0	0
Total	**12**	**15**	**15**	**12**

Intention to use in the future	PRI	PTI
Yes	25	25
No	0	1
Not sure	0	0
Dk	2	1
Total	**27**	**27**
Reasons for using		
• for limiting	4	7
• for spacing	4	8
• not to have too many children	15	8
• others	2	2
Total	**25**	**25**

Appendix 5t

Husband and wife communication

Husband and wife communication	PRI			PTI		
	Female	Male	Total	Female	Male	Total
Discussion of methods						
Yes	8	7	15	12	13	25
No	6	6	12	2	0	2
Discussion no of children						
Yes	7	8	15	12	12	24
No	7	5	12	2	1	3
Discussion of WPF						
Yes	9	9	18	12	12	24
No	5	4	9	2	1	3
Last time discussed of WPF						
Few weeks back	4	2	6	10	6	16
1-6 months	0	2	2	2	1	3
>1 year	0	5	5	0	5	5
no discussion	10	4	14	2	1	3

Appendix 5v

Factors affecting husband and wife communication

Factors	Discussion of WPF		Discussion of CM		Discussion of no. of children	
	Yes	No	Yes	No	Yes	No
Wife's age						
15-19 years	0	1	0	1	0	1
20-24 years	6	2	3	5	4	4
25-29 years	3	1	3	1	3	1
30-35 years	0	1	0	1	0	1
age at marriage						
13-14 years	2	1	1	2	1	2
15-19 years	11	6	9	8	9	8
20-24 years	4	2	4	2	4	2
25-29 years	1	0	1	0	1	0
religion						
Buddhist	17	9	15	11	14	12
Christian	1	0	0	1	1	0
Education						
Yes	9	2	6	5	8	3
No	9	7	9	7	7	9
Decision of marriage						
Parents	7	1	4	4	5	3
Self	**11**	7	**11**	7	**10**	8
Relatives	0	1	0	1	0	1
Decision in the family						
Husband	**12**	4	**8**	8	**9**	7
Wife	2	1	2	1	2	1
Mother-in-law	0	**2**	0	**2**	0	**2**
Father-in-law	2	2	3	1	2	2
Joint	2	0	2	0	2	0

Appendix 5w

Factors affecting husband and wife communication

	Discussion of WPF				Discussion of contraceptive methods				Discussion of no of children			
	PRI yes	PTI yes	PRI no	PTI no	PRI yes	PTI yes	PRI no	PTI no	PRI yes	PTI yes	PRI no	PTI no
Desired no. of children												
1	0	1	0	0	0	0	0	1	0	1	0	0
2	**16**	**19**	6	3	**14**	**21**	8	1	**13**	**19**	9	3
3	1	3	2	0	0	3	3	0	1	3	2	0
4	1	1	1	0	1	1	1	0	1	1	1	0
Total	18	24	9	3	15	25	12	2	15	24	12	3
No.of alive children												
0	2	4	2	0	0	3	4	1	2	4	2	0
1	6	7	3	1	4	7	5	1	6	5	3	2
2	**10**	**13**	4	2	**11**	**15**	3	0	**7**	**14**	7	1
Total	18	24	9	3	15	25	12	2	15	23	12	3
No. of sons												
0	**8**	**11**	4	2	**5**	**12**	7	1	**7**	**12**	5	1
1	**10**	**13**	5	1	**10**	**13**	5	1	**8**	**12**	7	2
Total	18	24	9	3	15	25	12	2	15	24	12	3
contraceptive decision maker												
husband	3	4	1	0	1	4	3	0	1	4	3	0
wife	1	0	1	0	0	0	2	0	0	0	2	0
joint decision	14	20	6	3	14	21	6	2	13	21	7	3
don't know	0	0	1	0	0	0	1	0	1	0	0	0
Total	18	24	9	3	15	25	12	2	15	25	12	3

Appendix 6: Analysis Plan

Data Analysis plan

Key Research Questions

- How does husband and wife communication influence in couple's contraceptive decision making?
- What are the factors influencing H\W communication?
- Have the workers learned to conduct a good communication between husband and wife?
- Any improvement of knowledge of contraceptive method well planned family, the responsible person for the sex of the baby and husband and wife communication among the workers after the intervention?
- Is there any change in the attitude and behaviour of the carpet factory workers after the intervention?

Key areas of investigation

Demographic information

- Ethnicity, age, religion, education level, income, occupation, husband's work, any brothers or sisters using Family planning

Fertility

- Marriage status: age at marriage, who decided the marriage, was it approved by the respondent
- Children: when was the first child born after marriage, children planned or not, number of children they desire and the number of children they have, desired number of sons and daughters, current pregnancy status

The contraceptive status among the respondents

- Ever used contraceptive method, the time of use, reason for discontinuing
- Current contraceptive status: what method, name, the place they got it
- Intention of using a contraceptive method: reason, for how long, when

Knowledge

- Knowledge on well planned family: meaning of well planned family
- Knowledge of different contraceptive methods: names, the body responses, benefits, draw backs,
- Knowledge of the place the methods are available
- Knowledge of the responsible person for the sex of the baby

Husband and wife communication:

- Meaning of HW communication
- Skills needed for good communication
- General HW communication : discuss about contraceptive method, well planned family, number of children, when was the last time they discussed, what are the reasons for not discussing
- Decision-making: who decides whether to use a contraceptive method, who makes the decision in the family, when do they make joint decision, the reason to make a joint decision.
- KURAKANI: the four steps of KURAKANI, use of the 4 parts of KURAKANI to make a good husband and wife communication.

Attitudes and perception regarding contraceptive method

- Misconcepts, misbelieve, myths about contraceptive methods.

Attitudes and perception regarding a well planned family and HW communication

- Importance of son in the society
- Importance of husband and wife communication

Area of investigation	Question numbers	Analysis status
1. **Demographics** • Ethnicity, age, religion, education level, income, occupation, husband's work, any brothers or sisters using Family planning	#s 2-24	EPIINFO version 5.0
2. **Fertility** • Marriage status: age at marriage, who decided the marriage, was it approved by the respondent • Children: when was the first child born after marriage, children planned or not, number of children they desire and the number of children they have, desired number of sons and daughters, current pregnancy status	#s 25- 28 #s 29-49	EPIINFO version 5.0 MSWord
3. **The contraceptive status among the respondents** • Ever used contraceptive method, the time of use, reason for discontinuing • Current contraceptive status: what method, name, the place they got it • Intention of using a contraceptive method: reason, for how long, when	#s 58,65, 66, 67, 68 #s 58-64 #s 73-75	EPIINFO version 5.0
4. Knowledge • Knowledge on well planned family: meaning of well planned family • Knowledge of different contraceptive methods: names, the body responses, benefits, draw backs, • Knowledge of the place the methods are available • Knowledge of the responsible person for the sex of the baby	#s 50-51 #s 52, 69-71 # 72 # 40	EPIINFO version 5.0 HW CHECKLIST OBSERVATION NOTES

5. Husband and wife communication: • Meaning of HW communication • Skills needed for good communication • General HW communication : discuss about contraceptive method, well planned family, number of children, when was the last time they discussed, what are the reasons for not discussing • Decision-making: who decides whether to use a contraceptive method, who makes the decision in the family, when do they make joint decision, the reason to make a joint decision. • KURAKANI: the four steps of KURAKANI, use of the 4 parts of KURAKANI to make a good husband and wife communication.	# 86 # 87 #s 76-83, #s 21-22, 84-85, 88-91 (post intervention ques)#s 89-91	EPIINFO version 5.0 MSWord HW CHECKLIST
6. Attitudes and perception regarding contraceptive method • Misconcepts, misbelieve, myths about contraceptive methods.	#s 94-102, 105-107, 109,111, 117-121	EPIINFO version 5.0 OBSERVATION NOTES
7. **Attitudes and perception regarding a well** planned family and HW communication • Importance of son in the society • Importance of husband and wife communication • Importance of a well planned family	#s 92, 103 #s 108, 110, 113-116 #s 93, 104, 112	EPIINFO version 5.0 OBSERVATION NOTES

What are the factors influencing H/W communication?

Demographic factors

- Age of the wife
- Age at marriage
- Age difference between husband and wife
- How many years of marriage
- Work shift
  - Day and night
  - Day

- Residence area
  - Urban
  - Rural
  - When moved to the city

Cultural factors

- Ethnicity
- Religion

Socio-Economic factors

- Income
- Education
  - Wife education level
  - Husband education level
  - The difference in husband and wife's education level
- Education
  - Wife education level
  - Husband education level
  - The difference in husband and wife's education level

Relationship between husband and wife

- Who decided the marriage
- Who makes the decision in the family
- Number of children present/desired no of children
- Who decides to use the contraceptive method

  Attitudinal question
  - Wives should get their husband's permission before taking any contraceptives
  - Husbands are always against their wives using contraceptive method

Factors influencing H/W decision making in contraceptive method

- Desired number of children/alive number of children
- Women's influence in the family
- Social class
- Education level of wife and husband

- Discussion of number of children
- Discussion of family planning methods
- Discussion of well-planned family
- Number of children
- Who makes the decision in the family

Have the workers learned to conduct a good communication between husband and wife?

- Analysis of the taped conversation of the couples(using the coding)

- Any improvement of knowledge of contraceptive method, well-planned family, the responsible person for the sex of the baby and husband and wife communication among the workers after the intervention?

Improvement of knowledge of contraceptive method

Pre and post interview

- How many types of contraceptive methods can be named?
- Name the benefits
- Name the draw back
- Name the side effects
- Name the source where one get the different contraceptive method

Improvement of knowledge of well-planned family

- Pre and post intervention: meaning of a well-planned family

The responsible person for the sex of the baby

- Pre and post intervention knowledge of the person responsible for the sex of the baby
- Attitudinal questions:
  - it is necessary to keep having children until a boy is born
  - if a wife has only girls the husband should marry another woman
  - if a couple cannot have children it is the women's fault

Improvement of knowledge of husband and wife communication

Meaning of husband and wife communication

Skills needed for a good communication

Abbreviations of KURAKANI.

Is there any change in the attitude and behavior of the carpet factory workers after the intervention?

Compare the answers to these questions in the pre and post intervention interviews.

Attitudes towards family planning and contraceptive methods

- **Respondents approval of FP**
- **Perception regarding spousal approval of FP**
- **Attitude regarding the benefit of well-planned family for the family**
  - In a well planned family, children get a better education
  - People are happier and healthier in a well-planned family
- **Attitude regarding the image of contraceptive users.**
  - Going to a health post for contraceptive method is shameful or embarrassing
  - When a women uses a contraceptive method her husband becomes angry
  - Contraceptive is often associated with promiscuity
  - A women is not supposed to talk about contraceptive method openly in the public
- **Attitude regarding the contraceptive methods**
  - If a women uses a temporary contraceptive methods she may become sterile
  - Religion is against women using contraceptive methods
  - Contraceptive methods have dangerous body responses
  - Contraceptive methods are for rich people only
  - More people would use contraceptives if they were more readily available
  - People do not know how contraceptive method works
  - Sterilization makes a person weak
  - Vasectomy makes a man unable to perform sex properly
  - Condom can fall off and get lost in the vagina
  - Copper-T can travel to the heart and the person will die
  - A person who has undergone vasectomy his offerings to god will not be valid

- **Attitude regarding husband and wife communication**
  - It is important for both husband and wife to jointly decide the number of children they should have.
  - A couple should decide the timing of the births of their children
  - Husband and wives should discuss contraceptive methods together
  - Husband and wife should be able to discuss any thing between themselves

Practice of contraceptive methods

- **Trends in contraceptive use over the years**
- **Current used method**
  - What method
  - For how long have been using
  - Source of the method
  - For how long intend to use
  - Reason for using
- **Not using contraceptive methods,**
  - reasons for not using
- **Intention of using methods in the future**
  - Reason for intending to use