SOCIO-CULTURAL CHARACTERISTICS OF PERMANENT FAMILY PLANNING USERS of Marginalized Population: A SOCIOLOGICAL PERSPECTIVE

A Research Report (GRANT) Submitted to Nepal Health Research Council (NHRC)

Ramshah Path, P.O. Box: 7626, Kathmandu, Nepal

Tel: 977-1-254220, 227460

Fax: 977-1-262469, 268284

e-mail: nhrc@healthnet.org.np or

nhrc1991@yahoo.com

Submitted by

Investigation Nepal
New Banewhwor, Tinkune
P.O.Box : 10473 Ktm, Nepal
Tel: 981030769
e- mail: mphs@ntc.net.np

2003

Acknowledgement

Formally, in Nepal The Family Planning Programme was started in 1965. However, the family planning services ware available in Nepal as early as 1956 through the Nepal Medical Association in collaboration with the Pathfinder fund. But the services of this association were only limited around the kathmandu valley. In 1968 the Family Planning Programme was formally established as Nepal Family Planning/Maternal Child Health Board. Today this programme is widely spread all the part and social communities of the country. Not only upper class or into the dominated societies the family planning programme is being effected to marginalized groups like as Meche, Kishan, Satar, Rajbansi, Dhimal etc. ethnic communities.

Day to day the popularity of the programme is increasing very rapidly. But through this programme what types of influences (positive or negative) are brought to marginalized population is still unknown. Lack of the depth studies and researches we can not say anything about the positives or negative effect of the programme in marginalized groups. There has been very few micro-level study or research are carried out concerning to effectiveness of family planning in different communities of rural areas. In this contest this study tries to find out the attitude and socio-cultural characteristics of both male and female permanent family planning users in marginalized population of Jhapa District from eastern Nepal. It may help to understand about the some issues of permanent family planning and be useful in articulating and implementing future policies regarding family planning programmes in rural areas of Nepal.

No doubt, this study is carried out through the financial support of the Nepal Health Research council, Ministry of Health. Without the economic help is provided by Nepal Health Research council this task can never be done. So first of all we would like to express our sincere thank to the Nepal Health Research Council and to the member secretary Dr. Anil Kumar Mishra and all the office staff. As like as our Hearty thanks go to local research assistant and to the respondents who provide us proper information and to local facilitators who help us to search the respondents. At last, we would like to extent out thanks to Mr. Krishna Karki for his help and Cooperation in preparing and typing to all this final shape.

Date 27 April 2003

Study Team Members

The Study Team Consisted of :

Dr. Bal Krishna Subedi (Director, NCASC, Teku) Principal Investigator.

Mr. Surendra Mishra (Lecturer, Tribhuvan University) Researcher

Mr. Shanker Prasad Bhandari (Lecturer, Trichandra Campus) Researcher

Mr. Lok Nath Dulal (Lecturer, Padma Kanya Campus) Researcher

Mr. Krishna Karki (Typist, Tribhuvan University) Data Analyst

Three female research assistants were hired from the community in Jhapa district to elicit data and information from the female respondents of the selected ethnic groups. The research assistants also helped in collecting qualitative information from the female respondents.

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ABSTRACT

Summary of the findings

This study entitled "Socio- cultural characteristics of permanent family Planning users of Marginalized population: A sociological perspective" was carried out on five ethnic groups i.e. the Satar, Meche, Rajbanshi, Kisan and Dhimal in Jhapa district of eastern development region of Nepal. The general objectives of this study is to find out the attitude and the socio-cultural characteristics of both male and female permanent family planning users. 100 users of permanent family planning method both male and female were selected to elicit data regarding age, ethnicity, occupation, types of family, number of living children by sex, education, religion and attitude of the users. (experience after the sterilization, advice given to others after sterilization, service obtained after sterilization, spouses reaction after five years of sterilization regarding family planning).

Findings regarding socio-economic and demographic characteristics of the users in the study area are as follows:

1. The young population in the study area comprises 42.3%, the economically active population 55.7%, sex ration 1.025 and the average household size is 6.4%. The young population is the highest (51.6%) in the Satar Community and the lowest in the Dhimal community (27.3%). The economically active population is the highest (69.7%) in the Dhimal community and the lowest (46.8%) in the Satar community. The dependency ration is the highest (113.8%) in the Satar

community and the lowest in the Dhimal community (43.5%).

2. Of the total users 16% were male and 84% were female. 60% of respondents in the study area belonged to the age group 25 to 39. It indicates the low population growth in future.

3. Of the total population ten years and above 29.8% males and 36.9% females were married. of the total married females 18.2% females were married before 24 years of age. 3.9% females were got married at the age of 10 to 14 years which indicates child marriage practice in the study area. 26.3% married female population of the Satar Community belong to the age group 10 to 24 year which is the highest percentage of the other sampled ethnic groups.

4. 84% and 16% respondents (husbands) were married at the age of 14 to 19 and 20-24 years respectively. Like this 92% female respondents (wives) were married at the age of 14 to 19 years. All the female respondents of the Satar, Meche and Rajbanshi community and 80% of female respondents of Kisan and Dhimal were married at the age of 14 to 19 years. This shows the early marriage pattern in the study area.

5. Nuclear family system is found more in the study area. 76% of the families are nuclear and 24% of the families are extended. No extended family was found in the Rajbanshi community.

6. 39.3% and 20% males and females, were illiterate and literate respectively. Only 2.8% males had got SLC and above education. 28.6% and 9.5% females were illiterate and literate respectively. None of the females of the study area had passed SLC examination. It shows the poor educational attainment of females in the study area.

7. 74% of the female respondents and 87.5% of the male respondents were found engaged in agriculture occupation. Most of female respondents of the Satar Community were found engaged primarily in animal husbandary, wage labour and small business.

8. Landlessness characteristics are found in such ethnic groups who were once land lord in the eastern Tarai. 16% of respondents (Satar, Kisan and Rajbanshi) were found landless and 42% of the respondents had 10 Kathas of agriculture land. Still the farmers use conventional method of farming.

9. The mean number of children of the respondents is 3.4. The Rajbanshi community has the highest (4.2) and the Dhimal has the lowest (2.9) mean number of children.

10. 53% of the respondents have used permanent family planning method at Bhadrapur hospital which is situated at the distance of 37.5 Km. from the residence of Dhimal and Satar. Some respondents of the Kisan community have used this method in India at the distance of 75 km. from their

residence. This indicates that people prefer to use permanent family planning method at the reliable and safe place regardless of the distance.

11. The rate of the users of permanent family planning is affected by many socio-cultural factors, preference of son is one of the most important factors. All the respondents in the study area used this method only after having 3 to 4 living sons.

Conclusions :

The use if permanent method of family planning among the respondents in the study area was found high among the female respondents. It was because of the lack of education and misconception about the effect of the use of permanent method of family planning among the males. The users of permanent method of family planning had used this method after having 4 children on an average, of that all had at least two sons. The cultural, religious and economic importance of son enforced them to use this method at older age. The findings also suggested that there were also lack of availability of permanent method of family planning in the vicinity of the residential places of the respondents. They had to go to far distance places to use permanent method of family planning. Most of the respondents had complained about the effect of operation on their health situation. They felt headache, weakness and tiredness after post operation period.

Recommendation

1. Fertility becomes high when the use of the methods of family planning is low. Education plays vital role in the adoption of the method of family planning. Basically women in the villages should be educated. For this, an adult woman education programme at the village level should be launched. They should be given health care education. An adult women education center as in India should be opened and a lady teacher should be appointed at the village level.
2. Though the study areas have health posts and health centers,. it lacks the family planning clinics and good medical halls where people may get family planning services easily. The health department of HMG should arrange the health programme and mobile camp periodically at the village level to deliver lecture about family planning methods and benefits of small family size and to provide family planning services. This type of programme may increase the knowledge and awareness about family planning methods, which may help to reduce fertility.
3. It is well known that rural people are poor as well as illiterate. They can be motivated towards family planning programme by offering some incentives. Permanent family planning method is not accepted at high rate by males due to lack of motivational techniques and practical difficulties. Motivation can be possible only by increasing family planning services through better organization and integration involving local people making frequent visits in the form of mobile camps within the VDC. Some incentives in cash or goods should be made for those couples who have not more than two children and have adopted permanent method of family planning. This type of incentive programme will increase the publicity of family planning programme in rural areas where it is most essential.

CHAPTER – I

INTRODUCTION

1.1. Background of the Study

The population of developing countries is increasing in such a way that it is showing sign of unprecedented in the human history. The fast increase is one of the most furious aspect of human beings which threatens all of us in the form of hunger, malnutrition, poor sanitation, problem of housing, unemployment and illiteracy.

Nepal is one of the developing countries of the world. In Nepal, population is increasing rapidly. In 1991 the growth rate was 2.1% per annum. There are many factors, which affect the population growth rate. Among them, the natural fertility has played a prominent role.

In Nepal, the population growth shows two dimensions. First, there is a problem of intraregional population disparity. The population density is highest in the Terai. Migration from the hills and Mountains into the Terai region is quite frequent and the continued migration would decrease cultivable land to the total population of the Tarai. Further more, the TFR is higher in the Tarai compared to the hills and mountains. It is interesting to note that why the Tarai has such a higher fertility rate than other areas?

The second dimension is the increasing trend in population growth from year to year. With the current growth rate, population will double within 33 years. However, it is feared that developmental plans,

programmes and policies will almost remain static, while the population will double.

David (1963) says that "magnitude of benefits divided from slowing down the rate of growth of population depends upon, to a great extent, on the methods and magnitudes of resources, both manpower and financial that can be allocated to population programmes. Furthermore, the rate at which an effective and efficient organization can be formed will definitely affect the magnitude of the programme, its implementation and, therefore, the benefits available to policy makers than all of the potential benefits slowing down population growth will be lost."

The Seventh Five Year Plan, taking into account the high growth rate of population and its multidimensional effect, had fixed a 15 year population target for the period from 1985 to 2002 to bring down the annual population growth to 1.2% and total fertility rate to 2.5% . This was a very optimistic plan, without really understanding the problem of high fertility in Nepalese society.

So, Nepal has to find out a means to get rid of the population problem and means to a better life for all the people. There are two ways for doing this: (I)Nepal has to make an effective utilization of the existing resources to increase the agricultural production and to enhance the industrial surplus; and (ii)to push down the population growth rate.

Both ways are equally complicated for Nepal. However, the present study emphasizes the second factor, which deals with the issue of population growth in Nepal.

A number of ways have been adopted to control the current population growth rate in Nepal. One of the means adopted is through family planning to reduce fertility.

Formally, The Family Planning Programme in Nepal was started in 1965. However, the family planning services were available in Nepal as early as 1956 through the Nepal Medical Association in collaboration with the pathfinder Fund. But the services of this association were limited around the Kathmandu valley. In 1968, the family planning programme was formally established as Nepal Family Planning/Maternal Child Health Board. The ultimate goal of the organization was to bring out a balance of the various resources and population growth to improve the quality of human life. For this it was realized that the population of Nepal must be limited to a level of 16 to 22 million.

1.2 Statement of the problem

The population problem can not be taken simply as a biological one. Rather, it is largely related to the people's economical and educational as well as socio-cultural practices (Devkota, 1984: 11-2). The kinds of birth control measures employed vary from one culture to another (Harries, 1988: 274). Medical sociology emphasises on socio-cultural practices related to health system in society. Socio-economic status, educational level and socio-cultural patterns play a crucial role on choosing the family planning services facilities.

As David (1963) puts it "Birth control is said to have been only one of the several responses to high fertility, with regard to fertility control. He further says that H.M.G. must seriously consider the benefits of changing some of its social legislation's that influence individuals'

behaviors with respect to family size. Such change must consider and include the raising of age of marriage."

However, it needs to be understood the society's perception. The need to be investigated: why do people choose to particular type of family planning device? what is the relationship between the socio- cultural background of the people and the use of contraceptives? There are very few studies and research on the health habits and socio-cultural patterns of different populations groups (MOH/WHO, 1990:50), especially from sociological/anthropological point of view.

Further, sterilization for men and women has been performed in different villages of Nepal. However, H.M.G. has tried to deliver family planning services, but the acceptance of family planning services has remained minimal among the eligible couples. Demographic and Health Survey (2001) reports that the most widely used modern method is female sterilization (15%) among currently married women (6%). The important question is why the natural fertility rate is so high among the Nepalese couples especially among the ethnic and lower caste groups living in rural area? why there is low acceptance of permanent family planning service among the ethnic and lower caste groups of the population? What are the socio-cultural characteristics of the permanent family planning users?

Similarly questions might arise : What is the attitude of the users towards adopting the permanent family planning method? This study is an attempt to understand the socio-cultural characteristics of the users of permanent family planning method in the rural areas in Eastern Development Region of Nepal.

1.2.1. Research Questions

Sterilization for men and women has been performed in different villages of Nepal over many years and circumstances. Nepal Demographic health Survey (2001) reports that the most widely used modern method is female sterilization. The important question is :

i) Why there is such a low acceptance of permanent family planning services among the ethnic and lower caste groups of the population?

ii) What are the socio-cultural characteristics of the permanent family planning users?

iii) What is the attitude of the users towards adopting the permanent family planning method?

1.2.2 Research Hypothesis

In this proposed study the relationship of various variables will be measured but the measurement of those variables is not developed in the form of hypothesis.

There is wide acceptability of permanent family planning procedures, however they are limited by the availability of services owing to various beliefs and experiences after the procedure.

1.3. Objectives of the Study

General Objectives

This study attempts to find out the attitude and the soio-cultural characteristics of both male and female permanent family planning users.

Specific Objectives

The specific objectives of this study are:

- To investigate the socio-cultural characteristics of the permanent family planning users of Marginalized population such as age, ethnicity, occupation, types of family, number of living children by

sex, education, religion and distance of residence from health institution.

- To find out their attitude towards adopting permanent family planning method.
- To assess the sociological perspectives and recommend for the success of the program.

1.4. Rationale/Justification of the Study

Many studies have been carried out dealing with fertility and effectiveness of family planning using quantitative method. Most of them have carried out research on macro-level and used and analyzed already available data. Many scholars, demographers and various national and international researcher unanimously agree that Nepal's birth rate is very high yet there has been very little micro-level study or research to assess the exact birth rate and the effectiveness of family planning in different communities of rural areas. That is why this study tries to find out the attitude and socio-cultural characteristics of both male and female permanent family planning users in different ethnic and lower caste groups of Jhapa district of Nepal. It may help to understand some issues of family planning which will be useful in articulating and implementing future policies regarding family planning programmes in rural areas of Nepal.

The contraceptive prevalence rate (CPR) in Nepal is about 30% (Response). Majority of the CPR is contributed by permanent method users (sterilized). This has a long term impact on the program as unsatisfied clients may create a long term barrier for acceptance of family planning among new users. Besides, the low rate of temporary users might have effect on the permanent method users.

CHAPTER – II

LITERATURE REVIEW

The need of any study from a sociological point of view for family planning has appeared only recently due to the increasing knowledge on changing economic, social and cultural patterns in the society. Methods of family planning, which may be quite suitable to one group, may not be effective to another because of social factors. Attitude surveys have shown that awareness of family planning is very widespread even in developed countries showing over 60% of people have attitudes favorable to restricting or spacing birth. However, the amount of contraceptives used by couples in developing countries is very low.

Procreation, childbirth, weaning, sexuality, death, disease and suffering might be private experiences, but they all have an intrinsic social dimension. The health conditions in which they take place are determined as much by cultural practices as by biological and environmental factors. (Nakajima, Mayor, 1996:3). In the same way culture also plays an important role in determining attitudes and setting barriers to the acceptance of modern contraception. why do people say they don't want any more children yet they don't use contraception? Taylor-Thomas (1991:30) lists the following factors restricting the widespread provision of family planning.

(i) Socio- cultural factors like illiteracy; religious and traditional beliefs and practices impose limitations on the acceptance of family planning.

(ii) Geographical factors such as remoteness and inaccessibility to family planning services, difficult terrain and poor communication along with infrastructure limit the expansion of family planning services delivered to the rural areas.

(iii) Inadequately trained family planning personnel, as well as a lack of financial and material resources, also impose restrictions on the expansion of these services.

The culture of silence and shame discourage people, especially for women to express their views about sex, family planning and sexual matters. Shyness and consideration of privacy, might be other causes of not using contraceptive. Culturally, women are expected to endure, to not make demands and to show modesty. Physical examinations and talking about sex and family planning is still uncomfortable (Young, 1979:19).

Nepali culture is not yet ready to accept the free use of temporary family planning methods by women, as there is a general notion that only low status women use it. It is because of dominant cultural values that a lot of eligible married women are reluctant to use family planning devices. 'Shame' is attached if 'others' come to know about the personal use of such devices (Dahal, 1992:10)

The reason of the low use of family planning services in Nepal is that the desired family size of Nepalese couples is high, i.e. 3.4 to 4.0 surviving children, with not less than 1-2 sons. Until and unless this family size is obtained, the use of family planning services will be minimal (Ibid, 1989).

Norms about family size are influenced by varying styles related to position in a status hierarchy, status indicators, such as education, occupation, income, wealth, power, prestige, caste and general class indicators may influence the desired number of children (Tuladhar, 1989:44).

In most Hindu societies, a son is very important not only economically and socially but also from the point of view of his parent's next lives after death (Bista, 1987:15).

The certainty of motherhood in the lives of Hindu women is the paramount test of their identity. According to the Hindu religion, the prime objective of marriage is to continue the line of pregnancy (Pokharel, 1970:64).

CHAPTER – III

RESEARCH METHOD

3.1. Type of Study (Descriptive Study)

The proposed study is descriptive. The relationship of above mentioned variables was described to find out how these factors were related with the permanent planning users.

3.2. Study Variables

Both qualitative and quantitative research method were used to carry out the research.

There are many variables, which directly and indirectly affect the users of permanent family planning services, but in this study only some of the socio-cultural factors were selected. The variables which were studied are : (i) age, (ii) Ethnicity, (iii) Occupation, (iv) Types of family, (v) number of living children by sex, (vi) Education, vii. Religion, (viii) Attitude of the users. (experience after the sterilization, advice obtained from others, who had sterilization, quality of service obtained after sterilization, spouse's reaction after sterilization.)

3.3. Study Site and its Justification

As mentioned above, the birth rate and TFR are high in the Tarai region of Nepal. It is also known that the multitude of ethnic and caste groups are found more in eastern and central Terai region of Nepal.

Jhapa district from eastern Tarai was selected for the study. 3 VDCs, namely Topgachhi, Dhaijan and Chandragadhi and 2

municipalities, Damak and Mechinagar were selected purposively for the study of Satar, Meche, Rajbanshi, Dhimal and Kisan ethnicity. These VDCs and municipalities were selected for the study of respective ethnic groups considering the density of population of the study groups, accessibility from district headquarters, and co-operation for data collection.

Table 3.1.

Universe and Sampled Group by VDCs.

Sampled locality	Total population	Sampled Group	Total population of the group	% of selected population
Topgachhi VDC	20619	Satar	1097	5.32
Dhaijan VDC	8256	Meche	691	8.37
Chandragadhi VDC	16052	Rajbanshi	2699	16.81
Damak Municipality	35009	Dhimal	2255	6.44
Mechinagar Municipality	49060	Kisan	607	1.23

Source: CBS-2001.

3.3.1. Target Population

100 users of permanent family planning method both male and female were selected from the Satar, Meche, Rajbanshi, Kisan and Dhimal ethnic groups for this study. 4 males and 16 females from the Satar, 20 females from each Meche, Rajbanshi and Dhimal and 12 males and 8 females from Kisan community were selected purposively for this study population. During the field survey few male users of permanent family planning method were found. So number of female respondents is

high because they were not available in the study area and have gone abroad in search of work.

3.3.2. Sampling Methods

As the study is concerned with the permanent family planning users the universe of the study (users) is not fixed. So non-probability sampling design was used. Purposive or judgemental sampling technique was applied to select the users.

3.4. Tools and Techniques for Data Collection

Tools and techniques such as semi structured questionnaire, unstructured interview schedule, a case study and key informant interview were developed to elicit both qualitative and quantitative information.

3.4.1. Semi-Structured Questionnaire

Semi structured questionnaire was used to elicit information from the users on age, ethnicity, education, religion, occupation, family types etc. It was used for both male and female users. The female users of family planning were interviewed by female interviewer, where as for male respondent; male were the interviewer.

3.4.2 Unstructured Interview Schedule :

As quantitative data can be gathered through questionnaire, unstructured interview schedule was used to elicit qualitative information such as feeling, perspective of society from the users.

3.4.3. Case Study

Five case studies one from each ethnic group was conducted to collect detailed information about the users of both sexes which gave a plenty of information to keep the study on the right track.

3.4.4. Key Informant Interview

The VHW or MCHW and the local leader and/or teachers were interviewed as key informants to gather information on the program and camp managed for male and female sterilization.

3.4.5. Pre-testing the Data Collection Tools

Ten questionnaires were pretested in the field by the researchers in Jhapa in different ethnic groups. It helped to improve the quality of the instruments. After pretesting the tools the changes that occurred were incorporated to standardize the instrument and irrelevant items were discarded.

3.4.6. Validity and Reliability of the Research

Validity is concerned with the data whereas reliability is concerned with the instrument applied in the research. Reliability of the instruments was improved by pretesting the tools. To make the study findings valid a representative sample was selected for data collection. All the variables included in the study were operationally defined and criteria of measurement was also clearly defined.

3.4.7. Biases

A question may arise concerning the biases of sample selection. To minimize the biases, a standard sampling procedure was applied to select sample unit. As the research is more qualitative in nature and incorporates

the sociological point of view, some subjectivity would be expected keeping in view the difficulty to reach population, their accessibility to services and various other factors.

3.4.8. Supervision and Monitoring

Primary data were collected in the field by the field assistants and collected data were supervised and checked daily by the field supervisor. Besides the field supervisor also cross-checked the sites whether the field assistants were doing job properly.

3.4.9. Data Management

Data collected through different tools were verified and edited then a coding manual was made and all the collected information were codified and entered into the computer

3.4.10.Data Analysis

All the information and data were recorded for computer analysis. Single and multi-table analysis were done and printed out. Dummy tables were made to put data in a standard form and all the analyzed data were synthesized and put on this table. Data and information were interpreted using descriptive statistics such as number/frequency, percentage and mean. All the processing and analysis of data were done by a group of research assistants with the help of researchers.

3.4.11. Dissemination of Research Results

The findings of the research can be disseminated in various formal and non-formal gatherings including conferences and meetings organized by NHRC and RONAST. If necessary, and if NHRC wishes to have

separate dissemination meeting conducted for this research a program can be fixed.

3.4.12. Utilization of the Research Findings (optional)

Present day study incorporates multi disciplinary approach. Medical Research can not be an exception to this as medical research as well as fruit of medical advancement are targeted to people; Besides, sociological perspectives are very important to make any program effective.

3.4.13. Limitations of the Study

This study is limited to above mentioned ethnic groups of Jhapa district of eastern development region of Nepal. The sample units selected through purposive sampling method might have error of which is not verified by any statistical method. Only some of the socio-cultural characteristics of the permanent family planning method are included in the study. So, the findings of this study may not be applicable to national level generalization but its finding will be a guide for launching future program for the similar target group.

CHAPER-IV
THE SETTING

4.1. Location and Physical Feature of Jhapa District

The present study was carried out in 3 selected VDCs Dhaijan, Chandragadhi, and Topgachhi, and 2 municipalities Damak and Mechinagar, which are located in Jhapa district, Mechi Zone. Jhapa district is in the east of Nepal Terai adjoining the Indian border to the south and east, Ilam district to the north and Morang district to the west. The Ratuwanaba river separates this district from Morang district in the west. According to 2001 census, the total population of Jhapa district is 691173. Of them 3,43,675 are males (49.72%), and 3,47,498 are females.(50.28%). This district has an area of 1532 sq. km and the population density is 430.36 person per sq. KM. The total number of household in this district is 139730. (2001 census). The average household size is around 5.

The district has humid subtropical monsoon climate. The summer is hot and winter is cold. Jhapa district is one of the most developed districts in Nepal. There are three municipalities in this district. Facilities such as electricity, telephone, hospital, road, school, market, etc are available in most of the VDCs in the district. Many indigenous ethnic and caste groups such as Dhimal, Meche, Koche, Rajbanshi, Tajpuriya, Ganagai, Satar, Danuwar, Bantar, Jhangad, Kisan, Musahar, reside in different VDCs of this district. This is a very prosperous district.

4.2. Introduction of the Study Area

There are 3 municipalities and 47 VDCs in Jhapa district of these 2 Municipalities and 3 VDCs were selected for the study considering the density of population of marginalized ethnic groups and accessibility.

a. Damak Municipality

Damak municipality is densely populated municipality of Jhapa district. The total population of this municipality is 35,009 (2001). This municipality is situated in the west of Jhapa district adjoining with the border of Morang district. The district headquarters Chandragadhi is 35 km east from here. Many ethnic and caste groups such as Brahmin, Chhetri, Rai, Dhimal, Newar, Limbu, Tamang, reside in this municipality. The study group the Dhimal is the 2nd largest ethnic group of this municipality. Total population of the Dhimal is 2255 (2001 census) in this municipality which is 6.4% of the total population of the municipality.

b. Mechi Nagar Municipality

Mechi Nagar municipality is situated 25 km. North east from district headquarter Chandragadhi. This municipality adjoins its eastern border with west Bengal state of India. It's total population is 49060. Many caste and ethnic groups such as Brahmin, Chhetri, Rajbanshi, Dhimal, Rai, Limbu, reside harmoniously here. The study group the Kisan was selected from this area. The total population of "Kisan" is 607 which is 1.2% of the total population of the municipality.

c. Topgachhi VDC

Topgachhi VDC is situated 30 KM west of district headquarter. The fertile plain land has attracted many ethnic and caste groups to reside here. The ethnic caste groups residing here are Brahmin, Chhetri, Limbu, Rai, Satar, Newar, Magar, Gurung, Tamang. The total population of this VDC is 20619. The Satar was selected as study group from this VDC. The total population of the Satar in this VDC is 1079 which is 5.2% of the total population of the VDC.

d. Chandragadhi VDC

Chandragadhi is the headquarters of Jhapa district. This VDC has been provided with all basic facilities. It shares its southern border with India. The total population of this VDC is 16052. Many ethnic and caste groups such as Brahmin, Chhetri, Satar, Newar, Rajbanshi, Rai, Limbu reside here. The Rajbanshi is the largest ethnic group in this VDC. The total population of the Rajbanshi in this VDC is 2699 which is 16.8% of the total population of the VDC.

e. Dhaijan VDC

Dhaijan VDC is situated about 13 km. North from district headquarter. This VDC is inhabited by many ethnic, caste groups such as Brahmin, Cheetri, Rajbanshi Meche, Rai, Limbu, Tamang, Newar etc. The Meche ethnic group was selected for the study from this VDC which forms the largest ethnic group of this VDC. The total population of the Meche is 691 which is 8.4% of the total population of the VDC(8256).

CHAPTER – V

SOCIO-ECONOMIC AND DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

In chapter V, an effort has been made to analyze the data collected through questionnaire by surveying hundred households with one respondent each of Topgachhi, Dhaijan and Chandragadhi, VDCs and Mechi and Damak municipality of Jhapa district. This chapter discusses the age and sex structure, ethnicity, occupation, types of family, number of living children by sex, education, religion and residential distance from health institution.

5.1 Age and Sex Structure of Population

The age and sex structure provide the composition of the total population. Table 5.1 gives the age and sex structure of the population of sampled households of different VDCs and municipalities of Jhapa district. It indicates that the young population (the age group 0 to 14) comprises 42.3%, the economically active population (the age group 15-59) are 55.7% and 2.0% are populations 60 years and above. The sex ratio of the sampled population is 1.025 and average household size is 6.4. When these data are compared with Jhapa district and Nepal of 2001 census it is found that the young population is higher in the study area than that of Jhapa district and Nepal as a whole. This age structure clearly indicates the young population structure. When these data of the sex ratio and average household size are compared with Jhapa district and Nepal it

is also found that both sex ratio and awrage household size are higher in the study area.

When the data of five ethnic groups are compared it is found that the young population (0-14 age) is highest (51.6%) amongst the Satar community and lowest in the Dhimal community (27.3%), the economically active population (15-59 years of age) is highest (69.7%) among the Dhimal community and lowest (46.8%) in the Satar community. The data also show that of the five sampled ethnic groups female population is high in the Dhimal and the Kisan community. It also indicates that the average household size is highest (7.5) among the Kisan community and lowest (5.5) in the Rajbanshi community. When the data of average household size are compared with Jhapa district and Nepal of the 2001 census it is found that the average household size of the Kisan community is higher than the Jhapa district and Nepal as a whole.

Table 5.1.
Age and Sex Structure of Population of Sampled Households by Ethnicity

Age Group	Satar % of total				Meche % of total				Rajbanshi % of total				Kisan % of total				Dhimal % of total				Total % of total			
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
0-4	12	10	9.7	8.1	8	6	6.4	4.8	4	4	3.6	3.6	6	10	4.0	6.7	4	6	3.0	4.5	34	36	5.3	5.6
5-9	20	10	16.1	8.1	14	8	11.3	6.4	8	10	7.3	9.1	15	12	10.0	8.0	6	4	4.5	3.0	63	44	9.8	6.9
10-14	0	12	0.0	9.7	12	8	9.7	6.4	18	10	16.4	9.1	9	9	6.0	6.0	10	6	7.6	4.5	49	45	7.7	7.0
15-19	8	4	6.4	3.2	6	2	4.8	1.6	6	2	5.5	1.8	6	8	4.0	5.3	4	6	3.0	4.5	30	22	4.7	3.4
20-24	4	2	3.2	1.6	0	4	0.0	3.2	0	2	0.0	1.8	3	6	2.0	4.0	6	4	4.5	3.0	13	18	2.0	2.8
25-29	2	2	1.6	1.6	2	10	1.6	8.1	0	2	0.0	1.8	9	6	6.0	4.0	2	6	1.5	4.5	15	26	2.3	4.1
30-34	6	6	4.8	4.8	12	2	9.7	1.6	4	4	3.6	3.6	3	6	2.0	4.0	10	10	7.6	7.6	35	28	5.5	4.4
35-39	2	2	1.6	1.6	4	4	3.2	3.2	2	6	1.8	5.5	3	6	2.0	4.0	6	10	4.5	7.6	17	28	2.6	4.4
40-44	6	4	4.8	3.2	4	4	3.2	3.2	6	2	5.5	1.8	3	3	2.0	2.0	4	6	3.0	4.5	23	19	3.6	3.0
45-49	0	2	0.0	1.6	2	2	1.6	1.6	2	6	1.8	5.5	0	3	0.0	2.0	2	4	1.5	3.	6	17	1.0	2.6
50-54	2	2	1.6	1.6	2	4	1.6	3.2	4	0	3.6	0.0	12	6	8.0	4.0	2	2	1.5	1.5	22	14	3.4	2.2
55-59	2	2	1.6	1.6	0	2	0.0	1.6	2	4	1.8	3.6	0	3	0.0	2.0	4	4	3.0	3.	8	15	1.3	2.3
60+	2	0	1.6	0.0	2	0	1.6	0.0	0	2	0.0	1.8	3	0	2.0	0.0	2	2	1.5	1.5	9	4	1.4	0.6
Total	66	58	53.0	46.7	68	56	54.7	44.9	56	54	50.9	49.0	72	78	48.0	52.0	62	70	46.7	52.7	324	316	50.6	49.4

Source : Field Survey, 2002.

5.2 Dependency Ratio

Dependency ratio shows the proportion of economically active and inactive population. The age and sex structure (Table 5.1) of the population shows that of the five ethnic groups the dependency ratio is highest (113.8%) in the Satar community and the lowest in the Dhimal community. (43.5%). The data also indicate that the dependency ratio is also high in the Rajbanshi community (103.7%). This is because of the few old people of 60 years and above and many young people in the age group 0 to 14. The data also indicate that 69.7% people of Dhimal community are economically active which is good when compared to rest of the sampled ethnic groups.

In the study area, most of the children after the age of ten years were seen actively participating in works like household keeping, taming animals and cattles, grass cutting and other small works of agriculture. Similarly old people were also found busy in agricultural works like seed sowing, weeding and harvesting crops. Naturally, too many dependent population as in the Satar and the Rajbanshi community affect the community as well as village's economy, labour force and productive potentiality.

5.3. Age, Sex and Ethnicity of the Respondents

The age and the sex structure provide the composition of the total respondents. Table 5.2 indicates that of the total respondents only 16% are male and 84% are female, out of 16 male respondents 8 respondents belong to the current age group 50-54, 4 belong to the age group 35 to 39 and 4 belong to the age group 55 to 59. Out of the 100 respondents 24%

females respondents belong to the current age group 30-34 and 20% belong to the current age group 25to 29, only 4% female respondents belong to the current age group 55 to 59. So far the ethnicity of the respondents is concerned male respondents were selected only from the Kisan community (12%) and the Satar community (4%). This is because of the absentee of male respondents of other ethnic groups during the period of household survey.

The data also indicate that in the age group 25 to 29 years, 40% female respondents belong to the Meche community, 30% belong to the Kisan community, in the age group 30-34 50% female respondents belong to the Dhimal community and 20% belong to the Rajbanshi, Meche, and the Satar community, in the age group 35 to 39 30% female respondents belong to the Meche and the Rajbanshi community and 20% belong to the Dhimal community. The age group below 20 and after 40 is considered as low fertile period and the age group between 25 to 34 is considered as high fertile period.

The data also indicate that in the study area 60% of the female respondents who have adopted permanent family planning method belong to the age group 25 to 39. It also indicates towards the possibility of population growth in future.

Table 5.2.

Age and Sex Structure of the Respondents by Ethnicity

Age Group	Satar				Meche				Rajbanshi				Kisan				Dhimal				Total			
	M	F	T	%	M	F	T	%	M	F	T	%	M	F	T	%	M	F	T	%	M	%	F	%
25-29		2	2	10		8		40		2		10		6		30		2		10			20	
30-34		4	4	20		4		20		4		20		2		10		10		50			24	
35-39						6		30		6		30	4			20		4		20	4		16	
40-44		4	4	20		2		10		2		10						2		10			10	
45-49		2	2	10						4		20											6	
50-54		2	2	10									8			40		2		10	8		4	
55-59	4	2	6	30						2		10									4		4	
Total	4	16	20	100		20		100		20		100	12	8		100		20		100	16		84	

Source : Field survey, 2002.

5.4. Marital Status of Population by Sex and Ethnicity

Marriage is one of the important factors to affect fertility. The data below (see Table 5.3) provides the marital status of population by age, sex and ethnicity in the study area. The data indicate that of the total population ten years and above 29.8% males were married, 16.6% males were unmarried, 36.9% females were married and 11.9% females were unmarried. The data also indicate that of the total married females 18.2% females were married before 24 years of age. The table also indicates towards the child marriage practice in the study area. 3.9% females got married at the age of 10 to 14 years. Of the total 7 married females in the age group 10 to 14 years 4 females belong to the Satar community and 3 females belong to the Kisan, community. Of the total married female population of the Satar community 26.3% belong to the age group 10 to 24, which is the highest percentage when compared with other sampled ethnic groups. No married females of the Rajbanshi community were found in the age group 10 to 14. The data also indicate that there may be higher fertility rate in future in the Satar, Kisan and Dhimal community.

Table 5.3

Marital Status of Population by Sex and Ethnicity (10 years and above)

Age group	Male		Female		Male			Female			Male			Female			Male			Female			Male			Female			Male			Female		
	M	UM	M	UM	M	UM	WR	M	UM	W	M	UM	WR	M	UM	W	M	UM	WR	M	UM	W	M	UM	WR	M	UM	W	M	UM	WR	M	UM	W
10-14	0	49	7	38				4	8			12			8		4	18			10			9		3	6						6	
15-19	11	19	14	8	4	4		4				6		2	2		2	6			2		3	3		4	4		4			4	2	
20-24	4	9	12	6	4			2						2			6				2			3		4	2					4		
25-29	15	0	26	0	2			2			2			10			2			2			9			6			2			6		
30-34	33	0	28	0	6			6			12			2			4			4			3			6			10			10		
35-39	17	0	26	(W2) 0	2			2			4			4			2			6			3			6			6			8		2
40-44	23	0	16	3	6			4			4			4						2			3				3		4			6		
45-49	5	(WR 1) 0	15	(W2) 0				2			1			2			20	21		6						3			2			2		2
50-54	20	(WR2) 0	14	0	2			2			2			4									10		2	6			2			2		
55-59	8	0	11	(W4) 0	2			2								2				4						3			4			2		2
60+	0	(WR9) 0	2	W (2)																2					3					2			2
Total	138 (29.8 %)	77 (16.6) WR 12 (2.6)	171 (2.2)	55 (11.9) W 10 (2.2)	28	4	30 = 138 (26.3 %)	25	8		18		30	10	10	2				26	14		31	15		41	15		34	16	2	44	8	8

Source : Field Survey, 2002.

5.5. Age at Marriage of the Respondents

Age at marriage is one of the most important factors to effect fertility. It appears that fertility goes down when marriage takes place at late twenty, especially after the age of 25 years.

It is well known fact that fertility rate is higher where marriage takes place comparatively at early ages. The data below (see table 5.4). Provides age at marriage of both husband and wife by ethnicity. Table indicates that 84% males (husband) were married at the age of 14 to 19 years and 16% were married at the age of 20-24 years. Like this 92% females (wives) were married at the age of 14 to 19 years and 8% were married at the age of 20 to 24 years. The data also indicate that all the female respondents (wives) of the Satar, Meche, and Rajbanshi were married at the age of 14 to 19 years and 80% female respondents of the Kisan and Dhimal were married at the age of 14 to 19 years. The data show the early marriage pattern in the study area. The interviewees responded that they did not educate their daughters as they considered the daughters as economic burden for the family. If the girls were not early married, there were chances of "illegal birth" or the girls might elope with boys from other caste without asking their parents, which might make them unhappy.

Table 5.4

Age at Marriage of the Respondents (Both Husband & wife) by Ethnicity

Age Group	Satar		Meche		Rajbahshi		Kisan		Dhimal		Total	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
14-19	20	20	16	20	16	20	16	16	16	16	84	92
20-24	0	0	4	0	4	0	4	4	4	4	16(100)	8(100)

Source : Field Survey, 2002.

5.6. Types of Family of the Respondents by Ethnicity

Family type is also considered one of the important factors to effect fertility. The data given below (see Table 5.5). indicate that 76% of the families are nuclear and 24% are extended families in the study area. It also indicates that 100 percent of the families of the Rajbanshi, 80% of the families of each the Dhimal and the Satar, and 60% of the families of Meche and the Kisan are nuclear, 40% of the families of each the Meche and the Kisan, and 20% of the families of each the Satar and the Dhimal are extended.

A family with husband, wife and their unmarried children is considered as nuclear family. The father, mother and their married children living together is considered as extended family. Joint family is a group of brother's families living together in which there is a joint residence, Kitchen and property. No joint family system was found among the study population.

Table 5.5

Types of Family of the respondents by Ethnicity.

Types of Family	Satar	Meche	Rajbanshi	Kisan	Dhimal	% of Total
Nuclear	16	12	20	12	16	76
Extended	4	8	0	8	4	24
Total	20	20	20	20	20	100

Surce : Field Survey 2002.

5.7. Educational Attainment of Population by Sex and Ethnicity

The children of all castes and ethnic groups go to primary school in the vicinity as they do not have to pay fees and get book free of cost. However, very few of them attend high school for the reason that they can not afford to buy books and other educational materials. The table provides the educational attainment of population by sex and ethnicity in the study area (see table 5.6). The data indicate that of the total population 39.3% of both sexes were illiterate, 20% of the respondents were just literate who could hardly write their names, 25.4% people of both sexes had got primary education and only 2.8% males had got education S.L.C. and above.

Female education plays an important role to effect fertility. The data indicate that of the total population (both sexes) 28.6% females were illiterate, 9.5% were literate who could hardly write their names, 9.1% had got primary education and 1.9% had got secondary education but none of the females of the study area had passed S.L.C. examination. It shows that the educational attainment of females in the study area were very poor. When the data on education are analyzed by ethnicity, it is found that of the total population of each ethnic group (both sexes) 41%, 35.3%, 21%, and 18.2% females of the Kisan, the Satar, the Dhimal and the Meche were illiterate respectively. Only 6 females of the Meche, 1 female of the Rajbanshi, and 4 females of the Dhimal community had got secondary education. The females of the Satar and the Kisan community had got only primary education. However, no females of the sampled ethnic groups had got S.L.C. education. This is because of the poor economic condition and lack of awareness about the significance of education in life.

Table 5.6

Educational Attainment of Population by Sex and Ethnicity (five years and above)

Educational Allaiment	Satar		Meche		Rajbanshi		Aisan		Dhimal		% of Total population	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Illiterate	12 (11.8)	36 (35.3)	4 (3.9)	20 (18.2)	6 (5.9)	26 (25.5)	33 (24.6)	55 (41.0)	6 (4.9)	26 (21.0)	61 (10.70)	163 (28.6)
Literate Just write name	20 (19.6)	10 (9.8)	10 (9.1)	8 (7.3)	12 (11.8)	8 (7.8)	21 (15.7)	6 (4.5)	8 (6.6)	22 (18.0)	71 (12.5)	54 (9.5)
1 to 5 class pass	18 (17.6)	2 (2.0)	24 (23.5)	16 (14.5)	28 (27.4)	15 (14.7)	9 (6.7)	47 (5.2)	14 (11.5)	12 (9.8)	93 (16.3)	52 (9.1)
6 to 10 pass	4 (3.9)		14 (13.7)	6 (5.5)	6 (5.9)	1 (1.0)	3 (2.2)	0	22 (18.0)	4 (3.2)	49 (8.6)	11 (1.9)
S.L.C. and above	0		8 (7.3)	0	0	0	0	0	8 (6.6)	0	16 (2.8)	0
Total	54 – 102	48	60=110	50	52=102	50	66 – 134	68	58 = 122	64	290 (50.9) – total 570	280

Source : Field Survey, 2002.

5.8. Number of Living Children

The data below (see Table 5.7) show the number of living children of the respondents. It indicates that of the 100 respondents the mean number of living children is 3.4. The data also show that the Rajbanshi has the highest mean number of children (4.2) and Dhimal has the lowest mean number of children (2.9). The number of male children is found higher than female children in all the ethnic groups. This may be one of the reasons for using permanent method of family planning. Because in Hindu society son preference is high for the continuity of lineage. In Hindu religion it is believed that if the son cremates the dead bodies of his parents they will get the heaven. This cultural factor inspires the couple to have at least one son.

Table 5.7

Number of Living Children by Sex and Ethnicity

Ethnicity	No. of living children				
	Male	Female	Total No.of children	Mean No. of Children	Ratio M:F
Satar	40	28	68	3.4	1.6:1
Meche	32	30	62	3.1	1.1:1
Rajbanshi	42	42	84	4.2	1:1
Kisan	32	36	68	3.4	0.8:1
Dhimal	42	16	58	2.9	2.8:1
Total	188	152	340	3.4	

Source : Field Survey, 2002.

5.9. Number of Living Children

There are many factors to determine the family size in Nepali society. Of the many factors, cultural factor plays an important role to

determine the number of living children by sex. In Hindu religion it is believed that the parents go to heaven after death if he/ she is cremated by his/her son. This cultural factor compels every parent to have at least one son at any cost. If they are unable to give birth to a son they will adopt one. Like this there are many factors such as continuity of the lineage, successor of the property, old age security which affect the value of son in society. During the field survey the respondents responded that they had high number of sons(see table no.5.7) because sons take care at the old age. The responses of the respondents to have more boy child were : want of one daughter, first son was dumb, continuity of the descent, unaware about the family planning, disagreement among the elder members of the family to use permanent family planning. Like this the responses regarding such number of living daughters are: want of son, daughter is the Laxmi of the home, daughter takes care and loves more than son, and the elders restricted to use permanent family planning method. However, the mean number of living children (3.4) is low compared to Jhapa district and Nepal as a whole.

5.10. Primary Occupation of the Respondents

As the study area is in the Terai region of Nepal, the productivity of land is good in this region. Agriculture is the main occupation and source of livelihood of most of the respondents. The table below (see Table No. 5.8) indicates that of the total female respondents about 74% respondents' main occupation is agriculture. Some respondents are engaged in animal husbandry, wage labour, and small business (selling of home made liquor). Like this 87.5% of the male respondents are engaged in agriculture. The data also indicate that of more than 70% female respondents of all the selected ethnic groups except the Satar are engaged in agriculture. Most of the female respondents of the Satar are engaged in animal husbandry, wage labour, and business.

Table 5.8
Primary occupation of the Respondents by Sex and Ethnicity

Occupation	Satar		Meche		Rajbans hi		Kisan		Dihinal		% of total	
	Female primary	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
Agriculture	6	4	14		18		8	10	16		62 (73.8)	14 (87.5)
Animal husbandry	5										5 (5.9)	
Wage labour	4		2		2			2	2		10 (12.0)	2 (12.5)
Business homemade liquor	1		4						2		7 (8.3)	
Total	16	4	20		20		8	12	20		84 (100)	16 (100)

Source : Field Survey, 2002.

5.11. Land Ownership

The data given below (see Table 5.9) show the land ownership of the respondents. It indicates that 16% respondents are landless, 42% of the respondents have 10 Kathas of agriculture land, and 14% have more than one bighas of agriculture land. The data also show that 8,6,and 2 respondents of the Satar, the Kisan and the Rajbanshi are landless respectively.

The Dhimal and the Rajbanshi are comparatively better off farmers in the study area. They have owned more land. Most of the Kisans are landless who have taken land of others on rent where as the landless Satars are engaged in other occupations.

The main crops cultivated in the various lands are paddy, wheat, maize, jute and oil seeds. For labour, especially for planting paddy, weeding and harvesting, women are efficient workers. They were found working in the fields such as harvesting paddy and weeding wheat. The farmers use conventional farming tools for agriculture. Although the use of tractors for agriculture has become familiar to all farmers, the plough pulled by two bullocks is used for ploughing the land extensively as it is cheaper than that of a tractor.

Table 5.9

Amount of Land Owned by Ethnicity

Amount of Land	Satar	Meche	Rajbanshi	Kisan	Dhimal	% of Total
Land less	8	0	2	6	0	16
1 to 10 Katha	6	12	10	6	8	42
11 to 15 Katha	0	0	2	2	2	6
16 to 20 Katha	4	6	2	4	6	22
20 Katha & above Katha	2	2	4	2	4	14
Total	20	20	20	20	20	100

Source : Field Survey, 2002.

5.12. Religion

Religion is also one of the factors to effect fertility. The table 5.10 provides the religious practice of the respondents. The data indicate that 92% respondents are Hindu and only 8% are Christians. The table also shows that 4 respondents each the Satar and the Dhimal belong to Christian religion. According to the respondents, they were initially Hindus but later they were converted into Christian religion due to the influence of Christianity in the vicinity.

Table 5.10

Religious Preference of the Respondents by Ethnicity

Religion	Satar	Meche	Rajbanshi	Kisan	Dhimal	Total
Hindu	16	20	20	20	16	92
Christian	4	0	0	0	4	8
Total	20	20	20	20	20	100

Source : Field Survey, 2002.

5.13. Place of Sterilization from Residence.

Fertility is affected by many factors. If health services are available to the vicinity it encourages people to use the services including family planning. The table provides data on the distance of the place of sterilization from the residence place of the respondents (see table-5.11). The data indicate that 53% of the respondents got permanent family planning/services method at Bhadrapur hospital which is situated at the distance of 40 KM from the residence of the Dhimal, (Damak) and 35 KM from the residence of the Satar (Topgachhi). The data also indicate that people, prefer to use the permanent family planning method at the reliable and safe place regardless of the distance. Some respondents of the Kisan Community have done permanent family planning in India which is situated on an average 75 KM. away from their residence where they work.

Table 5.11

Distance of the Place of Sterilization from Residence by Ethnicty

Place of Sterilization	Satar (Topgachhi)	Distance K.M.	Meche (Dhaijan)	Distance	Rajbanshi (Chandragadhi)	Distance	Kisan (Mechinagar)	Distance	Dhimal (Damak)	Distance	Total
Damak Health Center	4	15							2	1	6
Bhadrapur Hospital	12	35	8	15	20	3	5	15	8	40	53
Birtamod	4	25									4
Dhulabari			10	3			10	3			20
Naksalbadi India			2	100			0				2
Kharibari India							1	70			1
Siligudi India							2	80			2
Jalpaigudi India							2	75			2
Urlabari									10	3	10
Total	20		20		20		20		20		100

Source : Field Survey, 2002.

CHAPTER – VI
FAMILY PLANNING

This chapter analyses the attitude of the respondents towards adopting permanent family planning method and the emic and etic perspective of the people and the respondents towards using permanent family planning method. There are two types of permanent family planning method by which birth is checked for ever, like the laparoscopy used by the female and vasectomy used by the male.

6.1. Use of Permanent Method

The table (see table no. 6.1) shows the percentage of respondent by age, sex and ethnicity who had used permanent family planning methods. The data show that of the total respondents 42% of the female respondents of age 25 to 29 years had used permanent family planning method (minilap), and 20% respondents of the age group 30-34 had used minilap and 12% males of the age group 35-39 had used premanent family planning method (vasectomy). The data also indicate that 6 females of the Meche community and 2 females of the Dhimal community had used permanent family planning method at the age of 20-24, 18 females of the Dhimal community and 16 females of the Rajbanshi community had used permanent family planning method at the age of 25 to 34 years. It also suggest that most of the females of the sampled ethnic groups had used permanent family planning method before the age 34.

Table 6.1

Use of Permanent Family Planning Method by Age, Sex and Ethnicity

Age Group	Satar		Meche		Rajbahshi		Kisan		Dhimal		Total		Frequency %
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
20-24	0	0	0	6	0	0	0	0	0	2	0	8	8
25-29	0	6	0	8	0	10	0	6	0	12	0	42	42
30-34	0	4	0	2	0	6	4	2	0	6	4	20	24
35-39	4	0	0	4	0	4	8	0	0	0	12	8	20
40-44	0	6	0	0	0	0	0	0	0	0	0	6	6
Total	4	16	0	20	0	20	12	8	0	20	16	84	100

Source : Field Survey 2002.

6.2. Difficulties Experienced by the Respondents in Post Operation Period

Sterilization is the permanent method of birth control. In the study area the female respondents responded about the difficulties experienced in post operation period. The table indicates that (see table 6.2) no male respondents had any complication in post operation period. 10 female respondents of Rajbanshi, 6 respondents of Dhimal, 8 respondents of the Satar, 10 respondents of Meche and 4 respondents of the Kisan community had experienced some complication in the post operation period. They responded that they had many types of complications such as pain in the operated parts of the body, pain in the lower abdomen, pain during the period of menstruation, headache, pain in hands and legs, and feeling of fainting or unconsciousness. But other female respondents did not have any problems after the operation. It shows that the difficulties experienced by the respondents may or may not be the cause of technical mistake in operation. It may be related with the psychological and physiological makeup of the respondents.

Table 6.2.

Difficulties Experienced by the Respondents in Post Operation Period by Ethnicity (only Females)

Difficulties experienced	No of Respondents					Total no of respondent
	Satar	Meche	Rajbanshi	Kisan	Dhimal	
Pain in operated parts of the body	8	10	10	4	6	38
Pain during the menstruation period	-	-	-	-	-	-
Pain in the lower abdomen	-	-	-	-	-	-
Pain in hands and legs.	-	-	-	-	-	-
Headache	-	-	-	-	-	-
Felt to be faint	-	-	-	-	-	-

Source: Field Survey, 2002.

6.3. Change in Daily Routine and Physical Labour

The table below (see table 6.3) provides the responses on the change in daily routine and physical labour of the female respondents after sterilization. It shows that out of 84 female respondents 38 respondents reported about the change in their daily routine time and physical labour. After sterilization they reported that they felt tiredness could not get up early in the morning. They felt laziness and tiredness, and while working in the field or doing physical labour. After sterilization they felt unable to carry heavy load. They could not work physically for long period of time. The data also indicate that half of the respondents of the Meche and the Rajbanshi community (10 respondents each) reported about change in physical labour. The livelyhood of these ethnic groups depends on the earning by physical labour.

Table 6.3.

Change in Daily Routine and Physical Labour of the Respondents after Sterilization by Ethnicity

Responses	Satar	Meche	Rajbanshi	Kisan	Dhimal	Total no of respondents
Getting up late	8	10	10	4	6	38
Feeling laziness	-	-	-	-	-	-
Unable to work physically	-	-	-	-	-	-
Unable to carry heavy load	-	-	-	-	-	-
Felt tired to work for long period	-	-	-	-	-	-

Source : Field Survey, 2002.

Note : The respondent gave multiple responses.

6.4. Change in Health Condition

During the survey when the respondents were asked about the changes on their health situation after sterilization they responded that they could feel weaknesses physically. The table show that (see Table 6.4) out of the total female respondents 38 female respondents reported that they could feel many physical difficulties after sterilization. Some respondents reported that they became very weak and lost visibility after sterilization. The female respondents of all the ethnic groups reported about change in their health condition after sterilization. Of all the ethnic groups more number of respondents were from the Meche and the Rajbanshi community who reported changes in their physical condition.

Table 6.4.

Change in Health Condition after Sterilization by Ethnicity

Responses	No of Respondents					
	Satar	Methe	Rajbanshi	Kisan	Dhimal	Total
Feeling of weak health	8	10	10	4	6	38
Became thin	-	-	-	-	-	-
Weak in visibility	-	-	-	-	-	-

Source : Field Survey, 2002.

6.5. Attitude of the Respondents Regarding Permanent Family Planning Method

During the survey when the respondents both male and female were asked about their attitude towards permanent family planning as a method of birth control for rural people. Almost all the respondents responded positively. They responded that in rural areas where temporary means of family planning is not available in time and housing settlement is not favourable for its use. Permanent family planning method is only the reliable method for both male and female to check birth. They also suggested that in lack of proper technique of use of temporary means of family planning birth of a child could not be checked.

When they were asked about the social and religious restrictions for the use of permanent method they responded that only after having 1 to 2 sons a couple is allowed socially to use permanent family planning because it is a tradition that only son can cremate the dead bodies of the parents. Besides this there is no social and religious restrictions to use permanent sterilization.

6.6. Suggestions to Others to Use Permanent Family Planning

All the respondents were asked about their perceptions towards permanent family planning. They responded that they (both male and female) were satisfied with this method. Because this is only the reliable method of birth control. When they were asked whether they would suggest others to use permanent family planning all the respondents (both

male and female) except 2 male respondents of the Satar community, reported that they would suggest others to use the permanent method. Only 2 male respondents of the Satar community reported that they would suggest others to use temporary means of family planning because use of permanent family planning method makes the users physically weak. They suggested that it is not a proper method for those people who do physical labour.

6.7. Attitude of the Spouse After Getting Sterilization

All the respondents were asked about the attitude of the spouse and other family members towards using permanent family planning method. They responded that the use of permanent family planning method was not the decision of the users only rather it was decided by all the elder members of the family considering the number of living children. (See table 5.7) Although the respondents experienced some difficulties after getting sterilization, the attitude of their spouses and other members of the family was positive towards using permanent family planning. The respondents responded that their family members encouraged them to use this method because it was only the reliable method of birth control. The female respondents responded that their husbands and mother-in-laws helped in household works and in case of husband the wife helped in inside and outside works for some days after getting sterilization. Not only this they helped at that moment also when they (users) felt trouble or pain after some years of getting sterilization. The family members and the spouses took it positively.

6.8 Service Obtained After Sterilization

The respondents both male and female were asked about the medical treatment they obtained after getting sterilization. All the users (both sexes) of all ethnic groups responded that they had not had any type of serious medical treatment after getting sterilization. Although most of the respondents felt difficulties after sterilization only few female respondents reported that they had got some medical advice to use medicine to recover the pain. No serious medical services obtained by the users were reported.

6.9 Perception of Others Towards the Users

Hindu religion has many customs, and beliefs. It is believed that any offerings offered to gods or goddesses by a person who has used permanent family planning, are not accepted by the gods or goddesses. This belief sometimes discourages people to use permanent family planning and may also change the behaviour of people to the users towards using this method. The respondents of all the ethnic groups were asked about the change in the behaviour of others towards them after getting sterilization. The users responded that they had not felt any changes in the behaviour of the neighbors, relatives, friends. However, sometimes they suggested that it was not a useful method for physically weak and poor people. It may effect later at old age.

- Of the total respondents 42% and 20% of the female respondents had used permanent family planning method (minilap) at the age of 25 to 29 and 30 to 34 respectively. The data also indicate that most of the females of all the ethnic

groups had used permanent family planning method before the age 34.

- No male respondents had any complication in post operation period whereas 38 females of all ethnic groups had experienced some complications in the post operation period. They responded that they had complications such as pain in the operated parts of the body, pain in the lower abdomen , pain during period of menstruation, headache, pain in hands and legs and feeling of fainting or unconsciousness.
- Of the 84 female respondents 38 respondents reported about the change in their daily routine time and physical labour after sterilization. They reported that they felt tiredness, could not get up early in the morning, felt laziness, felt unable to carry heavy load and could not work for a long period of time. They also reported that they became very weak and lost visibility after sterilization.
- Almost all the respondents responded that permanent family planning method is only the reliable method for both male and female to check birth. They also responded that they would suggest to others to use this method to check birth.
- All the respondents both male and female used permanent family planning method with consent of all the elder members of the family. The family members encouraged them to use this method because they had expected no of living children. They also responded that their friends, relatives and neighbors had also positive attitude towards them after sterilization.

CHAPTER –VII

SUMMARY OF THE FINDINGS, CONCLUSION AND RECOMMENDATIONS

7.1 Summary of the findings

This study entitled "Socio- cultural characteristics of permanent family Planning users of Marginalized population: A sociological perspective" was carried out on five ethnic groups i.e. the Satar, Meche, Rajbanshi, Kisan and Dhimal in Jhapa district of eastern development region of Nepal. The general objectives of this study is to find out the attitude and the socio-cultural characteristics of both male and female permanent family planning users. 100 users of permanent family planning method both male and female were selected to elicit data regarding age, ethnicity, occupation, types of family, number of living children by sex. education, religion and attitude of the users. (experience after the sterilization, advice given to others after sterilization, service obtained after sterilization, spouses reaction after five years of sterilization regarding family planning.)

Findings regarding socio-economic and demographic characteristics of the users in the study area are as follows:

1. The young population in the study area comprises 42.3%, the economically active population 55.7%, sex ratio 1.025 and the average household size is 6.4%. The young population is the highest (51.6%) in the Satar Community and the lowest in the Dhimal community (27.3%). The economically active

population is the highest (69.7%) in the Dhimal community and the lowest (46.8%) in the Satar community. The dependency ratio is the highest (113.8%) in the Satar community and the lowest in the Dhimal community (43.5%).

2. Of the total users 16% were male and 84% were female. 60% of respondents in the study area belonged to the age group 25 to 39. It indicates the low population growth in future.

3. Of the total population ten years and above 29.8% males and 36.9% females were married. of the total married females 18.2% females were married before 24 years of age. 3.9% females were got married at the age of 10 to 14 years which indicates child marriage practice in the study area. 26.3% married female population of the Satar Community belog to the age group 10 to 24 year which is the highest percentage of the other sampled ethnic groups.

4. 84% and 16% respondents (husbands) were married at the age of 14 to 19 and 20-24 years respectively. Like this 92% females respondents (wives) were married at the age of 14 to 19 years. All the female respondents of the Satar Meche and Rajbanshi community and 80% of female respondents of Kisan and Dhimal were married at the age of 14 to 19 years. This shows the early marriage pattern in the study area.

5. Nuclear family system is found more in the study area. 76% of the families are nuclear and 24% of the families are extended. No extended family was found in the Rajbanshi community.

6. 39.3% and 20% males and females, were illiterate and literate respectively. Only 2.8% males had got SLC and above education. 28.6% and 9.5% females were illiterate and literate respectively. None of the females of the study area had passed SLC examination. It shows the poor educational attainment of females in the study area.

7. 74% of the female respondents and 87.5% of the male respondents were found engaged in agriculture occupation. Most of female respondents of the Satar Community were found engaged primarily in animal husbandary, wage labour and small business.

8. Landlessness characteristics are found in such ethnic groups who were once land lord in the eastern Tarai. 16% of respondents (Satar, Kisan and Rajbanshi) were found landless and 42% of the respondents had 10 Kathas of agriculture land. Still the farmers use conventional method of farming.

9. The mean number of children of the respondents is 3.4. The Rajbanshi community has the highest (4.2) and the Dhimal has the lowest (2.9) mean number of children.

10. 53% of the respondents have used permanent family planning method at Bhadrapur hospital which is situated at the distance of 37.5 Km. from the residence of Dhimal and Satar. Some respondents of the Kisan Community have used this method in India at the distance of 75 km. from the residence. This indicates that people prefer to use permanent family planning method at the reliable and safe place regardless of the distance.

11. The rate of the users of permanent family planning is affected by many socio-cultural factors, preference of son is one of the most important factors. All the respondents in the study area used this method only after having 3 to 4 living sons.

12. Conclusions :

The use of permanent method of family planning among the respondents in the study area was found high among the female respondents. It was because of the lack of education and misconception about the effect of the use of permanent method of family planning among the males. The users of permanent method of family planning had used this method after having 4 children on an average, of that all had at least two sons. The cultural, religious and economic importance of son enforced them to use this method at older age. The findings also suggested that there were also lack of availability of permanent method of family planning in the vicinity of the residential places of the respondents. They had to go to far distance places to use permanent method of family planning. Most of the respondents had complained

about the effect of operation on their health situation. They felt headache, weakness and tiredness after post operation period.

7.3 Recommendation

1. Fertility becomes high when the use of the methods of family planning is low. Education plays vital role in the adoption of the method of family planning. Basically women in the villages should be educated. For this, an adult woman education programme at the village level should be launched. They should be given health care education. An adult women education center as in India should be opened and a lady teacher should be appointed at the village level.

2. Though the study areas have health posts and health centers,. it lacks the family planning clinics and good medical halls where people may get family planning services easily. The health department of HMG should arrange the health programme and mobile camp periodically at the village level to deliver lecture about family planning methods and benefits of small family size and to provide family planning services. This type of programme may increase the knowledge and awareness about family planning methods, which may help to reduce fertility.

3. It is well known that rural people are poor as well as illiterate. They can be motivated towards family planning programme by offering some incentives. Permanent family planning method is not accepted at high rate by males due to lack of motivational techniques and practical difficulties. Motivation can be possible only by increasing family planning services through better

organization and integration involving local people making frequent visits in the form of mobile camps within the VDC. Some incentives in cash or goods should be made for those couples who have not more than two children and have adopted permanent method of family planning. This type of incentive programme will increase the publicity of family planning programme in rural areas where it is most essential.

Case Study - 1

Mrs. Luthri Kisan, an active, young and literate women aged 25, is a resident in ward number 4 of Mechi Nagar in Jhapa district. She is blessed with 1 son and 1 daughter aged 6 and 2 years respectively. She was married at the age of 16 and got first issue at the age of 19 years. She is economically poor having 5 Katha cultivable land including courtyard. She maintains her livelihood by doing labour work and raising small scale poultry. Her husband had been using condom for last 4 year after the birth of a son. He was encouraged to use it for spacing birth by the shopkeeper where he used to get medicine and contraceptives.

Mrs. Luthri was encouraged to use permanent method of family planning by her neighbours when a camp of family planning was organized at Dhulabari, 3 Km. away from her residence. She used permanent method of family planning at the age of 25 years in 2059 B.S. with the consent of her husband. She took decision because she was unable to maintain her family and wanted to check the birth permanently. As she reported she did not have any complication in operation and not any change in daily routine and physical labour.

CASE STUDY – 2

Mrs. Seti Dhimal an active and illiterate women aged 30 years, is a resident in ward number 16 of Damak municipality in Jhapa district. She has a son and a daughter aged 5 and 2 years respectively. She was married at the age of 20 years and gave birth to first child at the age of 25 years. She is economically very poor having no cultivable land except the homestead land. She does not cultivate others land. She maintains her family by doing labour, selling home made liquor and raising poultry. Her husband is a rikshaw puller, and earns a little daily which adds in the maintenance of the family.

Though Mrs. Seti is an illiterate woman, she encouraged her husband to use condom after she gave birth to a son. They used condom for 3 years and them gave birth to a daughter. She used permanent family planning method to check the birth at the age of 29 yrs in 2058. B.S. at Urlabari which is 1 km. away from her residence. Her husband did not use permanent method because he did physical labour and using permanent family planning method might cause him doing physical labour. She was encouraged by the village female health worker to use permanent family planning method because of the poor economic condition. She did not report any complication after post operation period. She did not have any complication in health condition and was doing physical labour as usual.

REFERENCES

Bista, D.B.-1987: People of Nepal, Ratna Pustak Bhandar, Kathmandu, Nepal.

C.B.S.-1995: Population Monograph of Nepal. C.B.S. Kathmandu, Nepal.

Dahal, D.R.-1992: Determinants of Fertility in Nepal, Population and Development in Nepal, CDPS, T.U., Kathmandu, Nepal.

Dahal, D.R. 1989: Demand Aspect of Fertility and Family Planning in Nepal. South Asia Studies on Population programmes and Strategies, UNFPA, Kathmandu, Nepal.

David, Kingslay 1963: Demographic Reality and Policy in Nepal, workshop Conference on Population family Planning Development in Nepal.

Devkota, P.L. – 1984: Illness Interpretation and Modes of Treatment in Kirtipur" Contribution to Nepalese studies, CNAS, T.U. Vol. IINo. 2: (11-20).

Harris, M. – 1988: Culutre, People, nature, Harper and Row Publisher, New York.

Ministry of Health, New ERA and ORC Macro, 2001.

"Nepal Demographic and health Survey".

Nakajma, H. Mayor, F. – 1996 : "Culture and Health" World Health. 49/2:3

Taylor – Thomas, J.T. 1991 : Community Based Family Planning Services in Africa: (29-36). (eds). Mohammed Bouzidi and Curt Fisher. IPPF, GTZ.

Tuladhar, J.M. – 1989: The Persistence of High Fertility in Nepal, Inter India Publication, New Delhi.

ANNEX – 1

QUESTIONNAIRE FOR USERS

Name of Data Collector .....

Date :

Respondent (Male or Female) :

Caste/ethnic group :

Current Address (district/Village/VDC/Ward):

Household head's Name :

Religion :

Household Information

Occupation	Individual name	Relation to head of house hold	Sex	Age	Marital status	Education	Residential Status				
							Primary	Secondary	Full time	Part time	Away

1. Age of first marriage (users of both)

   Type of family : Nuclear ☐ Extended ☐

2. amount of land owned (Bigha/katha/dhur):

3. Amount of land taken on rent :

4. Amount of land leased out :

5. Types of House :

6. Possession :

7. Number of living children : Male ..... Female .....

8. Why do you want that number of son/sons?

9. Why do you want that number of daughters?

10. Have you ever used any method of contraceptive ?

Yes ☐ No ☐

If yes, which methods you have ever used?

11. Why did you choose this/these methods?

12. Who decided that you should use contraceptives?

a. Self..... b. Wife/husband ..... c. Other (father/mother).....

13. At what age did you use permanent method of family planning? .....When was it?

14. Who decided to use this method?

15. Why did you select permanent method of family planing?

16. Where did you get sterilization?

17. Did you feel any difficulties while going through operation?

Yes ☐ No ☐

18. What type of difficulties you have felt? Please specify.

19. Do you have any social and religious restrictions for the use of permanent method?

Yes ☐ No ☐

If yes, please specify.

20. How far was the place of sterilization from your residence?

21. Does the permanent method of family planning available in the health post or health centre in your locality?

Yes ☐ No ☐

22. How did you know about the camp of family planning?

23. In your opinion, is it a proper method of birth control for the rural people?

24. Would you like to suggest other to use this method?

Yes ☐ No ☐

25. What is the attitude of your spouse family members to wards you after getting sterilization?

26. How do your friends, neighbors, relatives behave you after getting sterilization?

27. Do you feel any changes in their behavior after sterilization?

28. Do you feel any change in your daily routine after getting sterilization?

29. Have you been continuing your physical labor in the same way after getting sterilization?

Yes ☐ No ☐

If no.

30. Do you think that there is some change in your physical capacity after the sterilization ?

Yes ☐ No ☐

If yes, why do you think so ?