P. R. C. Report No. 60

EVALUATION OF FAMILY WELFARE AND M. C. H. PROGRAMME IN UTTAR KANNADA, KARNATAKA, 1985-86

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P R E F A C E

The present study carried out in Uttar Kannada district for the year 1985-86 is the eighth in the series of 'Current Evaluation of Family Welfare Acceptors and Non-acceptors' conducted by Population Research Centre, Dharwad.

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I wish to express my thanks to District and Family Welfare Officer, to Medical Officers and Village Level Health and Family Welfare Workers of Mundgod, Manchikeri and Shirali Primary Health Centres for their help and co-operation in the collection of field data. I must express my thanks to the respondents who have co-operated with interviewers and given complete and accurate information.

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EVALUATION OF FAMILY WELFARE AND MCH PROGRAMMES IN UTTAR KANNADA, KARNATAKA - 1985- 86.

CHAPTER - I

OBJECTIVES, STUDY DESIGN AND SAMPLE COVERAGE

1.1 INTRODUCTION

A careful and thorough evaluation of the Family Welfare programme is essential for gauging the current performance and the shape it is going to take in the future and for making necessary changes in the monitoring of the programme. Another important aspect that needs our immediate attention is the assessment of maternal and child health care programme, as it covers more than 60 percent of the population and is a better indication of the health of the community. Therefore, periodic studies need to be conducted in order to examine various factors that promote or hinder the acceptance of family planning and to determine the attitudes and reactions of the people towards Family Welfare as well as Maternal and Child Health Programmes. Therefore, current evaluation studies on Family Planning Programme are being conducted by the Population Research Centre, Dharwad every year, in one of the nine districts alloted to it in the State of Karnataka. Evaluation of Mat--ernal and Child Health Programme is a recent addition.

This evaluation study was undertaken in Uttar Kannada District of Karnataka during the year 1985-86 and it is the eighth in the series of Current Evaluation Studies of Family Welfare Programme. The reference period for the study is the financial years 1982-83, 1983-84 and 1984-85. The

study sample constitutes 500 acceptors and 500 non-acceptors. The acceptors are those who accepted sterilization or IUD during the reference period. A non-acceptor is defined by the following criteria, (i) a currently married couple wherei the wife is in the reproductive age group of 15-44, (ii) having atleast one living child, (iii) not using any methods of contraception as on the day of survey.

The respondents for the evaluation of Maternal and Child Health Programme are the non-acceptor wives who had (i) either given birth to a child during the one-year period preceeding to date of survey, (ii) or pregnant at the time of survey.

1.2 OBJECTIVES

The main objectives of the study are -

(i) To ascertain the accuracy and nature of reported performance of the family planning programme in order to find out the extent of ineligible cases, irregularities and descrepancies with regard to age and number of lvg.children.

(ii) To study the demographic and socio-economic characteristics of acceptors such as age, parity, living children, caste, education, occupation and income.

(iii) To study the level of physical and psychological complaints, after sterilization as well as IUD insertion and to evaluate the mode of service delivery to acceptors and their impressions about follow- up services.

(iv) To study the demographic and socio- economic characteristics of non-acceptors with a view to attempting a comparative analysis with acceptors.

(v) To find out causes for their non-acceptance of family planning methods.

(vi) To evaluate the programmes of Maternal and Child Health.

1.3. STUDY DESIGN

SELECTION OF DISTRICT, PRIMARY HEALTH CENTRES AND VILLAGES

1.3.1 SELECTION OF DISTRICT

Based on the performance of Family Welfare Programme during the reference period, all the nine districts are arr-anged in discending order of combined (Sterilization + IUD) acceptance rate and stratified into 3 regions, Region I con-sists of 3 districts namely Shimoga, Uttar Kannada and Belgaum, Region II consists of Dharwad, Bellary and Bijapur, while Raichur, Bidar and Gulburga come under Region III. It is therefore decided to undertake evaluation study in all the three regions, selecting one region every year. Of the above three regions, First region is selected at random and further, the median performance district viz; Uttar Kannada has been selected for the purpose of the present study. The details about districtwise acceptance rates are shown in Table 1.1.

1.3.2 SELECTION OF PRIMARY HEALTH CENTRES

There are 11 Primary Health Centres, one post-partum centre (PPC) and four Urban Family Welfare Centres (UFWCs) functioning in the district of Uttar Kannada during 1982-85. In order to select the sample of PHCs for the study, syste-matic random sampling technique is followed. All the PHCs functioning in the district are arranged in descending order based on their combined (sterilization + IUD) acceptance rate for the reference period. Mundgod, Shirali and Manchikeri are the selected Primary Health Centres. Table 1.2 gives the particulars about PHC-wise acceptance rates.

TABLE 1.1 DISTRICT-WISE ACCEPTANCE RATES 1982-85

Region	Region I				Region II		Region III			Karnataka State
District	Shimoga	Uttar Kannada	Belgaum	Dharwad	Bellary	Bijapur	Raichur	Bidar	Gulbarga	
Population 1981 Census (in 000's)	1657	1072	2980	2945	1489	2402	1784	996	2081	37135
Acceptance Rate @										
1982-83										
Sterilization	8.70	5.74	6.72	6.38	5.21	5.43	6.29	4.91	4.48	6.27
IUD	3.80	3.20	1.98	2.48	2.52	1.80	1.82	1.22	1.41	1.85
Combined St.+IUD	12.50	8.94	8.70	8.86	7.73	7.23	8.11	6.13	5.89	8.12
1983-84										
Sterilization	7.03	5.92	6.25	5.28	6.75	4.93	4.20	4.33	4.38	6.44
IUD	1.39	2.23	1.59	1.39	1.81	1.34	1.26	0.82	0.71	2.53
Combined St.+IUD	8.42	8.15	7.84	6.67	8.56	6.27	5.46	5.15	5.09	8.97

Table 1.1 Contd.

TABLE 1.1 Continued

Region	Region I			Region II			Region III			Karnataka State
	Shimoga	Uttar Kannada	Belgaum	Dharwad	Bellary	Bijapur	Raichur	Bidar	Gulbarga	
Population 1981 Census (in 000's)	1657	1072	2980	2945	1489	2402	1784	996	2081	37135
Acceptance Rate @										
1984-85										
Sterilization	6.53	5.89	6.64	7.42	5.06	6.12	4.38	5.52	3.53	7.12
IUD	1.88	2.78	1.63	1.52	2.31	1.67	1.45	1.19	0.93	3.25
Combined St.+IUD	8.41	8.67	8.27	8.94	7.37	7.79	5.83	6.71	4.46	10.37
Total 1982-85										
Sterilization	22.26	17.55	19.61	19.08	17.02	16.48	14.87	14.76	12.39	19.83
IUD	7.07	8.21	5.20	5.39	6.64	4.81	4.53	3.23	3.05	9.48
Combined St.+IUD	29.33	25.76	24.81	24.47	23.66	21.29	19.40	17.99	15.44	29.31

@ Number of acceptors per thousand population

Source: Monthly Bulletin of Family Welfare and MCH Programmes, Karnataka, March 1984 and March 1985, Demographic and Evaluation Cell, State Family Planning Bureau, Directorate of Health and Family Welfare Services, Bangalore.

TABLE 1.2 Continued

Primary Health Centres	Manchikeri	Joida	Murkawada	Mundgod	Hegde Katta	Hatti Keri	Kyadgi	Shirali	Manki	Angadi	Hiregutti
Population 1981 Census	59989	52215	132552	58745	96200	81057	84525	71231	112864	78425	93940
Acceptance Rate 1984-85											
Sterilization	9.30	5.59	4.78	5.35	4.25	6.27	6.29	4.96	3.75	3.03	2.63
IUD	4.72	6.49	2.96	2.98	2.70	3.66	1.83	1.92	3.01	2.45	2.22
Combined St.+ IUD	14.02	12.08	7.74	8.33	8.23	9.93	8.12	6.88	6.76	5.48	4.85
Total 1982-85											
Sterilization	27.73	16.47	18.15	18.44	15.21	15.71	17.37	14.26	11.42	11.43	9.46
IUD	10.87	12.66	7.83	7.20	9.11	7.59	5.26	5.64	7.73	6.02	6.16
Combined St.+ IUD	38.60	29.13	25.98	25.64	24.32	23.30	22.63	19.90	19.15	17.45	15.62

Source: District Health and Family Welfare Office, Karwar, Uttar Kannada.

TABLE 1.2 PRIMARY HEALTH CENTRE-WISE ACCEPTANCE RATES IN UTTAR KANNADA DISTRICT 1982-85

Primary Health Centres	Acceptance Rates										
	Manchikeri	Joida	Murkawada	Mundgod	Hegde Katta	Hatti Keri	Kyadgi	Shirali	Manki	Angadi	Hiregutt
Population 1981 Census	59989	52215	132552	58745	96200	81057	84525	71231	112864	78425	93940
Acceptance Rate											
1982-83											
Sterilization	8.98	4.12	5.71	6.29	6.15	4.95	5.96	4.43	4.05	4.77	3.87
IUD	2.35	1.19	2.24	1.48	3.41	1.62	1.53	1.92	2.22	1.02	1.75
Combined St.+IUD	11.33	5.31	7.95	7.77	9.56	6.57	7.49	6.35	6.27	5.79	5.62
1983-84											
Sterilization	9.45	6.76	7.66	6.80	4.81	4.49	5.12	4.87	3.62	3.63	2.96
IUD	3.80	4.98	2.63	2.74	3.00	2.31	1.90	1.80	2.50	2.55	2.19
Combined St.+IUD	13.25	11.74	10.29	9.54	7.81	6.80	7.02	6.67	5.72	6.18	5.15

Table 1.2 Contd.

1.3.3 SAMPLE SIZE AND ITS ALLOCATION

There were 403 vasectomy acceptors, 18,409 Tubectomy acceptors and 8,809 IUD acceptors during the reference period in Uttar Kannada district.

The sample of 500 cases are allocated amongst steri--lization(Tubectomy+ vasectomy) and IUD in proportion to the number of acceptors of these three methods during reference period in the sample district. Hence it is determined to cover 340 sterilization (Tubectomy+ Vasectomy) cases and 160 IUD cases.And these 340 sterilization (Tubectomy + Vasectomy) cases are further allocated amongst selected three Primary Health Centres in proportion to the total number of sterilization (Tubectomy+ Vasectomy) acceptors in the selected PHCs durihg the reference period. The same procedure is followed for IUD cases. The total number of sterilization (Tubectomy + Vasectomy) and IUD cases during the reference period in Mundgod,Shirali and Manchikeri are 1084 and 423, 1016 and 402; 1664 and 652 respectively.Since the number of vasectomy acceptors for three sample PHCs together is not significantly high (65), it is decided to cover only acceptors of tubectomy and IUD.

Accordingly the total sample cases that have to be covered in Mundgod, Shirali and Manchikeri are 144 (98 tube--ctomy and 46 IUD cases), 135 (92 tubectomy and 43 IUD cases), and 221 (150 tubectomy and 71 IUD cases)respectively.

1.3.4 SELECTION OF VILLAGES

In each sample PHC, all the villages are arranged in descending order of the total number of IUD acceptors. A sample of adequate number of villages with best performance is drawn with an idea of getting required number of IUD cases to be covered with 10 percent margin to allow for non-coverage. The sample of tubectomy cases is drawn from

the same villages. The coverage of IUD cases in the villages selected for the study is less because of several reasons which are explained in the section of sample coverage. In view of shortage in coverage of IUD cases, additional villag are covered till the required number of IUD cases are inter--viewed.Therefore, the total number of villages covered for IUD cases in Mundgod, Shirali and Manchikeri PHC's is 14, 8 and 12 respectively. However, the coverage of sample tubecto cases is completed in first three selected villages in Mundg PHC, and in first two villages in Shirali PHC. Surprisingly, the number of villages covered for tubectomy and IUD cases a same in Manchikeri PHC, because of the fact, that the total number of tubectomy cases in the first few selected villages are less than the total IUD cases.

A list of acceptors of tubectomy and IUD is prepared the sample villages from the records provided by PHC for the year 1982-83, 1983-84 and 1984-85.These are the acceptor res -dents to be contacted for the purpose of this study.

The Non-acceptor respondents are identified from the neighbouring houses of the interviewed IUD and tubectomy acceptors.In case the non-acceptors are not found in the nei -bouring houses of acceptors, the non-acceptors are covered from the same locality (street) of acceptors.

Equal number of acceptors and non-acceptors are cover in each selected village.

1.4 QUESTIONNAIRES

Two separate questionnaires are devised for the purpo of data collection.Questionnaire I refers to Acceptors. This questionnaire is broadly divided into 8 blocks.The Block I and II are concerned with General information and particular of household respectively. Block III deals with the particul

of acceptance, while questions on Demographic and Socio-economic profiles of the acceptors are included in Block IV. Block V is concerned with additional questions on IUD users. Block VI deals with previous practice of acceptors and Block VII is concerned with side effects/complications experienced and the last Block is meant for Follow up services.

Questionnaire II refers to Non-Acceptors and contains the following (11) blocks; (1) General information (2) Particulars of the Household (3) Demographic and Socio- economic particulars (4) Contacts with PHC/FW centre (5) Knowledge regarding Family Planning Methods (6) Reasons for non-adoption and future plan and blocks seven to eleven are concerned with Evaluation of MCH programme such as pre-natal and post-natal care, Immunization etc.,

This evaluation study is confined to rural areas and refers to the acceptors of female sterilization and IUD so the respondents are only women, who are interviewed by female interviewers, while respondents for non-acceptor questionnaire are either partners of non-acceptor couples, interviewed by male interviewers.

1.5 DATA COLLECTION

The collection of information required for the present study involves two phases. In the first phase, the sample Primary Health Centres are selected with the help of statistics provided by the District Health and Family Welfare Office, Karwar, Uttar Kannada. The sample villages are selected, on the basis of the villagewise number of IUD acceptors, available at the sample PHCs.

The detailed information of acceptors obtained from the service registers kept at the sample PHCs served as a source to identify the acceptors in each of the sample villages. The non-acceptor respondents are covered in the neighbouring households of acceptors and then efforts are made to

trace the non-acceptors in the target couple registers in order to know whether the target couple registers are updated or not.

In the second phase, data for the present study are collected by interviewing both the acceptor and non-acceptor respondents with the help of separate questionnaires.The field team of four male interviewers and three female int--erviewers, collected the data for this study from septe--mber, 1985 to November, 1985.

In the field data collection was supervised by the chief investigator. The collected information was checked immediately and wherever inconsistencies were found those were corrected by making revisits. Later all the filled in questionnaires were scrutinised on the same day. The colle--cted information is fairly reliable.

1.6 SAMPLE COVERAGE

As mentioned in earlier sections of this Chapter, the total cases to be covered in the three selected PHCs, viz; Mundgod, Shirali and Manchikeri are 144, (98 tubectomy + 46 IUD) 135, (92 tubectomy + 43 IUD) and 221 (150 tubectomy + 71 IUD) respectively.

In Mundgod PHC, three villages namely Chigalli,Malag and Indoor are selected on the basis of total number of IUD cases during the reference period. The required number of 98 tubectomy cases are to be covered in these three villages. However, 21 IUD cases are covered out of the required sample of 46 IUD cases in the three selected villages. In order to cover the remaining 25 sample IUD cases, the collection of data is extended to eleven addi--tional villages

In the case of Shirali PHC, the sample village is Shirali. Eighty four tubectomy cases are covered in this village. Remaining 25 sample tubectomy cases are covered in the next village in order, viz; Kaikini. But the interviewers collected information from 22 IUD acceptors only in these two villages. Hence 6 more additional villages are covered to inter-view remaining 21 sample IUD adoptors.

The villages Kampli, Magod and Kalache are selected in Manchikeri PHC area. However, 20 IUD cases out of the required 71 and 46 tubectomy cases out of the required 150 are covered in the selected three villages. Nine additional villages are covered to collect the information from the requisite number of 51 IUD cases and 104 tubectomy cases. As noted earlier, the number of additional sample villages is same for covering sample tubectomy cases.

In order to cover the sample 340 tubectomy cases and 160 IUD cases, a list of 583 tubectomy cases and 649 IUD cases belong to 34 villages under 3 selected PHC's together is prepared. The coverage of tubectomy cases is 58.0 percent and coverage of IUD cases is 25.0 percent.

For non-coverage of IUD cases, removal/expulsion of IUD (217) and out-migration (163) both temporary and permanent are the main reasons. Among 217 cases of removal / expulsion of IUD, the removal cases constitute 97.0 percent (210) and among 163 out-migrated cases, 64.0 percent (105) are out-migrated permanently. Other reasons for non-coverage are such as (i) undergone sterilization (46), (ii) failure of the device (3), (iii) separation from husband (3), (iv) death of adopter, (4), (v) refused to respond (3), (vi) cases of duplication (15).

However, the total number of not traced cases are 15 (2.3 percent) and out of area cases are 20(3.1 percent).

Regarding the reasons for non-coverage of tubectomy cases, the out-migration (121) accounts for a large percent--age (21.0 percent). There are 27 out of area cases and 15 cases could not be traced at the time of survey.Altogether,the number of not traced cases are 30. This suggests the need for proper maintenance of records.

TABLE 1.3 (A) DETAILS OF SAMPLE COVERAGE

Method	Primary Health Centre: Mundgod Tube-ctomy	Mundgod IUD	Shirali Tube-ctomy	Shirali IUD	Mahchikeri Tube-ctomy	Mahchikeri IUD	Total Tube-ctomy	Total IUD
otal Cases .isted for :overage	127	189	184	212	272	248	583	649
ases Covered Number	98	46	92	43	150	71	340	160
Percentage	77.17	24.34	50.0	20.28	55.14	28.63	58.3	24.65
:UD not in :itu removed/ Expelled	-	70	-	79	-	68	-	217
:terilized	-	7	-	19	-	20	-	46
Method Failed	-	1	-	2	-	-	-	3
:eparated	-	-	-	1	-	2	-	3
)ead	-	1	-	1	-	2	-	4
Refused	-	2	-	1	1	-	1	3
ut-migrated	23	51	12	50	86	62	121	163
ot traced	2	1	2	6	11	8	15	15
uplicate cases	-	3	-	9	-	3	-	15
ut of area ases	4	7	3	1	20	12	27	20
ases not equired for uota	-	-	75	-	04	-	79	-
otal not nterviewed Number	29	143	92	169	122	177	243	489
ercentage	22.83	75.66	50.0	79.72	44.86	71.37	41.70	75.35

TABLE 1.3 (B) DETAILS OF SAMPLE VILLAGES COVERED

PHC / Village	Sterilization		I.U.D.	
	No. of cases listed for coverage	Cases covered	No. of cases listed for coverage	Cases Covered
MUNDGOD				
1 Chigalli	30	27	29	05
2 Malagi	29	22	26	10
3 Indoor	68	49	19	06
4 Mainalli	-	-	19	-
5 Gunjavathi	-	-	15	02
6 Katur	-	-	13	06
7 Agadi	-	-	12	02
8 Ugginkeri	-	-	10	07
9 Hunagund	-	-	10	01
10 Pala	-	-	09	01
11 Kolagi	-	-	07	-
12 Nyasargi	-	-	07	01
13 Nandikatta	-	-	07	01
14 Arashanageri	-	-	06	04
SHIRALI				
1 Shirali	84	67	55	16
2 Kaikini	100	25	29	06
3 Konar	-	-	27	04
4 Bailur	-	-	27	03
5 Bengre	-/	-	22	02
6 Mavalli	-	-	21	08
7 Heble	-	-	18	01
8 Muttalli	-	-	13	03
MANCHIKERI				
1 Kampli	29	17	43	09
2 Magod	29	17	29	05
3 Kalache	29	12	29	06
4 Ummachagi	28	18	28	10
5 Vajralli	21	15	26	11
6 Mavinmane	47	17	18	10
7 Bharathanhalli	21	08	17	05
8 Idagundi	17	12	16	08
9 Arabail	33	24	15	01
10 Telangar	05	03	12	04
11 Tarehalli	02	-	11	01
12 Madanoor	11	07	04	01
Total:-	583	340	649	160

CHAPTER - II

SOCIO- ECONOMIC AND DEMOGRAPHIC CHARACTERISTICS OF ACCEPTORS AND NON- ACCEPTORS

2.1 INTRODUCTION

Acceptance of family planning is influenced by a host of social, economic, demographic, cultural, psychological and other factors. An adequate knowledge of the background of the acceptors and eligible couples is necessary to guage the quality of Family Welfare Programme performance. Hence an attempt is made here to analyse the socio-economic and demo--graphic characteristics of acceptors and non-acceptors. A comparative analysis is also attempted between the acceptors and non-acceptors wherever necessary.

In order to achieve the first objective of the study viz; to ascertain the accuracy and nature of reported perform--ance of the family planning programme at the selected PHC level during the reference period, a comparison is made bet--ween the data obtained from the service registers and the data collected through personal interviews with regard to age and parity.

2.2 RELIGION AND CASTE

Table 2.1 gives the percentage distribution of acce--ptor and non-acceptor couples by Religion and Caste. Among tubectomy acceptors 15.0 percent are Brahmins, 3.8 percent are Lingayats and Advanced Hindus, 20.9 percent are Intermediate Hindus and 51.0 percent are Scheduled Castes and Tribes.

Among IUD acceptors, 30.0 percent are Brahmins, 10.0 percent are Lingayats and Advanced Hindus, 25.0 percent are Intermediate Hindus and the percentage of Scheduled Castes and Tribes is 21.9 percent. It is to be noted that among tubectomy acceptors, Scheduled Castes and Tribes constitute large --

percent (51.0 %) whereas 65.0 percent of IUD acceptors are from caste groups of Hindus other than Scheduled Castes and Tribes. This shows that IUD acceptors are generally from higher caste groups.

Among the total acceptors, Hindus constitute 89.6 percent, Muslims 8.6 percent and Christians are 1.8 percent. Religious and Caste classification of non-acceptors is almost same as that of total acceptors. Among non-acceptors, 91.6 percent are Hindus, 7.0 percent are Muslims and 1.8 percent are Christians.

A comparison of these findings with the data of earlier evaluation study in Uttar Kannada (Hasalkar J.B., 1984) indicates that the proportion of Muslims among acceptors of tubectomy and IUD increased during the period between the two surveys (Table 2.16). This increase is more pronounced in case of IUD acceptors. The percentage of scheduled castes and scheduled tribes among IUD and tubectomy acceptors is higher in the present study, being 51.0 percent and 21.9 percent respectively as against the corresponding figures of 18.4 percent and 13.3 percent in the earlier survey.

The present study also reveals that the proportion of Scheduled Castes/Tribes among acceptors is much higher than that reported by Patil (1984) in Belgaum, Hasalkar (1986) in Shimoga and Bhattacharjee and Gopal (1986) in Uttar Kannad

contd.....

TABLE 2.1 PERCENTAGE DISTRIBUTION OF ACCEPTOR AND NON-ACCEPTOR COUPLES BY RELIGION & CASTE

Religion & Caste	Tubectomy		IUD		Total Acceptors		Non-acceptors	
	Number	%	Number	%	Number	%	Number	%
Brahmins	51	15.00	48	30.00	98	19.60	85	17.00
Lingayats and Advanced Hindus	13	3.82	16	10.00	29	5.80	40	8.00
Intermediate Hindus	71	20.88	40	25.00	111	22.20	120	24.00
Scs / Sts.	174	51.18	35	21.87	210	42.00	211	42.20
Muslims	28	8.24	15	9.38	43	8.60	35	7.00
Christians	3	0.88	06	3.75	9	1.80	9	1.80
Total	340	100.00	160	100.00	500	100.00	500	100.00

2.3 EDUCATION

It is obvious from Table 2.2 that 70.6 percent of tubectomy acceptors are illiterates, another 26.8 percent are found with 1-9 years of schooling and 2.7 percent of tubectomy acceptors had education of 10 years and more.

Among IUD acceptors 31.3 percent are illiterate, 47.5 percent had 1-9 years of schooling and 21.3 percent had education of 10 years & more. This reveals that the IUD acceptors had better education.

The corresponding figures among non-acceptor wives are 52.0 percent, 38.0 percent and 10.0 percent respectively

The percentage distribution of husbands of both acceptors and non-acceptors reveals the following. Forty-one percent of tubectomy acceptors' husbands are illiterates whereas 52.4 percent are found with 1-9 years of schooling and 6.5 percent had more than 10 years of education.

As for the educational level of husbands of IUD acceptors, 15.6 percent are illiterates, 46.9 percent had 1-9 years of schooling and 36.9 percent had education of more than 10 years. Among husbands of non-acceptors, 27.6 percent are illiterates, 55.0 percent had schooling of 1-9 years and 17.4 percent had more than 10 years of education.

It is evident that the percentage of illiterates among acceptors have increased relatively little over time. The literacy rate among tubectomy and IUD acceptors is 29.4 percent and 68.8 percent respectively according to present study, while the respective figures as per previous survey are 32.7 percent and 73.3 percent.

TABLE 2.2 Continued

	Education (completed school years)							
	Illiterate	Up to 4 years	5 to 7 years	8 to 9 years	10 years	11 + years	Literate without formal education	Total
Husbands of Acceptors								
Tubectomy								
Number	140	116	55	07	16	05	01	340
%	41.18	34.11	16.18	2.06	4.70	1.47	0.30	100.00
I.U.D.								
Number	25	34	34	07	35	24	01	160
%	15.63	21.25	21.25	4.37	21.87	15.00	0.63	100.00
Total								
Number	165	150	89	14	51	29	02	500
%	33.00	30.00	17.80	2.80	10.20	5.80	0.40	100.00
Non-Acceptor Husbands								
Number	138	148	109	18	54	33	-	500
%	27.60	29.60	21.80	3.60	10.80	6.60		100.00

TABLE 2.2 PERCENTAGE DISTRIBUTION OF ACCEPTOR AND NON-ACCEPTOR RESPONDENTS AND THEIR SPOUSES BY EDUCATION LEVEL

	Education (completed school years)							
	Illiterate	Upto 4 years	5 to 7 years	8 to 9 years	10 years	11 + years	Literate without formal education	Total
Acceptors								
Tubectomy								
Number	240	55	34	02	07	02	-	340
%	70.58	16.18	10.00	0.59	2.06	0.59	-	100.00
I.U.D.								
Number	50	33	34	09	32	02	-	160
%	31.25	20.63	21.25	5.62	20.00	1.25	-	100.00
Total								
Number	290	88	68	11	39	04	-	500
%	58.00	17.60	13.60	2.20	7.80	0.80	-	100.00
Non-Acceptor Wives								
Number	260	109	75	06	37	13	-	500
%	52.00	21.80	15.00	1.20	7.40	2.60	-	100.00

Table 2.2 Contd.

OCCUPATION

Table 2.3 presents the percentage distribution of acceptor and non-acceptor wives and their spouses by occupation. It is seen that the percentage of tubectomy acceptors who are not working at the time of acceptance accounts for 36.8 percent. Twenty-one percent of tubectomy acceptors are cultivators and 38.2 percent are agricultural labourers. The respective figures among IUD acceptors are 58.8 percent, 13.8 percent and 15.0 percent. Another notable feature is 6.3 percent of IUD acceptors are in salaried employment and another 3.8 percent are engaged in Trade and Commerce.

Among non-acceptor wives, 65.8 percent are economically inactive, 11.2 percent are cultivators and 16.2 percent are working as agricultural labourers.

It is evident from Table that 37.7 percent of spouses of tubectomy acceptors are engaged in cultivation, 36.2 percent are working as agricultural labourers and 7.1 percent are in salaried employment. Among spouses of IUD acceptors, 49.0 percent are engaged in agricultural work both as cultivators and agricultural labourers, Another 38.8 percent of IUD acceptors' husbands are working in non-agricultural occupations and 10.6 percent are in non-agricultural labour work. In case of non-acceptors' husbands, 35.2 percent are cultivators, 21.6 percent are agricultural labourers and 14 percent are in salaried employment.

TABLE 2.3 PERCENTAGE DISTRIBUTION OF ACCEPTOR AND NON-ACCEPTOR WIVES AND THEIR SPOUSES BY OCCUPATION

	Occupation	Acceptors						Non-acceptor wives	
		Tubectomy		I.U.D.		Total			
		Number	%	Number	%	Number	%	Number	%
1	Cultivators	72	21.18	22	13.75	94	18.80	56	11.20
2	Unskilled Labourers	03	0.88	03	1.87	06	1.20	18	3.60
3	Agri. Labourers	130	38.24	24	15.00	154	30.80	81	16.20
4	Skilled Labourers	-	-	01	0.63	01	0.20	-	-
5	Village Artisians	03	0.88	-	-	03	0.60	04	0.80
6	Trade & Commerce	03	0.88	06	3.75	09	1.80	05	1.00
7	Salaried Employment (Lower Services)	03	0.88	10	6.25	13	2.60	07	1.40
8	Salaried Employment (Higher Services)	01	0.30	-	-	01	0.20	-	-
9	Not working	125	36.76	94	58.75	219	43.80	329	65.80
10	No response	-	-	-	-	-	-	-	-
Total		340	100.00	160	100.00	500	100.00	500	100.00

Table 2.3 Continued

TABLE 2.3 Continued

Occupation	Acceptor's Spouses						Non-acceptor Husbands	
	Tubectomy		I.U.D.		Total			
	Number	%	Number	%	Number	%	Number	%
1 Cultivators	128	37.65	56	35.00	184	36.80	176	35.20
2 Unskilled Labourers	18	5.29	13	8.12	31	6.20	49	9.80
3 Agri. Labourers	123	36.18	23	14.38	146	29.20	108	21.60
4 Skilled Labourers	18	5.28	08	5.00	26	5.2	35	7.00
5 Village Artisians	09	2.65	-	-	09	1.80	14	2.80
6 Trade & Commerce	09	2.65	19	11.87	28	5.60	42	8.40
7 Salaried Employment (Lower Services)	24	7.06	33	20.63	57	11.40	70	14.00
8 Salaried Employment (Higher Services)	02	0.59	06	3.75	08	1.60	-	-
9 Not working	09	2.65	02	1.25	11	2.20	01	0.20
.0 No response	-	-	-	-	-	-	05	1.00
Total:-	340	100.00	160	100.00	500	100.00	500	100.00

2.5 LAND OWNERSHIP AND HOUSEHOLD INCOME

2.5.1 LAND OWNERSHIP

It is seen from Table 2.4 that the proportion of land owners among tubectomy acceptors is 50.6 percent.Among the proportion, 41.5 percent are with less than 5 acres of land; 6.8 percent had 5-9.9 acres and 2.4 percent with more than 10 acres of land.While among IUD acceptors, 35.6 percent 11.9 percent and 7.5 percent respectively are holding less than 5 acres, 5-9.9 acres and more than 10 acres.

The proportion of land owners among non-acceptors is 54.8 percent.Thirty-nine percent are with less than 5 acres of land, 11.4 percent had 5-9.9 acres of land and 3.6 percent with more than 10 acres of land.

2.5.2 INCOME

Table 2.5 gives the percentage distribution of acce--ptor and non-acceptor couples by their household income.. Majority (64 percent) of tubectomy acceptors are from the lowest income of less than Rs. 250 per month And 28.5 per--cent are from the households with monthly income of Rs.250 to less than Rs. 1250. Only 7.0 percent are from income brack Rs. 1250 and above.It indicates that tubectomy acceptors are from low income families.

Among IUD acceptors, the respective figures are 41.3 percent, 36.9 percent and 20.6 percent.This shows that IUD acceptors are economically well off.

About 49.2 percent of non-acceptors are from the households with monthly income of less than Rs. 250. And 39.4 percent are from income bracket of Rs. 250 to less than Rs. 1250. The percentage of non-acceptors is 11.0 percent in the higher income group of Rs. 1250 and above.

ABLE 2.4 PERCENTAGE DISTRIBUTION OF ACCEPTOR AND NON-ACCEPTOR COUPLES BY TOTAL CULTIVATED LAND HOLDINGS

Total Cultivated Land	Tubectomy		I.U.D.		Total		Non-acceptors	
	Number	%	Number	%	Number	%	Number	%
Less than 1 Acre	35	10.29	05	3.13	40	8.00	41	8.20
1.0 to 2.4 Acres	61	17.94	30	18.75	91	18.20	67	13.40
2.5 to 4.9 "	45	13.23	22	13.75	67	13.40	89	17.80
5.0 to 7.4 "	14	4.12	16	10.00	30	6.00	42	8.40
7.5 to 9.9 "	09	2.65	03	1.87	12	2.40	15	3.00
10.0 to 14.9 "	05	1.47	07	4.37	12	2.40	14	2.80
15.0 to 19.9 "	02	0.59	03	1.87	05	1.00	03	0.60
20 + Acres	01	0.30	02	1.25	03	0.60	01	0.20
No cultivated holdings	168	49.41	70	43.75	238	47.60	226	45.20
No response	-	-	02	1.25	02	0.40	02	0.40
Total:-	340	100.00	160	100.00	500	100.00	500	100.00

TABLE 2.5 PERCENTAGE DISTRIBUTION OF ACCEPTOR AND NON-ACCEPTOR COUPLES BY INCOME

Income (in Rupees) Per Annum	Tubectomy		I.U.D.		Total		Non-acceptor	
	Number	%	Number	%	Number	%	Number	%
Upto 999	03	0.88	-	-	03	0.60	01	0.20
1000 - 1499	08	2.35	-	-	08	1.60	13	2.60
1500 - 1999	15	4.41	06	3.75	21	4.20	32	6.40
2000 - 2999	67	19.70	19	11.87	86	17.20	75	15.00
3000 - 4999	125	36.77	41	25.63	166	33.20	125	25.00
5000 - 7499	63	18.53	23	14.38	86	17.20	100	20.00
7500 - 9999	23	6.76	10	6.25	33	6.60	46	9.20
10000 -14999	11	3.24	26	16.25	37	7.40	51	10.20
15000 -19999	09	2.65	16	10.00	25	5.00	18	3.60
20,000 +	15	4.41	17	10.62	32	6.40	37	7.40
No response	01	0.30	02	1.25	03	0.60	02	0.40
Total	340	100.00	160	100.00	500	100.00	500	100.00

2.6 TYPE OF FAMILY

The households of the respondents in the study area are broadly classified into nuclear and joint. The nuclear family is defined as comprising the married couple and their unmarried children and other than this family composition is considered Joint.

Majority of the acceptors (60.8 percent) are having nuclear families . Nearly 66.0 percent of tubectomy acceptors and 51.0 percent of IUD acceptors are from nuclear families and the rest from joint families. It is observed that the proportion of joint families is comparatively higher among non-acceptors (53.2 percent).

2.7 AGE AT MARRIAGE AND DURATION OF MARRIAGE

2.7.1 AGE AT MARRIAGE

The mean age at first marriage for tubectomy acceptors is 16.9 years. Nearly 14.0 percent of the tubectomy acceptors married at the age of 20 years and above. The mean age at first marriage is higher by 2 years (19 years) for IUD acceptors than tubectomy acceptors.Thirty-five percent of IUD acceptors married at the age of 20 years and above.This figure for non-acceptor wives is 18.4 percent, consequently the mean age at first marriage is 17.4 years.

The mean age at first marriage for husbands' of tubectomy, IUD acceptors and non-acceptors is 24.3 years; 25 years and 24.4 years respectively.

TABLE 2.6 PERCENTAGE DISTRIBUTION OF ACCEPTOR AND NON-ACCEPTOR WIVES AND THEIR SPOUSES BY AGE AT MARRIAGE

Age at Marriage	Wives						Non-acceptor	
	Tubectomy		I.U.D.		Total			
	Number	%	Number	%	Number	%	Number	%
Less than 15 Yrs.	85	25.00	14	8.75	99	19.80	113	22.60
15 - 19 Yrs.	202	59.41	90	56.25	292	58.40	278	55.60
20 - 24 "	40	11.76	48	30.00	88	17.60	80	16.00
25 - 29 "	07	2.06	08	5.00	15	3.00	11	2.20
30 - 34 "	-	-	-	-	-	-	-	-
35 - 39 "	-	-	-	-	-	-	01	0.20
40 - 44 "	-	-	-	-	-	-	-	-
45- 49 "	-	-	-	-	-	-	-	-
Not reported	-	-	-	-	-	-	-	-
Married more than once	06	1.77	-	-	06	1.20	17	3.40
Total	340	100.00	160	100.00	500	100.00	500	100.00
an age at 1st arriage	16.90 Yrs.		19.00 Yrs.				17.38 Yrs.	

Table 2.6 Contd.

Table 2.6 continued.

Age at Marriage	Husbands: TUBECTOMY Number	TUBECTOMY %	I.U.D. Number	I.U.D. %	TOTAL Number	TOTAL %	Non-acceptor Number	Non-acceptor %
Less than 15 Yrs.	01	0.30	01	0.63	02	0.40	02	0.40
15 - 19 Yrs.	31	9.12	05	3.13	36	7.20	44	8.80
20 - 24 Yrs.	167	49.12	85	53.12	252	50.40	238	47.60
25 - 29 Yrs.	96	28.23	50	31.25	146	29.20	168	33.60
30 - 34 Yrs.	17	5.00	15	9.37	32	6.40	25	5.00
35 - 39 Yrs.	02	0.59	02	1.25	04	0.80	04	0.80
40 - 44 Yrs.	01	0.29	-	-	01	0.20	01	0.20
45 - 49 Yrs.	01	0.29	-	-	01	0.20	-	-
Not reported	03	0.88	02	1.25	05	1.00	-	-
Marriaged more than once	21	6.18	-	-	21	4.20	18	3.60
Total:-	340	100.00	160	100.00	500	100.00	500	100.00
Mean age at first marriage	24.27 Yrs.		25.00 Yrs				24.43 Yrs.	

2.7.2 DURATION OF MARRIAGE

The distributional pattern of respondents by duration of marriage reveals that for 62.1 percent of tubectomy acceptors' duration of married life is 5-14 years. In case of 16.5 percent of tubectomy acceptors, it is 15-19 years.

In contrast, 73.8 percent of IUD acceptors represented the 1-9 years of duration. In respect of 16.3 percent of IUD acceptors the duration is 10-14years.

Similarly, among non-acceptor wives the duration of married life is 1-9 years in case of 62.0 percent.Another 17.8 percent of the non acceptor wives represented the 10-14 years of married life.

2.8 A G E

2.8.1. AGE AT SURVEY

Table 2.8 gives the percentage distribution of acceptor and non-acceptor wives and their spouses by age at the time of survey. It is evident that 10.3 percent of the tubectomy accept--ors are in the age group of 20-24 years and 66.8 percent are found in the age group 25-34 years.

Among IUD acceptors, 35.6 percent are aged between 20 and 24 years.Another 48.8 percent are in the age group 25-34 years.

The proportion of non-acceptors in the age group 20-24 years and 25-34 years is 39.0 percent and 44.4 percent respect--ively.

A comparison of total acceptors with that of non-acceptc wives indicate that the proportion of non-acceptor wives aged 20-24 years is more (39 percent) as against 18.4 percent of total acceptors. A reverse trend is observed for those aged 25-39 years. The mean age is 31 years for tubectomy acceptors, 27 .7 years for IUD acceptors, almost 30 years for total acceptors. However, the non-acceptor wives are younger by 3 years (26.8 years) than total acceptors.

TABLE 2.7 PERCENTAGE DISTRIBUTION OF ACCEPTOR AND NON-ACCEPTOR WIVES AND THEIR HUSBANDS BY DURATION OF MARRIAGE

Duration of Marriage:	Wives							
	Tubectomy		IUD		Total		Non-acceptor	
	Number	%	Number	%	Number	%	Number	%
1 - 4 Yrs.	21	6.18	59	36.88	80	16.00	125	25.00
5 - 9 Yrs.	115	33.82	59	36.88	174	34.80	185	37.00
10 - 14 Yrs	96	28.24	26	16.25	122	24.40	89	17.80
15 - 19 Yrs.	56	16.47	08	5.00	64	12.80	42	8.40
20 - 24 Yrs.	32	9.41	05	3.12	37	7.40	27	5.40
25 - 29 Yrs.	13	3.82	03	1.87	16	3.20	12	2.40
30 +	01	0.29	-	-	01	0.20	03	0.60
Married more than once	06	1.77	-	-	06	1.20	17	3.40
No response	-	-	-	-	-	-	-	-
Total	340	100.00	160	100.00	500	100.00	500	100.00

Table 2.7 Continued.

TABLE 2.7 Continued

Duration of marriage	Husbands							
	Tubectomy		I.U.D.		Total		Non-Acceptor	
	Number	%	Number	%	Number	%	Number	%
1 - 4 Yrs.	18	5.30	58	36.25	76	15.20	124	24.80
5 - 9 Yrs.	104	30.59	59	36.88	163	32.60	185	37.00
10 - 14 Yrs.	93	27.35	23	14.37	116	23.20	89	17.80
15 - 19 Yrs.	56	16.47	08	5.00	64	12.80	42	8.40
20 - 24 Yrs.	32	9.41	05	3.12	37	7.40	27	5.40
25 - 29 Yrs.	12	3.53	03	1.87	15	3.00	12	2.40
30 +	01	0.29	-	-	01	0.20	03	0.60
Married more than once	21	6.18	04	2.50	25	5.00	18	3.60
No response	03	0.88	-	-	03	0.60	-	-
Total:-	340	100.00	160	100.00	500	100.00	500	100.00

It is seen from Table 2.8 that tubectomy acceptors' husbands constitute 70.6 percent in the age group 30-44 years. Majority of IUD acceptors' husbands (80.0 percent) and non-acceptor husbands (79.8 percent) are in the age group 25-39 years.

In case of total acceptors' husbands 67.0 percent are aged between 25 and 39 years and this percentage is 79.8 percent among non-acceptor husbands.Mean ages of IUD accep--tors' husbands and non-acceptor husbands are almost same. The non-acceptor husbands are comparatively younger than total acceptors' husbands.

2.8.2 AGE AT ACCEPTANCE

Table 2.9 presents the percentage distribution of acceptor wives and their husbands by age at the time of acceptance. Majority of the tubectomy acceptors (62.4 per--cent) are found in the age group 25-34 years.The proportion in the younger age group (15-24 years) is 22.9 percent and that for aged 35 years and above is 14.7 percent.The general observation of population experts is, for the acceptors of tubectomy the higher concentration is in the age group 25-34 followed by 15-24 years and same trend is noticed in the study area also.

It is significant to note that nearly 52.0 percent of IUD acceptors are in the younger age group of15-24 years. Another 40.0 percent are in the middle age group of 25-34 years and only 8.1 are aged 35 years and above.But a study by India Population Project- III (Bhattacharjee P.J. and Gopal Y.S. 1986) indicates that all the acceptors of IUD in Uttar Kannada district are found in the age group 25-34 only.

According to present study, the mean age at acceptance of IUD acceptors is low (26.2 years) compared with the

TABLE 2.8 PER-CENTAGE DISTRIBUTION OF ACCEPTOR AND NON-ACCEPTOR WIVES AND THEIR SPOUSES BY AGE AT SURVEY

Age (completed years)	Tubectomy			
	Acceptors Wives		Husbands	
	Number	%	Number	%
15 - 19	01	0.30	-	-
20 - 24	35	10.29	-	-
25 - 29	142	41.76	27	7.94
30 - 34	85	25.00	82	24.12
35 - 39	49	14.41	99	29.12
40 - 44	19	5.59	59	17.35
45 - 49	08	2.35	40	11.76
50 +	01	0.30	28	8.24
Husband dead	-	-	05	1.47
Total	340	100.00	340	100.00
Mean age	31.03		38.93	
	I. U. D.			
15 - 19	04	2.50	-	-
20 - 24	57	35.63	06	3.75
25 - 29	55	34.38	41	25.63
30 - 34	23	14.37	53	33.13
35 - 39	15	9.37	34	21.25
40 - 44	05	3.12	14	8.75
45 - 49	01	0.63	08	5.62
50 +	-	-	03	1.87
d	-	-	-	-
Total	160	100.00	160	100.00
Mean age	27.72		34.00	

TABLE 2.8 Continued

Age (completed years)	Total			
	Acceptors Wives		Husbands	
	Number	%	Number	%
15 - 19	05	1.00	-	-
20 - 24	92	18.4	06	1.2
25 - 29	197	39.4	68	13.6
30 - 34	108	21.6	135	27.0
35 - 39	64	12.8	133	26.6
40 - 44	24	4.8	73	14.6
45 -49	09	1.8	49	9.8
50 +	01	0.2	31	6.2
Husband dead	-	-	05	1.0
Total	500	100.0	500	100.0
Mean age	29.97		37.28	

Age (completed years)	Non-Acceptors			
	Wives		Husbands	
	Number	%	Number	%
15 - 19	32	6.4	-	-
20 - 24	195	39.0	15	3.0
25 - 29	150	30.0	147	29.4
30 - 34	72	14.4	154	30.8
35 - 39	39	7.8	98	19.6
40 - 44	12	2.4	46	9.2
45 - 49	-	-	28	5.6
50 +	-	-	12	2.4
	-	-	-	-
Total	500	100.0	500	100.0
Mean age	26.77		33.98	

tubectomy acceptors (29.1 years). The variation in the median age at acceptance between tubectomy acceptors (27.8 years) and IUD acceptors (26.3 years) is less in comparison with the difference in the mean age of both acceptors.

As for the age distribution of husbands, 44.1 percen of tubectomy acceptors' husbands are aged 25-34 years while 55.6 percent are aged more than 35 years.

Whereas 65.0 percent of IUD acceptors' husbands are aged 25-34 years and 28.8 percent IUD acceptors are aged more than 35 years. Among total acceptors' husbands, 50.8 percent are in the age group 25-34 years and 48.0 per--cent are aged 35 years and above. The age distribution of spouses of both IUD and tubectomy acceptors revealed that the husbands of IUD acceptors (32.3 years) are younger than the spouses of tubectomy acceptors (36.8 years).

Overtime, the proportion of those who accepted tubectomy or IUD under 30 years have increased from 37.3 percent to 64.1 and from 63.3 percent to 78.8 percent respectively suggesting a trend that younger women are coming forward to accept these methods in the study area. The mean age at the time of tubectomy and IUD had declined from 31 years to 29 years and from 28 years to 26 years respectively during 1981-82 and 1982-85. Still the mean age at acceptance for Uttar Kannada district is slightly higher as compared to the corresponding figure for Belgaum (Patil R.L. 1984) and Shimoga (Hasalkar J.B. 1986) districts evaluated earlier.

TABLE 2.9 PERCENTAGE DISTRIBUTION OF ACCEPTOR WIVES AND THEIR SPOUSES BY AGE AT ACCEPTANCE

Age (completed years)	Wives Acceptors						Husbands					
	Tubectomy		IUD		Total		Tubectomy		IUD		Total	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
15-19	3	0.88	11	6.88	14	2.80	-	-	-	-	-	-
20-24	75	22.06	72	45.00	147	29.40	01	0.30	10	6.25	11	2.20
25-29	140	41.18	43	26.88	183	36.60	60	17.65	60	37.50	120	24.00
30-34	72	21.18	21	13.12	93	18.60	90	26.47	44	27.50	134	26.80
35-39	34	10.00	08	5.00	42	8.40	99	29.12	27	16.87	126	25.20
40-44	14	4.12	05	3.12	19	3.80	43	12.65	13	8.13	56	11.20
45-49	02	0.58	-	-	02	0.40	29	8.53	05	3.12	34	6.80
50 +	-	-	-	-	-	-	18	5.28	01	0.63	19	3.8
Total	340	100.00	160	100.00	500	100.00	340	100.00	160	100.00	500	100.00
Mean Age	29.10		26.19		28.17		36.78		32.25		35.29	
Median age	27.80		26.30		26.93		35.46		30.75		33.95	

tubectomy acceptors (29.1 years). The variation in the median age at acceptance between tubectomy acceptors (27.8 years) and IUD acceptors (26.3 years) is less in comparison with the difference in the mean age of both acceptors.

As for the age distribution of husbands, 44.1 percen of tubectomy acceptors' husbands are aged 25-34 years while 55.6 percent are aged more than 35 years.

Whereas 65.0 percent of IUD acceptors' husbands are aged 25-34 years and 28.8 percent IUD acceptors are aged more than 35 years. Among total acceptors' husbands, 50.8 percent are in the age group 25-34 years and 48.0 per--cent are aged 35 years and above. The age distribution of spouses of both IUD and tubectomy acceptors revealed that the husbands of IUD acceptors (32.3 years) are younger than the spouses of tubectomy acceptors (36.8 years).

Overtime, the proportion of those who accepted tubectomy or IUD under 30 years have increased from 37.3 percent to 64.1 and from 63.3 percent to 78.8 percent respectively suggesting a trend that younger women are coming forward to accept these methods in the study area. The mean age at the time of tubectomy and IUD had declined from 31 years to 29 years and from 28 years to 26 years respectively during 1981-82 and 1982-85. Still the mean age at acceptance for Uttar Kannada district is slightly higher as compared to the corresponding figure for Belgaum (Patil R.L. 1984) and Shimoga (Hasalkar J.B. 1986) districts evaluated earlier.

TABLE 2.9 PERCENTAGE DISTRIBUTION OF ACCEPTOR WIVES AND THEIR SPOUSES BY AGE AT ACCEPTANCE

Age (completed years)	Wives Acceptors						Husbands					
	Tubectomy		IUD		Total		Tubectomy		IUD		Total	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
15-19	3	0.88	11	6.88	14	2.80	-	-	-	-	-	-
20-24	75	22.06	72	45.00	147	29.40	01	0.30	10	6.25	11	2.20
25-29	140	41.18	43	26.88	183	36.60	60	17.65	60	37.50	120	24.00
30-34	72	21.18	21	13.12	93	18.60	90	26.47	44	27.50	134	26.80
35-39	34	10.00	08	5.00	42	8.40	99	29.12	27	16.87	126	25.20
40-44	14	4.12	05	3.12	19	3.80	43	12.65	13	8.13	56	11.20
45-49	02	0.58	-	-	02	0.40	29	8.53	05	3.12	34	6.80
50 +	-	-	-	-	-	-	18	5.28	01	0.63	19	3.8
Total	340	100.00	160	100.00	500	100.00	340	100.00	160	100.00	500	100.00
Mean Age	29.10		26.19		28.17		36.78		32.25		35.29	
Median age	27.80		26.30		26.93		35.46		30.75		33.95	

2.8.3 EVALUATION OF DATA ON AGE

It is evident from Table 2.11 that only for 13.4 % of of acceptors (both tubectomy and IUD) the reported age at acce-ptance, according to registration data and according to survey data are identical.The reported age as per registration is lowe than survey data by 1-3 years in respect of 26% of acceptors.

And for 11.8% of acceptors, the reported age as per reg-stration is lower by 4-6 years in comparison with survey data. In case of 3.0 percent and 1.8% of acceptors the registration data is lower by 7-9 years and 10-12 years respectively.

The reported age at the time of registration is higher than survey data by 1-3 years in respect of 32.4% of acceptors. The registration data is higher by 4-6 and 7-12 years compared to survey data in respect of 8 % and 3.4% respectively.

It is noteworthy that no much difference is observed i the mean age of total acceptors as per survey (28.2 years) and as per registration (28.3 years). The mean age of tubectomy acceptors is 29.1 years as per survey data and it is 29.5 year as per registration data.The mean age of IUD acceptors is 26.2 years and 25.7 years as per survey and registration data respe-ctively. This shows that how a popular statistic such as mea is inadequate for comparative analysis in some specific situa-tions.

In case of 15.8 % non-acceptor wives, the age, reporte by them at the time of survey and the age recorded by PHC staf in the target couple registers are tallied.

At the time of survey 24.4 % non-acceptor wives report higher age than the age registered in the records by 1-5 years. Another 3.2% and 1% non-acceptor wives respectively reported higher age compared to the age registered in the records by 6- years and 11-15 years.

The reported age at the time of survey is lower than registration data by 1-5 years in case of 34 percent non-acceptor wives. And 8.8 percent non-acceptor wives reported lower age than the registration figures by 6-10 years and 4 percent reported lower age than the registration data by 11-15 years.The mean age of non-acceptor wives is 26.8 years

and 27.8 years as per survey and registration data respect--ively. The reasons for discrepant entries in the demographic characteristics of acceptors and non-acceptors in the records of the PHCs need to be identified and efforts are needed to maintain their accuracy.

2.8.4 INDEX OF DISSIMILARITY

In order to examine the level of discrepencies in the age distributions between survey and registration data, Index of dissimilarltiy is adopted. The index is calculated as the sum of absolute values of the differences between two percentage distributions. Table 2.15 shows that Indices of dissimilarity values of survey and registration data are highest for tubectomy acceptors (27.6) and that for IUD acceptors ID values are 12.5. This indicates that the report--ing of data on age is much better in case of IUD acceptors than tubectomy acceptors.The ID values for non-acceptor wives are 27.2.

2.9 PARITY

The average number of children ever born (parity) to tubectomy acceptors is 4.4 with 2.3 sons and 2.1 daugh--ters (Table 2.14). This average among IUD acceptors is 2.5 with 1.1 sons and 1.4 daughters. The non-acceptors reported an average of 3.0 ever born children (1.4 sons and 1.6 daughters).

2.10: NUMBER OF LIVING CHILDREN :

2.10.1 NUMBER OF LIVING CHILDREN AT SURVEY

It is apparent from the data that the number of living children to the tubectomy as well as IUD acceptors at the time of survey is almost same as that of number of children surviving at the time of acceptance.It denotes the fact that all the children living at the time of acceptance

TABLE 2.10 PERCENTAGE DISTRIBUTION OF ACCEPTORS BY AGE AT ACCEPTANCE AND NON-ACCEPTOR WIVES BY PRESENT AGE AS PER SURVEY DATA AND REGISTRATION DATA

Age group	Tubectomy				IUD				Total			
	Survey data		Registration data		Survey Data		Registration data		Survey Data		Registration data	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
15-19	03	0.88	-	-	11	6.88	08	5.00	14	2.80	08	1.60
20-24	75	22.06	45	13.24	72	45.00	81	50.62	147	29.40	126	25.20
25-29	140	41.18	155	45.59	43	26.88	42	26.25	183	36.60	197	39.40
30-34	72	21.18	95	27.94	21	13.12	19	11.87	93	18.60	114	22.80
35-39	34	10.00	42	12.35	08	5.00	09	5.63	42	8.40	51	10.20
40-44	14	4.12	01	0.30	05	3.12	01	0.63	19	3.80	02	0.40
45-49	02	0.58	-	-	-	-	-	-	02	0.40	-	-
Not recorded in T.C.Register	-	-	02	0.58	-	-	-	-	-	-	02	0.40
Total	340	100.00	340	100.00	160	100.00	160	100.00	500	100.00	500	100.00
Mean age	29.10		29.53		26.19		25.72		28.17		28.30	

Table 2.10 Contd.

TABLE 2.10 Continued

Age Group	Non-Acceptor Wives			
	Survey Data		Registration Data	
	Number	Percentage	Number	Percentage
15-19	32	6.40	13	2.60
20-24	195	39.00	130	26.00
25-29	150	30.00	176	35.20
30-34	72	14.40	92	18.40
35-39	39	7.80	39	7.80
40-44	12	2.40	06	1.20
45-49	-	-	-	-
Not recorded in T.C. Registers	-	-	44	8.80
Total	500	100.00	500	100.00
Mean Age	26.77		27.85	

TABLE 2.11 PERCENTAGE DISTRIBUTION OF ACCEPTOI AND NON-ACCEPTOR WIVES BY DIFFERENCE IN AGE REPORTED AT SURVEY AND AT THE TIME OF REGISTRATION

Age difference survey data - Registration data	Acceptors						Non-acceptor wives	
	Tubectomy		IUD		Total			
	Number	%	Number	%	Number	%	Number	%
+ 6 years & More	29	8.53	15	9.38	44	8.80	11	2.20
+ 5 years	15	4.41	02	1.25	17	3.40	10	2.00
+ 4 years	09	2.65	13	8.12	22	4.40	14	2.80
+ 3 years	19	5.59	06	3.75	25	5.00	28	5.60
+ 2 years	36	10.59	12	7.50	48	9.60	33	6.60
+ 1 year	34	10.00	23	14.38	57	11.40	47	9.40
0	32	9.41	35	21.88	67	13.40	79	15.80
- 1 year	43	12.65	27	16.87	70	14.00	50	10.00
- 2 years	33	9.70	13	8.12	46	9.20	48	9.60
- 3 years	38	11.18	08	5.00	46	9.20	43	8.60
- 4 years	17	5.00	04	2.50	21	4.20	29	5.80
- 5 years	12	3.53	-	-	12	2.40	18	3.60
- 6 years & more	22	6.47	02	1.25	24	4.80	46	9.20
Not reported	01	0.29	-	-	01	0.20	44	8.80
Total	340	100.00	160	100.00	500	100.00	500	100.00

TABLE 2.12 PERCENTAGE DISTRIBUTION OF ACCEPTORS AND NON-ACCEPTORS BY PARITY

Parity	Acceptors						Non-Acceptors	
	Tubectomy		IUD		Total Acceptors			
	Number	%	Number	%	Number	%	Number	%
0	-	-	01	0.63	01	0.20	-	-
1	01	0.29	38	23.75	39	7.80	137	27.40
2	44	12.94	61	38.12	105	21.08	146	29.20
3	74	21.76	27	16.87	101	20.20	79	15.80
4	94	27.65	17	10.63	111	22.20	50	10.00
5	48	14.12	07	4.37	55	11.00	26	5.20
6	41	12.06	04	2.50	45	9.00	17	3.40
7	18	5.29	04	2.50	22	4.40	18	3.60
8	11	3.24	01	0.63	12	2.40	13	2.60
9	04	1.18	-	-	04	0.80	05	1.00
10	02	0.59	-	-	02	0.40	-	-
11 +	03	0.88	-	-	03	0.60	09	1.80
Total	340	100.00	160	100.00	500	100.00	500	100.00
Average	4.36 (2.28 M + 2.08 F)		2.53 (1.10 M + 1.43 F)				2.96 (1.38 M + 1.58 F	

acceptance are surviving at survey also.However, there is slight variation in the percentage distribution of tubectomy acceptors by number of living children at survey and at acceptance.The percentage of tubectomy acceptors with 2 and less than 2 living children at survey is 19.4 percent and at acceptance is 18.5 percent.Similarly, 80.6 percent of the tubectomy acceptors are found with 3 and mor living children at survey and this percentage is 81.5 perce at acceptance.

2.10.2 NUMBER OF LIVING CHILDREN AT ACCEPTANCE

Table 2.13 shows the percentage distribution of acceptors and non-acceptors by number of living children at acceptance.Tubectomy acceptors had 3.89 children surv--iving (2.1 sons and 1.8 daughters) on an average at the time of operation. Ninenteen percent of the tubectomy acc--eptors are found with 2 or less children.The proportion of the acceptors with three or more children living is 81.0 percent.

In contrast, the average number of living children is 2.3 with 1.0 sons and 1.3 daughters to the IUD acceptors Sixty-six percent of IUD acceptors had 2 and less than 2 living children.Remaining 33.8 percent of IUD acceptors had 3 and more living children.While 72.6 percent of non-acceptors are found with two and less than 2 living childre

A sexwise break-up of living children shows that or an average non-acceptors had 1.2 sons and 1.4 daughters. It is obvious that tubectomy acceptors had comparatively a large number of children than the IUD acceptors.The non-acceptors had less number of living children than acceptors This is in agreement with the findings of studies conducte in North Kanara (1984), Belgaum (1984) and Shimoga (1986). These studies reported more or less same average number of

TABLE 2.13 PERCENTAGE DISTRIBUTION OF ACCEPTORS AND NON-ACCEPTORS BY NUMBER OF LIVING CHILDREN AT ACCEPTANCE AS PER SURVEY & REGISTRATION DATA

Number of Living Children	Acceptors										Non-acceptors	
	Tubectomy				IUD				Total Acceptors			
	Survey data		Registration data		Survey data		Registration data		Survey data		Registration data		Survey Data	
	No.	%	No.	%	No.	%	No.	%	No.	%	No	%	Number	%
0	01	0.29	-	-	01	0.63	01	0.63	02	0.40	01	0.20	-	-
1	04	1.18	04	1.18	45	28.12	48	30.00	49	9.80	52	10.40	158	31.60
2	58	17.06	60	17.65	60	37.50	59	36.87	118	23.60	119	23.80	155	31.00
3	86	25.30	85	25.00	27	16.87	28	17.50	113	22.60	113	22.60	71	14.20
4	94	27.65	94	27.65	15	9.38	16	10.00	109	21.80	110	22.00	49	9.80
5	47	13.82	47	13.82	07	4.37	06	3.74	54	10.80	53	10.60	28	5.60
6	30	8.82	29	8.53	03	1.87	01	0.63	33	6.60	30	6.00	13	2.60
7	10	2.94	11	3.24	01	0.63	01	0.63	11	2.20	12	2.40	10	2.00
8	07	2.06	05	1.47	01	0.63	-	-	08	1.60	05	1.00	07	1.40
9	02	0.59	02	0.59	-	-	-	-	02	0.40	02	0.40	03	0.60
10	-	-	01	0.29	-	-	-	-	-	-	01	0.20	02	0.40
11 +	01	0.29	01	0.29	-	-	-	-	01	0.20	01	0.20	04	0.80
Not recorded in T.C. Register	-	-	01	0.29	-	-	-	-	-	-	01	0.20	-	-
Total	340	100.00	340	100.00	160	100.00	160	100.00	500	100.00	500	100.00	500	100.00
Average	3.89 (2.05 M+1.84F)		3.89 (2.05 M + 1.84F)		2.34 (1.02M +1.32F)		2.23 (0.94M + 1.29 F)		3.40		3.35		2.63 (1.21 M + 1.42 F)	

living children at the time of acceptance.

2.10.3 EVALUATION OF DATA ON NUMBER OF LIVING CHILDREN

In case of 92.6 % of acceptors, no difference is obser -ved regarding the total number of living children at acc ptanc reported at the time of survey and at the time of registration (Table 2.14). In case of 4.2 % acceptors the registration figur are lower than the survey figures by 1 to 5 children.And 3.2% o acceptors reported less number of living children at survey tha the registration figures by 1-4 children.

The average number of living children to tubectomy acc -ptors is 3.9 as per both survey and registration data.Among IU acceptors the average number of living children is 2.3 accordin to survey and 2.2 according to registration.

2.10.4 INDEX OF DISSIMILARITY

The indices of dissimilarity values of both survey and registration data are 1.2 and 5.0 for the variable number of living children(at the time of acceptance) to tubectomy and IUD respectively. Surprisingly, the extent of dissimilarity is comp -aratively higher for the number of living children of IUD acce -tors.

The Index of dissimilarity computation shows that the unevenness between distribution is more for the age variable in case of tubectomy acceptors and it is more for the number of living children of IUD acceptors.

2.11 CONCLUSION

Data on socio-economic variables such as religious and caste composition, occupational pattern and income distribution both among acceptors and non-acceptors reveal that both the groups are, more or less, from the same socio- economic status. Data on educational status of acceptors and non- acceptors indicate that literacy status does not seem to come in the way of accepting family planning methods.

TABLE 2.14 PERCENTAGE DISTRIBUTION OF ACCEPTORS BY DIFFERENCE IN NUMBER OF LIVING CHILDREN REPORTED AT SURVEY AND AT THE TIME OF REGISTRATION

Number of living children survey data - registration data	Tubectomy		IUD		Total	
	Number	Percentage	Number	Percentage	Number	Percentage
+ 5 children	1	0.30	1	0.63	2	0.40
+ 4 "	1	0.30	-	-	1	0.20
+ 3 "	-	-	1	0.63	1	0.20
+ 2 "	2	0.59	1	0.62	3	0.60
+ 1 Child	8	2.35	6	3.75	14	2.80
0	313	92.06	150	93.75	463	92.60
- 1 Child	11	3.23	1	0.62	12	2.40
- 2 children	1	0.30	-	-	1	0.20
- 3 "	1	0.29	-	-	1	0.20
- 4 "	1	0.29	-	-	1	0.20
- 5 "	-	-	-	-	-	-
Not reported	1	0.29	-	-	1	0.20
Total	340	100.00	160	100.00	500	100.00

TABLE 2.15 INDICES OF DISSIMILARITY VALUES OF SURVEY AND REGISTRATION DATA

Age group	Acceptors						Non-acceptors		
	Tubectomy			IUD					
	Registration data 1	Survey data 2	Difference 2-1 = 3	Registration data 1	Survey data 2	Difference 2-1 = 3	Registration data 1	Survey data 2	Difference 2-1 = 3
15-19	-	0.88	0.88	5.00	6.88	+1.88	2.60	6.40	+3.80
20-24	13.24	22.06	+ 8.82	50.62	45.00	-5.62	26.00	39.00	+13.00
25-29	45.59	41.18	- 4.41	26.25	26.88	+ 0.63	35.20	30.00	- 5.20
30-34	27.94	21.18	- 6.76	11.87	13.12	+ 1.25	18.40	14.40	- 4.00
35-39	12.35	10.00	- 2.35	5.63	5.00	- 0.63	7.80	7.80	0.00
40-44	0.30	4.12	+ 3.82	0.63	3.12	+ 2.49	1.20	2.40	+ 1.20
45-49	-	0.58	+ 0.58	-	-	-	-	-	
Total	100.00	100.00		100.00	100.00		100.00	100.00	
Index of dissimilarity			27.62			12.5			27.2
Number of living children									
0	-	0.29	+0.29	0.63	0.63	0.00			
1	1.18	1.18	0.00	30.00	28.12	- 1.88			
2	17.65	17.06	- 0.59	36.87	37.50	+ 0.63			
3	25.00	25.30	+ 0.30	17.50	16.87	- 0.63			
4 +	56.17	56.17	0.00	15.00	16.88	+ 1.88			
Total	100.00	100.00		100.00	100.00				
Index of dissimilarity			1.18			5.02			

TABLE 2.16 FINDINGS OF FOUR EVALUATION STUDIES - A COMPARISON

Variable	Uttar Kannada 1982-85	Uttar Kannada 1981-82	Belgaum 1982-83	Shimoga 1983-84
AGE (in years)				
Tubectomy	29.1	31.1	28.5	27.9
IUD	26.2	28.0	24.2	-
Non-acceptors	26.8	26.5	28.8	24.4
NUMBER OF LIVING CHILDREN				
Tubectomy	3.9	4.4	3.8	3.7
IUD	2.3	2.4	2.1	-
Non-acceptors	2.6	2.5	2.6	2.6
LITERACY RATE				
Tubectomy	29.4	32.7	30.1	26.7
IUD	68.8	73.3	42.6	-
Non-acceptors	42.0	36.7	30.1	32.3
ILLITERATES				
Tubectomy	70.6	67.3	69.9	73.3
IUD	31.3	26.7	57.4	-
Non-Acceptors	52.0	63.3	69.9	67.7
HINDUS				
Tubectomy	90.9	88.3	85.0	96.3
IUD	86.8	93.4	83.3	-
Non-Acceptors				

Table 2.16 Contd.

Table 2.16 Continued

Variable	Uttar Kannada 1982-85	Uttar Kannada 1981-82	Belgaum 1982-83	Shimoga 1983-84
MUSLIMS				
Tubectomy	8.2	6.6	14.3	3.7
IUD	9.4	3.3	16.7	-
Non-acceptors	7.0	9.3	11.5	5.2
CHRISTIANS				
Tubectomy	0.9	5.1	0.7	-
IUD	3.8	3.3	-	
Non-acceptors				
SCHEDULED CASTES/ TRIBES				
Tubectomy	51.2	18.4	30.8	44.2
IUD	21.9	13.3	11.1	-
Non-acceptors	42.2	13.3	25.0	41.6

When compared, IUD acceptors are better educated, economically better off and belonging to higher caste groups than tubectomy acceptors. Hence it is necessary to popularise spacing methods among poor sections of the society.

The survey data show that there are two ineligible cases among tubectomy acceptors, who accepted tubectomy at the age of 40 years and above. A higher percentage of women in the younger age groups is found to have resorted to sterilisation in 1982-85 than in 1981-82. A declining trend in the mean age at acceptance of tubectomy as well as IUD is observed. But the average number of living at the time of acceptance has not declined as much over time. It seems there is not much change observed in the desired family size and after completing or achieving their desired norm only, they accept family planning. This is further supported by the data on number of living children to non-acceptors. It is therefore necessary to bring down the present norm of family size, concentrated efforts are needed to motivate women to accept family planning at a younger age when their family size is smaller.

CHAPTER - III

PRACTICE OF FAMILY PLANNING AND RELATED ASPECTS

3.1 INTRODUCTION

This chapter examines the underlying reasons for accepting family planning in general and a particular meth In addition to this, details about the pre-adoption medica screening, advice on post-adoption care and precaution give by the medical / para-medical staff are presented.An attem is also made to study the post-acceptance complications experienced and follow-up services received by the respon--dents and their level of satisfaction concerning the servi offered by Health and Family Welfare personnel. Additional information regarding previous practice of family planning method/s and reasons for their discontinuation is presente in this chapter.

3.2 PREVIOUS PRACTICE

Table 3.1 A and B gives the percentage distribution of acceptors by their previous practice of family planning method/s and reasons for discontinuation . Of the total 500 acceptors (340 tubectomy + 160 IUD acceptors) 12.1 percent (41)of tubectomy acceptors and 31.9 percent (51) of IUD acceptors have used other method/s of family planni prior to the acceptance of the present method. This percent--age is fairly high in comparison with the findings of studies conducted in Belgaum and Shimoga.During 1981-82 Hasalkar (1984) found in Uttar Kannada district that 8.7 percent of tubectomy acceptors and 13.3 percent of IUD acceptors have practised one or the other methods of famil planning previously. In general, the data of the present study suggest that a considerable proportion of respondent made some attempt to control their fertility prior to the

adoption of present method.

As shown in Table, majority (88.4%) among the previous users of tubectomy acceptors have adopted IUD prior to adoption of the present method. Remaining 11.6% of acceptors have used oral pills in the past. An analysis of the reasons for discontinuing the use of previously practised method/s among these respodents shows that 20 (46.5%) of the total 43, discontinued due to complications experienced. Seven (16.3%) respondents discontinued the use since they wanted a permanent method. Desire for more children is the reason for discontinuation in case of 4 (9.3%) respondents. Two (4.6%) and 6 (13.9%) acceptors of IUD discontinued the use for the purpose of renewal / on doctor's advice and due to expulsion of IUD respectively. Two respondents (4.7 %) reported failure of the method and another two respondents mentioned that the method was not convenient to use. However, major reasons for discontinuation are complication/side effects and wanted to adopt a permanent method.

Among present acceptors of IUD, 81.8% reported to have practised IUD previously. Other method/s practised by the remaining respondents are oral pills (10.9%) and condom (7.3%). Out of 55 respondents, (Table 3.1-B) 51 had practised previously for once and 6 had practised for twice intermittently.

The reported reasons for discontinuation are compli--cations/ side effects (32.7 %), want of a child (20.0%) on doctor's advice / renewal purpose (34.5 %), expulsion of IUD (3.6%), failure of method (1.8%) method was not con--venient for use (5.5%) and opposition from family members (1.8%). Therefore major reasons mentioned are for renewal purpose / on doctor's advice and complications/ side effects.

TABLE 3.1-A PERCENTAGE DISTRIBUTION OF TUBECTOMY ACCEPTORS BY PREVIOUS PRACTICE AND REASONS FOR DISCONTINUATION

	Reasons for discontination	IUD/CT	Oral Pills	Total	%
1	Complication / side effects	16	4	20	46.51
2	Wanted a child	4	-	4	9.30
3	Wanted to adopt a permanent method	7	-	7	16.28
4	On doctor's advise/ renewal purpose	2	-	2	4.65
5	Expelled	6	-	6	13.96
6	Failure of the method	2	-	2	4.65
7	Method was not convinent for use	1	1	2	4.65
	Total	38	5	43	100.00

Note: Two respondents who reported use for twice intermittently are considered two times

TABLE 3.1-B PERCENTAGE DISTRIBUTION OF IUD ACCEPTORS BY PREVIOUS PRACTICE AND REASONS FOR DISCONTINUATION

Reasons for discontinuation	IUD/CT	Oral Pills	Nirodh	Total	%
1 Complications/ side effects	14	4	-	18	32.73
2 Wanted a child	9	1	1	11	20.00
3 On doctor's advise/ renewal purpose	19	-	-	19	34.54
4 Expelled	2	-	-	2	3.64
5 Failure of the method	-	-	1	1	1.82
6 Method was not convinent for use	-	1	2	3	5.45
7 Opposition from family members	1	-	-	1	1.82
Total	45	6	4	55	100.00

Note: Four respondents who reported use for twice intermittently are considered two times.

3.2.1 PREVICUS PRACTICE OF IUD USERS

The data on IUD users by number of IUD insertions reveal that 44 respondents had practised IUD more thanonce. Out of these 44 cases, 43 respondents got inserted IUD twice and there is one respondent who had three IUD insertions. Table 3.2 gives the distribution of 43 IUD users by interval between first insertion and removal and reasons for removal of IUD indicates that the post-acceptance complications such as excess bleeding at menstruation, stomach pain , waist pain, cough and asthama and expulsion are the responsible reasons for the discontinuation of IUD before one year of insertion. It is apparent that the possibilities of expul--sion and incidence of side effects of its use (69.0%) are more during the first year of insertion. The reported reason for removal after one year of insertion is for renewal. The percentage of renewal cases increased with the increase of the duration of practise. This percentage of removal is more (68.4%) after 2 years of insertion and before 3 years of insertion. And desire for children is another reason to discontinue the use of IUD after 6 months and before 2 years of insertion (43.2 %).

3.3 CURRENT PRACTICE

3.3.1 SOURCE OF MOTIVATION

It is reported (Table 3.3) that 84.1% of tubectomy acceptors and 87.5% of IUD acceptors had volunteered to accept family planning. Another interesting observation is that more respondents voluntarily accepted IUD thantubectomy About 13.5% of the tubectomy acceptors and 11.9% IUD acceptors are motivated by family planning staff including doctor.The percentage of those reported that they are self motivated is on the whole relatively higher in study area as compared to other districts surveyed earlier. It is considered that

TABLE 3.2 DISTRIBUTION OF IUD/CT ACCEPTORS BY INTERVAL BETWEEN FIRST INSERTION AND REMOVAL AND REASONS FOR REMOVAL

Interval	Reasons for removal					Total
	Renewal purpose	Expelled	Got removed due to complications	Want of children / a child	Opposition from family members/spouse	
Upto 6 months	-	02(66.67)	05 (38.46)	-	-	07 (16.28)
7 to 12 months	-	01(33.33)	04 (30.76)	01 (14.29)	-	06 (13.95)
13 to 18 "	01(5.26)	-	02 (15.39)	01 (14.29)	01(100.00)	05 (11.63)
19 to 24 "	02(10.53)	-	02(15.39)	02 (28.57)	-	06 (13.95)
25 to 30 "	06(31.58)	-	-	-	-	06 (13.95)
31 to 36 "	07 (36.84)	-	-	01(14.29)	-	08 (18.62)
37 to 42 "	01 (5.26)	-	-	-	-	01 (2.32)
43 to 48 "	-	-	-	01(14.29)	-	01 (2.32)
49 + months	02(10.53)	-	-	01(14.29)	-	03 (6.98)
Total	19(100.00) (44.19)	03(100.00) (6.98)	13(100.00) (30.23)	07(100.00) (16.28)	01(100.00) (2.32)	43 (100.00)

TABLE 3.3 PERCENTAGE DISTRIBUTION OF ACCEPTORS BY SOURCE OF MOTIVATION

	Source of Motivation	NUMBERS	
		Tubectomy	IUD
1	Volunteered	286 (84.12)	140 (87.50)
2	Friends and neighbours	4 (1.17)	-
3	Family Planning staff including doctor	46 (13.53)	19 (11.88)
4	Relatives - Husband	2 (0.59)	1 (0.62)
5	Other Government Officials	2 (0.59)	-
	Total	340 (100.00)	160 (100.00)

Note: Figures in brackets are percentages

highly motivated couples may be satisfied with a smaller family size and may accept sterilisation at an earlier stage of family building. But in the study area women have accepted tubectomy with four children on an average which indicates the necessity of streneous efforts that should be taken in future in order to cover the younger couples with small family size under family planning programme.

3.3.2 REASONS FOR ACCEPTANCE

Table 3.4 presents the percentage distribution of respondents by reasons for accepting family planning method/s. Among tubectomised women, the idea not to have more children on economic growth is the major reason in the case of 78.8% of the respondents. Because of domestic exigency that there is none to look after at the time of delivery, 4.4% of the respondents accepted tubectomy. Another 4.4% accepted tubectomy on the advice of doctor / Family Planning workers. In case of 6.8% of respondents, trouble experienced at the time of deli--very compelled to accept tubectomy. Seven persons are fed up with frequent female issues and six persons with premature births/ death of too many children. Force from family members because of monetary benefit compelled 5 respondents to adopt tubectomy..

Adoptors of IUD mentioned two major reasons for accepting family planning method. Main reason is spacing. Sixty five percent of acceptors reported this reason. The other reason is not to have more children on economic grounds. Thirty-one percent of IUD acceptors stated this cause. Only 5 respondents accepted IUD due to problem/trouble at the time of delivery.

To sum up, predominant reason for acceptance is not to have more children on economic grounds in case of tubectomy acceptors, while acceptance of IUD is for spacing.

Similar findings have been reported in other evaluation studies (Deepak Grover and Kulkarni P.M., 1982;Patil R.L., 1984; Hasal-kar J.B. 1984; Hasalkar J.B.1986).

3.3.3 REASONS FOR PREFERRING A PARTICULAR METHOD

Out of 340 tubectomy cases, 219 (64.4%) are laparo-scopic tubectomy cases and 121 (35.6%) are conventional tubectomy cases. The main reasons given by respondents for preferring a particular method are analysed in this section.

About 22.1% of the respondents accepted tubectomy because it is a popular method (Table 3.5). In case of 22.7% respondents it is the family planning personnel's advice that motivated them to prefer tubectomy to other methods. And 18.5% respondents considered the method laparoscopy as good and con-venient and it requirds no hospitalization, so they preferred Fifteen percent of respondents preferred tubectomy because of fear of the likely adverse side effects of other methods.Nine percent of the respondents stated that they are ignorant of other methods of family planning.Another 9.1% of the respon-dents cited because of the advice of acceptors and other people they accepted tubectomy. Seven respondents mentioned fear of failure of laparoscopy as the reason for preferring conventional tubectomy.

For IUD acceptors, "the advice of family planning personnel" (28.1%) "method is good for spacing" (26.3%) and "no adverse side effects in using this method" (26.9%) are the important reasons for preferring IUD method to other methods of family planning. Fourteen (8.8%) respondents adopted this method on the advice of acceptors/people. Ten (6.3%) respondents preferred IUD because they are not inte-rested in adopting permanent method.

TABLE 3.4 PERCENTAGE DISTRIBUTION OF ACCEPTORS BY REASONS FOR FAMILY PLANNING ACCEPTANCE.

Sr.No.	Reasons	Tubectomy	IUD
1	Not to have more children on economic grounds	269 (79.11)	51 (31.87)
2	On advise by doctor/ Family Planning worker	15 (4.41)	-
3	Trouble at the time of delivery	23 (6.77)	5 (3.13)
4	There was none to take care during delivery	15 (4.41)	-
5	Got only female children	7 (2.06)	-
6	Frequent pre-mature births/death of too many children	6 (1.77)	-
7	Motivation on the grounds of incentives/force from family members	5 (1.47)	-
8	Spacing	-	104 (65.00)
	Total	340 (100.00)	160 (100.00)

Note: Figures in brackets are percentages

TABLE 3.5 PERCENTAGE DISTRIBUTION OF ACCEPTORS BY REASONS FOR PREFERRING THE PARTICULAR METHOD

Sr. No.	Reasons	Tubectomy	IUD
1	On advise by the family planning personnel	77 (22.65)	45 (28.13)
2	The method is good and convenient and requires no hospitalisation	63 (18.53)	42 (26.25)
3	This method has no adverse side effects like other methods	51 (15.00)	43 (26.88)
4	Ignorent of other methods	31 (9.12)	03 (1.87)
5	The method is popular	75 (22.06)	03 (1.87)
6	Failure of previous method	05 (1.47)	-
7	Acceptors/ People advised this method only	31 (9.12)	14 (8.75)
8	Heard rumours that failure rate for Laparascopy is more	7 (2.05)	-
9	Not interested in adopting permanent method	-	10 (6.25)
	Total	340 (100.00)	160 (100.00)

Note: Figures in the brackets are percentages

3.3.4 PRE-ADOPTION MEDICAL SCREENING AND ADVICE

In order to create a steady demand, the family plann-ing programme must provide effective services to the acceptors before and after adopting a family planning method. To avoid or to reduce the incidence of post-acceptance side effects/ complications, there should be pre-adoption medical screening for all those who are willing to adopt the method.

It can be seen from Table 3.6 that 96.5% of tubectomy acceptors and 67.5% of IUD acceptors are screened medically prior to operation /IUD insertion. Regarding preadoption medical screening the data of the present study show a better picture than many of the districts surveyed earlier.

Efforts are made to find out whether there is any poss-ible linkage between the post acceptance side effects and the pre-adoption medical screening. It is apparent that pre-adoption medical screening do not have any relationship with the inci-dence of post-acceptance complications.

Table 3.7 presents the distribution of acceptors by nature of post-acceptance precautions advised. It is observed that at the time of operation 20.3% acceptors are not told anything about the post-acceptance precautions or complications. In case of IUD acceptors, none were told anything about the precautions. Twenty-seven percent tubectomy acceptors are advi-sed to abstain from sex for 1-3 months and 44.1% received advice about abstinence and to take nutritious food and diet control over some food items. About 8.5% of the tubectomy acceptors are advised to take nutritious food and diet control over some food items.

TABLE 3.6 PERCENTAGE DISTRIBUTION OF ACCEPTORS BY NATURE OF POST-ACCEPTANCE COMPLICATIONS AND PRE-ADOPTION MEDICAL SCREENING

	Complications	Tubectomy			IUD			Total
		Screened	Not Screened	Total	Screened	not Screened		
1	Stomach pain (burning sensation), back & waist pain etc.	87	02	89 (51.15)	03	02	05 (17.24)	
2	Bleeding and white discharge	29	02	31 (17.82)	11	05	16 (55.17)	
3	Sepsis & Pus formation	10	01	11 (6.32)	-	-	-	
4	General weakness and debility	36	02	38 (21.84)	-	-	-	
5	Disturbed menstrual cycles	05	-	05 (2.87)	06	01	07 (24.14)	
6	Obesity	-	-	-	01	-	01 (3.45)	
	Sub Total	167 (95.98)	07 (4.02)	174 (100.00)	(51.18) 21 (72.41)	08 (27.59)	29 (100.00)	(18.12)
7	No complications	161	05	166	(48.82) 87	44	131	(81.88)
	Grand total	328 (96.47)	12 (3.53)	340 (100.00)	(100.00) 108 (67.50)	52 (32.50)	160 (100.00)	(100.00)

TABLE 3.7 DISTRIBUTION OF ACCEPTORS BY NATURE OF POST-ACCEPTANCE PRECAUTIONS ADVISED

Sr. No.	Advised Precautions	Tubectomy	IUD
1	Advised only abstinence	91 (26.77)	-
2	Abstinence + Nutritious food and diet	150 (44.12)	-
3	Only Nutritious food and diet	29 (8.53)	-
4	Not advised any precautions	69 (20.29)	160 (100.00)
5	Not reported	01 (0.29)	-
	Total	340 (100.00)	160 (100.00)

3.3.5 POST-ACCEPTANCE COMPLAINTS

Table 3.6 shows the percentage distribution of acceptors by nature of post-acceptance complications and pre-adoption medical screening. Almost 49.0% of tubectomy acceptors and 82.% of IUD acceptors reported 'no trouble' after operation/IUD insertion. Remaining 51.0% of tubectomy acceptors and 18.0% of IUD acceptors have suffered some post-acceptance complications.

Among those tubectomy acceptors who had post-operation complications, 51.2% of them reported stomach pain, back and waist pain, 21.8% reported general weakness and debility and 17.8% reported heavy bleeding and white discharge. Only 5 tubectomy acceptors reported disturbed menstrual cycle and 11 respondents stated sepsis and pus formation at the place of operation.

In case of IUD acceptors, heavy bleeding and white discharge (16) disturbed menstrual cycle (7) and stomach pain, back and waist pain(5) are the major complaints.

3.3.6 FOLLOW-UP SERVICES

The particulars about the distribution of acceptors who received follow-up services and their level of satisfaction towards the services, are given in Table 3.8. The data show that 92.1% of the tubectomy acceptors and 88.8% of IUD acceptors reported that they are visited by one or the other health and family planning staff. About 86.8% of the tubectomy acceptors are followed up either by female and male health workers separately or by both male and female workers. Very few respondents reported the visit of doctor and health assistant. Nearly 71.0% of IUD acceptors reported that the female health worker visited them for follow-up.

Among those who received follow-up services, 96.2 % of tubectomy acceptors and 96.5% of IUD acceptors expressed

their satisfaction with regard to follow-up services. Remaining acceptors who are not satisfied with the services provided by the health and family planning staff specified the reasons such as "not providing any medicine", treatment was not effective / not taking proper care" etc.

3.3.7 VISIT TO CLINIC

It is evident, as shown in Table 3.9, that 78.8% of tubectomy acceptors and 73.8% of IUD acceptors are advised to visit the clinic after acceptance by the family planning staff. Among the tubectomy acceptors who are advised to visit the clinic, 64.2% had been to the clinic for general check up or for treatment of the post-acceptance complications. Remaining 35.8% (96) are not visited the clinic inspite of the advice by family planning staff. 82 respondents out of 96, mentioned that they have no post-acceptance complications. Nine respondents stated that ANM/Health Workers are providing medicines and five respondents could not find time to visit the clinic.

Twenty-one percent (72) of the tubectomy acceptors are not told to visit the clinic by any staff of family planning. Only 9 respondents out of 72 utilised the services of the clinic without any such advice.

Among IUD acceptors who received the advice to visit the clinic, 26.3% of the respondents had been to the clinic and 73.7% are not visited the clinic mainly because of no complications. Forty-two IUD acceptors are not told to visit the clinic after insertion.

TABLE 3.8 PERCENTAGE DISTRIBUTION OF ACCEPTORS BY FOLLOW-UP SERVICES RECEIVED AND THEIR SATISFACTION TOWARDS FOLLOW-UP SERVICE

Level of satisfaction	Tubectomy Visited by: Doctor + Male + Female Health workers	Male health worker	Female health worker	Male + Female health workers	Male, Female Health workers + Health Asst.	Not visited by Family Planning Staff	Total
Satisfied	7 (2.33)	18 (5.98)	122 (40.53)	144 (47.84)	10 (3.32)	-	301 (96.17) (100.00)
Not satisfied							
1 Not providing any medicine	-	-	-	2 (66.67)	1 (33.33)	-	03 (0.95) (100.00)
2 Treatment was not effective/not taking proper care	-	1 (11.11)	5 (55.56)	3 (33.33)	-	-	09 (2.88) (100.00)
Sub Total	7	19	127	149	11	-	313 (92.06)
No body visited	-	-	-	-	-	27 (100.00)	27 (7.94) (100.00)
Grand total	7 (2.06)	19 (5.59)	127 (37.35)	149 (43.82)	11 (3.24)	27 (7.94)	340 (100.00) (100.00)

Table 3.8 Contd...

TABLE 3.8 Continued

Level of Satisfaction	I. U. D. visited by: Male health workers	Female health workers	Male + Female health workers	Male and female health workers + health asst.	Not visited by family planning staff	Total
Satisfied	2 (1.46)	108 (78.83)	24 (17.52)	3 (2.19)	-	137 (96.48) (100.00)
Not Satisfied						
1 Not providing any medicine	-	1 (100.00)	-	-	-	1 (0.70) (100.00)
2 Treatment was not effective / not taking proper care	-	4 (100.00)	-	-	-	4 (2.82) (100.00)
Sub-Total	2 (1.41)	113 (79.58)	24 (16.90)	3 (2.11)	-	142 (88.75) (100.00)
No body visited	-	-	-	-	18 (100.00)	18 (11.25) (100.00)
Grand Total	2 (1.25)	113 (70.63)	24 (15.00)	3 (1.87)	18 (11.25)	160 (100.00) (100.00)

TABLE 3.9 : DISTRIBUTION OF ACCEPTORS BY VISIT TO THE CLINIC AFTER ACCEPTANCE

Reasons	Tubecto-my	IUD
I Advised to visit & visited		
i) For general check-up	56 (20.90)	09 (7.63)
ii) For post-acceptance complications - troubles	116 (43.28)	22 (18.64)
II Advised to visit but not visited		
i) No troubles/complications	82 (30.60)	81 (68.64)
ii) ANM/Health worker providing medicines	09 (3.36)	01 (0.85)
iii) Not interested in disclosing the matter		03 (2.54)
iv) Could not find time to visit	05 (1.86)	
v) Reasons not specified		02 (1.70)
Sub-Total:-	268 (78.82) (100.00)	118 (73.75) (100.00)
III Not advised to visit but visited		
i) For general Check-up		
ii) For post-acceptance complications	07 (2.72)	01 (2.38)
IV Not advised and not visited		
Keeping in good health	63 (87.50)	41 (97.62)
Sub-total	72 (21.18) (100.00)	42 (26.25) (100.00)
Grand total	340 (100.00)	160 (100.00)

3.3.8 GENERAL SATISFACTION REGARDING FAMILY PLANNING SERVICES

An overwhelming majority of the tubectomy acceptors (92.9%) and IUD acceptors (98.1%) expressed that they are satisfied with the services provided by family planning staff in general. Only 6.8% of tubectomy acceptors and 1.9% IUD acceptors expressed their dissatisfaction with the services offered by the staff.

3.3.9 ATTITUDE TOWARDS RECOMMENDING FAMILY PLANNING TO OTHERS

The propaganda about family planning methods which the acceptors themselves carry out among their neighbours, friends and relatives is, perhaps, more effective than the motivati--onal /educational campaign carried out by the officials. Hence an attempt is made to study the attitude of acceptors towards recommending a family planning to others and to explore the reasons for the same. Out of 500 acceptors, 84.6% are willing to motivate others regarding the acceptance of family plann--ing method/s. A method-wise break-up of these respondents indicates that more number of tubectomy acceptors (86.2%) are willing to motivate others than the IUD acceptors (81.3%).

The analysis of reasons for their willingness to moti--vate others indicates that 47.8% of tubectomy acceptors and 52.3% of IUD acceptors are in favour of small family, inspite of their suffering due to post acceptance complications, they wanted to motivate others. And another 51.2% of tubectomy acceptors and 44.6% of IUD acceptors who have not experienced any post-acceptance complications would like to express their satisfaction with regard to the method adopted and willing to clarify the doubts and fears of others.

Among the acceptors, those who are not willing to motivate others, reported the following reasons for their

TABLE- 3.10 : Percentage distribution of acceptors by their general satisfaction regarding services offered by Family Planning staff.

Satisfied / not satisfied	Tubectomy	IUD
1. Satisfied	316 (92.94)	157 (98.12)
2. Not satisfied	23 (6.77)	03 (1.88)
3. Not reported	01 (0.29)	--
TOTAL	340 (100.00)	160 (100.00)

disinterest - "no body listens to me", "it is their will and wish", "they will take us to task if any complication arises later", " motivate only when others consult them", "suffering due to complications". Among IUD acceptors," not willing to disclose their acceptance" is major reason for their indiffe--rent or negative attitude to motivate others.

3.4 CONCLUSION

Data on previous practice of family planning method/s show that only 41 (12.1%) out of 340 tubectomy acceptors and 51 (31.9%) out of 160 IUD acceptors reported to have practi--sed IUD, oral pill and condom. The major reasons for discon--tinuation of previously practised method/s are adverse side effects, renewal / doctors' advice, desire for additional child--ren. In case of IUD acceptors, a large proportion stated the reason for removal as renewal. The findings of the present study reveal that there are not many acceptors of spacing methods and most of them are in favour of terminal methods and only after achieving desired number of children. Hence, there is a need to promote the acceptance of non-terminal methods and more efforts are needed to motivate the rural people to accept these non-terminal methods at the earlier stages of their married life.

Regarding the source of motivation, the study shows that majority of the respondents (85.2%) had vodunteered to accept family planning. Only 14.8% respondents considered family planning staff, friends, neighbours, relatives includ--ing husband as source of motivation. No doubt, majority of the acceptors are self motivated to accept family planning, still it is necessary to activate the family planning workers. These workers should contact large number of rural people for changing the attitude of villagers in favour of small family norm at the earlier stages of their married life.

TABLE 3.11 PERCENTAGE DISTRIBUTION OF ACCEPTORS BY REASONS FOR THEIR WILLINGNESS OR OTHERWISE TO MOTIVATE OTHERS

	Reasons	Tube-ctomy	IUD
A	Willing to Motivate		
1	Though I am suffering from side effects, I motivate others because it is better to have limited children	140 (47.78)	68 (52.31)
2	The method is good and convenient, better to adopt/ some people fear of F.P. methods but it is not so.	150 (51.20)	58 (44.62)
3	It is the duty of every body	-	03 (2.30)
4	Reasons not specified/not reported	3 (1.02)	01 (0.77)
	Sub-Total:-	293 (100.0) (86.18)	130 (81.25) (100.00)
B	Not willing to motivate		
1	Nobody listens to me	2 (4.26)	-
2	It is their will & wish	13 (27.65)	1 (3.33)
3	They will take us to task if any complications arise later	9 (19.15)	6 (20.00)
4	Motivate when only others consult them	2 (4.26)	-
5	Suffering from side effects including failure of method	18 (38.30)	-
6	All most all are accepting voluntarily.	3 (6.38)	-
7	Not interested in disclosing the matter	-	22 (73.34)
8	Not reported	-	1 (3.33)
	Sub-Total	47 (100.0) (13.82)	30 (100.0) (18.75)
	Grand Total	340 (100.00)	160 (100.00)

In case of tubectomy acceptors, the dominant reason to accept family planning is not to have more children on economic compulsions and in case of IUD acceptors it is spacing. Demand for laparoscopic tubectomy is increasing because of its perce--ived safety. Therefore, Government must prepare for this increasing demand for laproscopic tubectomy organizationally and administratively.

It is observed that not enough attention is paid in case of IUD acceptors with regard to pre-adoption medical screening no advice is given on post-adoption care and precau--tion.

Comparatively a large proportion of tubectomy acceptors have suffered due to the post-acceptance complications than the IUD users. The general complaint reported by the laparosco--pic acceptors in the study area is complication following sterilization. In order to reduce the incidence of complications after laparoscopic tubectomy, doctors in PHC should be trained thoroughly in laparoscopy.Follow-up services are needed for acceptors especially for laparoscopic acceptors and the PHC workers should pay greater attention to provide frequent follow-up services to these acceptors.

The study shows that majority of the acceptors reported that they are visited by one or the other family planning staff. It is observed that, by and large, acceptors are satisfied with the services offered to them. About three-fourth of the respon--dents are advised to visit the clinic after acceptance. Among those who received the advice a large proportion of tubectomy acceptors utilised the services of the clinic.This proportion is small among IUD acceptors because of no post-acceptance complaints.

Regarding the attitude of acceptors towards recommend-
-ing family planning to others the study shows that the major-
-ity of the acceptors are willing to recommend family planning
to others. The information, education and communication
activities (IEC) at the periphery should exploit this
highly effective source of motivation.

TABLE 3.12 FINDINGS OF SOME EVALUATION STUDIES

Particulars	Districts in which the Evaluation study was conducted				
	Uttar Kannada 1982-85	Uttar Kannada 1981-82	Belgaum 1982-83	Shimoga 1983-84	Tumkur & Hassan 1979-80
Previous Practice (only temp. methods)					
(i) Tubectomy Acceptors.	12.1	8.7	1.4	2.8	Data not available
(ii) IUD Acceptors	31.9	13.3	14.8	-	
Source of Motivation					
(a) Motivated by self					
(i) Tubectomy Acceptors.	84.1	75.0	65.7	79.7	36.0
(ii) IUD Acceptors	87.5	63.3	74.1	-	24.0
(b) Motivated by F.P.Staff					
(i) Tubectomy Acceptors	13.5	24.5	32.9	18.9	23.0
(ii) IUD Acceptors	11.9	36.7	22.2	-	6.0
Reasons for Acceptance					
(a) Tubectomy Acceprors					
(i) Economic compulsion	78.8	81.1	74.6	79.3	65.0
(b) IUD Acceptors					
(i) Spacing	65.0	63.3	92.6	-	39.0
Pre-adoption Medical Screening					
(i) Tubectomy Acceptors	96.5	82.1	84.2	92.6	79.0
(ii) I.U.D. Acceptors	67.5	36.7	77.8	-	36.0
Post-Acceptance complications at the time of Survey					
(i) Tubectomy Acceptors	51.0	30.6	36.6	57.6	46.0
(ii) IUD Acceptors	18.0	40.0	29.6	-	33.0
Follow-up services received					
(i) Tubectomy Acceptors	92.1	83.0	97.0	93.0	Data not available
(ii) IUD Acceptors	88.8	73.0	70.0	-	

C H A P T E R - IV

NON- ACCEPTORS

4.1 INTRODUCTION

This Chapter is concerned with the non-acceptor respondents of the survey. As already explained in the intro--ductory chapter, the non-acceptor is defined as member of a currently married couple, wife in the reproductive age group of 15-44years; having at least one living child and not using any method of contraception as on the day of interview.The present Chapter is concerned with (i) the level of knowledge of respondents regarding different methods of family planning, (ii) the availability of services of family planning and (iii) respondents' contacts with health and family welfare institution.To assess the family planning activities in the study area, each respondent was asked about the home visits of family planning workers, the nature of information given by them and the opinion of the respondents about the utility of such information.The responses are analysed and presented in the following paragraphs . One of the important objectives of the present study is to find out the reason for the non-practice of any family planning method by the eligible couples.Besides, future plans of the non-acceptors with regard to contraception are also analysed in this Chapter.

A special mention is made here concerning the socio-economic and demographic characteristics of non-acceptors for the convenience of interested and enthusiastic readers, even though all such details of non-acceptors are presented in Chapter II.

The proportion of Hindus,Muslims and Christians among non-acceptors is 91.6%, 7..0% and 1.8% respectively.Among non-acceptor wives 52.0% are illiterate, 38.0% had schooling of 1-9 years and 10.0% had more than 10 years of schooling.1

In case of husbands, 27.6% are illiterate, 55.0% had scho l--ing of 1-9 years and 17.4% had more than 10 years of school--ing. Majority of the non-acceptor wives are economically inactive. Among non-acceptor husbands, 35.2% are cultivators, 21.6% are agricultural labourers and 14.0% are in salaried employment.

About 49.2% of non-acceptors are from the households with monthly income of less than Rs. 250 and 39.4% are from income bracket of Rs. 250 to less than Rs.1250. The proport--ion of non-acceptors in the higher income group of Rs.1250 and above is 11.0%.

The average ages of non-acceptor wives and their husbands at the time of marriage are 17.4 years and 24.4 years respectively. The proportion of non-acceptor wives in the age groups of 20-24 years and 25-34 years is 39.0% and 44.4% respectively.

The average ages of non-acceptors wives and their husbands at the time of survey are 26.8 years and 33.9 years respectively.

Non-acceptors had 1.2 sons and 1.4 daughters on an average.They reported an average of 3.9 ever born children (1.4 sons and 1.6 daughters).

4.2 FAMILY PLANNING METHODS: KNOWLEDGE AND ITS SOURCES

Table 4.1 indicates that the permanent methods of family planning are known to majority of the non-acceptor respondents. Further analysis shows that the female steri--lization is known to a large proportion of respondents than male sterilization. The known temporary methods in order are IUD (82.8%) ,Condom (62.0%) and Oral Pills (55.6%). Other methods are known to few.Awareness of the family planning methods is more but the practice of family planning is less.

TABLE 4.1 PERCENTAGE DISTRIBUTION OF NON-ACCEPTORS BY KNOWLEDGE OF FAMILY PLANNING METHODS

Methods known	Number and Percentage
Tubectomy	498 (99.60)
Laprotomy	471 (94.2)
Vasectomy	449 (89.80)
I.U.D.	414 (82.8)
Nirodh	310 (62.00)
Oral Pills	278 (55.60)
Foam Tablets	1 (0.20)
Others	4 (0.80)

Note: Percentage figure in each row is as of total 500 non-acceptor respondents.

To lessen the gap between the awareness and the practice there is an urgent need to make available better family plan--ning services within the easy reach of the people.

Table 4.2 shows the percentage distribution of non-acceptors by source of knowledge about family planning methods. It reveals that 81.0% of the respondents mentioned friends / relatives/neighbours are the most important sources of inform--ation. PHC staff as the sources of information is stated by 79.0 % of the respondents, while acceptors of sterilization and users of other family planning methods are mentioned by 68.0% of the respondents. The proportion of those who quoted mass media as a source for their knowledge about family plan--ning methods is small. It, therefore, signifies that inter-personal communication will be effective in creating awareness for family planning methods. Further, the need for revamping the mass media for more effective role in the Information, Education Communication (IEC) activities is also highlighted.

4.3 KNOWLEDGE ABOUT SERVICE SOURCES

To get some insights into the respondents' awareness towards family planning, the respondents were asked about the knowledge on availability of services. Table 4.3 shows that 97.6% of the respondents are aware of the places where facilities for sterilization are available and they have knowledge, that operation is done free of cost and in addi--tion some money is offered. About 66.0 % of the respondents mentioned about the availability of IUDservices.The knowledge of the respondents about the availability of condom (41.6%) and of oral pills (35.6%) is fairly high.

TABLE 4.2 PERCENTAGE DISTRIBUTION OF NON-ACCEPTORS BY SOURCE OF KNOWLEDGE ABOUT FAMILY PLANNING METHODS

Source of Knowledge	Number and Percentage
Through friends/ relatives /neighbours	405 (81.00)
P.H.C. Staff	395 (79.00)
Acceptors of F.P. Methods	338 (67.60)
Radio	163 (32.60)
Wall Posters	69 (13.80)
Booklets - Books, Newspapers, Magzines etc.	68 (13.60)
Film Show	66 (13.20)
Private medical practitioners	11 (2.20)
Village level Officials	02 (0.40)

Note: Percentage figure in each row is as of total 500 non-acceptor respondents

TABLE - 4.3

Percentage distribution of non-acceptors by knowledge about availability of Family Planning services.

Method	Number and percentage
Sterilisation	488 (97.6)
I.U.D.	330 (66.0)
Nirodh	208 (41.6)
Oral Pills	178 (35.6)

Note : Percentage figure in each row is as of total 500 non-acceptor respondents.

4.4 RESPONDENTS' CONTACTS WITH HEALTH AND FAMILY WELFARE INSTITUTIONS

4.4.1 VISIT TO CLINIC BY THE RESPONDENTS

It is apparent that only 7.4% of the respondents have made visits to Primary Health Centre or Family Welfare Centre in connection with the family planning. (Table 4.4-A). Remaining 92.6 % of the non-acceptors never visited the clinic for the sake of family planning advice. It denotes the fact that major-ity of them have no interest and not bothered to seek the advice on family planning. It signifies the necessity of making special efforts to motivate the people with regards to family planning.

4.4.2 HOME VISIT BY FAMILY PLANNING WORKERS

In order to assess the regularity of extension efforts made by family planning workers, the question regarding the visit of any family planning worker during the month previous to interview was asked to the respondents. About 58.0 percent

of the respondents reported about the visits by family planning worker during one month prior to survey. And 39.2 percent respondents mentioned that they were not visited by any family planning worker(Table 4.4.B). The data show that the Family Planning Workers are not paying regular visits to all eligible couples.

4.4.3 OPINIONS ABOUT FAMILY PLANNING WORKERS

Questions were also asked to the respondents who reported as contacted by family planning workers, to express their opinion about the family planning workers, with the intention to know about the nature of information given by them and the opinion of the respondents about the utility of such information. About 38.3% of the respondents said that family planning workers are good as they made enquiriesabout general health of family members and had given information about immunization programme. And 34.5 % of the respondents mentioned that family planning workers provide tablets for minor ailments and provide tablets to pregnant women. About 25.9 percent of the respondents prescribed the family planning workers as helpful because they advised orpersuaded for acceptance of family planning methods. Only 1.4% of the respondents consider the visit of family planning as of no use.

4.4.4 REASONS FOR APPRECIATION OR OTHERWISE TOWARDS FPWs' VISIT FOR F.P.MOTIVATION

Each respondent was asked to specify the reason for appreciation or otherwise towards family planning workers' visit for family planning motivation. Thepurpose of seeking this information is to guage the readiness of eligible couples to receive information about family planning methods from the concerned workers, or from somebody else and to understand their perception about family planning.

Majority of the respondents (80.2%) are quite specific in their answers and would appreciate the visit of family planning workers to their house to explain about family planning

methods (Table 4.4. C).And 17.8% of them would not appreciate the visit of family planning workers for one or the other reason. Two percent respondents did not give any response to this question.

Among those who would appreciate the visit of family planning workers, 90.3% respondents expressed their appreci--ation because family planning workers informed about various family planning methods and persuaded for acceptance.Almost 5.0 percent of the respondents are happy as the family plann--ing workers are enquiring about their health. Another 4.7% did not specify any reason for their appreciation.

Among those who are not in favour of home visits by family planning workers, 52.8% reported that they are not inte--rested in accepting family planning as they want to have more children.About 3.4% reported that the family planning workers are not doing their duty properly. Fear of operation or side effects is the reason for not appreciating the visit of family planning workers in case of 20.2 percent of respon--dents.About 10.1% of the respondents reported that they do not like family planning/ no idea of adopting family planning. And 9.0% of the respondents said that they did not need any help from family planning workers as they are too old. About 5% of the respondents reported that on religious grounds they are not in favour of the visits by family planning workers.

4.5 REASONS FOR NON-ACCEPTANCE

The reasons for not currently using any family planning method as given by the respondents are listed in Table 4.5. The dominant reason for non-acceptance as mentioned by the respon--dents is the desire to have more children and the desire to have either male or female children. About 64.0% of the respo--ndents expressed this desire.Out of this 64.0 percent, 25.8% respondents expressed desire for male children. The other

TABLE 4.4 RESPONDENTS' CONTACTS WITH PHC/F.W. CENTRE

A Visit to PHC/FWC by Respondents in connection with Family Planning:

	Number	Percentage
Visited (at least once)	37	7.40
Not visted	463	92.60
Total	500	100.00

B Utility of Visits @ by Family Planning Worker

They enquire about general health of family members	102	35.17
They tell about immunisation programme	09	3.11
Provide tablets to minor ailments and also to pregnant mothers	100	34.48
They advised or persuaded for acceptance of family planning methods	75	25.86
Just they had come no use	04	1.38
Sub total	290 (58.00)	100.00
None visited	196 (39.20)	
Not reported	14 (2.80)	
Grand Total	500 (100.00)	

@ visits during the period of one month prior to survey

Table 4.4 Continued

TABLE 4.4 Continued

C Reasons for Appreciation or Otherwise towards FPW's visit For Family Planning Motivation

Appreciation Because	Number	Percentage
Advised and persuaded for family planning	362	90.27
Enquired about our health	20	4.99
Reasons not specified	19	4.74
Sub Total	401 (80.20)	100.00
No Appreciation because		
Want to have more children	47	52.81
They are not doing their work properly	03	3.37
Fear of operation/side effects/ Not feeling well	18	20.22
Do not like Family Planning / no idea of adopting family planning	09	10.11
Too old to accept family planning	08	9.0
On religious grounds	04	4.49
Sub total	89 (17.80)	100.00
No response	10 (2.00)	
Grand Total	500 (100.00)	

reasons responsible for their non-acceptance are such as afraid of the likely side effects of family planning methods, not keeping good health, religious disapproval , domestic exigency and oldage etc.

About 9.0% respondents are afraid of the likely side-effects of family planning methods .So they did not go in for family planning.Another 5.0 % of the respondents reported that they are suffering from some physical ailments and therefore do not like to accept any family planning method.And 4.8 % stated that their elders including husband did not permit them to adopt family planning.Religious disapproval is the reason for non-acceptance in case of 2.0% respondents.Domestic exige--ncy is the reason in case of 2.8 % respondents.About 4.8 % mentioned that family planning acceptance is not necessary due to advanced age (secondary sterility). And 2.8% reported that they are not interested in adopting family planning but they have not specified any reason for their disinterest. About 4.0% of the respondents reported other miscellaneous reasons for non- acceptance such as busy with work in fields,children are not keeping good health, post-partum sterility etc.

An analysis of the reasons for non-acceptance cross clas--sified with the number of male/female children living shows that, among the 129 reppondents who mentioned that they are looking foreward to have male children, 68.2% (88) of the respondents are with no male child living and 30.2 % of the respondents are with one male child living.Among 32 who expre--ssed the desire to have female children, 84.4 % (27) are with no female child living.Among the respondents who reported the reason to have more children 62.7% are with one child living and 29.2% are with two children living.

Further analysis shows that the respondents who are looking forward to have more male children had, on an average, only 0.4 male children living, while the corresponding figure among total acceptors is 2.1. In a similar way, those who desi

to have more female children had 0.3 average female children living. While it is 1.8 for total acceptors. The respondents who reported the reason as desire to have more children of either sex had 1.6 average children living. This figure among total acceptors is 3.9. This comparison indicate that the respondents are not going in favour of family planning until they achieve the desired number of children.

4.6 ATTITUDE TOWARDS FAMILY LIMITATION

The non-acceptors are asked about their future plans towards family limitation. Table 4.6(a) gives the percentage distribution of non-acceptors by willingness to adopt family planning methods. In response to a question on attitudes towa--rds using family planning methods, it is observed that out of 500 non-acceptors, majority (72.8%) of them are interested in adopting one or the other family planning methods in future. And 21.0 % are not willing to accept any method and 6.2% are not thought of it.

Among the non-acceptors willing to accept family planning methods in future 75.3 %intended to accept tubectomy and 18.4 % non-acceptors have not decided about the method they would adopt in future. Only 4 persons are willing to accept vasectomy. And 14 respondents are in favour of using IUD in future. Those who have decided in favour of condoms are only 5.

The respondents who are willing to accept family planning in future are also asked about the stage of their reproduction life at which they would accept the method. It is evident from Table 4.6(b) that all the respondents have certain pre-condi--tions for accepting family planning in future.

Table 4.6(b) shows that 2.5% of the respondents would accept family planning after one child, 23.1% and 36.3% respondents wanted two and three children respectively before

TABLE 4.5(a) PERCENTAGE DISTRIBUTION OF NON-ACCEPTORS BY TOTAL NUMBER OF LIVING CHILDREN AND REASONS FOR NON-ACCEPTANCE

Total number of living children	Desire to have more children	Desire to have male children	Desire for female children	Opposition from elders including husband	Afraid of adverse effects/fear of operation	Against to religion	Not keeping good health	Nobody is there to look after during post-operation period	Advanced age	Not interested	Others	Total
One child	101 (63.93)	26 (16.46)	4 (2.53)	2 (1.27)	11 (6.96)	2 (1.27)	3 (1.89)	-	2 (1.27)	3 (1.89)	4 (2.53)	158 (100.00)
Two Children	47 (30.32)	45 (29.03)	18 (11.61)	6 (3.87)	10 (6.45)	1 (0.64)	5 (3.22)	3 (1.94)	7 (4.52)	2 (1.29)	11 (7.10)	155 (100.00)
Three children	6 (8.45)	32 (45.07)	6 (8.45)	7 (9.85)	7 (9.85)	1 (1.41)	2 (2.82)	3 (4.23)	2 (2.82)	3 (4.23)	2 (2.82)	71 (100.00)
Four children	3 (6.12)	16 (32.65)	3 (6.12)	5 (10.21)	6 (12.25)	1 (2.04)	8 (16.33)	3 (6.12)	2 (4.08)	1 (2.04)	1 (2.04)	49 (100.00)
Five children	2 (7.14)	6 (21.43)	1 (3.57)	2 (7.14)	3 (10.72)	2 (7.14)	2 (7.14)	4 (14.29)	2 (7.14)	3 (10.71)	1 (3.57)	28 (100.00)
Six + children living	2 (5.13)	4 (10.26)	-	2 (5.13)	11 (28.20)	3 (7.69)	5 (12.82)	1 (2.56)	9 (23.08)	2 (5.13)	-	39 (100.00)
Total	161 (32.2)	129 (25.8)	32 (6.4)	24 (4.8)	48 (9.6)	10 (2.0)	25 (5.0)	14 (2.8)	24 (4.8)	14 (2.8)	19 (3.8)	500 (100.00)

TABLE 4.5(b) PERCENTAGE DISTRIBUTION OF NON-ACCEPTORS BY NUMBER OF MALE CHILDREN LIVIN(AND REASONS FOR NON-ACCEPTANCE

Total Male children living	Desire to have more children	Desire to have male children	Desire for female children	Opposition from elders including husband	Afraid of adverse effects/fear of operation	Against religion	Not keeping good health	Nobody is there to look after during post operation period	Advanced age	Not interested	Others	Total
No male child	38 (26.03)	88 (60.28)	1 (0.68)	1 (0.68)	8 (5.48)	2 (1.37)	1 (0.68)	-	2 (1.37)	1 (0.68)	4 (2.75)	146 (100.00)
One male child	106 (48.85)	39 (17.97)	5 (2.31)	12 (5.53)	17 (7.83)	1 (0.46)	8 (3.68)	4 (1.84)	9 (4.15)	6 (2.77)	10 (4.61)	217 (100.00)
Two male children	12 (14.63)	1 (1.32)	18 (21.95)	8 (9.76)	10 (12.20)	3 (3.66)	10 (12.20)	7 (8.54)	5 (6.09)	4 (4.88)	4 (4.88)	82 (100.00)
Three male children	3 (11.53)	-	7 (26.92)	1 (3.85)	5 (19.23)	2 (7.69)	3 (11.54)	1 (3.85)	2 (7.69)	1 (3.85)	1 (3.85)	26 (100.00)
Four male children	1 (7.14)	1 (7.14)	-	1 (7.14)	4 (28.57)	2 (14.28)	3 (21.43)	1 (7.14)	1 (7.14)	-	-	14 (100.00)
Five male children	1 (11.11)	-	1 (11.11)	-	3 (33.33)	-	-	-	3 (33.33)	1 (11.11)	-	9 (100.00)
Six + male children	-	-	-	1 (16.66)	1 (16.66)	-	-	1 (16.67)	2 (33.33)	1 (16.67)	-	6 (100.00)
Total	161 (32.2)	129 (25.8)	32 (6.4)	24 (4.8)	48 (9.6)	10 (2.0)	25 (5.0)	14 (2.8)	24 (4.8)	14 (2.8)	19 (3.8)	500 (100.00)

TABLE 4.5 (c) PERCENTAGE DISTRIBUTION OF NON-ACCEPTORS BY NUMBER OF FEMALE CHILDREN LIVING AND REASONS FOR NON-ACCEPTANCE

Total female children living	Desire to have more children	Desire to have male children	Desire for female children	Opposition from elders including husband	Afraid of adverse effects/fear of operation	Against to religion	Not keeping good health	Nobody is there to look after during post operation period	Advanced age	Not interested	Others	Total
No female child	77 (57.89)	-	27 (20.30)	3 (2.26)	10 (7.52)	-	4 (3.01)	2 (1.50)	3 (2.26)	2 (1.50)	5 (3.76)	133 (100.00)
one female child	70 (40.22)	33 (18.97)	4 (2.30)	10 (5.75)	17 (9.77)	5 (2.87)	10 (5.75)	4 (2.30)	8 (4.60)	4 (2.30)	9 (5.17)	174 (100.00)
Two female children	11 (10.28)	58 (54.21)	-	6 (5.61)	12 (11.21)	1 (0.93)	3 (2.80)	4 (3.74)	4 (3.74)	4 (3.74)	4 (3.74)	107 (100.00)
Three female children	2 (4.44)	22 (48.89)	-	3 (6.67)	4 (8.89)	2 (4.44)	4 (8.89)	2 (4.44)	1 (2.22)	4 (8.89)	1 (2.22)	45 (100.00)
four female children	1 (4.17)	12 (50.00)	1 (4.17)	-	2 (8.33)	2 (8.33)	-	1 (4.17)	5 (20.83)	-	-	24 (100.00)
Five female children	-	2 (18.18)	-	2 (18.18)	3 (27.27)	-	2 (18.18)	1 (9.09)	1 (9.09)	-	-	11 (100.00)
Six + female children	-	2 (33.33)	-	-	-	-	2 (33.33)	-	2 (33.33)	-	-	6 (100.00
Total	161 (32.2)	129 (25.8)	32 (6.4)	24 (4.8)	48 (9.6)	10 (2.0)	25 (5.0)	14 (2.8)	24 (4.8)	14 (2.8)	19 (3.8)	500 (100.00

resorting to family planning. Another 36.3 % respondents would accept family planning after getting 4 or more children.

A small (34) proportion of respondents mentioned some time lag to accept family planning. Of these 34 respondents, 12 respondents who are willing to accept temporary methods stated a time lag ranging between one week to 4 months. Surprisingly, 22 respondents, who are willing to go in for either tubectomy or laparoscopy, reported a time lag of 3 months to 4 years, without any intention of having additional children. It is possible that some of the non-users had given this answer just to evade the truth. The responses are little bit evasive and needs some more clarification. Hence the reasons or underlying causes for this are to be properly researched.

Another point to be noted here is that, 76.4 percent respondents are willing to adopt a permanent method and average children desired by them is 3.5. And only 5.2% are in favour of temporary methods and their average children desired is 2.5 . It shows that strenuous efforts are necessary to popularise the temporary methods.

4.7 REASONS FOR NON-ACCEPTANCE OF F.P. IN FUTURE

The respondents who had not indicated any intention to accept family planning even in future were asked to give reason(s) for that. The reasons given by the respondents are presented in Table 4.7. A careful examination of the table indicates that the broad reasons for their unwillingness to any family planning are fear of operation/ side effects of family planning (39.8%) and advanced age (22.2%). For most of the respondents, who reported fear of side effects of family planning as the reason for non-acceptance, family planning implies only sterilization and much worried about the post operative complications and they think it is a major

Table. 4.6(a) : Percentage Distribution of non-acceptors by willingness to adopt F.P.methdds in future

Willingness	Number	: Percentage
Willing to adopt F.P. methods	364	72.8
Not willing to adopt	105	21.0
Not yet 'thought of it'	31	6.2
TOTAL	500	(100.0)

Table- 4.6(b) : Percentage distribution of non-acceptors by method and decided stage of future adoption.

Method / → After so many children ↓	:Vasectomy:	Tubectomy:	I.U.D.	:Condom:	Not thought of it.	: Total
One child	--	--	5 (35.71)	2 (40.0)	2 (2.99)	9 (2.47)
Two children	--	58 (21.17)	7 (50.0)	2 (40.0)	17 (25.37)	84 (23.08)
Three children	3 (75.0)	96 (35.04)	--	--	33 (49.25)	132 (36.26)
Four children	1 (25.0)	69 (25.18)	2 (14.29)	--	13 (19.40)	85 (23.35)
Five children	-	33 (12.04)	--	1 (20.00)	2 (2.99)	36 (9.89)
Six children and more	--	18 (6.57)	--	--	--	11 (3.02)
TOTAL	4 (100.0)	274 (100.0)	14 (100.0)	5 (100.0)	67 (100.0)	364 (100.0)

surgery.Hence they arenot interested to accept family planning even in future. All these findings point to an urgent need for a systematic educational campaign to remove all such misconce--ptions about family planning and to educate them in the real philosophy behind the programme and its advantages to the family.

And other reasons for non-acceptance in future stated by the respondents are ill-health of the wife/husband, (7.4%) opposition from husband (6.5%), on religious grounds (9.3%), not interested (7.4%), nobody is there to look after at the time of operation(4.6%) , want more children (2.8%).

4.8 PREVIOUS CONTRACEPTIVE PRACTICE

With a view to know something about their previous practice of family planning the respondents were asked to give details of the same. It is evident that out of 500 respondents 78 (15.6%) have practised one or the other methods of family planning previously (Table 4.8). This represents the proportion of non-acceptors who seem to be earnest in regulating their fertility behaviour. The details such as the method practised, duration of practice and reasons for dicontinuing that par--ticular method are presented in this section.

Out of 500 non-acceptors, only 78 had a previous history of contraceptive use for varying periods.Out of these 78, 69 had practised only once. Of the remaining, 8 had prac--tised twice and one for thrice intermittently.

Table 4.8 gives the percentage distribution of the respondents by method used and duration of practice. The Table shows that 61.4% of the respondents practised (previ--ously) IUD,17.1% and 21.6% of the respondents reported the use of oralpills and condom respectively.

The data on the interval between the commencement of use and discontinuation indicate that higher discontinuation was observed in case of oral pill users (73.3%) and condom

Table :- 4.7 Percentage distribution of Non-accepto unwilling to adopt even in future by their reasons for non-acceptance of F.P. in future

Reasons for non-acceptance of family planning in future.	Frequency	Percentage
Afraid of operation / side effects of F.P.	43	9.81
Advanced age (secondary sterility)	24	2.22
Ill-healh of the wife/husband	8	7.41
Opposition from husband	7	6.48
On religious grounds	10	9.26
Not interested/not like it	8	7.41
Nobody is their to take care of during operation	5	4.63
Want more children	3	2.78
TOTAL	108	(100.00)

Table-4.8 : Percentage distribution of previous uders (currently non-adopters) by method and duration of practice

Duration of pra--ctice / Method	Less than 6 months	6 - 12 months	12 - 24 months	25 + months	Total
I. U. D.	04 (7.41)	11 (20.37)	22 (40.74)	17 (31.48)	54 (61.36) (100.0)
Oral pills	11 (73.34)	--	02 (13.33)	02 (13.33)	15 (100.0
Nirodh	10 (52.63)	03 (15.79)	05 (26.32)	01 (5.26)	19 (2 (100.0
TOTAL	25 (28.41)	14 (15.90)	29 (32.96)	20 (22.73)	88 (100.0)

Note :- Nine respondents who reported use for more than once were considered as many times as the number of segments of use they reported.

users (52.6%) during the first six months of use. The corres--ponding percentage of IUD acceptors was only 7.4%. The propo--rtion discontinued was 20.4% and 15.8% during 6 to 12 months of use of IUD and Condom respectively. During 12 to 24 months, 40.7 % IUD adopters, 13.3% Oral Pill users, 26.8% condom use: discontinued the use of respective methods. The percentage wh discontinued IUD, oral pill and condom after 2 years and abov was 31.5%, 13.3% and 5.3% respectively.

Table 4.9 presents the percentage distribution of previous users by method used and reasons for discontinuatio Most of the respondents who reported the use of IUD (72.2%) and oral pill (53.3%) mentioned that side effects/complicatio was the reason for discontinuation. The other reasons cited by the IUD users are want of additional child/children (18.5%) device expelled (5.6%) and afraid of ill-effects/failure of method (3.7%).

In case of oral pill users, negligence/inconvenient to take daily (20.0%) want of additional child/children (13.3%), fear of ill effects/failure of method (6.7%) are the reasons for discontinuation.

Desire to have a child/children (47.4%) due to compli--cations (21.1%) and irregular supply (21.1%), these reasons made the users of condom to discontinue the use.

4.9 CONCLUSION

Information collected on knowledge of family planning indicated that most of the non-acceptors are aware of the permanent methods of fertility control. Knowledge of other methods like IUD, condom and oral pill is also fairly high. Same is the case with the knowledge about the source of avai --ability of services.

In the study area, the major sources of family planni

TABLE 4.9 PERCENTAGE DISTRIBUTION OF PREVIOUS USERS (CURRENTLY NON-ACCEPTORS) BY METHOD USED AND REASONS FOR DISCONTINUATION

Method	Reasons									Total
	Want of child /children	On Doctor's advice	All types of pains, excess bleeding, white discharge & weakness	Negligence/ inconvenience to take it daily	Expelled without the knowledge of user	Irregular supply	Afraid of ill-effects/ failure of method	Giddiness	Sexual dissatisfaction	
I.U.D.	10 (18.52)	06 (11.11)	33 (61.11)	-	03 (5.56)	-	03 (3.70)	-	-	54 (61.36) (100.00)
Oral Pills	02 (13.34)	01 (6.66)	07 (46.67)	03 (20.00)	-	-	01 (6.66)	01 (6.66)	-	15 (17.05) (100.00)
Nirodh	09 (47.37)	-	04 (21.05)	01 (5.26)	-	04 (21.05)	-	-	01 (5.26)	19 (21.59) (100.00)
Total	21 (23.86)	07 (7.96)	44 (50.00)	04 (4.55)	03 (3.41)	04 (4.55)	03 (3.41)	01 (1.13)	01 (1.13)	88 (100.00)

Note:- Nine respondents who reported use for more than once, were considered as many times as the number of segments of use they reported.

information seems to be inter-personal rather than mass media. Only a small proportion of respondents made visits to the clinic to seek advice on family planning. It implies that most of them are not keen to regulate their fertility. It is appa--rant that 58.0% of the respondents reported that they are contacted regularly by family planning worker's and the rema--ining group stated that they had not been visited by family planning workers during the period of one month prior to surve It indicates the extent of inadequate extension services.Among those who are visited by family planning workers, most of them reported that the visits are more or less useful to them. Majority of the respondents stated that they would appreciate the visit of family planning worker's to their door steps in order to get information on family planning.

The study further indicates that the single major reason for not using any family planning method is the desire for additional children. The next reason in order is fear of side effects/complications. The respondents who wanted additional male and female children had, on an average,less thanone child. Those who desired additional children irrespe--ctive of sex had less than two children on an average. So our findings strengthen the idea that people in the study area think about family planning only after achieving their desired family size and in their mind, family planning means mainly to stop child bearing and not as much for spacing between successive births.

The data on attitude towards family limitation in future also support the above observation. It is apparent that a large majority of non-acceptors are interested in using family planning methods in future and that too permanent methods of fertility control provided they have some more children.The main reason for non-acceptance of family planning in future

appears to be fear of side effects of operation and other family planning methods. And other reasons for non-acceptance are on religious grounds, opposition from husband etc. This calls for intensified efforts on persuation and motivation to bring them in the fold of family planning acceptors.

The present analysis shows that only 15.6% of the current non-acceptors have practised any family planning method/s in the past. Among them, majority reported the use of IUD. Theduration of practice is comparatively more in case of past users of IUD than in case of previous users of oral pill and condom. Complications experienced is the dominant reason to discontinue the methods such as IUD and oral pill.

C H A P T E R - V

MATERNAL AND CHILD HEALTH PROGRAMME

5.1 INTRODUCTION

In India, mothers in the age group 15-49 years and children under the age 15 constitute nearly two third of the population.Moreover, mothers and children constitute a vulnerable group, more susceptible to diseases. Therefore, the health of mothers and children is closely related to the general health of the community and it is the best indicator of health development. Hence, it is necessary to take care of such an important segment of society.The need for an integrated approach to maternal and child health and family planning seems obvious. Improvement of the health of mothers and children is a pre-requisite for family planning. On the other hand, the adoption of small family norm is a sure means of improving maternal and child health. This is the reason why education and services for family planning are built into maternal and child health programmes.

With the intention of improving the health status of mothers and children, Government of India started and expanded the services of maternal and child health in all respects.The priority areas in the Maternal and Child Health Services are management of pregnancy and child birth, child health and family planning.Basic health activities involved are prenatal, natal and post-natal care, health supervision of infants and children including nutrition and immunization. So it is worth-while to assess the level of health services available to the mothers and children in the study area and utilisation of such services.

Efforts are made to collect data regarding the knowledge and practices of maternal and child health in order to eva-luate the programme of Maternal and Child Health Services and its effectiveness.

The respondents for this section are non-acceptor wives, who had given birth to a child during a period of one year prior to the date of survey and non-acceptor wives pregnant at the time of survey. The total number of women contacted is 266. Out of 266 women, 167 women had given birth to a child during a period of one year prior to the date of survey and 99 women are pregnant at the time of survey.

Among these 266 women, 42.5% of women are in the age group of 20-24 years and the proportion of women under 30 years of age is 83.0%, whereas highest proportion of their husbands about 36.0% is found in the age group of 25-29 years. Nearly 70,0% of the respondents'husbands are below 35 years of age. About 63.2% of women are found with 2 or less than 2 number of children surviving. On an average the respondents had 2.5 children surviving and 2.8 children born alive. It can be observed that 46.2% of women as compared to 74.4% of their husbands are literate.

The first part of this Chapter is concerned with the details of the respondents who had given birth to a child within one year prior to the survey.

5.2 PRENATAL CARE

In order to reduce prenatal mortality and prevent childhood disabilities, it is essential to maintain a closer medical surveillance of pregnant women. To examine the nature of services provided to the pregnant women, details are collected from the concerned respondents such as, registration of their names with PHC, medical check-up (done by either health worker or doctor) immunization and iron and folic tablets received etc,.

5.2.1 MEDICAL EXAMINATION

Table 5.1 indicates the details of prenatal care received by the respondents. Eighty percent of the respon--dents reported that they are examined at their residence by health worker once in a /fortnight/ month from the fifth month of pregnancy. The data show that 19.8% of the respon--dents are not examined by any health worker at the time of pregnancy.

5.2.2 IMMUNIZATION AND SUPPLY OF IRON AND FOLIC ACID TABLETS

It is known that immunization of pregnant women is one of the effective measures in controlling neonatal teta--nus. But is is evident from several sample surveys, that neonatal mortality is found to be consistently higher in rural India, probably because of less coverage of pregnant women for immunization and less availability of trained staff and places of delivery.

Here an attempt is made to study the proportion of pregnant women who received prenatal care in the form of tetanus toxoid injections and Iron and Folic tablets. In the study area 77.3% of the respondents reported that they have received T.T.injections. When it comes to number of doses, the figure is different, only 58.7% respondents received the required 2 doses of tetanus toxoid injections and 20.4% had taken only one dose.

It is clear that 62.3% respondents received iron and Folic tablets from health worker during pregnancy. The proportion who reported the receipt of tablets also mentioned the number of tablets received. Only a few respondents received the required quantity of 100 tablets and most of them received only one fourth or half of the required quota. The data show that the coverage

is not only less but also inadequate in terms of requirements. This presents the darker side of the services that are available to the respondents.This suggests that there is considerable scope for improvement in the quantum and quality of prenatal care.

5.3.1 DELIVERY

Before collecting data on the respondents' knowledge about child care, some more information is also collected on maternity such as places where the women had gone for delivery, persons who attended to the delivery etc. It is hoped that such data may be useful as background information while drawing the programme for improving health and maternity facilities.

Table 5.1 presents the distribution of respondents by place of delivery. It is clear that only 15.6 percent women had given birth to their children at PHC/Sub-Centre/ Govt. hospital.Private institution is mentioned by 4.8% respondents. Majority (79.6%) of the respondents reported home as their place of delivery. Above findings are strikingly close to the observation made by Bhattacharjee P.J. and Gopal Y.S. (1986) in Uttara Kannada district.It is clear fhat a vast majority of deliveries took place at home and rural women avail the services at PHC/SC/PHU only in case of some complications or emergency etc,.

5.3.2 BIRTH ATTENDANTS AT HOME

All the respondents who had mentioned the place of delivery as home are further asked to mention about the persons who attended the delivery.It can be seen from Table 5.2 that 30.1% respondents mentioned that the female health worker conducted the delivery at home. Another 30.1% mentioned relatives / neighbours; 19.6% stated trained dai, 15.8% reported untrained dai and 4.5% reported private physician conducted delivery at home.

TABLE 5.1 DISTRIBUTION OF MOTHERS BY PLACE OF DELIVERY AND PRENATAL CARE RECEIVED

Place of Delivery	T.T.		Total	Iron and Folic		Total	Check-up during Pregnancy		Total
	Taken	Not taken		Received	Not received		examined by H.W.	not examined	
Home	102 (76.7)	31 (23.3)	133 (100.00)	85 (63.9)	48 (36.1)	133 (100.00)	108 (81.2)	25 (18.8)	133 (100.00)
PHC/S.C./Govt. Hospital	21 (80.8)	5 (19.2)	26 (100.00)	15 (57.7)	11 (42.3)	26 (100.00)	20 (76.9)	6 (23.1)	26 (100.00)
Private Institutions	6 (75.0)	2 (25.0)	8 (100.00)	4 (50.0)	4 (50.0)	8 (100.00)	6 (75.0)	2 (25.0)	8 (100.00)
Total	129 (77.25)	38 (22.75)	167 (100.00)	104 (62.28)	63 (37.72)	167 (100.00)	134 (80.24)	33 (19.76)	167 (100.00)

It is apparent that tetanus is one of the leading causes of neonatal mortality in India accounting for over 70.0 % of such deaths in rural areas. Of the infants who developed tetanus, 86.0% had been attended to at the time of delivery by untrained dai or family members who were ignorant of aseptic techniques.In the study area also, 45.9% deliveries had been conducted by either untrained dai or family members. This point stresses the need to educate the people regard--ing care that should be taken at the time of delivery and especially with reference to type of attendence.

5.4 POST -NATAL CARE

The health worker is expected to visit the mother after her delivery in order to examine the health conditions of both mother and child. The health worker has to make atleast 3 home visits (one day after delivery, one week after delivery and 3 weeks after delivery). Health Worker is expected to enquire the mother about the complaints experienced, if any, after delivery and has to give necessary advice and has to educate the mothers to take nutritious food.

In order to know whether the respondents have recei--ved post-natal care or otherwise one more question is asked to respondents regarding this aspect. It is clear that (Table 5.3) 65.3% are in receipt of post-natal care from health worker and remaining 34.7% reported that they have not received any post-natal care.

It is necessary for female health worker to provide services to nursing mothers, particularly during the first months after delivery. This will ensure the health and survival of child as well as mother. In rural areas, the care of infants has been neglected so far and it is high time that we should take due notice of it and

TABLE 5.2 PERCENTAGE DISTRIBUTION OF MOTHERS WHO HAD HOME DELIVERY BY TYPE OF ATTENDANCE RECEIVED

Type of Attendance	Number of mothers delivered at home and percentages	
	Number	Percentage
1 Female Health Worker	40	30.08
2 Trained Dai	26	19.55
3 Untrained Dai	21	15.78
4 Relatives/Neighbours	40	30.08
5 Private Physician	06	4.51
Total	133	100.00

Note: Out of 167 mothers 34 mothers have delivered at PHC/Government Institutions and Private Maternity homes.

services to infants should be provided with the help of female health workers. There should be repeated follow-ups of this procedure atleast upto the time the baby is one year old with a view to keeping an eye on the physical and mental capabilities of the growing child.

5.5 ADVICE ON FAMILY PLANNING

The objective of MCH is to offer 'health' to mothers and children, while one of the objectives of Family Planning is to ensure the welfare of the family through health. This common objective is the reason why education and services for family planning are built into maternal and child health programmes.

In the present study, efforts are made to analyse the data on family planning advice received by the respondents and their response in turn to such an advice. It is clear that 57.5% respondents received information about family planning. In other words, the health staff approached only 57.5% respondents in the study area when the respondents are either pregnant or after the delivery with the purpose of giving information or advice on family planning Whereas 42.5% respondents reported that they have not received any advice on family planning. The findings suggest that not much importance is attached to the provision of information on family planning to pregnant women and nursing mothers. But it (during pregnancy or immediately after delivery) is the best suited time for providing information on family planning. Therefore, it is necessary to strengthen the extensional efforts of the programme.

Among those respondents who received advice to go in for family planning, only one respondent practiced IUD for sometime and 11 respondents expressed willingness to accept any of the family planning methods within a few months

(Table 5.4). Remaining 84 respondents did not respond favou--rably and accept any family planning methods because of several reasons such as desire to have more children and desire to have children of particular sex (49), ill health (9), domestic exigencies (8), fear of side effects (8), opposition from elders (10) etc.

5.6 CHILD CARE

Children constitute the human capital potential from the societal point of view, therefore, wastage of children should be minimal. But in India the infant mortality rate is still high. Hence, the child development programmes are aimed at not only to prevent and cure the diseases of childre but to promote the health and development of children, ultim--ately with the aim of reducing the infant mortality. Immu--nization of the child, management of diarrhoeal diseases, better feeding and weaning practices play an important role in reducing the mortality rate among infants to the maximum extent. An attempt is made to assess how far the respondents had knowledge regarding these three aspects. How many childre were given these three aspects. How many children were given the immunization of required doses at right age ? How many respondents started breast feeding their babies on the first day of birth? and how many respondents had started giving solid food at right age ? Answers to these questions are analysed in the following sections.

5.7.1 IMMUNIZATION

Children are more susceptible to diseases like dipth--eria, whooping cough, tetanus and polio. The morbidity and mortality rate owing to these diseases is high even though facilities for treatment and control of these diseases are available. These facilities can be availed of through

TABLE 5.3 PERCENTAGE DISTRIBUTION OF MOTHERS BY POST-NATAL CARE AND FAMILY PLANNING ADVICE RECEIVED

Post-Natal Care	Number	%
Provided by Health Worker	109	65.27
Not Provided	58	34.73
Total	167	(100.00)

Advice on Family Planning Received	Number	%
Yes	96	57.5
No	71	42.5
Total	167	(100.00)

TABLE 5.4 DISTRIBUTION OF METHODS BY THEIR RESPONSE TO FAMILY PLANNING ADVICE RECEIVED

Response to Family Planning Advice			Number	%
1 Practised I.U.D.			01	(1.0)
2 Willing to accept family planning shortly.			11	(11.5)
3 Not willing to accept family planning due to following reasons			84	(87.5)
(i) want to have more children and want to have children of particular gender	...	49(58.4)		
(ii) Ill health	...	09(10.7)		
(iii) Domestic exigencies	...	08(9.5)		
(iv) Fear of side effects	...	08(9.5)		
(v) Opposition from elders	...	10(11.9)		
Sub Total		84(100.0)		
Grand Total			96(100.0)	

immunization programme at PHC's in the rural areas. In 1978, India has embarked upon a comprehensive programme of immuni--zation with a goal to reduce the incidence of diphtheria, Whooping cough, tetanus, polio, childhood tuberculosis and typhoid fever by making vaccination available to all children under 2 years of age.

The alarming morbidity and mortality rates among children and infants bear clear evidence to the fact that people are not utilising these services to the fullest extent. This may be due to the lack of knowledge among villagers about the availability of such services, or it may partly be due to deficiencies in the programme implementation.

An attempt is made to know the degree of the uti--lisation of immunization facilities in the study area, which gives the detailed information about how many children have received the immunization of required doses at appropriate age and what is the drop out rate between first and succesive doses, in case the child didn't get any immunization, whether the concerned mothers have knowledge about immunization, if so the sources of such knowledge etc.

5.7.2 D.P.T.

Children can be immunised against the three diseases-diphtheria, whooping cough and tetanus by a combined vaccine. The primary course of triple immunization should start when the infant is 3 months old. The ideal is to give three doses at intervals of 4-6 weeks. In the study area, the total number of children aged one year and less is 167. Out of these 167, 34 children are aged 2 months and less. This group is not eligible for the immunization like DPT, Polio because of their tender age.

At the age of third month, a child should get 1st dose of DPT. An analysis of children by age, denotes that out of 17 aged 3 months only one child had 1st dose of DPT. An appropriate stage of second dose is between 4th and 5th

months. Out of 40 children aged between 4th and 5th months, 72.5% did not get any DPT dose, 27.5% got 1st dose, 17.5% got 2nd dose. The drop out rate between first and second dose is 36.0%.

Between 6th and 7th months, the third and final dose should be given . In this age group, 39.5% got 1st, 26.3% got 2nd and only 13.2% got 3rd dose. The drop out rate between 1st and 3rd is 66.7%. All those children who are aged 8 months and above should get all the doses of DPT. but the actual percentage is 42.1% only. About 52.6% had 3 doses and 55.3% had 1st dose of DPT. The drop out rate bet--ween 1st and 3rd is 23.9%.

On the whole, only 48(36.0%) had one dose of DPT of the 133 total children aged 3 months and above, 37 (32.0% had 2 doses of DPT out of 116 children aged 4 months and above and 22 (28.9%) had 3 doses of DPT out of 76 children aged 6 months and above.

5.7.3 POLIO DROPS

For polio drops, starting point, interval between 2 doses and the ideal dosage are same as for DPT. When com--pared to DPT, the proportion who had received polio drops is somewhat higher, but the drop out rate is more.

Among the 17 children aged 3 months, none got the first dose of polio drops. Among those children aged between 4th and 5th months, 30.0% got 1st dose and17.5% got second dose. The dropout rate between 1st and 2nd doses is 42.0%. Among the children aged between 6 and 7 months, 47.0% got 1st 28.9% had 2nd and 10.5% got 3rddose.The drop out rate between 1st and 3rd dose is 77.8%. Among those children aged 8 months and more, 65.7% got 1st and 2nd doses of polio dro and only 44.7% got 3rd dose.The drop out rate is 32.0%.

The drop out in case of polio vaccine is considerably higher. This may either be due to the respondents lack of understanding the need to bring back the children for further doses of the vaccine and the distance they must travel to reach the health centres or due to lacunae in the total ser--vice programme, improper follow-up , indifferent attitude of the service staff.

5.7.4 B. C. G.

As a matter of procedure, BCG vaccine should be given to all new born infants as soon after the birth aspossible. In the present study, only, 18.0% respondents reported that their children got BCG vaccine and 82.0% reported that their children did not receive BCG vaccine. Surprisingly, only 17.6% respondents who had hospital delivery reported that their children got BCG vaccine and 82.4% respondents' children did not get BCG vaccine.The coverage is far from satisfactory which stresses the serious concern

5.7.5 KNOWLEDGE ON IMMUNIZATION

The respondents whose children did not get immuni--tion are asked to state their knowledge as well as source of khowledge about DPT, polio and BCG vaccination. Majority of the mothers have adequate knowledge about DPT(78.2%), polio (79.5%) and BCG (77.4%).Among these respondents, majority reported health staff as the source of their knowledge about DPT(79.6%) ,polio (77.5%) and BCG (80.2%).Very few respondents mentioned Health Guide,Neighbours, Media and Relatives as sources of knowledge about immunization(Table 5.6)

5.8 ORAL REHYDERATION THERAPY

Dehyderation due to diarrhoea is a major cause of infant and childhood mortality. Oral rehydration therapy

TABLE 5.5 DISTRIBUTION OF CHILDREN BY AGE AND THE LEVEL OF IMMUNIZATION GIVEN

Age of the Child	Total Number	DPT				POLIO				BCG	
		No Dose	1 Dose	2 Doses	3 Doses	No Dose	1 Dose	2 Doses	3 Doses	Given	Not Given
Less than 2 months	34 (100.0)	34 (100.0)	-	-	-	34 (100.0)	-	-	-	1 (2.9)	33 (97.1)
3 months	17 (100.0)	16 (94.1)	1 (5.9)	-	-	17 (100.0)	-	-	-	3 (17.6)	14 (82.4)
4-5 months	40 (100.0)	29 (72.5)	11 (27.5)	7 (17.5)	1 (2.5)	28 (70.0)	12 (30.0)	7 (17.5)	1 (2.5)	7 (17.5)	33 (82.5)
6-7 months	38 (100.0)	23 (60.5)	15 (39.5)	10 (26.3)	5 (13.2)	20 (52.6)	18 (47.4)	11 (28.9)	4 (10.5)	7 (18.4)	31 (81.6)
8 + months	38 (100.0)	17 (44.7)	21 (55.3)	20 (52.6)	16 (42.1)	13 (34.2)	25 (65.8)	25 (65.8)	17 (44.7)	12 (31.6)	26 (68.4)
Total	167 (100.0)	119 (71.3)	48 (28.7)	37 (22.2)	22 (13.2)	112 (67.1)	55 (32.9)	43 (25.7)	22 (13.2)	30 (18.0)	137 (82.0)

Note: Figures in paranthises are percentages

TABLE 5.6 DISTRIBUTION OF MOTHERS WHOSE CHILDREN DID NOT GET ANY INNUNIZATION BY THEIR SOURCE OF KNOWLEDGE ABOUT DPT, POLIO, AND BCG

Soured of Knowledge	DPT	POLIO	BCG
1 Health Staff	74 (79.6)	69 (77.5)	85 (80.2)
2 Health Guide	03 (3.2)	03 (3.4)	03 (2.8)
3 Neighbours	11 (11.8)	12 (13.5)	12 (11.3)
4 Media	01 (1.1)	01 (1.1)	02 (1.9)
5 Others (Relatives)	04 (4.3)	04 (4.5)	04 (3.8)
Sub Total	93 (78.15) (100.0)	89 (79.46) (100.0)	106 (77.37) (100.0)
No knowledge	26 (21.85)	23 (20.54)	31 (22.63)
Total	119 (100.0)	112 (100.0)	137 (100.0)

(ORT) is a simple and cheap way of reducing morbidity and mortality caused by diarrhoeal diseases. Oral rehy--dration therapy is the administration of a salt-sugar solution.

The health workers and medical officers are expected to provide adequate information, training and guidance to mothers about ORT. To evaluate the knowledge of the respon--dents about the ORT, information is collected in this conn--ection. Only 20.4 % (34) respondents had the knowledge about oral rehydration therapy. Of these 34, 23.5 %(8) respondents reported that they got information from Health Worker. Medic officer as source of knowledge is mentioned by 35.3% (12) respondents. Media and neighbours as a source of knowledge is stated by 5.9 percent (2) respondents. Another 35.3% (12) respondents reported that they got information from elders in the family.

Overall, the exact knowledge of ORT is known to small proportion of the respondents (29.4%).Remaining res--pondents had practised some traditional methods to prevent dehydration due to diarrhoeal diseases.These 24 (70.6%) respondents mentioned that they had given tender coconut water or lemon juice with salt to their children. Propaga--tion of home remedy of ORT for children is welcome indeed over due. The widespread availability of this solution is therefore an important public health measure that needs immediate attention.

5.9 BREAST FEEDING AND WEANING PRACTICES

Malnutrition and under-nutrition are the serious health problems among children in India especially in rural areas. The underlying cause for this no doubt is poverty. Besides this, ignorance and lack of appreciation of people

TABLE 5.7 DISTRIBUTION OF MOTHERS BY SOURCE OF KNOWLEDGE ABOUT ORAL REHYDRATION THERAPHY

Source of knowledge	Number of Respondents	%
Health Worker	08	(4.8)
Medical Officer	12	(7.2)
Neighbours	01	(0.6)
Elders in the family	12	(7.2)
Media	01	(0.6)
No knowledge about oral rehydration theraphy	133	(79.6)
Total	167	(100.0)

about nutritional values also contribute to malnourishment of the children.

There is no substitute to breast milk to feed the infant. It will be more beneficial if the mother starts feeding her baby on the same day of its birth. In addition to breast feeding, giving solid food should start at earlier stages of child's growth (mostly at 3rd month), so that different types of supplements are available and children will attain normal physical growth.But the problem is how far our rural people are aware of this fact and how many have adequate knowledge of breast feeding and weaning pra--ctices.

To examine this, relevant questions are asked to each of the respondents. It can be seen from Table 5.8 that 49.0% of the respondents have the adequate knowledge about breast feeding and weaning practices.Further analysis shows that among these respondents only 36.6% breast fed their babies on the same day of birth, 7.3% after one day, 21.9% after two days and rest, after 3 days and above. Forty one percent respondents are not have knowledge about breast feeding and weaning practices.

An interesting feature is that 5.9% respondents breast fed their babies on the same day of birth, another 5.9% after one day, 31.8% after 2 days without any knowledg on breast feeding practices. In other words, out of 35 res--pondents who breast fed their babies on the same day 85.7% had knowledge and 14.3% had no knowledge about feeding pra--ctices. Similarly, out of 11 respondents who had given breast milk to their children after one day, 54.6% had know--ledge and 45.4% had no knowledge.Those who breast fed their babies after 2 days and above, majority of them had no

knowledge . Hence the knowledge factor has no relevance in usual practice. Mothers did have various apprehensions and superstitions about breast feeding and they may follow acc--ordingly. This observation is quite clear from the findings of weaning practices.

Out of 167 children, 37.0% are given solid food after the completion of 2nd month. Of the 25 respondents who started solid food to their children at 3rd month, only 5 respondents have knowledge about weaning practices. Those mothers who introduced solid food to their children between 4 and 6 months and during 7-9 months, 45.0% and 73.0% have better knowledge about weaning practices respectively. Therefore, it is essential to motivate mothers towards exclusive breast-feeding in the prenatal period, to encourage them throughout the first six months. All the misconceptions of nursing mothers needed tact--ful handling through personal discussion by doctors, nurses and para-medical staff. The use of locally produced nutritio--nal foods during the weaning period is essential. Knowledge about the dietary needs of children, including the timing of meals, form (density) of the food, can be conveyed to women. The best way is to train mothers in the procedure.

5.10 CARE FOR EXPECTANT MOTHERS

This section is concerned with the respondents who are pregnant at the time of survey. To ensure that a health child is born the expectant mother should take care right from the early stage of pregnancy. She has to register her name for antenatal care and for child birth in the PHC. She has to go for medical check-up regularly which enables the doctor to evaluate her pregnancy properly, to foresee any complica--tion that may arise during delivery and to take timely steps to prevent them. She should be educated by health workers reg--arding the need for and importance of nutritious food. The

TABLE 5.8-A PERCENTAGE DISTRIBUTION OF MOTHERS BY KNOWLEDGE ABOUT BREAST FEEDING AND THEIR ACTUAL PRACTICE

Given Breast milk to infants	Mothers who have knowledge about breast feeding		Mothers with no knowledge about breast feeding	
	Number	%	Number	%
On the same day of its birth	30	36.59	05	5.88
After one day	06	7.32	05	5.88
After 2 days	18	21.94	27	31.76
After 3 days	26	31.71	39	45.89
After 4 & more days	02	2.44	09	10.59
Total	82 (49.19)	100.0	85 (50.89)	100.0

TABLE 5.8-B DISTRIBUTION OF MOTHERS BY KNOWLEDGE ABOUT WEANING PRACTICES AND THEIR ACTUAL PRACTICE

Given solid food to infants at the age	Have knowledge about weaning practices		No knowledge about weaning practices	
	Number	%	Number	%
Less than 3 months	05	(19.2)	20	(55.6)
4 to 6 months	09	(34.6)	11	(30.5)
7 to 9 months	11	(42.3)	04	(11.1)
10 to 12 Months	01	(3.9)	01	(2.8)
Sub Total	26 (31.71)	(100.0)	36 (42.35)	(100.0)
Not given solid food	56 (68.29)		49 (57.65)	
Grand Total	82 (100.0)		85 (100.0)	

first few months of pregnancy is the time for the development of all vital organs of the foetus. Special care should, therefore be taken to restrict the intake of unnecessary drugs during that period. Hence, after registration with PHC every pregnant woman is expected tope visited by either health worker or Government doctor. Therefore, efforts are made to examine the type of care that is being provided for pregnant women in the study area.

5.10.1 REGISTRATION WITH GOVT./PRIVATE DISPENSARY FOR ANTENATAL CARE AND DELIVERY.

It is seen from Table 5.9 that 27 (36.9%) respondents registered their names at the third month and before and out of them, 20 (74.0%) registered with PHC, 7 (26.0%) registered with private dispensary. Thirty six (49.3%) respondents regi--stered with PHC between 4 and 6 months. Among these only 3 (8.3%) respondents registered with private dispensary. Ten (13.7%) respondents registered with PHC after 7 months of pregnancy. Remaining 26 (26.3%) respondents are not registered their names either with Government dispensary or with private dispensary.

Among those registered with PHC, 31.8% registered at 3rd month or before, 52.4% registered between 4 and 6 months and 15.9% registered at 7th month or after for antenatal care as well as for child birth.

Those who have not registered their names for antenatal care and delivery, 8 (30.8%) respondents reported that they are not aware of the registration, 7 (26.9%) respondents stated that they will register after some time as it is too early to register names (early stage of pregnancy), 5 (19.2%) respon--dents mentioned that they had not faced any health problems at the time of their earlier pregnancy or child birth, so they felt it is not necessary to register their names, 6 (23.1%)

respondents reported that none of the health staff had come to register their names.

5.10.2 VISIT OF HEALTH WORKERS

Among the 63 pregnant women who registered with PHC for the purpose of antinatal care and child birth, 40 (63.5%) respondents reported the visit of health worker to their home after registration and 23 respondents stated that none of the health staff had come to their house (Table 5.10).Those who reported the visit of health worker mentioned that the health workers made the visits ranging from 1 to 10 times.

5.10.3 IMMUNIZATIONAL STATUS

It is already mentioned in the earlier section the importance of immunising the pregnant women against tetanus. The ideal stage to give tetanus toxiod injection is 6th month. So the information is collected how many pregnant women did get the immunization dose, among the respondents with duration of pregnancy more than 6 months.

It is clear from Table 5.11, 21 (35.6%) pregnant women got one dose of tetanus toxoid injection, and 12 (20.3 got 2 doses and 4 (6.8%), women reported that they had 3 doses by tetanus toxoid injection.Twenty-two respondents (37.3%) are not immunized against tetanus.There are 40 pregn--ant women, whose duration of pregnancy is less than 6 months.

5.11 CONCLUSION :

In the study area, the coverage of pregnant women for pre-natal services is not satisfactory.During pregnancy, 58.7 of women are immunised against tetanus and 62.3% received Iron and Folic acid tablets. Out of this 62.3%, only a few respondents reported the receipt of required quantity.This suggests that there is considerable need for improvement in the quantum and quality of prenatal care.

TABLE 5.9 DISTRIBUTION OF CURRENTLY PREGNANT WOMEN BY PLACE OF REGISTRATION FOR ANTENATAL CARE AND DELIVERY

Stage of Pregnancy	Registered with		Not Registered by Reason				Total
	Government dispensary	Private dispensary	Not aware	Early stage of pregnancy	No trouble experienced at the time of previous pregnancy/ delivery	None had come	
Less than 3 months	20 (31.7)	07 (70.0)	02 (25.0)	07 (100.0)	01 (20.0)	01 (16.7)	38 (38.4)
4-6 Months	33 (52.4)	03 (30.0)	03 (37.5)	-	01 (20.0)	02 (33.3)	42 (42.4)
7 + months	10 (15.9)	-	03 (37.5)	-	03 (60.0)	03 (50.0)	19 (19.2)
Total	63 (100.)	10 (100.0)	08 (100.0)	07 (100.0)	05 (100.0)	06 (100.0)	99 (100.0)

TABLE 5.10 PERCENTAGE DISTRIBUTION OF CURRENTLY PREGNANT WOMEN WHO REGISTERED WITH GOVERNMENT FACILITY BY VISIT OF HEALTH WORKER / DOCTOR

Visited by Health Worker/ Doctor	Number	%
Yes	40	63.5
No	23	36.5
Total	63	100.0

TABLE 5.11 DISTRIBUTION OF PREGNANT WOMEN BY IMMUNISATIONAL STATUS

Received Tetanus Toxoid Injection	Number	%
One dose	21	35.6
Two doses	12	20.3
Three doses	04	6.8
Not availed of facility	22	37.3
Sub Total	59	100.00
Not applicable	40@	
Grand Total	99	

@Note: - As the duration of pregnancy is less than 6 months.

Majority (79.6%) of the respondents reported home deliveries and 45.9% of the deliveries are conducted by either untrained dais or family members.Most of the deliveries are occuring at home in rural areas. Rural people are not aware of occurance of complications as a result of untrain[illegible] villagers' attendence at the time of delivery. This point stresses the need to educate the people regarding care that should be taken at the time of delivery and especially with reference to type of attendence.

Information or advice on family planning is received by slightly more than half of the respondents. The utility of such advice is not satisfactory. The immunization facilities are not utilised fully. Among the mothers whose children didn't get any immunization , majority of them have adequate knowledge of immunisation. In the light of these findings, it is clear that the mere provision of preventive health service facilities does not result ih high coverages and that strate--gies must be evolved for optimal utilisation. It is essential to promote intensified immunisation programme by creating an awareness among parents of the causes, signs, symptoms seri--ousness and complications arising out of communicable diseases.

Only 29.4% mothers have exact knowledge about oral rehydration therapy. Propagation of the home remedy of oral rehydration for children are welcome. The widespread avail--ability of oral rehydration solution is therefore an impor--tant public health measure which needs immediate attention. Forty-nine percent of the mothers have adequate knowledge about breast feeding and weaning practices but it has no relevance in actual practice. Therefore it is essential to motivate the mothers towards exclusive breast feeding in the prenatal period, to encourage them throughout the first six months.The use of locally produced nutritionally and cultu--rally acceptable foods during the weaning period is essential.

Nearly 74.0% of respondents who are pregnant at the time of survey, reported the registration of their names with either Government or private dispensary for antenatal care and delivery. But the findings of the study revealed that only small proportion of expecting mothers are getting proper medical care . This warrants that more and more facilities are required to be provided to expecting mothers.

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RHO/-.

CHAPTER -VI

SUMMARY AND POLICY IMPLICATIONS

The present study aims at the Current Evaluation of Family Welfare and Maternal Child Health Programmes in Uttar Kannada District of Karnataka. It provides information on socio-economic and demographic characteristics of a representive Sample of acceptors as well as non-acceptors. In case of acceptors, the study presents the particulars of acceptance, side effects /complications experienced after acceptance, follow-up services received, history of previous contraception and the attitude of acceptors towards motivating people in connection with family planning. As for non-acceptors, it gives the details regarding the respondent's contacts with PHC/ FW Centre, their knowledge regarding family planning methods, reasons for non-acceptance and future plans in respect of their fertility control. It also provides some information about maternal and child health services and general health practises of respondents with reference to maternal and child care.

The reference period for this study is the financial years 1982-83, 1983-84 and 1984-85. The selection of sample district is based on the district-wise combined acceptance rate of sterilization and IUD for the years 1982-83; 1983-84 and 1984-85. Nine districts of Karnataka which are confined to Population Research Centre, Dharwad are stratified into three regions based on performance. Of the three regions, first region (High Performance) is selected at random and median performance district of this region is selected as the sample district for the present study.

Among the eleven PHC's of Uttara Kannada District, which were arranged again on descending order of performance, three PHC's namely Mundgod, Shirali and Manchikeri are selected by adopting systematic random sampling.

The predetermined sample sizes are 500 acceptors and 500 non-acceptors. Acceptors are those who accepted either tubectomy or IUD during the reference period of three consecutive years 1982-85. The non-acceptor couples are those who are currently married, where in the wife is in the reproductive age group of 15-44 years, having atleast one living child, not using any methods of contraception as on the day of survey. The respondents for the evaluation of maternal and child health programme are the non-acceptor wives who had either given birth to a child during the one year period preceding the date of survey, or pregnant at the time of survey. The 500 acceptor cases are allocated amongst sterilization and IUD in proportion to the number of acceptors of these two methods during the reference period in Uttar Kannada District. Therefore, total number of sterilization and IUD cases to be covered in the sample district are 340 and 160 respectively.

Further, these 340 sterilization and 160 IUD cases are allocated amongst selected 3 PHC's in proportion to the number of cases of each of these two methods in the selected PHC's. Accordingly, the sample cases that have to be covered in Mundgod, Shirali and Manchikeri are 144 (98 tubectomy and 46 IUD cases) 135 (92 tubectomy and 43 IUD cases) 221 (150 tubectomy and 71 IUD cases) respectively.

In each sample PHC, all the villages are arranged in descending order of the total number of IUD acceptors. Then the first few villages in the list are selected in order to cover the required number of IUD cases. The sample of tubectomy cases is also drawn from the same villages. In view of shortage in coverage of IUD cases, additional villages are covered till the required number of IUD cases are interviewed. Altogether the number of villages covered under 3 selected PHC's for data collection is 34.

Equal number of acceptors and non-acceptors are covered in each selected village. The non-acceptor respondents are identified from the neighbouring houses of the interviewed acceptors.

A list of 583 tubectomy cases and 649 IUD cases belong to 34 villages under 3 selected PHC's is prepared to cover the required sample of 340 tubectomy cases and 160 IUD cases. Therefore the coverage of tubectomy and IUD cases is 58.0 % and 25.0 % respectively.

Out migration (both temporary and permanent) of respondents is the main reason for non-coverage of tubectomy cases. Removal / expulsion of IUD and out migration of respondents are the main reasons for non-coverage of IUD cases.

The proportion of scheduled castes and scheduled tribes is higher among tubectomy acceptors, whereas majority of the IUD acceptors are from caste groups of Hindus other than scheduled castes and scheduled tribes. Religious and caste classification among acceptor and non-acceptor respondents quite comparable. About 47.6 % of acceptors are from higher

caste Hindus, 42.0 % are scheduled castes and scheduled tribes, 8.6 % are Muslims and 1.8 % are Christians. Among non-acceptors, 49.0 % are higher caste Hindus, 42.2 % are scheduled castes and scheduled tribes, 7.0 % are Muslims and 1.8 % are Christians.

Majority of the tubectomy acceptors are illiterates as against IUD acceptors had better educational attainments. The literacy rate among acceptors is lower at 42 % than 48 % literate among non-acceptor wives. Similarly 67.0 % of acceptors' husbands are literate and 72.4 % of non-acceptor husbands are literates. This shows that education has no impact in acceptance of family planning.

Among tubectomy acceptors, 36.8 % are not working, 21 % are cultivators and 38.2 % are agricultural labourers. Majority of IUD acceptors are house wives and rather economically inactive. About 13.8 % are cultivators and 15 % are agricultural labourers. Moreover, 6.3 % are in salaried employment and 3.8 % are engaged in Trade and Commerce.

A substantial proportion (65.8 %) of non-acceptor wives are not working as against 43.8 % among acceptors. About 31 % of acceptors are engaged in agricultural labour work and another 18.8 % are cultivators, while 16.2 % and 11.2 % of non-acceptor wives are agricultural labourers and cultivators.

As for acceptors' spouses, 36.8 % are cultivators, 29.3 % are agricultural Labourers, 11.4 % are in salaried employment. The respective percentages among non-acceptors' husbands are 35.2 % , 21.6 % and 14.0 % .

IUD acceptors are from higher income families as compared with both tubectomy acceptors and non-acceptors.

The mean ages at first marriage for tubectomy, IUD acceptors and non-acceptor wives are 16.9 years, 19 years and 18.4 years respectively.

Acceptors of tubectomy are mainly concentrated in the age group 25-34 years, while acceptors of IUD are concentrated in the age groups 15-24 and 25-34 years. The mean age at acceptance of tubectomy acceptors is 29.0 years and it is 36.8 years for their husbands. IUD acceptors (26.2 years) and their spouses (32.3 years) are comparatively younger than the tubectomy acceptors and their husbands. However, mean ages of non-acceptor wives and their husbands are 26.8 years and 34.0 years respectively.

Tubectomy acceptors had 3.89 children surviving (2.1 sons and 1.8 daughters) on an average at the time of acceptance. The average number of living children is 2.3 with 1.0 son and 1.3 daughters to the IUD acceptors. Non-acceptors reported an average of 2.6 children surviving at survey with 1.2 sons and 1.4 daughters.

A declining trend in the mean age at acceptance of tubectomy as well as IUD is observed in the study area over time. But the average number of living children at the time of acceptance has not declined as much over time.

A comparison of survey and registration data reveals that there is not much difference in the mean ages of acceptors between two sets of data. But only for 13.4 % of acceptors the reported age at acceptance according to registration data and according to survey data are identical. The reported age as per registration is lower than survey data by 1-3 years, 4-6 years, 7-9 years and 10-12 years respectively in case of 26 %, 11.8 %, 3% and 1.8 % acceptors.

And for 32.4 %, 8 % and 3.4 % acceptors the reported age as per registration is higher than survey data by 1-3 years, 4-6 years and 7-12 years respectively.

Indices of dissimilarity values of survey and registration data show that the reporting of data on age is much better in case of IUD acceptors than tubectomy acceptors and non-acceptor wives.

Reporting of living children at the time of acceptance is observed to be comparatively better than age reporting. About 92.6 % , of acceptors reported correctly regarding number of living children at survey as well as at registration. Consequently the average number of living children at the time of acceptance is identical as per both registration and survey data. Index of dissimilarity computation shows that the unevenness between two distributions is more in case of IUD acceptors than the tubectomy acceptors.

.... on previous practice of family planning method/s show that only 92 out of 500 acceptors reported to have practised IUD, Oral Pill and Condom and the major reasons for discontinuation of previously practised method/s are adverse side effects, renewal / doctor's advice, desire for additional children. In case of IUD acceptors, a large proportion stated the reason for removal as renewal.

Regarding the source of motivation, the study shows that majority of the acceptors (84.1 % of tubectomy acceptors and 87.5 % of IUD acceptors) are self motivated. The percentage of tubectomy acceptors and IUD acceptors motivated by family planning staff including doctor is 13.5 % and 11.9 % respectively.

In case of tubectomy acceptors, the dominant reason to accept family planning is not to have more children on economic compulsions and in case of IUD acceptors it is spacing.

About 3.5 % tubectomy acceptors and 32.5 % IUD acceptors reported that they are not medically screened prior to sterilization / IUD insertion.

As for advice on post-adoption care and precautions, about 20.3 % acceptors of tubectomy are not told anything. Remaining acceptors are advised to abstain from sex for 1-3 months, and advised about taking nutritious food and diet control over some food items. In case of IUD acceptors, none were told anything about precautions.

Comparatively a large proportion of tubectomy acceptors (51.0 %) have suffered due to post-acceptance complications than IUD users (18.0 %). Major complications reported are stomach pain, back and waist pain.

About 92.1 % of the tubectomy acceptors and 88.8 % of IUD acceptors reported the visit of family welfare staff to their houses. Majority of the acceptors are satisfied with the services provided at Primary Health Centre and at their houses.

About three fourth of the acceptors are advised to visit the clinic after acceptance. Among those who received the advice a large proportion of tubectomy acceptors utilised the services of the clinic.

Regarding the attitude of acceptors towards recommending family planning to others, the study reveals that the majority of the acceptors (84.6 %) are willing to recommend family planning to others. Remaining 15.6 % acceptors, who are not willing to motivate others, reported the following reasons for their disinterest - " no body listens to me ", " it is their will and wish", " they will take us to task if any complication arises later ", " motivate only when others consult them ", suffering due to complications ". Among IUD acceptors, "not willing to disclose their acceptance " is major reason for their indifferent or negative attitude to motivate others.

Information collected on knowledge of family planning indicated that most of the non-acceptors are aware of the

permanent methods of fertility control. Knowledge of other methods like IUD, Condom and Oral Pill is also fairly high. Same is the case with the knowledge about the source of availability of services.

In the study area , the major sources of family planning information seems to be inter personal rather than mass media. Only a small proportion of respondents made visits to the clinic to seek advice on family planning. It implies that most of them are not keen to regulate their fertility. It is apparent that 58.0 per cent of the respondents reported that they are contacted regularly by family planning workers and the remaining group stated that they had not been visited by family planning workers during the period of one month prior to survey. It indicates the extent of inadequate extension services. Among those who are visited by family planning workers, most of them reported that the visits are by and large, useful to them. Majority of the respondents stated that they would appreciate the visit of family planning workers to their door steps in order to get information on family planning.

The study further indicates that the single major reason for not using any family planning method is the desire for additional children. The next reason in order is fear of side effects / complications. The respondents who wanted additional male and female children had, on an average, less than one male and female child. Those who desired additional children irrespective of gender had less than two children on an average. So, our findings strengthen the

idea that people in the study area think about family planning only after achieving their desired family size and in their mind, family planning means termination of child bearing and not as much for spacing between successive births.

The data on attitude towards family limitation in future also support the above observation. It is apparent that a large majority of non-acceptors are interested in using family planning methods in future and that too permanent methods of fertility control provided they have some more children. The main reason for non-acceptance of family planning in future appears to be fear of side effects of operation and other family planning methods. And other reasons for non-acceptance are on religious grounds, opposition from husband etc. .

The present analysis shows that only 15.6 % of the current non-acceptors have practiced any family planning method/s in the past. Among them, majority reported the use of IUD. The duration of practice is comparatively more in case of past users of IUD than in case of past users of oral pill and condom. Complications experienced is the dominant reason to discontinue the methods such as IUD and oral pill.

In the study area, the coverage of pregnant women for pre-natal services is not satisfactory. About 58.7 per cent of women are immunised against tetanus and 62.3 % received Iron and Folic acid tablets during pregnancy. Out of this 62.3 %, only a few respondents reported the receipt of required quantity.

Majority (79.6 %) of the respondents reported home deliveries and 45.9 % of the deliveries are conducted by either untrained dais or family members.

Information or advice on family planning is received by slightly more than half of the respondents. The utility of such advice is not satisfactory.

The immunization facilities are not utilised fully in the study area. Only 36.0 % had one dose of DPT of the 133 infants aged 3 months and above, 32.0 % had two doses of DPT out of 116 children aged 4 months and above and 28.9 % had 3 doses of DPT out of 76 children aged 6 months and above. Among children aged 3 months and above, 4 months and above and 6 months and above about 41.0 % had one dose of Polio drops, 37.1 % had two doses of Polio drops and 29.0 % had three doses of Polio drops respectively. Only 18.0 % respondents reported that their children got BCG vaccine. Among the mothers whose children did not get any innunization, majority of them have adequate knowledge of immunization. About 29.4 % of mothers have exact knowledge about oral rehydration therapy. And 49.0 % of the mothers have knowledge about breast feeding and weaning practices but it has no relevance in actual practice. Nearly 74.0 % of respondents who are pregnant at the time of survey, reported the registration of their names with either Government or Private despensary for ante-natal care and delivery.

POLICY IMPLICATIONS

1 The study shows a large number of discrepencies in records maintained under the family planning programme especially in connection with demographic characteristics. The reasons for discrepant entries in the demographic characteristics of acceptors and non-acceptors in the PHC's need to be identified and efforts are needed to maintain accuracy in recording the characteristics of the acceptors and non-acceptors in the records. More over, 4.1 % of the sample cases are not traced at the time of survey. This suggests the need for proper maintenance of records especially T.C. Registers.

2 Though, a declining trend is observed in the mean age at acceptance of tubectomy and IUD overtime, yet the mean age at acceptance is higher in the study area compared to other districts evaluated earlier. Efforts are needed to motivate women to accept family planning still at a younger age. Average size of the acceptors highlights the need of educating the rural people about the advantages of the small family.

3 The study revealed that the acceptors of IUD are from families with comparatively higher socio-economic status. It is necessary to popularise spacing methods among poorer section of the society.

The study reveals that there are not many acceptors of spacing methods and most of them are in favour of tubectomy and that too after achieving desired number of children. There is a need to promote the acceptance of non-terminal methods and more efforts are needed to motivate the rural people to accept these non-terminal methods at the earlier stages of their married life.

4 Most of the women are of the opinion that acceptance of vasectomy by their husbands will affect their husbands' health and they did not want their husbands who are the sole earning members to undergo any physical pain or inconvenience. Such misconceptions need to be removed from the minds of people.

5 Majority of the acceptors, particularly laparoscopic acceptors reported complaints/complications following sterilization. The PHC workers should pay greater attention to provide frequent follow-up services to these acceptors. In case of laparoscopic tubectomies, very high complication rates have been reported due to in experience of doctors or little training received in laparoscopy. Therefore, atleast one surgical team in every PHC should be trained thoroughly in laparoscopy.

6 In the study area, 2.3 % laparoscopic acceptors reported pregnancy after sterilization. Hence care must be taken to see that all women are medically screened properly prior to operation. Laparoscopic operations would be effective if confined to clinics.

7 About 15.6 % acceptors in the study area are no willing to motivate others to accept family planning due to various reasons. Active participation of family planning adopters will bring success to the programme. This can be achieved by the greater involvement of health workers in follow-up services to avoid the complications after operation.

8 - The study suggests that interpersonal communication will be effective in creating awareness for family planning methods. Further, the need for revamping the mass media for more effective role in the Information, Education and Communication (IEC) activities is also highlighted. The present study reflects that the awareness of the family planning methods is more but the actual practice is less. In order to lessen the gap between awareness and practice, there is an urgent need to make available better family planning services within easy reach of the people.

9 Educational level or economic status doesnot seem to hinder the acceptance of family planning. It points toward special and widespread efforts to change the attitude of people and motivate them towards small family norm without waiting for socio-economic changes in the community.

10 The study reveals that 80.0 per cent of non-acceptors are in favour of home visits by family planning workers in order to get information on family planning. Nearly 48.0 per cent non-acceptors reported that the family planning workers are not paying regular visits. This indicates the

extent of inadequate extension services. Efforts are needed to activitate these workers. So that the larger proportion of couples who are willing to use family planning methods but donot do so at present can be helped and the other couples properly be educated and motivated.

11 The main reason for non-acceptance appears to be fear of side effects of sterilisation and other family planning methods. And other reasons for non-acceptance are on religious grounds and opposition from husband. This also strengthens the need for intensified persuation and motivational efforts especially inter-personal communication.

12 The present study shows that the pre-natal and post-natal services to the expecting and lactating mothers are not satisfactory. This warrants that these services are required to be provided to all expecting and lactating mothers in order to insure better health for mother and child.

13 In the study area 45.9 % deliveries had been conducted by either untrained dai or family members. This point stresses the need to educate the people regarding care that should be taken at the time of delivery and especially with reference to type of attendence.

14 The findings suggest that not much importance is given to the idea of educating and motivating the expecting and lactating mothers regarding family planning. But this is the best suited time for advising on family planning.

15 It is very essential to promote intensified programme of immunisation by creating an awareness among parents of the causes, signs, symptoms, seriousness and complications arising out of communicable diseases.

16 Propagation of the home remedy of oral rehydration for children is quite necessary through widespread availability of this oral rehydration solution.

17 Motivation of mothers towards exclusive breast feeding in the pre-natal period, to encourage them throughout the first six months is very crucial. The use of locally produced nutritional foods during the weaning period is essential. Knowledge about the dietary needs of children, including timing of meals and form (density) of the foods, can be conveyed to women. The best way is to train mothers in this procedure.

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