

PRC REPORT NO.72

**EVALUATION OF FAMILY WELFARE AND MCH PROGRAMME IN  
BELGAUM DISTRICT KARNATAKA STATE, 1989-90.**

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## F O R E W O R D

Periodic evaluation of Family Welfare and Maternal Child Health Programmes is one of the major research activities of Population Research Centres. Over the years, our Centre has conducted several studies of this kind. The present report is such a study done in one of the relatively better developed districts in Karnataka during 1989-90.

Like others studies in this series, this report reiterates (i) while almost all cases of sterilization are genuine, not all cases of IUD are so, (ii) though more of the younger women are now accepting family planning methods, they do so only after having three or more children, (iii) large number of adoptors, especially those of IUD, are not subject to pre-medical check-up, and follow-up visits tend to be casual; (iv) while knowledge of tubectomy and laproscopy is universal, it is not so with respect of vasectomy and temporary methods, (v) failure rate in the case of laproscopy is not negligible, (vi) while utilization of MCH services is high it is yet to have an impact on family planning acceptance.

In releasing this report to wider audience, I sincerely hope that the findings of this study would prove useful in evolving effective strategies for improving the programme performance. The research team headed by Mr. R. L. Patil has put considerable effort in collecting and analysing the data. They would be glad to receive comments and suggestions from the readers.

Dharwad  
5-2-1992

Mari Bhat  
DIRECTOR

## A C K N O W L E D G E M E N T

Evaluation of the ongoing Family Welfare Programme has been an important activity of the Population Research Centre, Dharwad during the past decade and more. The present study conducted in Belgaum District is the twelfth in the series. The reference period of the study is 1988-89.

The field work for collection of data for the current study was carried out between January 29th to February 23rd, 1990. The major credit of the study is attributable to the field and tabulation staff for the merit this exercise may possess. In this connection, I place on record the services rendered by Shriyuts G. C. Jadar, R. V. Deshpande, K. E. T. Rajaram and Smts. A. S. Joshi, Hema W Hombal and C. K. Pathak. My thanks are due to Shri. R. H. Onkar, Shri. D. S. Phadke and Smt. S. U. Mathad for neat stencilling of the study report.

I express my indebtedness to Dr. Mari Bhat, Director, Dr.T. Rajaretnam, Deputy Director and Shri. R. K. Koteswar, Research Officer, for their valuable comments on the draft.

I express my gratitude to District Health and Family Welfare Officer, Belgaum District and Medical Officers of the Health and Family Welfare Department and all other para-medical staff who supported the study. Last but not least, we owe a debt of gratitude to the respondents who obliged us amidst their pre-occupation.

February, 1992.

R. L. PATIL

Evaluation of Family Welfare and MCH  
Programme in Belgaum District (1989-90)  
Karnataka State

EXECUTIVE SUMMARY

An evaluation of the family welfare programme in Belgaum district of Karnataka was conducted by Population Research Centre, Dharwad during December, 1989 to January, 1990. A total of 485 cases ( 251 sterilisation + 214 IUD) who had adopted the method during 1988-89 were listed from the four selected PHCs. Among the cases listed all sterilisation cases were found to be genuine while one out of 10 IUD cases were not genuine. 251 cases (115 Tub., 40 Laproscopy and IUD 96 ) were contacted and interviewed. Further 243 non-adoptors with wives in the reproductive age group 15-44 and having atleast one living child at survey were also covered.

1. The field verification of the sterilisation and IUD cases listed from the sample PHCs showed that all the cases of sterilisation were found to be genuine while 10 per cent of the cases of IUD were found to be not genuine adoptors. As large number of IUD insertions are done by para-medical staff, greater vigilance by the supervisory staff appear to be a must to avoid fictitious IUD cases.

2. The evaluation study clearly shows that now-a-days even young couples are coming forward to accept family planning but they do so only after achieving a large family of 3 or more living children. Thus, the pro-motion of Family Planning among young couples seem to be not a major factor but make them to accept family planning before they expand their family size is the real task. So, couples should be motivated to adopt a spacing method as soon as they had their first child. It is believed that once the habit of contraception starts quite early in the reproductive life, couples would be tempted to have a small family either by continuing with the temporary method or by adopting a terminal method.

3. The socio- economic characteristics of the adoptors indicate that generally the adoptors are drawn from households of all socio- economic levels and this clearly implies that the programme can be vigorously implemented among all sections of the society irrespective of their social and economic levels, ~~and this clearly implies that the programme can be vigorously implemented among all~~

~~sections of the society irrespective of their social and economic standing.~~

4. Laparoscopy had the highest failure rate in the survey area and hence this needs to be looked into on a high priority basis.

5. A large number of adoptors were not subjected to premedical check - up before being sterilised or inserted with IUD. There is need to ensure proper screening of the clients volunteering for family planning especially IUD. Studies have shown that the IUD retention rate is often low because for a large number of acceptors the device is not suitable (Bhatia 1989) and hence they dropout the method early. In order therefore to prevent early dropouts a thorough medical check up of the prospective cases for IUD insertion is a must.

6. A large number of acceptors reported complaint or side effects due to adoption of family planning methods inspite of the fact that almost all adoptors were visited by the health workers soon after the adoption. The only inference that can be drawn is that follow-up visits were made but they were only casual visits without proper drugs and medicines. Therefore, in order to ensure effective care the grass root level health workers should be provided with enough medicines to meet any eventuality in the field.

7. Knowledge of Tubectomy and Laparoscopy is almost universal among non-acceptor couples. Sadly Vasectomy which is relegated to background should receive the due attention it deserved in view of the simplicity of the operation and which incidentally does not involve hospital confinement. Knowledge of female temporary methods like oral pills and IUD was substantial. Effort in this direction need to be further accelerated so that more and more women take to temporary methods.

8. The small family norm has not yet caught the imagination of the couples as was evidenced by the attitude of acceptors and non-acceptors towards family planning. 85 per cent of sterilised couples had adopted the method after having 3 or more living children while a majority of non-acceptors had stated that they intend to expand further their family size. Thus the study indicated that the desired family size was above the replacement level fertility. This is the major hindrance for the programme

personnel and hence efforts should be directed to achieve a break through so that couples realise the advantages of a small family. Educational and motivational aspects of the programme should be given their due place of importance. The vicious circle of the idea of a large family can be broken only by means of constant persuasion of the couples to adopt small family norm.

9. Utilisation of MCH services by non-acceptors who had given birth preceeding one year of survey and those who were pregnant at the time of survey was high. However, this is not matched by higher adoption rate. This implies that integration of family planning with MCH services has not yielded due fruits. This calls for the review of the functioning of the family planning programme. Medical Officers of health and family planning PHCs should ensure dissemination of family planning information to all those availing maternal services through para-medical staff who directly interact with the couples.

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EVALUATION OF FAMILY WELFARE AND MCH  
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KARNATAKA STATE

CHAPTER- I : INTRODUCTION

1.1 Background

During the last one decade, the Population Research Centre, Dharwad has been conducting studies to evaluate the ongoing Family Welfare and MCH Programme, every year in one Northern District of Karnataka State, at the instance of Ministry of Health and Family Welfare, Government of India. The present study was conducted in Belgaum district and is the twelfth in the series.

1.2 Belgaum District

Belgaum district is located in the Northern part of the State bordering the State of Maharashtra. The district with a population of 2.97 million as per 1981 census ranks second in population size in the State. The proportion of urban population in the district being 22.6 per cent did not differ significantly from that of the State being 23.8 per cent. The general literacy level in the district being 36.4 per cent was only slightly lower than that of State being 38.4 per cent. About 18 per cent of the sown area in the district is irrigated as against 13 per cent in the State as a whole. The district accounts for 12 per cent of registered factories in the State, ranks second in the State (Chachadi, 1983). As regards the family welfare programme, the district's couple protection rate of 39.7 per cent in 1988 is not far behind that of the State (42 per cent). The level of socio-economic development largely indicate that the district is fairly well developed.

1.3 Objectives of the study

- i) To assess the genuineness of the reported cases of adoptors of family welfare methods during April, 1988 to March, 1989.
- ii) To study the socio-economic and demographic profile of acceptors of family planning methods.
- iii) To study the motivational factors involved in accepting the family planning methods.
- iv) To study the nature and extent of follow-up services received by the acceptors.
- v) To study the socio-economic and demographic profile of non-acceptors.

vi) To assess the extent of utilisation of Maternal and Child Health services ( MCH ) by non-acceptors.

#### 1.4 Selection of the District

All the nine Districts of Northern Karnataka coming under the jurisdiction of our Centre( for this evaluation study purpose only ) were ranked on the basis of their family planning performance during the reference period, 1988-89. Shimoga, Bidar and Bijapur districts formed the high performance districts, Belgaum, Bellary and Dharwad districts the medium performance districts, and Uttara Kannada, Gulburga and Raichur districts the low performance districts. One district from the high performance area namely Shimoga was covered during the year 1988-89. This year i.e. during 1989-90 the middle of the three medium performance districts i.e. Belgaum district has been taken up for this evaluation study.

#### 1.5 Selection of Primary Health Centres

In order to ensure adequate number of interviews from the selected PHCs and to restrict the cost of field operations, it was decided to select 4 PHCs on the basis of best performance of family welfare programme during the year 1988-89. The selected PHCs are, Hirebagewadi, Kabbur, Raibag and Yargatti. Table 1.1 presents the acceptance rate per 1000 population PHC -wise along with the rate for district and State for the year 1988-89.

#### 1.6 Sample size and selection of villages

It was proposed to cover 250 acceptors who had accepted sterilization and IUD during the reference period. The sample size was allocated for coverage of sterilization and IUD acceptors based on their proportional share in the total performance of the district. It was observed from the performance statistics that 62 per cent were sterilization acceptors and the remaining 38 per cent were IUD users. Accordingly, it was proposed to cover 155 sterilization acceptors and 95 IUD acceptors. The sample size was further distributed proportionately to the four PHCs based on their performance level.

In each sample PHC, all villages were arranged in descending order in terms of the total number of IUD acceptors and a number of villages which have registered the highest number of IUD cases was drawn so as to ensure coverage of the required number of acceptors (sterilization and IUD ) allocated for the PHC. If found necessary, additional villages with next highest performance in IUD was added until the required number of cases (sterilization

and IUD ) were interviewed in the PHC area. A total of 10 villages were covered in the study.

It was decided to cover the non-acceptors from these villages and the number being covered from each village will be equal to that of the number of acceptors covered from the same village. It is to be noted that a non-acceptor in this study is defined as currently married couple with wife in the reproductive age-group 15-44 , having at least one living child and currently not protected by any family planning method. A sample of the required number of non-acceptor couples including an additional 10 per cent of cases to allow for non-coverage, was drawn from the eligible couple register maintained in respect of these villages, and all available cases ( husband or wife ) were interviewed.

#### 1.7 Interview schedules

Two separate structured questionnaires were designed, one for acceptors and the other for non-acceptors. The acceptor schedule contained information on household particulars, particulars of acceptance, socio-economic and demographic particulars, previous practice of F. P. methods, side effects and complaints if any experienced and follow-up services received from health and family welfare staff. For IUD acceptors, some additional information such as duration of use, reasons if discontinued the use etc., were included.

The schedule for non-acceptors covered information on household particulars, the socio-economic and demographic characteristics, knowledge of family planning methods reasons for non-adoption of family planning methods etc. Information on maternal and child health (MCH) programme; delivery and post-natal care and family planning advice

received, immunisation of mother and children, mothers' knowledge of breast feeding and weaning practices, future plan of family planning, etc.

The data were collected through personal interview at the place of residence of the acceptors and non-acceptors. The field team consisted of 3 male and 2 female interviewers and the field work was carried out between January 29th to February 23, 1990 under the supervision of the principal investigator of the study.

Table 1.1: Acceptance Rates (per 1000 population) in the four selected Primary Health Centres during 1988-89.

Name of P.H.C.	Number of acceptors			Population	Rate per 1000 popn.
	STERIL; : zation :	I.U.D. :	Combined :		
1. Hirebagewadi	769	323	1092	84000	13.0
2. Kabbur	600	348	948	65489	14.5
3. Raibag	492	331	823	59308	13.9
4. Yaragatti	394	232	626	55123	11.4
Belgaum Dist.	21988	11592	33580	2974861	11.3
Karnataka state	301379	205447	506826	37135714	13.6

CHAPTER- II, FIELD VERIFICATION OF FAMILY PLANNING ACCEPTORS

This Chapter gives an account of the sample coverage reasons for non-coverage, genuineness of the cases, discrepancies in age and number of living children of acceptors between PHC register and survey.

2.1 Genuineness of the cases

The statistics regarding the number of cases listed for verification, the number of cases found genuine and the number of cases interviewed are presented in Table 2.1. A total 485 cases were listed from the four selected PHCs. Methodwise, 185 cases were Tubectomy, 66 Laparoscopy and 238 IUD. Vasectomy was conspicuous by its non-acceptance by any in the survey area. A verification of reported cases at their reported addresses showed that all Tubectomy and Laparoscopy cases were genuine while 24 ( or 10 per cent of ) IUD cases were not genuine adoptors of the method.

As regards coverage for interview, out of the genuine cases it was 115 or 62.2 per cent of Tubectomy, 40 or 60.6 per cent of Laparoscopy and 96 or hardly 45 per cent of IUD cases were interviewed.

2.2 Methodwise and PHC-wise coverage

Table 2.2 shows methodwise and PHC-wise coverage of cases for interview. It is seen that the overall coverage of cases to the total genuine cases in Yaragatti PHC was the highest being 61.0 per cent, followed by Hirebagewadi 60.3 per cent, Kabbur 56.9 per cent and Raibag 40.9 per cent.

Methodwise , coverage of Tubectomy acceptors was the highest in Hirebagewadi being 77 per cent, followed by Yargatti ( 71 per cent ), Kabbur ( 63 per cent ) and Raibag ( 45.5 per cent). With 80 per cent coverage of laparoscopy cases Yaragatti tops the list; followed by Kabbur ( 78.9%), Hirebagewadi ( 71.4 %) and Raibag (28.6%). With respect to IUD the coverage was nearly 49 per cent in Yargatti, while Hirebagewadi was close to this ( 48.4%), however the coverage was relatively lower in Kabbur (42%) and Raibag ( 41.7 %).

2.3 Reasons for Non-coverage

Table 2.3 presents the number and percentage



distribution of cases covered by reasons for non-coverage. Methodwise it was 81 per cent for Tubectomy, 84 per cent for Laparoscopy and 89 per cent for IUD who had outmigrated either temporarily or permanently. There was a lone case of death of adoptor of laparoscopy. Over 5 per cent of cases could not be covered as it was not possible to contact them during the stay of the interviewers in the village. Nearly 8 per cent of cases were not covered because of other reasons.

#### 2.4 Discrepancy in age of acceptor

Age at adoption of family planning acceptors is an important demographic variable for evaluation of family planning programme on fertility. It is often found that data in respect of age of acceptors as obtained from the official registers suffer from recording errors and hence it adversely affects efforts to evaluate the programme impact on fertility. Therefore, the evaluation studies place considerable emphasis to assess the reliability of age of acceptors recorded in the PHC registers by means of a thorough independent field enquiry.

Table 2.4 presents the distribution of acceptors of family planning methods by difference in their age between register and survey taking survey as standard. It is seen from the Table that for all methods combined the age recorded in the PHC register in respect of only 7.6 per cent of cases tallied with the age obtained in the survey and that this figure did not vary significantly for different methods. For all other cases there were differences in the age between register and survey. For instance the data shows that for all methods combined the age difference between register and survey on either side was 1-2 years for over 33 per cent cases, 3-4 years for 31 per cent of cases and 5+ years for 27 per cent of cases. It may be noted that the difference in the age of acceptors between survey and register was largely due to the fact that the age recorded in the survey was higher than obtained in the survey.

An analysis of the difference in the age between register and survey was made controlling for the age obtained in the survey. It is seen from Table 2.4 that the age of younger women was over-estimated, in the register while the age of older women was underestimated. It is interesting to note that the proportion of age

difference was very high in respect of young adoptors of 15-24 ages compared to other groups. For instance for all methods combined the proportion of cases for whom the age as per register was higher than survey was 87 per cent for adoptors in the age group of 24 and less, 42 per cent for those in the age-group of 25-29 years, and 36 per cent for those in the age of 30 and above. On the other hand the proportion of cases for whom stated age was lower in the register was 7 per cent for those in age-group 24 or less, 48 per cent for those in 25-29 age group and 54 per cent for those aged 30 and above.

A methodwise analysis of the data showed that the age difference were relatively lower for IUD than for female sterilization. For instance the age difference of 5+ years on either side was as large as 36 per cent for Tubectomy, and 27 per cent for Laparoscopy while it was over 16 per cent for IUD. However, these differences are narrowed if we take into consideration the age difference of atleast one year on either side. For instance the proportion of cases for whom the age difference on either side was 93 per cent for Tubectomy, 92.5 per cent for laparoscopy and 91.7 per cent for IUD.

The analysis showed that in over 27 per cent of cases the difference was 5+ years. Further, the age of a great majority ( 81 %) of young acceptors of 15-24 ages was over estimated and for the age of a majority (54 %) of old acceptors of 30+ ages was underestimated in the register as compared to survey data.

## 2.5 Discrepancies in the No. of living children

Discrepancies in the number of living children of adoptors at adoption between register and survey was analysed on similar lines as in the case of age-date. Table 2.5 presents the relevant statistics. Table shows that in over 88 per cent of cases the number of children recorded in the survey and register was the same, with marginal differences between the methods. It is interesting to note that the proportion of cases for whom atleast one child was reported higher in register was 4.4 per cent for tubectomy, 5 per cent each for laparoscopy and IUD. Except for one case of IUD in all other cases the difference was only one child. On the other hand the proportion of cases where atleast one child was reported lower in register than in survey was 7 per cent

tubectomy, 5 per cent laparoscopy and over 6 per cent IUD.

## 2.6 Summary

Out of 485 cases listed, 465 or 95.9 per cent of the cases were found to be genuine. Methodwise all cases of Tubectomy, and laparoscopy were found to be genuine while 10 per cent of IUD cases were found to be not genuine adoptors of the method. Among the genuine cases 61.7 per cent of sterilised, and 45 per cent of IUD cases were interviewed in the survey. The total number of cases (sterilization + IUD) covered was 251.

There were substantial differences in the age of adoptors between register and survey and this was largely due to over estimation of ages of younger women and under-estimation of ages of older women in the PHC register. Discrepancies in the number of living children of acceptors between register and survey was seldom noticed. Thus it can be said that the age of acceptors is incorrectly assessed or manipulated by the health and family planning personnel presumably to show the quality of performance.

Table 2.1 : The number and percentage distribution of cases listed, assessed as genuine cases and the number interviewed - methodwise.

Cases	Tubectomy		Laparascopy		IUD		Total	
	No.	%	No.	%	No.	%	No.	%
Listed	185	-	66	-	233	-	485	-
Genuine @	185	100.0	66	100.0	214	90.0	465	95.9
Interviewed £	115	62.2	40	60.6	96	44.9	251	54.0
Not interviewed	70	37.8	26	39.4	118	55.1	214	46.0

@ - percentage to total listed

£ - percentage to genuine cases

Table 2.2 : Primary Health Centre-wise and Methodwise coverage of cases for Interview

Name of Primary Health Centres	Tubectomy		Laparoscopy		IUD		Total					
	Gen- : In- : No. : cases :	Interviewed : In- : % : cases :	Gen- : In- : No. : cases :	Interviewed : In- : % : cases :	Gen- : In- : No. : cases :	Interviewed : In- : % : cases :						
Elrebagewadi	31	24	77.4	21	15	71.4	64	31	48.4	116	70	60.3
Kabbur	54	34	63.0	19	15	78.9	50	21	42.0	123	70	56.9
Ralbag	55	25	45.5	21	6	28.6	61	25	41.0	137	56	40.9
Varagatti	45	32	71.1	5	4	80.0	39	19	48.7	89	55	61.8
<b>Total</b>	<b>185</b>	<b>115</b>	<b>62.2</b>	<b>66</b>	<b>40</b>	<b>60.6</b>	<b>214</b>	<b>96</b>	<b>44.9</b>	<b>465</b>	<b>251</b>	<b>54.0</b>

Table 2.3 : The number and percentage distribution of cases not covered by reasons for non-coverage

Reasons for non-coverage	Tubectomy		Laparascopy		IUD		Total	
	No.	%	No.	%	No.	%	No.	%
1) POM	27	38.6	10	38.5	48	40.7	85	39.7
2) TOM	30	42.8	12	46.1	57	48.3	99	46.3
3) Dead	-	-	1	3.8	-	-	1	0.5
4) Not available for interview during the stay of interviewer	6	8.6	3	11.5	3	2.5	12	5.6
5) Others	7	10.0	-	-	10	8.5	17	7.9
<b>Total</b>	<b>70</b>	<b>100.0</b>	<b>26</b>	<b>100.0</b>	<b>118</b>	<b>100.0</b>	<b>214</b>	<b>100.0</b>

POM = Permanently out migrated

TOM = Temporary out migrated

Table 2.4 : Differences in the age of acceptors between  
record and survey, Methodwise:

Age difference between register and survey	Age at adoption as per survey							
	15-24		25-29		30 +			
	No.	%	No.	%	No.	%	No.	%
	<u>T U B E C T O M Y</u>							
Higher by 5 + yrs.	24	48.9	7	19.5	1	4.2	33	26.9
Higher by 3 to 4 yrs.	11	22.4	7	17.2	5	20.8	23	20.9
Higher by 1 to 2 yrs.	11	22.4	5	12.2	2	8.3	18	15.8
No difference	3	6.2	3	7.3	2	8.3	8	7.0
Lower by 1 to 2 yrs.	-	-	13	31.7	3	12.5	16	13.0
Lower by 3 to 4 years	-	-	4	9.8	4	16.7	8	7.0
Lower by 5 + years	-	-	1	2.4	7	29.2	8	7.0
T o t a l	49	100.0	41	100.0	24	100.0	32	100.0

Data not available for 1 case.

<u>L A P A R O S C O P Y</u>								
Higher by 5 + years	9	42.9	1	7.1	-	-	10	25.0
Higher by 3 to 4 yrs.	3	14.3	3	21.4	1	20.0	7	17.5
Higher by 1 to 2 yrs.	8	38.0	3	21.4	1	20.0	12	30.0
No difference	-	-	2	14.3	1	20.0	3	7.5
Lower by 1 to 2 yrs.	1	4.8	2	14.3	1	20.0	4	10.0
Lower by 3 to 4 yrs.	-	-	2	14.3	1	22.0	3	7.5
Lower by 5 + years	-	-	1	7.1	-	-	1	2.5
T o t a l	21	100.0	14	100.0	5	100.0	40	100.0

Table 2.4 Continued

Age difference between register and survey	Age at adoption as per Survey							
	15-24		25-29		30 +		Total	
	No.	%	No.	%	No.	%	No.	%
	<u>I. U. D.</u>							
Higher by 5 + years	7	11.1	-	-	-	-	7	7.3
Higher by 3 to 4 years	27	42.9	4	13.8	1	25.0	32	33.3
Higher by 1 to 2 years	16	25.4	4	13.8	1	25.0	21	21.9
No difference	5	7.9	3	10.3	-	-	8	8.3
Lower by 1 to 2 years	5	7.9	8	27.6	-	-	13	13.5
Lower by 3 to 4 years	3	4.8	3	10.3	-	-	6	6.3
Lower by 5 + years	-	-	7	24.1	2	50.0	9	9.4
<b>T o t a l</b>	<b>63</b>	<b>100.0</b>	<b>29</b>	<b>100.0</b>	<b>4</b>	<b>100.0</b>	<b>96</b>	<b>100.0</b>

	<u>ALL METHODS</u>							
Higher by 5 + years	40	30.1	9	10.7	1	3.0	50	20.0
Higher by 3 to 4 years	41	30.8	14	16.7	7	21.2	62	24.8
Higher by 1 to 2 years	35	26.3	12	14.3	4	12.1	51	20.4
No difference	8	6.0	8	9.5	3	9.1	19	7.6
Lower by 1 to 2 years	6	4.5	23	27.4	4	12.1	33	13.2
Lower by 3 to 4 years	3	2.3	9	10.7	5	15.2	17	6.8
Lower by 5 + years	-	-	9	10.7	9	27.2	18	7.2
<b>T o t a l</b>	<b>133</b>	<b>100.0</b>	<b>84</b>	<b>100.0</b>	<b>33</b>	<b>100.0</b>	<b>250</b>	<b>100.0</b>



Table 2.5 : Discrepancies in number of living children of adopters at adoption between record and survey - Methodwise

Difference in number of living children between register and survey base-survey	No. of living children at adoption as per survey							
	1-2		3-4		5 +		Total	
	No.	%	No.	%	No.	%	No.	%
<u>ALL METHODS</u>								
Higher by 2 or more children	1	1.0	-	-	-	-	1	0.4
Higher by 1 child	7	7.1	3	2.8	2	4.9	12	4.8
No difference	89	89.9	97	89.8	33	80.5	219	88.3
Lower by 1 child	2	2.0	8	7.4	1	2.4	11	4.4
Lower by 2+ children	-	-	-	-	5	12.2	5	2.0
<b>T o t a l</b>	<b>99</b>	<b>100.0</b>	<b>108</b>	<b>100.0</b>	<b>41</b>	<b>100.0</b>	<b>248</b>	<b>100.0</b>
<u>T U B S C O T O M Y</u>								
Higher by 2 or more children	-	-	-	-	-	-	-	-
Higher by 1 child	2	22.2	1	1.3	2	6.9	5	4.4
No difference	7	77.8	70	93.3	23	79.3	100	88.4
Lower by 1 child	-	-	4	5.3	1	3.4	5	4.4
Lower by 2 children	-	-	-	-	3	10.3	3	2.7
<b>T o t a l</b>	<b>9</b>	<b>100.0</b>	<b>75</b>	<b>100.0</b>	<b>29</b>	<b>100.0</b>	<b>113</b>	<b>100.0</b>

Table 2.5 continued.....

Table 2.5 Continued.....

Difference in number of living children between register and survey base- survey	No. of living children at adoption as per survey							
	1-2		3-4		5 +		Total	
	No.	%	No.	%	No.	%	No.	%
<u>L A P A F A S C O P Y</u>								
Higher by 2 or more children	-	-	-	-	-	-	-	-
Higher by 1 child	2	14.3	-	-	-	-	2	5.0
No difference	12	85.7	15	93.8	9	90.0	36	90.0
Lower by 1 child	-	-	-	-	1	10.0	1	2.5
Lower by 2 children	-	-	1	6.2	-	-	1	2.5
<b>T o t a l</b>	<b>14</b>	<b>100.0</b>	<b>16</b>	<b>100.0</b>	<b>10</b>	<b>100.0</b>	<b>40</b>	<b>100.0</b>
<u>I. U. D.</u>								
Higher by 2 or more children	1	1.3	-	-	1	33.3	1	1.0
Higher by 1 child	3	3.9	2	11.8	-	-	5	5.3
No difference	70	92.2	12	70.6	1	33.3	83	87.4
Lower by 1 child	2	2.6	3	17.6	-	-	5	5.3
Lower by 2 children	-	-	-	-	1	33.3	1	1.0
<b>T o t a l</b>	<b>76</b>	<b>100.0</b>	<b>17</b>	<b>100.0</b>	<b>3</b>	<b>100.0</b>	<b>95</b>	<b>100.0</b>

Note: One IUR acceptor had no living children.

CHAPTER- III : SOCIO-ECONOMIC AND DEMOGRAPHIC PROFILE OF ACCEPTORS

This Chapter deals with the study of socio-economic and demographic characteristics of the acceptors who were interviewed in the survey. The demographic characteristics studied are age, parity, number of living children and childless experience. The social characteristics studied are religion, and educational level of the acceptor and spouse. The economic characteristics include household income, cultivated holding, and occupation followed by the acceptor and spouse. In addition, a comparison of the demographic characteristics of acceptors of this survey with a similar sample of acceptors covered in this district during 1982-83 has been made to know whether there are any changes in the demographic characteristics of the acceptors in this district during the six year span.

3.1 Demographic profiles

Age at adoption

Table 3.1 presents distribution of adoptors by age at adoption, methodwise. The mean age at acceptance was 25.8 years for tubectomised, 24.2 years for adoptors of laparoscopy and 22.6 years for IUD adoptors. For the tubectomy and laparoscopy methods combined it was 25.4 years. The proportion of adoptors aged 30+ was 21 per cent for tubectomy, 12.5 per cent for laparoscopy and 4 per cent for IUD. Interestingly no acceptor was found in the age group of 40-44. On the other hand, as many as 43 per cent of tubectomy adoptors, 53 per cent of laparoscopy adoptors and 76 per cent of IUD adoptors were below age 25 which shows that the adoptors including the sterilized are largely young couples.

The mean age of tubectomy and IUD adoptors as obtained in a similar evaluation study conducted in the same district during 1982-83 was 23.7 and 25 respectively ( see foot note of the same Table ). Thus, it is evident from the present study that the recent adoptors are 3 years younger than those who had accepted 6 years back, in the same district.

3.2 Parity

The number of children ever born ( parity ) to the acceptor is shown in Table 3.2. Sterilization adoptors had on an average 4 live births. Methodwise, the average

number of children born to tubectomy acceptors being 4.1 was higher than that of laparoscopic acceptors (3.6). IUD adoptors had on average 2.1 live births. The proportion of adoptors with 2 or less live births being 69 per cent was the highest among IUD adoptors while the corresponding proportion was as low as 13 per cent for sterilisation adoptors. Further over 32 per cent of sterilization acceptors had 5 or more live births while among the IUD acceptors this proportion was only 3 per cent.

### 3.3 Number of living children

The number of living children to the adoptors at adoption of the method is presented in Table 3.3. It is seen that the sterilization adoptors had on an average 3.4 living children as against 1.8 for IUD adoptors. The mean number of living children was 3.4 for adoptors of both tubectomy and laparoscopy. The higher difference in mean parity and mean living children of tubectomy as compared to laparoscopy was mainly due to a higher proportion of tubectomy acceptors experiencing 2 or more child losses ( see Table 3.5 ).

The proportion of acceptors having two or less living children was as high as 80 per cent for IUD, 35 per cent for laparoscopy and only 8.6 per cent for tubectomy. For all sterilization methods combined, it was 15.6 per cent. Thus only about one-sixth of the sterilization adoptors had a small family size of two or less living children at adoption of the method. It is significant to note that a little over one-fourth of the tubectomy acceptors and an equal proportion of laparoscopy acceptors had a large family size of 5 or more living children at acceptance as against only 2 per cent among IUD acceptors.

The mean number of living children to tubectomy and IUD acceptors as obtained from the 1982-83 survey ( shown in the same table ) was 3.8 and 2.1 respectively which is only slightly higher than from the present situation.

### 3.4 Living children by age at adoption

Table 3.4 presents the percentage distribution of adoptors of sterilization and IUD, classified by age at adoption. It is seen from Table that the mean of number of living children for younger adoptors of 15-24 age group

is 2.9 and it increased to 4.0 and 4.6 respectively for the adoptors of 25-29 and 30+ age groups. An identical pattern is seen with respect to IUD acceptance. For, the mean number of living children for the IUD acceptors in age groups 15-24, 25-29 and 30+ was 1.6, 2.2 and 2.5 respectively. The analysis indicates that acceptors of higher ages also have higher family size at adoption.

Although the data suggests that the family size of young adoptors (15-24 age group) was relatively lower than older adoptors, an examination of the proportion of young adoptors having a small family size of 2 or less living children was hardly a fourth. On the other hand, over a half had 3 living children. This implies that even among younger adoptors a large majority of them had a large family size of 3 or more living children.

### 3.5 Child loss among acceptors

Table 3.5 presents the number and percentage distribution of acceptors by the number of child losses experienced before adoption of the method. It is seen from the table that nearly 24 per cent of sterilized adoptors and over 11 per cent of IUD adoptors had experienced at least one child loss at adoption of the method. Among the permanent method adoptors the child loss was slightly higher among tubectomy acceptors being 25 per cent than among laparotomy acceptors being 20 per cent. It is further noticed that 2 or more child loss among adoptors of IUD and laparotomy was only about 2 per cent as compared to 11 per cent among tubectomy acceptors. The analysis indicates that experience of child loss was generally higher among sterilization acceptors than among IUD acceptors, and again higher among tubectomy acceptors than among laparotomy acceptors.

Table 3.6 presents the average number of living children of acceptors by their experience of child loss. It is seen from the table that the mean number of living children to the adoptors increase with the increase in the number of child losses. For instance, the average number of living children of the tubectomy acceptors who had not experienced child loss was 3.6, while it was 4.3 for those who had one child loss and 4.6 for those who had two child losses. The corresponding figures for adoptors of laparotomy were 3.2, 3.4, and 3.9.

The analysis reveals that mothers who do not

experience child loss are more likely to accept family planning with lesser number of living children than those who experience child loss. This implies that better the chances of child survival, lesser would be the chance of couples desiring a large family before adopting family planning.

### 3.6 Sex preferences

It is the presence of male or female children which facilitates the acceptance of family planning. This aspect has been examined here. Table 3.7 gives the distribution of sterilization adoptors by living children, classified by number of male and female living children. It was noted that for 155 sterilisation adoptors there were 299 male and 244 female children living at adoption, which shows that there were 122 male children for every 100 female children. Further, it is seen from the table that less than 2 per cent of acceptors had no male child at adoption while 14 per cent of the acceptors did not have a female child. This certainly indicates a stronger desire for sons, however the fact that 86 per cent of adoptors had both male and female children at adoption indicates that a certain combination of both the sexes facilitates adoption.

It is of considerable interest to note that 13.5 per cent of adoptors with two male children and 27 per cent of adoptors with three male children, had no female child at adoption except 2 adoptors who had each only one female child. The rowwise percentage distribution shows that the proportion of adoptors having atleast two male living children was 74 per cent while it was 48 per cent only who had atleast two female living children.

### 3.7 Socio-economic profiles

#### Education of wife and husband

Table 3.8 gives the number and percentage distribution of acceptors and their spouses by their educational level. It is seen that over 75 per cent of sterilization acceptors and 53 per cent of IUD acceptors were illiterates. The proportion however did not differ between tubectomy and laparoscopy acceptors. Again the proportion of acceptors who had education above primary level was 24 per cent among IUD acceptors and only 6 per cent among sterilization acceptors. The analysis indicates that majority of sterilization acceptors were illiterates while the IUD acceptors were drawn from relatively higher literacy group.

As regards the educational background of the husbands it is seen that over 60 per cent of husbands of sterilized females and nearly 70 per cent husbands of IUD acceptors were literates. The proportion of husbands having education above primary level was higher for IUD ( 30.4 per cent ) than for sterilisation ( 16.0 per cent ).

### 3.8 Occupation of wife and husband

Table 3.9 presents the number and percentage distribution of acceptors and their spouse by occupation. The occupation followed by acceptors and their spouses has been broadly classified into four categories viz; the cultivator, agricultural coolie, other occupations and housewife /no work.

It is seen that the proportion of wives engaged in non-agricultural occupations ( others ) was low among the adoptors. For instance, it was 7.2 per cent among tubectomised, 5.1 per cent among adoptors of laparoscopy and 17.7 per cent among IUD adoptors. On the other hand nearly 29 per cent of tubectomised, 36 per cent of laparoscopy adoptors and about 20 per cent of IUD adoptors were cultivators. The proportion of agricultural coolies was relatively higher among the adoptors of tubectomy ( 25.2 per cent ), and laparoscopy ( 25.6 per cent ) than among IUD adoptors (12.5 per cent). Non-working housewives were more (50 per cent ) among IUD adoptors than among sterilized 37.1 per cent.

As regards the occupation of husbands it is seen that 59 per cent of husbands of sterilized females were engaged in the agricultural sector as against 42 per cent of husbands of IUD users. The proportion of husbands of tubectomised women engaged in the agricultural sector being 55 per cent was much lower than among the husbands of laproscopic acceptors ( 77 per cent ). The proportion of husbands engaged in non-agricultural vocations was the highest among the husbands of IUD wives ( 54 per cent ) followed by husbands of tubectomised (41 per cent ) and the least among the husbands of laproscopy ( 30.5 per cent ).

The analysis indicates that a higher proportion of sterilized females were engaged in occupations related to agricultural sector than IUD adoptors while more number of IUD adoptors than sterilized were found in non-agricultural sector. Similarly, it was observed that a higher proportion of husbands of sterilized were found engaged in agricultural sector occupations than husbands of IUD adoptors

### 3.9- Religion and Caste

Table 3.10 shows the number and percentage distribution of acceptors by religion and caste.

Among the sterilized, over 21 per cent were Lingayats, 39 per cent other Hindus, 18 per cent scheduled castes, 19 per cent Muslims and the remaining 2.6 per cent were Christians and Jains. It is interesting to note that the proportion of SCs and Muslims among the tubectomised was higher being 20 per cent than among adoptors of laparoscopy; the corresponding figures being 12.5 and 17.5 per cent.

As regards IUD adoptors 57 per cent were Caste Hindus, 19.8 per cent scheduled Castes, 18.8 per cent Muslims and 4.2 per cent from other religious groups.

### 3.10 - Household type

Table 3.11 presents number and percentage of acceptors by the type of family they belonged. Among the sterilized over 68 per cent belonged to nuclear family and the remaining to joint family. The corresponding figures for IUD were 62.5 per cent and 37.5 per cent. It is seen that the proportion of acceptors belonging to joint family was higher among adoptors of IUD than among sterilization acceptors. Similarly between the permanent methods the proportion belonging to joint families was higher among tubectomised ( 34 per cent ) than among adoptors of laparoscopy ( 25 per cent ).

### 3.11- Size of the land cultivated by the household

Table 3.12 presents the number and percentage distribution of acceptors by the size of the land cultivated by their households. It is seen from the Table that over 33 per cent households of tubectomised and 30 per cent of that of laparoscopy acceptors were landless and that this percentage was higher among the households of IUD adoptors ( 44 % ). A higher proportion of landless households of the IUD adoptors is in conformity with our earlier observation noting that a higher proportion of IUD adoptors were drawn from non-agricultural vocations. However, the proportion of households of IUD adoptors cultivating large size of land ( 15 + acres ) being 7.6 per cent was close to the households of tubectomy adoptors ( 6.1 per cent ) and slightly less than the households of laparoscopy adoptors ( 10 per cent ).



The analysis indicates that the proportion of households cultivating land was higher <sup>among sterilised than</sup> among adoptors of IUD.

### 3.12- Per capita annual income of household

Table 3.13 presents the per capita annual income of the households of acceptors. It is seen that over 31 percent of households of sterilised can be termed as poor with per capita income below Rs. 600/-per annum. The corresponding proportion among IUD adoptors was relatively less ( 20%). Among the sterilised a higher proportion of laproscopy acceptors were drawn from poor households (35%) as compared to tubectomy acceptors ( 30%). The proportion of acceptors of better economic status ( with a per capita income of 1200 or more )was 38 per cent, 18 per cent and 49 per cent respectively among the tubectomy laproscopy and IUD acceptors. The data suggest that a higher proportion of IUD adoptors were from better economic status families than sterilisation acceptors. Among the sterilised, the proportion of acceptors drawn from better economic group was higher among tubectomy acceptors than among laproscopy acceptors.

### 3.13- Age at effective marriage of wife

The analysis of age at effective marriage of acceptors helps to understand the stage at which family building commenced among the adoptors of various methods of family planning <sup>and</sup> to know whether the age at effective marriage has anything to do with the choice of the method. Table 3.4 presents the number and percentage distribution of acceptors by their age at effective marriage. The proportion of adoptors with a low age at effective marriage of 14 or less years was the highest among the tubectomised ( 45.2 per cent ) followed by laproscopy adoptors ( 35.9 per cent). However, the proportion of acceptors who had started their effective married life after 19 years was the same among IUD ( 15.8 per cent ) and laproscopy ( 15.4 per cent ) acceptors, while it was the lower among the tubectomised ( 9.6 per cent ). As a large proportion of IUD adoptors had started their effective married life at age 15 or later, it can be said that temporary methods are more popular among females marrying at higher ages.

### 3.14 - Sex and age of the last child

Table 3.15 presents percentage distribution of acceptors by sex and the age of the last living child at adoption. It is seen from the table that the proportion

adopting family planning method when the child was an infant ( age less than a year ) was as high as 81.9 per cent among the sterilized as against only 44.7 per cent among IUD acceptors. This shows that sterilization methods are adopted following child birth while IUD insertions are made at any time after birth of a child. As regards sex preference, there is no evidence to suggest sex preference among the sterilized as the proportion accepting sterilization with a male or female infant being over 81 per cent was close to each other. However, among the IUD adoptors the fact that 58 per cent had adopted when the child was a male infant as against a lower corresponding per cent (27.9 per cent ) for female infants suggests preference for males.

### S u m m a r y

IUD adoptors were found to be the youngest among the adoptors with a mean age of over 22 years at adoption followed by laparoscopy adoptors; mean age 24.1 years and the relatively the oldest were the tubectomised with a mean age of over 25 years.

The average parity was the highest for tubectomised; 4.1 live births followed by adoptors of laparoscopy 3.6 live births and the lowest average 2.1 live births was found for adoptors of IUD. The average number of living children to adoptors of tubectomy and laparoscopy being 3.4 was much higher than for IUD adoptors being 1.8 living children. An analysis of the average number of living children by age at adoption of sterilised showed that even among the young adoptors of 15-24 ages, hardly one fourth of them had a small family of 2 or less living children. Among the older adoptors aged 25 and more, the proportion having a large family size of 4 or more living children was over 64 per cent. On the other hand, a large majority of 65 per cent of IUD adoptors had a small family of 2 or less living children irrespective of the age at adoption.

The analysis of child loss experience showed that 25 per cent of tubectomised, 20 per cent of laparoscopy adoptors and over 11 per cent of IUD adoptors had experienced at least one child loss prior to acceptance. The analysis showed that child loss experience was higher among permanent method adoptors than among temporary method adoptors.

A majority of adoptors of sterilisation had preferred a combination of 2 male and a female child at adoption. The proportion of illiterates among the sterilised was higher

75( per cent ) than among the IUD adoptors;53 per cent, the corresponding proportion among the husbands was 39 and 30 per cent respectively.

A majority of 56 per cent of sterilised were working in the agricultural sector while 68 per cent of IUD adoptors were working in the non-agricultural sector. It is true in respect of the occupations followed by husbands as well;for instance a majority of 59 per cent of the husbands of sterilised were engaged in the agricultural sector while 58 per cent of the husbands of IUD adoptors were engaged in the non-agricultural sector.

78 per cent of sterilised and 77 per cent of IUD adoptors were Hindus. It is gratifying to note that nearly 20 per cent of sterilised and over 18 per cent of IUD were Muslims. The proportion of caste Hindus such as Brahmins and Lingayats was the highest ( 32 per cent ) among IUD adoptors than among the sterilised ( 21.3 per cent ). The proportion of the scheduled castes among the IUD acceptors being 19.8 per cent was slightly higher than among sterilised 18.8 per cent.

As regards the family type, a great majority of acceptors belonged to nuclear households. However, between the methods relatively higher proportion of IUD adoptors were drawn from joint households.

The adoptors drawn from landless households was the highest ( 47 per cent ) among IUD adoptors followed by tubectomised, ( 33.6 per cent ) and adoptors of laproscopy ( 30.6 per cent ). The households of laproscopy adoptors had higher land holding than adoptors of tubectomy and IUD.

A majority of IUD adoptors were drawn from households of higher income than adoptors of sterilisation. Between the permanent method adoptors, a higher proportion of tubectomised belonged to higher income households than adoptors of laproscopy.

15.8 per cent of IUD adoptors and 11 per cent of sterilised females had started their effective married life at the age of 19 or more. Between the adoptors of sterilisation the proportion starting their married life at 19 years or more was higher among the laproscopy adoptors ( 15.4 per cent ) than among the tubectomised ( 9.6 per cent ).

81.9 per cent of sterilised and 44.7 per cent of IUD adoptors had adopted the method when their last child

was less than a year. The ultimate decision to accept family planning method was not influenced by the sex of the last living child among the sterilised while a majority of IUD adoptors had adopted when their last living child was a male.

A comparison of the data on age at adoption and the average number of living children as obtained from the earlier study conducted in Belgaum showed that the age of adoptors of tubectomy and IUD had declined by 3 years while the decline in the number of living children between the earlier and the present survey was marginal being 0.3 child per acceptor.

Table 3.1 : Number and percentage distribution of acceptors of family planning methods by age at adoption, Methodwise.

Age group:	Tubectomy		Laparoscopy		Sterilization		IUD	
	No.	%	No.	%	No.	%	No.	%
15-19	7	6.1	6	15.0	13	8.4	28	29.2
20-24	42	36.5	15	37.5	57	36.8	35	36.5
25-29	42	36.5	14	35.0	56	36.1	29	30.2
30-34	19	16.5	5	12.5	24	15.5	3	3.1
35-39	5	4.3	-	-	5	3.2	1	1.0
40-44	-	-	-	-	-	-	-	-
<b>Total</b>	<b>115</b>	<b>100.0</b>	<b>40</b>	<b>100.0</b>	<b>155</b>	<b>100.0</b>	<b>96</b>	<b>100.0</b>
Mean age	26.3		24.8		25.9		23.0	
As per 1982-83 survey	28.7		-		-		25.0	

Table 3.2 : Number and percentage distribution of acceptors by parity at adoption, Methodwise.

Size of Parity	Tubectomy		Laparoscopy		Sterilization		IUD	
	No.	%	No.	%	No.	%	No.	%
0	-	-	-	-	-	-	1	1.0
1	1	0.8	1	2.5	2	1.3	31	32.3
2	8	7.0	10	25.0	18	11.6	35	36.4
3	37	32.1	15	37.5	52	33.5	23	24.0
4	30	26.1	3	7.5	33	21.5	3	3.1
5	17	14.8	5	12.5	22	14.2	1	1.0
6	14	12.2	4	10.0	18	11.6	2	2.1
7 +	8	7.0	2	5.0	10	6.4	-	-
<b>Total</b>	<b>115</b>	<b>100.0</b>	<b>40</b>	<b>100.0</b>	<b>155</b>	<b>100.0</b>	<b>96</b>	<b>100.0</b>
Mean Parity	4.1		3.6		4.0		2.3	

Table 3.3 : Number and percentage distribution of acceptors by number of living children methodwise.

Children living	Tubectomy		Laparoscopy		Sterilization		IUD	
	No.	%	No.	%	No.	%	No.	%
0	-	-	-	-	-	-	1	1.0
1	1	0.8	1	2.5	2	1.3	38	39.6
2	9	7.8	13	32.5	22	14.2	38	39.6
3	46	40.0	13	32.5	59	38.1	15	15.6
4	29	25.2	3	7.5	32	20.6	2	2.1
5	18	15.7	5	12.5	23	14.8	2	2.1
6	8	7.0	4	10.0	12	7.7	-	-
7 +	4	3.5	1	2.5	5	3.2	-	-
<b>Total</b>	<b>115</b>	<b>100.0</b>	<b>40</b>	<b>100.0</b>	<b>155</b>	<b>100.0</b>	<b>96</b>	<b>100.0</b>
<b>Mean</b>	<b>3.82</b>		<b>3.4</b>		<b>3.4</b>		<b>1.8</b>	
Mean as per 1982-83 survey	3.8							

Table 3.4 : Percentage distribution of adoptors of sterilization and IUD by living children at adoption classified by age at adoption

Living Children	Sterilisation			IUD		
	Age at adoption			age at adoption		
	15-24	25-29	30 +	15-24	25-29	30 +
0	-	-	-	-	-	-
1	2.9	-	-	49.2	24.1	-
2	24.2	5.4	6.9	38.0	41.4	75.0
3	55.7	30.3	10.3	11.1	24.1	25.0
4	12.9	30.3	20.7	-	6.9	-
5	2.9	23.2	27.6	1.6	3.4	-
6 +	1.4	10.7	34.5	-	-	-
Total	100.0 (70)	100.0 (56)	100.0 (29)	100.0 (63)	100.0 (29)	100.0 (3)@
Mean	2.9	4.0	4.6	1.6	2.2	2.5

@ - excludes one with no living child.

Table 3.5 : Number and percentage distribution of acceptors by number of child losses experienced, Methodwise.

Child Loss	Tubectomy		Laparoscopy		Sterilisation		IUD	
	No.	%	No.	%	No.	%	No.	%
Nil	86	74.7	32	80.0	118	76.1	85	88.5
One	20	17.4	7	17.5	27	17.4	9	9.4
Two or more	9	7.8	1	2.5	10	6.5	2	2.1
Total	115	100.0	40	100.0	155	100.0	96	100.0

Table 3.6 : Percentage distribution of acceptors experiencing the child loss by the average number of living children at adoption, methodwise.

Child loss:	Tubectomy		Laparoscopy		Sterilisation		IUD	
	No. of acceptors	Mean living children	No. of acceptors	Mean living children	No. of acceptors	Mean living children	No. of acceptors	Mean living children
Nil	86	3.6	32	3.2	118	3.3	85	1.7
One	20	4.3	7	3.4	27	3.9	9	2.9
Two	9	4.6	1	6.0	10	5.3	2	1.0
At least one child	29	4.4	8	3.7	37	4.3	11	2.5



Table 3.7 : Percentage distribution of sterilisation adoptors by living children classified by male and female living children

Living Children :	Male living children				Female living children			
	0	1	2	3+	0	1	2	3+
1	66.6	-	-	-	-	3.4	-	-
2	-	28.9	13.5	-	50.0	18.6	-	-
3	-	36.8	44.4	27.2	40.9	61.0	37.8	-
4	-	18.4	19.8	27.2	9.0	11.9	43.2	18.9
5 +	33.8	15.8	22.2	45.5	-	5.1	18.9	81.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	(3)	(38)	(87)	(33)	(22)	(59)	(37)	(37)
Row %	1.9	24.5	52.2	21.3	14.1	38.1	23.9	23.9
Mean	2.5	3.2	3.4	4.2	2.6	2.9	3.3	4.8

Table 3.8 : Number and percentage distribution of acceptors by their education and that of their spouse

Educational level	Tubectomy		Laparoscopy		sterilisation		IUD	
	No.	%	No.	%	No.	%	No.	%
<b>W i f e</b>								
Illiterate	83	75.4	30	76.9	113	75.8	51	53.1
Primary	20	18.2	7	17.9	27	18.1	22	22.9
Above primary	7	6.4	2	5.1	9	6.0	23	24.0
<b>Total</b>	<b>110</b>	<b>100.0</b>	<b>39</b>	<b>100.0</b>	<b>149</b>	<b>100.0</b>	<b>96</b>	<b>100.0</b>
Data N.A.	5		1		6			
<b>H u s b a n d</b>								
Illiterate	39	36.1	18	50.0	57	39.6	28	30.4
Primary	49	45.4	15	41.7	64	44.4	36	39.1
Above primary	20	18.5	3	8.3	23	16.0	28	30.4
<b>Total</b>	<b>108</b>	<b>100.0</b>	<b>36</b>	<b>100.0</b>	<b>144</b>	<b>100.0</b>	<b>92</b>	<b>100.0</b>
Data N.A.	7		4		11		4	

Table 3.9: Number and percentage distribution of acceptors by their occupation and that of their spouse, methodwise.

Occupation	Tubectomy		Laparascopy		Sterilisation		IUD	
	No.	%	No.	%	No.	%	No.	%
<u>W i f e</u>								
Not working (Household work)	43	38.7	13	33.3	26	37.3	48	50.0
Cultivator	32	28.8	14	35.9	46	30.7	19	19.8
Agri. Coolie	28	25.2	10	25.6	38	25.3	12	12.5
Others	8	7.2	2	5.1	10	6.7	17	17.7
Total	111	100.0	39	100.0	150	100.0	96	100.0
Data N.A.	4		1		5			
<u>H u s b a n d</u>								
Not working	3	2.7	-	-	3	2.0	3	3.2
Cultivators	43	38.7	14	38.9	57	38.7	27	28.7
Agri. Coolie	19	17.1	11	30.5	30	20.4	13	13.8
Others	46	41.4	11	30.5	57	38.8	51	54.3
Total	111	100.0	36	100.0	147	100.0	94	100.0
Data N.A.	4		4		8		2	

Table 3.10 : Number and percentage distribution of acceptors by Religion and Caste, methodwise.

Religion & Caste	: Tubectomy		: Laparoscopy		: Sterilisation		: IUD	
	No.	%	No.	%	No.	%	No.	%
Brahmin	-	-	-	-	-	-	2	2.0
Lingayat	24	20.9	9	22.5	33	21.3	29	30.2
Other Hindus	42	36.5	18	45.0	60	38.7	24	25.0
Scheduled Castes	23	20.0	5	12.5	28	18.1	19	19.8
Muslims	23	20.0	7	17.5	30	19.3	18	18.8
Others	3	2.6	1	2.5	4	2.6	4	4.2
Total	115	100.0	40	100.0	155	100.0	96	100.0

Table 3.11 : Number and percentage distribution of acceptors by household type, methodwise.

Type of Family	: Tubectomy		: Laparoscopy		: Sterilisation		: IUD	
	No.	%	No.	%	No.	%	No.	%
Nuclear (one couple)	76	66.1	30	75.0	106	68.4	60	62.5
Joint (more than one couple)	39	33.9	10	25.0	47	31.6	36	37.5
Total	115	100.0	40	100.0	155	100.0	96	100.0

Table 3.12 : Number and percentage distribution of acceptors by the size of the land cultivated by the household, methodwise.

Size of the cultivated land	Tubectomy		Laparoscopy		Sterilisation		IUD	
	No.	%	No.	%	No.	%	No.	%
Nil	38	33.6	12	30.8	50	32.9	44	47.8
Below 5 acres	50	44.2	19	48.7	69	45.4	29	31.5
5 to less than 15 acres	17	15.0	4	10.2	21	13.8	12	13.0
15 + acres	8	7.1	4	10.2	12	7.9	7	7.6
Total	113	100.0	39	100.0	152	100.0	92	100.0
Data N. A.	2		1		3		4	

Table 3.13 : Number and percentage distribution of family planning methods by per capita annual income of the members of household Methodwise:

Per capita annual income (in Rs.)	Tubectomy		Laparascopy		Sterilisation		IUD	
	No.	%	No.	%	No.	%	No.	%
Upto Rs. 300	9	8.2	2	5.4	11	7.5	9	10.8
Rs. 301- 400	2	1.8	2	5.4	4	2.7	3	3.4
• 401- 600	22	20.0	9	24.3	31	21.1	6	6.9
• 601- 800	14	12.7	6	16.2	20	13.6	8	9.2
• 801-1200	21	19.1	11	29.7	32	21.8	18	20.7
• 1201 +	42	38.2	7	18.9	49	33.3	43	49.4
Total	110	100.0	37	100.0	147	100.0	87	100.0
Data N.A.	5		3				9	

Table 3.14 : Number and percentage distribution of acceptors by age at effective marriage, Methodwise.

Age at effective marriage	Tubectomy		Laparascopy		Sterilisation		IUD	
	No.	%	No.	%	No.	%	No.	%
14 or less yrs.	52	45.2	14	35.9	66	42.9	23	24.2
15 - 18 years	52	45.2	19	48.7	71	46.1	57	60.0
19 + years	11	9.6	6	15.4	17	11.0	15	15.0
Total	115	100.0	39	100.0	154	100.0	95	100.0
Data N.A.	-		1		1		1	

Table 3.15 : Percentage distribution of acceptors by sex and age of the last living child at adoption, Methodwise.

Age of the last living child	Tubectomy	Laparascopy	Sterilisation	Total
<b>Male</b>				
0	85.7	70.0	82.5	58.8
1	6.5	20.0	9.3	11.7
2 +	7.8	10.0	8.2	29.4
<b>Total</b>	100.0 ( 77)	100.0 ( 20)	100.0 ( 97)	100.0 ( 51)
<b>Female</b>				
0	86.8	70.0	81.0	27.9
1	7.9	5.0	6.9	18.6
2 +	5.3	25.0	12.1	53.5
<b>Total</b>	100.0 ( 38)	100.0 ( 20)	100.0 ( 58)	100.0 ( 43)
<b>All</b>				
0	86.1	70.0	81.9	44.7
1	6.9	12.5	8.4	14.9
2 +	7.0	17.5	9.7	40.4
<b>Total</b>	100.0 (115)	100.0 ( 40)	100.0 (155)	100.0 ( 94)

CHAPTER- IV : REASONS FOR ACCEPTING FAMILY PLANNING, SIDE EFFECTS AND SERVICE DELIVERY ASPECTS

This chapter analysis the respondents motive for accepting family planning including source of motivation, experience of post/adoption complaints, pre-adoption medical check up, and availing of follow-up care from health and family welfare personnel.

4.1 Reasons for accepting family planning methods

A question was asked to the acceptors as to why she had accepted family planning. Table 4.1 sets out the number and percentage distribution of the sterilised females by their reasons for accepting family planning, classified by living children, is given in Table 4.2.

As regards reasons for adoption of sterilisation there are two predominant reasons. One, the respondents reported that they were finding it difficult to maintain a large family and second they did not desire any more children. These reasons were stated by over 70 per cent of sterilisation acceptors. Both these reasons were stated more often by tubectomised than adoptors of laproscopy. Over 85 per cent of those who had stated these reasons had 3 or more living children. This clearly shows that a minimum of 3 living children is almost a basic requisite for accepting a terminal method. 14 per cent of sterilised females reported child care problems. Interestingly this reason is stated by over 22 per cent of laproscopy adoptors as against 10 per cent adoptors of tubectomy. Further among those stating this reason over 85 per cent had 3 or more living children. On the other hand less than 4 per cent had reported that they had accepted the method as they considered two children is enough. Another 9 per cent of acceptors had stated a number of other reasons.

Among the IUD acceptors more than four-fifths had stated to have accepted the method for spacing purpose, while 5 per cent had accepted it on a permanent basis. Child care problems and difficult to maintain a large family was stated by over 3 per cent each. The analysis indicates that a large majority of sterilised were prompted to accept family planning due to economic pressures, however the economic pressure is felt only after achieving their desired family size of 3 or more living children and not early. The main reason for acceptance of IUD is spacing.



#### 4.2- Motivator

Each adoptor was asked as to who motivated her to adopt family planning. Table 4.3 shows the percentage distribution of acceptors by motivator as perceived by them. About 59 per cent of the adoptors stated that decision to accept family planning was of their own. Nearly 32 per cent of the adoptors had named female health worker as the person who persuaded them to adopt family Planning. Surprisingly, the male health worker as motivator was reported by only 1.2 per cent of the adoptors. Another 2.8 per cent had named other PHC staff like the doctor and health supervisor as the motivator. The remaining 4.8 per cent had stated neighbours, relatives and adoptors as the motivator.

Methodwise, the adoption was voluntary in respect of over 75 per cent of tubectomised and 37.5 per cent of adoptors of laproscopy. The corresponding proportion among IUD adoptors was 40 per cent. 20 per cent tubectomised and 42 per cent of adoptors of laproscopy were motivated either by female health workers or by other PHC staff. The corresponding proportion among IUD adoptors was as high as 51 per cent. Neighbour/ relatives / and adoptors as motivators was stated by 3.5 per cent of tubectomised, 8.4 per cent of adoptors of IUD.

The analysis shows that the decision to accept a permanent method was largely voluntary, while IUD adoption was largely due to the motivational efforts of the health workers. In the over all promotional work female health worker emerges as an important catalytic agent. The data suggests that the role of the family planning personnel in motivating the couples to adopt family planning method was much less among the adoptors of permanent methods than among the adoptors of temporary methods and that among the family planning personnel female health workers play an important role as motivators. Over 97 per cent of tubectomised, 100.0 per cent adoptors of Laproscopic and 87 per cent of IUD adoptors had obtained the consent of their spouse for adoption (Table not given ).

#### 4.3 - Reasons for preferring the particular method

Each adoptor was asked as to why she preferred the method she had adopted. Table 4.5 set out the number and percentage distribution of adoptors by reason for preferring the method they had adopted. It is seen from the Table

that over one-fifth of all adoptors were not aware of any method other than the one they had adopted. Methodwise, nearly 29 per cent of IUD adoptors and 19 per cent of tubectomy adoptors and 8 per cent of laproscopic adoptors were not aware of other methods. Nearly one fourth of the adoptors reported that they were advised by the health and family welfare personnel to adopt this particular method. Methodwise it was 21 per cent, 23 per cent and 29 per cent ~~and 29 per cent~~ respectively among the tubectomy, laproscopy and IUD adoptors. Thus nearly 45 per cent of the adoptors had really no choice. It is intriguing to note that 11.6 per cent had adopted because the method they had adopted earlier had failed. Sadly enough the lone method that failed was laproscopy. Over 12 per cent of the adoptors had reported that they adopted the method as they could ill-afford hospital confinement. Methodwise 60 per cent of laproscopy adoptors and 3.9 per cent IUD adoptors had stated this reason. A substantial proportion of adoptors (21.3 %) and IUD ( 26 %) than adoptors of laproscopy ( 7.9%). In addition, there were some other reasons reported by the respondents such as desire for a permanent method ( 2.3%) tubectomy is safer than other methods ( 3.3%) and desire for children at a later date etc,. The analysis shows that a large number of respondents had no real choice to be made as either they were not aware or were advised about only one method which they had ultimately adopted. The failure rate of laproscopy method was very high in the survey area.

#### 4.4- Medical check up of the adoptors

It is normal practice to subject the prospective adoptors to medical check up to ascertain their physical fitness for adoption of the method. Each adoptor was therefore, asked about the nature of physical check up they underwent before adoption of the method. These details are presented in Table 4.5. It is seen that the proportion of adoptors who had no prior medical check up was the highest among the IUD adoptors ( 51.6 % ) followed by laproscopy adoptors ( 32.5%) and tubectomy adoptors ( 31.9 % ). The data shows that the nature of medical check up involved was largely the blood and urine tests.

The analysis shows that a large number of adoptors were not physically checked prior to their adoption. This implies that adequate attention was not paid to varify the physical fitness of the prospective adoptors.

#### 4.5 - Duration of use of IUD

Table 4.6 shows the number and percentage distribution of adoptors of IUD by status of use at the time of survey and the reasons for discontinuation. The interval between the date of survey and date of insertion varied between a low of 10 months to a high of 22 months. It is seen from the table that during this interval 49 per cent had discontinued. The predominant reason for discontinuation was removal of the device ( 46.9%) and expulsions ( 2.1%).

Table 4.7 shows the duration of use of IUD by current use status. It may be seen that among those who discontinued use of the device at survey, over 70 per cent had used it for a period of 6 months or less and 21 per cent had used it for ~~other~~ 6 months <sup>or more but</sup> less than a year. On the other hand, among those who continued <sup>the</sup> use of the device, majority of them ( 55 % ) were using it for more than a year while another 45 per cent for 7 to 11 months.

The life table analysis showed that 53 per cent of adoptors were using the device at the end of 12th month of use.

The analysis shows that dropout due to removal and expulsion was very high among IUD adoptors. However, the retention rate among those who had continued to use IUD at survey was found to be high.

#### 4.6 - Complaints and side-effects

Table 4.8 sets out the number and percentage distribution of adoptors by persistence of complaints/side effects at survey, before survey and at any time. Those who experienced complaints/ side effects were divided into two categories; those whose complaint persisted at survey and those whose complaint had subsided at survey.

It may be noted that a substantial portion of acceptors being 41 per cent had ever experienced a complaint/ side effect after adoption. Methodwise the proportion ever experiencing complaint / side effect was 38.3 per cent among tubectomy acceptors, 47.5 per cent of adoptors of laproscopy and 41.6 per cent of IUD users. The data shows that the proportion experiencing side effect / complaint did not vary between adoptors of sterilisation and IUD. However, the proportion of adoptors reporting the persistence of complaint at survey was much higher among adoptors of sterilisation ( Tub. 33 % ) . (Lap. 42.5%) than among IUD

adoptors ( 3.1%).The analysis thus suggests that the complaint / side effects experienced by adoptors of sterilisation were more severe than those experienced by adoptors of IUD.

B - Nature of complaints

Table 4.9 presents the nature of complaint / side effects persisting at survey as reported by the adoptors.

The data show that back or waist ache was the major complaint as reported by 66.7 per cent of tubectomised and over 88 per cent of adoptors of laproscopy. Excess bleeding and white discharge was reported by all the three IUD adoptors , 13.9 per cent of tubectomised also had reported this complaint. Pain in the place of operation was reported by over 19 per cent of the tubectomised and 11.8 per cent adoptors of laproscopy. It is thus evident that a large number of sterilised had experienced back or waist ache while IUD users had experienced excess bleeding and white discharge.

C - On-set of complaints

Table 4.10 presents the number and percentage distribution of adoptors reporting complaints / side effects by on set of complaints. The data indicated that on set of complaint need not be followed immediately on accepting the method, but most likely during the first year of adoption. Between the methods a higher proportion of adoptors IUD experienced the complaining earlier than adoptors of sterilization.

D - Treatment of complaint

Each of the respondent experiencing complaint or side effect was asked about the treatment sought. Table 4.11 presents the number and percentage distribution of acceptors experiencing complaint / side effect by the place of treatment for the complaint. It is seen that 30 per cent of adoptors ( all methods ) experiencing side effects/ complaints had not sought treatment from any agency. Methodwise the proportion not seeking treatment being nearly 58 per cent was the highest for adoptors of laproscopy followed by IUD users ( 25 % ) and tubectomised ( 22.7 % ).

The analysis shows that majority of tubectomised and adoptors of IUD had sought treatment while a majority of adoptors of laproscopy had not sought treatment. The

health worker constitute the main agency who had provided treatment to a bulk of ( 42.77 ) adoptors followed by PHC and PHU staff (10.7 % ).15.5 per cent of the adoptors ( mostly tubectomised ) had reported that they had availed treatment from private clinic.

#### 4.7 Follow-up services

Table 4.12 shows the number and percentage distribution of acceptors by the category of persons visiting them for follow-up care. It is seen from the Table (for all methods ) that the female health workers were responsible for the follow-up care of four fifth of the adoptors. Methodwise it is seen that nearly 92 per cent of the follow-up care of the IUD users, 85 per cent of adoptors of laproscopy and over 72 per cent of the tubectomised was taken by female health worker alone. The share of male health workers and that of other health staff in the follow-up service being 2 per cent each was negligible. Nearly 14 per cent of the tubectomised had reported that nobody visited them for follow-up care. For all methods combined over 8 per cent of the adoptors had not received any follow-up care.

#### B ) Interval between adoption and first follow-up visit

Table 4.13 presents the distribution of adoptors by interval between adoption of the method and the first follow-up visit by health and family welfare personnel. The Table shows that nearly 39 per cent of the adoptors were visited within three days of adoption. Methodwise the first visit within 3 days was the highest being 69 per cent for adoptors of laproscopy followed by tubectomy ( 46.5%) and the least being 17 per cent for IUD adoptors. However, if we consider the follow-up visit within a week of adoption, over two-thirds ( 66 %) of adoptors were visited by workers within 7 days of adoption. Methodwise over 87 per cent of adoptors of laproscopy, 71 per cent of tubectomised and over 52 per cent of IUD adoptors were first visited within a week. It is further seen that by the first fortnight cent per cent of adoptors of laproscopy, nearly 88 per cent of tubectomised and over 83 per cent of IUD adoptors were visited by the health and family welfare workers.

#### C - Number of follow-up visits

In this section we have examined the number of visits paid by male and female health workers since they

were instrumental in providing follow-up care to most of the adoptors. Table 4.15 shows the number and percentage distribution of adoptors by number of visits by male and female health workers. It is gratifying to note that nearly 91 per cent of the adoptors were visited more than once. The proportion of adoptors reporting 4 or more visits was as high as 55 per cent. Methodwise the corresponding percentages were 62 per cent for tubectomised, 37.5 per cent adoptors of laparoscopy and over 56 per cent of adoptors of IUD.

The analysis shows that male and female workers had visited a large majority of adoptors more than once. The number of visits was relatively higher for tubectomised and adoptors of IUD than to adoptors of laparoscopy.

#### D - Nature of Follow-up care Received

Table 4.15 shows the number and percentage distribution of adoptors by the nature of follow-up care as reported by the adoptors. It is seen that over 54 per cent of the adoptors had stated that they had either the physical check up by the health workers, or oral enquiry was made about their health after adoption. A substantial proportion (45.7%) of adoptors had however reported that in addition to the oral or physical check up they were also provided with medicines. Methodwise a higher proportion of sterilised had received check up along with medicine than adoptors of IUD. Over 56 per cent of tubectomised and 45 per cent of adoptors of laparoscopy had received medicine along with physical or oral check up compared to a lower proportion (34.1%) among adoptors of IUD.

#### E - Satisfaction with follow-up services

Table 4.16 presents the number and percentage distribution of adoptors satisfied with the follow-up service received. Nearly 95 per cent of the adoptors were satisfied with the follow-up care received. Methodwise, cent per cent of IUD adoptors had reported that they were satisfied with the follow-up care received while the corresponding proportion was over 90 per cent among the sterilised. By and large a large majority of adoptors were satisfied with the follow-up care received by them.

#### Summary

The motive for acceptance of family planning to a large number of adoptors of permanent methods comes from the realisation of the fact that they already had a large family which either it is difficult to maintain or needs to be prevented

from further expansion. As expected a large majority of IUD adoptors had adopted for purposes of spacing.

As regards the motivator it was observed that the role of motivator was much less in the ultimate decision to adopt a permanent method, than for adoption of IUD. More than four-fifth of the spouses of the adoptors had consented for the adoption of a method of family planning.

As for the preference for the method adopted, it was observed that for a large number of adoptors there was no real choice to be made because either they were not aware of other methods or were advised about only one method which they had ultimately adopted. The apprehensions about many methods of family planning still persist among sizeable number of adoptors. It was intriguing to note that over one-tenth had adopted tubectomy because of failure of laparoscopy.

A majority of IUD adoptors and a substantial portion of sterilised were not subjected to premedical check up prior to adoption of the method.

As regards the duration of use of IUD it was noted that, nearly half of adoptors had discontinued the use before 12 months of use. However, among those retaining the device at the time of survey, it was observed that a large majority were retaining the device beyond 12 months of use. The Life Table analysis showed that 53 per cent of adoptors were using the device at the end of 12 months of use.

Nearly two-fifth of the adoptors had experienced one or other complaint after adoption. However, proportion of adoptors reporting that the complaint persisted at survey was higher among sterilised than among adoptors of IUD. A large number of permanent method adoptors had experienced back or waist ache while IUD adoptors had experienced excess bleeding and white discharge. Majority of these complaints had manifested within six months of adoption. However, it was noted that among the permanent method, adoptors reporting complaint side effects, the complaint had manifested after six months of nearly a third of them.

Majority of tubectomised and adoptors of IUD reporting complaint / side effects had sought treatment while a majority of adoptors of laparoscopy had not sought treatment at all. For a bulk of adoptors experiencing complaint the treatment was provided by the health and family welfare personnel.

A large majority of adoptors were visited by the male and female health workers. It was observed that female health worker had emerged as the single most functionary to provide follow-up care in terms of the acceptors covered and the number of visits made per acceptor. As regards the nature of follow-up care it was noted that in majority of cases it involved the physical and oral check up. However, a considerable number of adoptors had reported that they were given medicine by the health and family welfare personnel at the time of follow-up visit. A large majority of adoptors were satisfied with the follow-up visit.



Table 4.1 : Number and percentage distribution of acceptors by motive for acceptance of family planning methods.

Motive for accepting family planning methods	Tubectomy		Laparascopy		Sterilisation		IUD	
	No.	%	No.	%	No.	%	No.	%
1. Two are enough	1	0.9	5	12.5	6	3.9	-	-
2. Difficult to maintain a big family	45	39.5	10	25.0	55	35.7	3	3.1
3. Did not desire any more children	44	38.6	11	27.3	55	35.7	5	5.2
4. Due to child care and other problems	12	10.5	9	22.5	21	13.6	3	3.1
5. Pressure from F.P. personnel	1	0.9	2	5.0	3	1.9	4	4.2
6. For spacing purpose	-	-	-	-	-	-	79	82.3
7. Others	11	9.6	3	7.5	14	9.1	2	2.1
<b>T o t a l</b>	<b>114</b>	<b>100.0</b>	<b>40</b>	<b>100.0</b>	<b>154</b>	<b>100.0</b>	<b>96</b>	<b>100.0</b>
Data N.A.	1		-		1		-	

Table 4.2 : Number and percentage distribution of sterilisation adoptors by number of living children at adoption and by motive for accepting family planning

Motive for accepting F. P. method	Living children at adoption							
	Two		Three		4+		Total	
	No.	%	No.	%	No.	%	No.	%
1. Difficult to maintain a big family	8	14.3	18	33.9	29	52.8	55	100.0
2. Did not desire any more children	2	3.6	20	36.4	33	60.0	55	100.0
3. Child care problems	3	14.3	12	57.1	6	28.6	21	100.0
4. Pressure from F. P.	-	-	2	66.6	1	33.3	3	100.0
5. Two are enough	6	100.0	-	-	-	-	6	100.0
6. Others	3	18.3	7	54.3	4	27.2	14	100.0

Table 4.3: The number and percentage distribution of acceptors by motivate as perceived by the acceptors.

Motivators	Tubectomy		Laparoscopy		IUD		Total	
	No.	%	No.	%	No.	%	No.	%
1. Self/spouse	87	75.6	23	57.5	39	40.6	149	59.3
2. Health worker (Female)	20	17.4	14	35.0	46	47.9	80	31.9
3. Health worker (Male)	2	1.7	1	2.5	-	-	3	1.2
4. Other PHC staff	2	1.7	2	5.0	3	3.1	7	2.8
5. Neighbours/relatives/other adoptors	4	3.5	-	-	8	8.4	12	4.8
<b>T o t a l</b>	<b>115</b>	<b>100.0</b>	<b>40</b>	<b>100.0</b>	<b>96</b>	<b>100.0</b>	<b>251</b>	<b>100.0</b>

Table 4.5: Number and percentage distribution of acceptors by the nature pre-medical checkup.

Nature of pre-medical check up	Tubectomy		Laparoscopy		IUD	
	No.	%	No.	%	No.	%
1. No medical check up	36	31.9	13	32.5	47	51.6
2. Blood test	8	7.1	7	17.5	2	2.2
3. Blood and urine test along with other physical checks	65	57.5	20	50.0	31	34.1
4. Oral and physical checks only	1	0.9	-	-	-	-
5. Cannot recaptulate	2	1.8	-	-	6	6.6
6. Others	1	0.9	-	-	5	5.5
<b>Total</b>	<b>113</b>	<b>100.0</b>	<b>40</b>	<b>100.0</b>	<b>91</b>	<b>100.0</b>
Data N.A.	2				5	

Table 4.6 : Current Status of use and reasons for discontinuation of IUD

Current status of users	Number	Percentage
Current using	49	51.0
Expelled	2	2.1
Removed	45	46.9
<b>Total</b>	<b>96</b>	<b>100.0</b>

Table 4.4 : Number and percentage distribution of adoptors by preference for a particular method

Reasons for preference	Method preferred and adopted							
	Tubectomy		Laparascopy		IUD		Total	
	No.	%	No.	%	No.	%	No.	%
1. Desired a permanent method	5	5.0	-	-	-	-	5	2.3
2. Tubectomy is safer than other methods	7	7.0	-	-	-	-	7	3.3
3. Could ill-afford long hospital confinement	-	-	23	60.5	3	3.9	26	12.1
4. Advised by F.P. personnel to adopt this method	21	21.0	9	23.7	22	28.6	52	24.2
5. Adverse effects of other methods	23	23.0	3	7.9	20	26.0	46	21.3
6. Desired children later	-	-	-	-	10	12.9	10	4.6
7. Failure of laparoscopy	25	25.0	-	-	-	-	25	11.6
8. Ignorant of other methods	19	19.0	3	7.9	22	28.6	44	20.5
<b>Total</b>	<b>101</b>	<b>100.0</b>	<b>38</b>	<b>100.0</b>	<b>77</b>	<b>100.0</b>	<b>215</b>	<b>100.0</b>
Data N.A.	15		2		10			
Acceptor was F. P. staff	-		-		9			

Table 4.7 : Duration of use of IUD by current use status

Duration of use in completed months	Currently users	Discontinued
Below one month	-	2 (4.3)
1 - 3 months	-	13 (28.3)
4 - 6 months	1 (2.0)	17 (36.9)
7 -11 months	22 (44.9)	10 (21.7)
12 + months	26 (53.0)	4 (8.7)
<b>T o t a l</b>	<b>49(100.0)</b>	<b>46(100.0)</b>
Data N.A.	One case	

Table 4.8 : Number and percentage distribution of adoptors experiencing a complaint at survey before survey, and at any time (methodwise)

Method	: No. of : :acceptors:	: At survey :		: Before survey:		: At any time	
		No.	%	No.	%	No.	%
Tubectomy	115	36	31.3	8	7.0	44	38.3
Laparoscopy	40	17	42.5	2	5.0	19	47.5
IUD	96	3	3.1	37	38.5	40	41.6
<b>T o t a l</b>	<b>251</b>	<b>56</b>	<b>22.3</b>	<b>47</b>	<b>18.7</b>	<b>103</b>	<b>41.0</b>

Table 4.9: Number and percentage distribution of acceptors by nature of complaint persisting at survey

Nature of complaint	Tubectomy		Laparoscopy		IUD		All	
	No.	%	No.	%	No.	%	No.	%
Ache (back & waist)	24	66.7	15	88.2	-	-	39	69.6
Excess bleeding and white discharge	5	13.9	-	-	3	100.0	8	14.3
Pain in the place operation	7	19.4	2	11.8	-	-	9	16.1
T o t a l	36	100.0	17	100.0	3	100.0	56	100.0

Table 4.10 : No. and percentage distribution of adoptors reporting complaints by onset of complaints (at any time)

Onset of complaint after adoption	Tubectomy		Laparoscopy		IUD	
	No.	%	No.	%	No.	%
Within 3 months	18	40.9	8	42.1	31	77.5
4 - 6 months	9	20.5	5	26.3	6	15.0
After 6 months	17	38.6	6	31.6	3	7.5
T o t a l	44	100.0	19	100.0	40	100.0

Table 4.11: Number of percentage distribution of adoptors reporting complaints by place of treat for the complaints (any time). experienced by adoptors.

Agency providing treatment	Tubectomy		Laparoscopy		IUD		All methods	
	No.	%	No.	%	No.	%	No.	%
Not availed treatment	10	22.7	11	57.9	10	25.0	31	30.1
Health workers (Males and Females)	15	34.1	6	31.6	23	57.5	44	42.7
PHC/PHU	5	11.4	2	10.5	4	10.0	11	10.7
Private clinic	13	29.5	-	-	3	7.5	16	15.5
Others	1	2.3	-	-	-	-	1	0.9
T o t a l	44	100.0	19	100.0	40	100.0	103	100.0

Table 4.12: Number and percentage distribution of adoptors by category of persons visiting them after adoption

person visiting the adoptor	Tubectomy		Laparoscopy		IUD		All	
	No.	%	No.	%	No.	%	No.	%
No body visited	16	13.9	-	-	5	5.2	21	8.1
Health worker (female)	83	72.2	34	85.0	88	91.7	205	81.7
Health worker (male)	8	7.0	4	10.0	-	-	12	4.8
Both workers (M + F)	5	4.3	1	2.5	-	-	6	2.4
Other Health and FP staff	3	2.6	1	2.5	3	3.1	7	2.8
T o t a l	115	100.0	40	100.0	96	100.0	251	100.0

Table 4.13 : Number and percentage distribution of adoptors by interval between adoption and first visit by health personnel

Interval between adoption and visit	Tubectomy		Laparoscopy		I.U.D.		All methods	
	No.	%	No.	%	No.	%	No.	%
0 - 3 days	46	46.5	27	69.2	15	17.0	88	38.9
4 - 7 days	25	25.2	7	17.9	31	35.2	63	27.9
8 - 15 days	16	16.2	5	12.8	16	18.2	37	16.4
16 +	12	12.1	-	-	26	29.5	38	16.8
T o t a l	99	100.0	39	100.0	88	100.0	226	100.0
Data N.A.	-	-	1		3			

Table 4.14 : Number and percentage distribution of adoptors by number of visits by male and female health workers.

No. of visits	Tubectomy		Laparoscopy		IUD		A l l	
	No.	%	No.	%	No.	%	No.	%
<u>Male workers</u>								
1 visit	1	14.3	1	25.0	-	-	2	18.2
2 to 3 visits	2	28.5	1	25.0	-	-	3	27.3
4 to 5 visits	2	28.5	-	-	-	-	4	18.2
6 + visits	2	28.5	2	50.0	-	-	4	36.3
T o t a l	7	100.0	4	100.0	-	-	11	100.0
<u>Female workers</u>								
1 visit	8	10.8	3	9.4	4	5.1	17	9.1
2 - 3 visits	20	27.0	17	53.1	30	38.0	67	35.8
4 - 5 visits	16	21.6	4	12.5	25	31.6	45	24.1
6 + visits	30	40.5	8	25.0	20	25.3	58	31.0
T o t a l	74	100.0	32	100.0	79	100.0	187	100.0



Table 4.15 : Number and percentage distribution of adoptors by nature of follow-up care received

Nature of follow-up care	Tubectomy		Laparoscopy		I. U. D.		A l l	
	No.	%	No.	%	No.	%	No.	%
physical check-up only	12	12.1	5	12.5	38	42.2	55	23.9
oral enquiry only	31	31.3	17	42.5	22	23.7	70	30.4
physical or oral check-up and medicines	56	56.6	18	45.0	31	34.1	105	45.9
T o t a l	99	100.0	40	100.0	91	100.0	230	100.0

Table 4.16 : percentage distribution of adoptors satisfied with the follow-up care

Method	No. receiving follow-up care	No. satisfied	percentage satisfied
Tubectomy	99	91	91.9
Laparoscopy	40	36	90.0
IUD	91	91	100.0
T o t a l	230	218	94.8

CHAPTER- V : NON-ACCEPTORS OF FAMILY PLANNING

Introduction

This chapter deals with the analysis of data gathered from non-acceptors. A non-acceptor couple is defined as a currently married couple with wife in the age group of 15-44, having at least one living child and not using any family planning method at the time of survey. The respondent for the non-acceptor sample is either of the spouses who was available for interview. Among the total 243 non-acceptors covered 62 ( 25 per cent ) were males and 181 ( 74 per cent ) were females.

5.1 Demographic characteristics

A ) A g e

Table 5.1 presents the number and percentage distribution of husbands and wives by their age. The Table shows that the mean age of wives was nearly 25 years and that of husbands was over 31 years. Thus, the husbands appear to be generally older by 6 years than their wives. However, the most crucial aspect is the age of wife. A majority of over 55 per cent of the wives were drawn from the younger age group of 15-24 years, while over 28 per cent belonged to the middle age category of 25-29. The proportion of older wives in the age group of 30 and over was 15 per cent. Over 74 per cent of wives were in the peak reproductive age group of 20-29 years.

B) Parity

The parity distribution of non-adoptors is presented in Table 5.2 (A). It is seen that non-adoptors had 2.9 live births of which the male live birth being 1.3 was slightly lower than female live births 1.6. The proportion belonging to Ist, IInd and IIRD parity was 23.0., 29.6 and 18.5 per cent respectively. 12.8 per cent had 4 live births, while 16 per cent of the couples had 5 or more live births.

Living Children

The number and percentage distribution of non-adoptors by number of living children is presented in Table 5.2 (B). The non-adoptors had on an average 2.5 living children. The sex composition of the family shows that the non-adoptors had more of female living children ( 1.4 ) than males ( 1.1 ). It is interesting to note that 60 per cent of the non-adoptors had a small family size of two or less living children. 21 per cent had 3 living children

18 per cent of the non-adoptors had a large family of 4 or more living children. A comparison of the average parity of 2.9 with the average living children of 2.5 shows that the child loss among non-adoptors was nearly 14 per cent.

## 5.2 Socio-economic background

The socio-economic background included both the household and individual characteristics. Among the household characteristics are included aspects such as religion and caste, the cultivated land holding of the household, and the per capita annual income etc. The individual characteristics consists of the educational level and the occupation followed individually by couples.

Table 5.3 presents the number and percentage distribution of non-acceptors by religion and caste, the land cultivated by the household and the per capita annual income. Among the non-acceptors two major religious groups are represented viz; the Hindus and Muslims. The representation of other religious groups is negligible. For instance, the Hindus constitute a great majority of 82 per cent of which 59 per cent belong to caste Hindus while the remaining 23 per cent belong to Scheduled Castes. Nearly 15 per cent non-acceptors are Muslims and that all other religious groups constitute a negligible 2.9 per cent.

Nearly two-fifth of non-acceptors ( 38.7 per cent) were landless. The marginal farmers cultivating less than 5 acres of land constitute 34 per cent. A substantial portion of non-adoptors being 27.3 percent cultivated 5 or more acres of land.

As regards the annual per capita income (PCI), we have classified the households into three broad economic groups viz; ( a) poor household with a per capita income upto Rs. 600/-, (b) not so poor households with a per capita income of Rs. 601- 1200 and (c) household with better economic status with per capita income of Rs. 1200 or more. According to this classification 17 per cent of the non-acceptors belonged to poor households, 43.6 per cent were from not so poor households, while as high as 39 per cent belong to households of better economic status.

### Educational and occupational background of non-acceptors

Table 5.4 presents the number and percentage distribution of non-acceptors by education and occupation. It is seen from the Table that proportion of illiterate

wives being 68.7 per cent was considerably higher than the corresponding proportion of husbands (41.1 per cent). The proportion of wives who had studied beyond primary level was over 24 per cent but this proportion was much higher among husbands being 41 per cent.

As regards the occupations followed, it was observed that the non-working wives constituted as high as 47.3 per cent, this category was negligible among husbands. Less than a fourth (23 per cent) of wives were reported to be cultivators while this proportion was as high as 38.7 per cent among husbands. Agricultural and non-agricultural labour category constituted nearly 20 per cent among wives and over 23 per cent among husbands. The proportion of wives engaged in other vocations like petty trade, salaried services etc., constituted 9.9 per cent among wives and as high as 37 per cent among husbands.

The analysis shows that the predominant religious groups found among non-acceptors were Hindus and Muslims and that among the Hindus, scheduled castes constituted a sizeable number. A large majority of wives are illiterate and the corresponding proportion among husbands was relatively lower than among wives. As regards the economic status of the households measured in terms of per capita income and land holding the data suggests the prepondance of well to do section.

### 5.3 Knowledge of family planning among non-adoptors.

Table 5.5 presents percentage of non-acceptor respondents (male and female) having knowledge of family planning methods.

It is seen that knowledge of tubectomy is universal among the respondents. The next most known method laproscopy by over 79 per cent of the respondents. Sex-wise 85 per cent of females and nearly 63 per cent of males knew about this method. Knowledge of vasectomy was much less among the respondents, it was known to 43.5 per cent of males and only 17.7 per cent of females.

As regards the temporary methods, the knowledge of IUD and oral pills was 48 per cent and 39.5 per cent respectively among the respondents, although relatively more number of female knew about IUD and oral pills 48.6 and 40.9 per cent respectively. The variation in the

knowledge between the sexes was not very significant. (The knowledge of IUD and oral pill was 46.8 and 35.5 per cent respectively among the male respondents). However, the proportion of male respondents knowing about condom/Nirodh being 58 per cent was much higher than among female respondents; 11 per cent.

The analysis shows that knowledge of female sterilisation viz; tubectomy and laparoscopy is nearly universal, while awareness of male sterilisation is very low. It is encouraging to note that the knowledge of temporary methods like IUD and oral pills was not too low while Nirodh was a less known temporary method.

#### 5.4 Prior contraception

##### A) Prior contraception

The number and percentage distribution of non-adoptors by their previous practice of contraception and the age of the youngest living child is presented in Table 5.6.

It may be seen that the prior practice of contraception was negligible among the non-adoptors. Only 5.8 per cent out of 243 non-acceptors interviewed reported to have practised some temporary methods. Out of 14 respondents, 5 ( or over 35 per cent ) had used IUD, another 35 per cent had used oral pill ~~and the remaining nearly 29 per cent had used oral pill~~ and the remaining nearly 29 per cent had used condoms. Most of IUD and oral pill users had discontinued the use due to complaint / side effect while most of the condom users had discontinued as they had desired a child.

##### B) Age of the last living child

We have examined the data with regard to the age of the youngest living child of the respondents in order to ascertain their fecundity. This is because it is less likely that a woman would conceive in future if the youngest living child is atleast 4 years old. It is seen that nearly 40 per cent of the non-adoptors had the youngest living child aged below 1 year and nearly 54 per cent between 1 to 3 years. The proportion of non-adoptors having an youngest child aged 4 or more years was just over 6 per cent.

#### 5.5 Reasons for non-acceptance of F. P. methods

The number and percentage distribution of non-acceptors by reasons for non-acceptance of family planning

is presented in Table 5.7. The table includes the responses of male and female non-adoptors but however the cross classification of data by age is done by controlling for the age of female non-adoptors and the wives of male non-adoptors. Desire for additional children was the major reason for non-acceptance of family planning as reported by over two-fifth ( 42 per cent ) of the non-adoptors. The desire for either a male or female child constitute another 31 per cent. Nearly 10 per cent of the respondents have stated health reasons a few respondents being 6.2 per cent stated fear of adverse effects. Over 10 per cent of the respondents have stated some miscellaneous reasons.

It is worthwhile to examine the stated reasons for non-acceptance of family planning controlling for age of wives so as to gain some insight into the veracity of the responses. It is seen that among the younger respondents below the age of 25 a large majority of 57 per cent had stated desire for additional children for non-adoption of family planning. Interestingly among those stating the desire for a male child, the proportion being 30.9 per cent among the relatively older wives of 25-34 is higher than among the younger couples wives below 25 years of age ( 25.9 per cent ), however, the proportion stating this reason being 21 per cent was the lowest among older wives of 35 years or more. It is significant to note that, health reason and fear of adverse effects of family planning is more often stated by older respondents aged 25 or more than by younger respondents.

The analysis explicitly shows that a large majority of non-adoptors intend to further expand their family size and hence have refrained from accepting family planning.

#### 5.6 Future plans

Each of the non-acceptor was asked about his/ her future plan in respect of family planning. Table 5.8 presents the number and percentage distribution of non-acceptors by their willingness or otherwise to adopt a method of family planning classified by the number of living children.

It is seen from the Table that 174 or 71.6 per cent were willing to accept family planning in future, 43 or 17.7 per cent were unwilling to accept any method of family

in future while 26 or 10.7 per cent had not yet decided about future family planning.

It is seen from the Table that among the non-adoptors willing to adopt family planning in future a large majority of 71.3 per cent were willing to adopt sterilisation in future. A negligible proportion ( 2.9 per cent ) of them had stated that they would <sup>adopt</sup> a female temporary method. 25.8 per cent of non-adoptors were willing to adopt a method in future but they had not yet decided about the method to be adopted.

It is of considerable interest to examine the responses controlling for the number of living children. Among those who are willing to adopt sterilisation, the proportion increases with increase in the number of living children. For instance, the proportion of those willing to adopt sterilisation in future was 64.5 , 78.0 and 91.3 per cent respectively among those having two, three and four or more living children. Hardly 2.9 per cent couples were willing to adopt temporary methods. Among those willing to adopt a method of family planning in future but not decided about the method, a large number of them belonged to a small family size of two or less living children (32.7 per cent) followed by those having three living children (19.5 per cent ) and the least ( 4.3 per cent ) among those with a large family of 4 or more living children. It is further seen that among those non-acceptors whose future plan with regard to family planning had not yet crystalised, a large majority ( 84.6 per cent ) of them had a small family size of two or less living children.

43 or 17.7 per cent of the non-acceptors had stated that they were not willing to adopt family planning in future. Among them over 53 per cent were not willing because they had apprehensions about family planning methods and the remaining over 46 per cent did not specify any reason for their unwillingness to adopt a method in future.

The analysis clearly shows that a majority of the non-acceptors were willing to adopt a permanent method in future. A substantial proportion of non-acceptors who had not yet decided about the method, and those who had not yet decided about future plan of family planning had a small family size of two or less living children. The number of those who were not willing to adopt family planning in future was sizeable.

S u m m a r y

The mean age of non-acceptor wives including the wives of male non-acceptors was 25 years. The mean age of male non-acceptors and husbands of female non-acceptors was 31 years. Non-adoptors had on an average less than 3 live births and had 2.5 living children with a child loss of 14 per cent. Hindus and Muslims constituted the two predominant religious group among the non-adoptors. The size of the scheduled caste couples was sizeable.

Literacy was very low among wives than among husbands. Economically it was observed that there was a preponderance of well to do section among non-acceptors.

The knowledge of female sterilisation viz; tubectomy laparoscopy was nearly universal among male and female non-adoptors. The awareness of male sterilisation was generally much less among the respondents. However, it was observed that the knowledge of female temporary methods such as oral pills and IUD was substantial among both male and female non-adoptors.

Prior practice of contraception among non-adoptors was negligible and that a large majority of non-acceptors belonged to a highly fecund groups.

A large majority of non-adoptors still desire more children and hence have not yet adopted family planning in future and that a majority of willing respondents have favoured the adoption of sterilisation in future. However, a substantial proportion of non-adoptors who favour family planning in future have yet to decided about the method to be adopted. Less than one-fifth of non-adoptors were unwilling to adopt any method in future.



Table 5.1 : Number and percentage distribution of non-adoptors wives and husbands by Age.

Age - group	Wives		Husbands	
	No.	%	No.	%
15 - 19	24	9.9	-	-
20 - 24	111	45.7	8	3.3
25 - 29	70	28.8	92	38.3
30 - 34	24	9.9	80	33.3
35 - 39	14	5.7	37	15.4
40 - 44	-	-	16	6.6
45 - 49	-	-	7	2.9
T o t a l	243	100.0	240	100.0
Mean age	24.8		31.6	

For 3 husbands data was not available.

Table 5.2 (A) : Number and percentage distribution of Non-adoptors by Parity

Parity Size:	Male	Female	Total	%
0	49	53	-	-
1	120	89	56	23.0
2	42	45	72	29.6
3	19	31	45	18.5
4	10	19	31	12.8
5	3	3	22	9.1
6	-	3	6	2.5
7	-	-	3	1.2
8 +	-	-	8	3.3
T o t a l	243	243	243	
Mean	1.3	1.6	2.9	100.0

**Table 5.2 (B) : Number and percentage distribution of Non-adoptors by number of living children**

Living Children (Size)	No. of living children			
	Male	Female	Total	%
0	58	58		
1	132	96	67	27.6
2	35	42	80	32.9
3	9	37	52	21.4
4	8	6	26	10.7
5	1	3	7	2.9
6	-	1	3	1.2
7	-	-	4	1.6
8 +	-	-	4	1.6
<b>T o t a l</b>	<b>243</b>	<b>243</b>	<b>243</b>	<b>100.0</b>
<b>M e a n</b>	<b>1.1</b>	<b>1.4</b>	<b>2.5</b>	

Table 5.3 : Number and percentage distribution of non-acceptors by religion and caste, cultivated land holding and annual per capita income.

Characteristics	Number	%
<b>a) Religion &amp; Caste</b>		
Non-SC Hindus	144	59.3
Scheduled Castes	56	23.0
Muslims	36	14.8
Others	7	2.9
Total	243	100.0
<b>b) Cultivated land holding</b>		
No land	92	38.7
Below 5 acres	81	34.0
5 + acres	65	27.3
Total	238	100.0
Data N.A.	5	
<b>c) per capita annual income</b>		
Up to Rs. 401 - 400	10	4.3
" 401 - 600	30	12.8
" 601 - 1200	102	43.6
" 1200 +	92	39.3
Total	234	100.0
Data N.A.	9	

Table 5.4 : Number and percentage distribution of non-acceptor wives & husbands by education and occupation

	Wife		Husband	
	No.	%	No.	%
<b>a) Education</b>				
Illiterate	167	68.7	99	41.1
Primary	17	7.0	43	17.8
Middle	41	16.9	38	15.8
Above middle	18	7.4	61	25.3
T o t a l	243	100.0	241 <sup>+</sup>	100.0
+ 2 cases Data N.A.				
<b>b) Occupation</b>				
Not working or household work only	115	47.3	1	0.4
Cultivation	56	23.0	94	38.7
Agricultural and non-agricultural labour	48	19.8	57	23.1
Others	24	9.9	91	37.4
T o t a l	243	100.0	243	100.0

Table 5.5 : Distribution of non-acceptor by Knowledge of family planning method

Knowledge of F. P. methods	All		Male		Female	
	No.	%	No.	%	No.	%
Vasectomy	58	23.9	27	43.5	31	17.1
Tubectomy	242	99.6	61	98.3	181	100.0
Laparoscopic	193	79.4	39	62.9	154	85.1
I. U. D.	117	48.1	29	46.8	88	48.0
Oral Pills	96	39.5	22	35.5	74	40.9
Condom	56	23.0	36	58.1	20	11.0
Total non-acceptor	243		62		181	

Table 5.6 : Number and percentage distribution of non-acceptors by previous practice of family planning and reasons for discontinuation.

Methods practiced	Reasons for discontinuation				Total
	Method not convenient	Desired a child	Complaint or side effect	Not specified	
IUD	1	1	3	-	5
Oral pills	-	1	3	1	5
Condom	-	3	-	1	4
T o t a l	1	5	6	2	14

Number and percentage distribution of non-acceptor wives by age of the last living child at survey

Age of the last living child	No.	%
Less than one year	96	39.5
1 year	66	27.2
2 years	43	17.7
3 years	22	9.0
4 + years	16	6.6
T o t a l	243	100.0

Table 5.7: Number and percentage distribution of non-acceptors by reasons for non-acceptance of family method classified by age of wife.

Reasons	: Below 25		: 25 - 34		: 35 +		: All	
	No.	%	No.	%	No.	%	No.	%
Desired additional children	77	57.0	22	23.4	3	21.4	102	42.0
Desired a male child	35	25.9	29	30.9	3	21.4	67	27.6
Desired a female child	7	5.2	3	3.2	-	-	10	4.1
Health reasons	7	5.2	13	13.8	4	28.6	24	9.9
Fear of adverse effects	2	1.5	10	10.6	3	21.4	15	6.2
Others	7	5.2	17	18.0	1	17.1	25	10.2
	135	100.0	94	100.0	14	100.0	243	100.0

Table 5.8 - Number and percentage distribution of non-acceptors by their future plan for family planning, classified by the number of living children

Willing to adopt	:Two or less:		: Three :		:Four or more:		: All :	
	No.	%	No.	%	No.	%	No.	%
<b>a) <u>Willing to adopt in future</u></b>								
Willing to adopt sterilization of either partner	71	64.5	32	78.0	21	91.3	124	71.30
Willing to adopt female temporary methods	3	2.7	1	2.4	1	4.3	5	2.95
Willing to adopt but method not decided	36	32.7	8	19.5	1	4.3	45	25.85
<b>T o t a l</b>	<b>110</b>	<b>100.0</b>	<b>41</b>	<b>100.0</b>	<b>23</b>	<b>100.0</b>	<b>174</b>	<b>100.00</b>
<b>b) <u>Not willing to adopt Family Planning in future</u></b>								
Not willing because of adverse effects	3	20.0	7	77.8	13	68.4	23	53.5
Reasons not stated	12	80.0	2	22.2	6	31.6	20	46.5
<b>T o t a l</b>	<b>15</b>	<b>100.0</b>	<b>9</b>	<b>100.0</b>	<b>19</b>	<b>100.0</b>	<b>43</b>	<b>100.0</b>
<b>c) Not yet decided about future family planning</b>								
	22 (	84.6)	2 (	7.7)	2 (	7.7)	26 (	100.0)

The analysis shows that a large majority had registered for ANC either at public or private medical institution. Among those availing ANC a large majority had preferred PHC, PHU or other government hospitals.

#### 6.2 Number of times ANC received

Table 6.2 presents the number of times ANC received by those registering for ANC. It is seen that 68.2 per cent had received 1-3 ANC visits. Surprisingly over 10 per cent had not received any ANC visits inspite of registration.

Of 85 mothers registering for ANC 47 (55.3%) had received some advise on family planning and the remaining 38 had not received any advice (Table not given ).

The analysis indicates that although a large majority of those intending to avail ANC had received it. It was intriguing to note that some of these mothers had not received ANC inspite of registration.

#### 6.3 T.T. Immunisation

Table 6.3 presents the extent of TT immunisation among those receiving ANC. It is seen that 80 per cent of the mothers had received TT injection, over 7 per cent had not received TT and about 12 per cent had refused to take TT injections. Among those immunised against TT. Over 14 per cent had received one dose, about 25 per cent two doses and as high as 42.3 per cent had received 3 doses. Thus the analysis shows that the TT immunisation was not universal among those availing ANC.

#### 6.4 Birth attendant

Table 6.4 presents distribution of non-acceptors by attendant at birth given in the preceeding one year of survey. The data shows that over 73 per cent of births had occurred at homes of which 17 per cent were attended either by a trained Dai or by ANMs and the remaining 56 per cent were attended by either untrained Dais or by neighbours and relatives. Over 26 per cent of the deliveries had occurred either in government or private hospitals.

Out of 72 mothers delivering at home over 30 per cent had received post-natal care (Table not given ). The post-natal care included enquiry about the health of the mother and child.

The analysis shows that although majority of the deliveries were conducted by untrained personnel, the proportion of deliveries attended by trained personnel and doctors is substantial in the survey area.



6.5 (A) Immunisation of the children with DPT and Polio vaccines

Information on the immunisation status of the child born preceeding one year of survey against DPT and Polio was collected. The primary course of immunisation starts when the child is 6 weeks old. The triple immunisation consists of three doses to be administered to the child at an interval of 4 weeks. In the present study out of a total of 98 children, 12 children were less than 6 weeks old, 7 children were aged between 2.3 months, 36 children were in 4-6 months group and the remaining 43 children were 7 or more months old at survey. Thus it is seen that a total of 86 children who were 6 or more weeks old were eligible for triple immunisation. The status of immunisation controlling for the age of the child is given in Table 6.5.

As the recommended age for first dose of DPT and Polio is 6 weeks, and the interval between doses is 4 weeks, it is reasonable to expect that by the time the child reaches the third month, it should have received a minimum of two doses. It is seen from the Table that nearly 43 per cent of the children had received two doses. While 14 per cent had received one dose when the child was aged 3 months. The data shows that between 4-6 months the proportion getting the third dose of DPT and Polio being 25 per cent each is the largest while among children aged 7+ months a majority of them had received the third dose of DPT and Polio. However, it is seen that the proportion of children receiving either the first or the second dose was still considerable among children in the age-group of 4-6 months and 7+ months. Finally, the proportion of children not immunised against DPT being 38.3 per cent as against Polio being 30.2 per cent was substantially high.

The analysis shows that nearly one third of the children were not immunised against either DPT or Polio and that the data suggests that the process of immunisation for a large number of children started much later than the recommended age of immunisation being 6 weeks after birth.

B - Immunisation against BCG and Measles

BCG vaccine is administered to the child at any time after the birth while immunisation against Measles is done only after the child is past 9 months. It is seen from the Table 6.5 that 97 children were eligible to receive BCG vaccine, but the actual number receiving BCG was 61 of 62.9 per cent. As regards Measles there were 30 children who

were nine months or more old and thus eligible to receive immunisation against measles. It is seen that out of 30 children less than half of them being 46.7 per cent were immunised against Measles while a majority of over 53 per cent were not immunised.

#### 6.6 Knowledge of Oral Rehydration Therapy (ORT)

The ORT has emerged as a simple technique for diarrhoea management. The government is making all out efforts to popularise this technique so that mothers can make use of the technique in case the child suffers dehydration. The health workers and the mass media are expected to provide adequate information to mothers about ORT. A question was therefore asked to each of the mothers who had given birth preceding one year of survey about their knowledge of ORT. It is seen from Table 6.6 that over 80 per cent of mothers did not know about ORT. Of the remaining 20 per cent who reported knowledge of ORT, over 12 per cent had received the knowledge from health workers and only one respondent had learnt about ORT through mass media and the remaining 6 per cent had not specified the source of knowledge.

#### C - Practice of Breast and supplementary feeding to children

It is an established fact that the breast milk is the best for children upto 4 to 6 months of age. It is further believed that feeding of colostrum is good for health of the child as it provides necessary immunity against many diseases. The infant gets the colostrum only if it is fed on the day of it's birth. However, the traditional practice is to feed the infant after one or two days so as to avoid colostrum. It is in this context that mothers were asked about their breast feeding practices. Table 6.7 presents information on breast-feeding and supplementary feeding practices. It is seen from the Table that only 5.2 per cent had breast fed their children on the same day and the remaining nearly 95 per cent had started feeding their infants only after the second day of birth ( means third day or late ).

#### D - Supplementary feeding of solid food

It is expected during the first 4 to 6 months <sup>that</sup> ~~the~~ breast-milk alone is sufficient for the child and from them onwards supplementary food to be added for adequate growth of the child as it would be inadequate. It is seen from the Table that a substantial portion of children aged less than

6 months received supplementary feeding while a majority of children past 7 months had not received supplementary feeding. For instance, the data shows that the extent of supplementary food received by the children aged less than 3 months, 3-4 months and 5-6 months was 20.0%, 14.3 % and 28.6 per cent respectively while only less than half of the children ( 47.7% ) past 7 months were given supplementary feeding. As regards supplementary feeding to children aged 6 months or less it is important to note that it is likely to be supplementary liquids like she-buffalo or cow milk rather than solid food and that this supplementary feeding must have been out of inadequacy of breast milk. However, non-supplementary feeding to a large majority of children past 7 months show lack of awareness of the necessity of supplementing breast milk with solid food.

E - Care of the Expectant Mothers

This section deals with the antenatal care of the mothers who were pregnant at the time of survey.

Registration with government/ private dispensaries for ante-natal care

Distribution of currently pregnant women by place of registration for antenatal care by stage of pregnancy is given in Table 6.8. The table shows that there were 59 women who were pregnant at time of survey, and that ANC was available for 58 only. Out of these 58 women, 38 or 65.5 per cent of them had registered for antenatal care either at the government or private dispensaries. Among those registered for ANC over 44 per cent, had registered during the first trimester and 50 per cent had registered during the second and third trimester of pregnancy.

As regards the reasons for non-registration it may be noted that out of 20 currently pregnant women nearly 37 per cent or 7 of them did not know about ANC. 10.5 per cent stated that they did not register because health workers had not visited them. Nearly 16 per cent stated that they had not encountered any problem, while another 4 or 21 per cent reported that they propose to register at a later date etc.

F - Immunisation of the expectant mother against Tetanus Toxoid (TT)

Data was collected in respect of TT immunisation of currently pregnant women registering at government dispensaries only. The data is presented in Table 6.9 . Out of

31 women who had registered with government dispensaries as many as 14 women had duration of pregnancy less than 6 months and hence were not entitled to receive TT immunisation. It may be seen that out of the remaining 17 women over one third of them ( 35.2%) were not immunised against TT . Among those immunised, 47 per cent had received one dose and nearly 18 per cent had received two or more doses.

The analysis shows that nearly one third of pregnant women had not registered to avail ANC. Surprisingly, among registering with an intention to avail ANC a substantial portion were not immunised against TT.

### S u m m a r y

The utilisation of MCH services by the mothers who had given birth proceeding one year of survey showed that nearly three-fourth of them had registered either with government or private dispensaries for antenatal care; a large majority had however utilised the services of government dispensaries. Nearly 90 per cent of those registering for ANC were immunised against Tetanus Toxoid ( TT).

Three-fourth number of mothers had delivered at home while a little over one-fourth of them had delivered at government and private dispensaries. For a majority of mothers the birth attendant was a untrained person, however the number of deliveries being attended by trained personnel was sizeable.

Nearly one-third of children were not immunised against either DPT or Polio. A majority of children had received BCG vaccine and that immunisation against measles was found to be lagging behind.

Only one-fifth of the mothers had knowledge of Oral Rehydration Therapy, Breast-feeding habit continued to be traditional and that feeding of colostrum was not practiced by large majority of mothers.

Nearly two-thirds of the women currently pregnant had registered either with private or government dispensaries for ANC, majority of women had preferred government dispensaries for ANC. It was observed that among those registering for ANC, a substantial portion of women were not immunised against TT.

Table 6.1 : Status of Antenatal registration (for women who had given birth preceding one year of survey)

Status	No.	%
Registered with PHC, PHU and other govt. hospitals	65	66.3
Registered (with private Institute)	16	16.3
Not aware of registration but availed ANC from PHC	4	4.1
Not registered	13	13.3
<b>T o t a l</b>	<b>98</b>	<b>100.0</b>

Number and percentage distribution of non-acceptors by reasons for non-registration for antenatal care.

Reasons	No.	%
Health workers did not visit	8	61.5
No knowledge about registration	3	23.0
No specific reason stated	2	15.4
<b>T o t a l</b>	<b>13</b>	<b>100.0</b>

6.2 No. and percentage distribution of non-acceptors by number of antenatal checks ( ANC ) received

No. of ANC visits	No.	%
NIL	9	10.5
1-3	58	68.2
4 +	18	21.2
<b>Total (+)</b>	<b>85</b>	<b>100.0</b>

(+) Includes 16 cases who had availed ANC through private institutions  
FP advice received along with ANC

Table 6.3 : No. and percentage distribution of non-adoptors by No. of TT doses received by those receiving ANC and not receiving ANC

No. of TT doses	A N C received	
	No.	%
1	12	14.1
2	21	24.7
3	36	42.3
Not received TT	6	7.1
Refused avail TT	10	11.8
<b>T O T A L</b>	<b>85</b>	<b>100.0</b>

Table 6.4 : No. and percentage distribution by type of attendance at delivery

Delivery attendance	No.	%
<b>A- Home</b>		
ANM	10	10.2
Trained Dai	7	7.1
Untrained Dai	30	30.6
Relatives and neighbours	25	25.5
<b>B- Institutional</b>		
PHC, PHU and Head quarter hospital	14	14.3
Private hospital	12	12.2
<b>TOTAL</b>	<b>98</b>	<b>100.0</b>

Table 6.5:(A) - Number and percentage distribution of children by age (in months) on the level of immunisation against DPT and Polio.

Age of the child	D. P. T.			Not immunised	Total	P O L I O			Not immunised
	One dose	Two doses	Three doses			One dose	Two doses	Three doses	
2 - 3 months	1 (14.2)	3 (42.9)	-	3 (42.9)	7 (100.0)	1 (14.2)	3 (42.9)	-	3 (42.9)
4 - 6 "	5 (13.9)	7 (19.4)	9 (25.0)	15 (41.7)	36 (100.0)	6 (16.7)	7 (19.4)	9 (25.0)	14 (38.9)
7 + "	2 (4.7)	4 (9.3)	22 (51.2)	15 (34.9)	43 (100.0)	7 (16.3)	4 (9.3)	23 (53.5)	9 (20.9)
<b>T o t a l</b>	<b>8 (9.3)</b>	<b>14 (16.3)</b>	<b>31 (36.0)</b>	<b>33 (38.3)</b>	<b>86 (100.0)</b>	<b>14 (16.3)</b>	<b>14 (16.3)</b>	<b>32 (37.2)</b>	<b>26 (30.2)</b>

Table 6.5 - (B) I : Immunisation against BCG and Measles

	B. C. G.			Measles	
	Number	Percentage		Number	Percentage
Received BCG Vaccine	61	62.9	Immunised	14	46.7
Not received BCG	36	37.1	Not immunised	16	53.3
<b>T o t a l</b>	<b>97</b>	<b>100.0</b>	<b>T o t a l</b>	<b>30</b>	<b>100.0</b>

Table - 6.6 : Distribution of mothers by source of knowledge about oral rehydration

Source of knowledge	No.	%
Mass media	1	1.0
Health workers	12	12.4
Source not specified	6	6.2
No knowledge of oral rehydration	78	80.4
<b>T O T A L</b>	<b>97</b>	<b>100.0</b>
Data N.A.	1	

Table 6.7 (A) Distribution of mothers by breast feeding

Time of breast feeding after the birth of child	No.	%
Started within 12 Hrs. of birth	5	5.2
After one day	--	--
After two days	9	9.4
After three days	27	28.1
After for ormore days	55	57.3
<b>TOTAL</b>	<b>96</b>	<b>100.0</b>
Data N.R	1	

Table 6.7 (B) Practice of supplementary feeding

Commencement of supplementary feeding by the age of infant	Total children	No. given supplementary feeding	% getting supplementary feeding to total
Within 3 months	10	2	20.0
3- 4 months	14	2	14.3
5-6 months	28	9	28.6
7+ months	44	21	47.7
<b>TOTAL</b>	<b>96</b>	<b>33</b>	<b>34.4</b>
Data N.A.	1		



Table 6.8(A): Distribution of currently pregnant women by place of registration for ante-natal care

Stage of pregnancy	: Regd. at Govt. Instn.		: Regd. with private hospital		: T o t a l	
	No.	%	No.	%	No.	%
Ist trimister	12	38.7	5	71.0	17	44.7
IIInd and IIIrd trimister	17	54.8	2	29.0	19	50.0
Stage of pregnancy not specified	2	6.5	.-	--	2	5.3
TOTAL	31	100.0	7	100.0	38	100.0
Not registered					20	
Gr. total					58	
DATA N.A.					1	

Table - 6.8(B) : Reasons for not registering for ante-natal care

R e a s o n s	No.	Percentage
No knowledge of ANC	7	36.8
Health workers have not visited us	2	10.5
Propose to register	4	21.1
Not encountered any problem	3	15.8
Others	3	15.8
Total	19	100.0
Data NA	1	

Table 0.9 : Distribution of currently pregnant women registered with government dispensaries by the nature of ante-natal care received

TT Immunisation	No.	Percentage
1	8	47.1
2	2	11.8
3	1	5.9
Not immunised	6	35.2
TOTAL	17	100.0
Not applicable (Duration of pregnancy is less than 6 months )	14	
Grand total	31	

Summary Findings and Policy Implications

1. An evaluation of the family welfare programme in Belgaum district of Karnataka was conducted by Population Research Centre, JSS Institute of Economic Research, Dharwad. A total of 485 cases ( 251 sterilisation and 214 IUD cases ) who had adopted the method during 1988-89 were listed from the four selected PHCs. Among the cases listed all sterilisation cases and 90 per cent of IUD cases were found to be genuine. Of the genuine cases 251 cases (Tubectomy 115, Laproscopy 40 and IUD 96 ) were contacted and interviewed. Further 243 non-adoptors with wives in the reproductive age group of 15-44 and having atleast one living child at survey were also covered.

2. Demographic Characteristics of Adoptors

The mean age of sterilisation adoptors 25.4 years and that of IUD adoptors was 22.6 years. The adoptors of sterilisation had on an average of 4.1 live births and 3.4 living children at adoption, while IUD adoptors had 2.1 live births and 1.8 living children. Among the ~~XMB~~ adoptors of sterilisation, hardly 15.5 per cent had a small family of two or less living children and even among young adoptors ( 15-24 age group ) it was only 27 per cent. Nearly 24 per cent of sterilisation adoptors and 11 per cent IUD adoptors had experienced atleast one child loss.

The data on age of the adoptor as per registration data tallied with that of the survey data only in 7 per cent of the cases. In respect of 64 per cent of cases, the age stated in the register was higher than ~~obtained~~ in the survey, while in respect of 27 per cent of cases the age stated in the register was lower than that obtained in the survey. For over 58 per cent of cases, the age difference ranged from 3 to 5 years and for another 33 per cent cases it was only 1-3 years. It was observed that the age of younger women of 15 -24 years was invariably overestimated and that of older women of 25+ years was largely underestimated.

With regard to the number of living children, it was observed that in over 88 per cent of cases, the number of living children stated in the register tallied with the data obtained in the survey. Discrepancy in the number of living children was observed in respect of 12 per cent

## F O R E W O R D

The Government of India set up a Demographic Research Centre in the Institute in the year 1961. Since then, a series of studies in the fields of demography and family planning are being undertaken by the Demographic Centre of the Institute.

The first study undertaken by our Centre in Dharwar town in 1962 to assess the knowledge, attitude and practice of family planning showed that the family planning idea had yet to catch firm roots among the people of the Dharwar area. But the resurvey in 1969 revealed some encouraging results. There was enormous increase in the awareness and knowledge (89 per cent) of family planning.

Dharwar town happens to be the centre of education and culture of northern-Karnatak (Mysore). It was therefore thought worthwhile to study the knowledge and practice of family planning among High School Teachers in Hubli-Dharwar Municipal Corporation area of Mysore State. A survey was accordingly conducted in 1971.

Almost 100 per cent of teachers were aware of family planning. In all, 35 per cent of male teachers and 61 per cent of female teachers with knowledge of family planning were practising it.

The report is based on the data collected through personal interview method. The study was conducted by a team headed by Shri. A.P. Katti. I am happy that the team has done a good job.

I hope the study will be found useful by all those who are interested in the field of family planning.

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DIRECTOR

28th September, 1973

of tubectomy, 10 per cent of laproscopy and 13 per cent for IUD acceptors. The difference was largely 1 child on the higher side and 1 to 2 children on the lower side, in respect of sterilisation cases, while for IUD cases difference was 1 to 2 children on either side.

3. Socio-economic characteristics of adoptors

Among the sterilised 60 per cent belonged to caste Hindus such as Brahmin and Lingayat, 18 per cent scheduled castes and over 19 per cent Muslims. The corresponding figures for IUD were 57 per cent, 18 per cent and 19 per cent. The proportion of illiterates was higher ( 75 %) among sterilised females than among IUD adoptors (52%). As regards the type of family of the acceptors it was observed that the proportion of sterilised females belonging to nuclear households was higher ( 68%) than among the adoptors of IUD ( 52 %). The rest of the adoptors belonged to joint family households. The proportion of households not cultivating land being 47 per cent was higher among adoptors of IUD than among the sterilised ( 32 %). The proportion of households with a per capita annual income of more than Rs. 1200 was higher ( 49.4%) among IUD adoptors than among the sterilised ( 33 %).

4. Reasons for accepting family planning

Two important reasons were stated by over 70 per cent of adoptors for adopting sterilisation, viz., (a) did not desire any more children and (b) finding it difficult to maintain a large family. Among those who stated these reasons, a large majority had 3 or more living children. Child care problems was stated by over 13 per cent of the acceptors. Surprisingly, just about 4 per cent had stated that they adopted sterilisation as they desired a small family of two children.

Among the IUD adoptors, 82 per cent adopted it for purposes of spacing while six per cent adopted on a permanent basis.

As regards preference for the method adopted, it was observed that a majority of the adoptors had no real choice as they were either ignorant of other family planning methods or told only about the method they had adopted.

5. IUD continuation rate

More than half of the IUD adoptors were using the device at survey. All those who had discontinued the device had used it for less than a year. Among those who continue to use the device at survey, over 53 per cent of them were using it for more than one year.

6. Complaints / side effects and follow-up service

A sizeable number of adoptors ( 41 %) had experienced complaint / side effect due to adoption of the method. However, the proportion experiencing a complaint at survey amongst the sterilisation adoptors being 34 per cent was much higher than among the IUD adoptors being 3.1 per cent. As regards the nature of complaint, it was mostly back and waist ache for sterilised females and white discharge for IUD adoptors. Majority of the adoptors had availed treatment from government dispensaries like PHC, and PHU.

Barring a small proportion all adoptors were visited at their home by male and female health workers. A large majority of adoptors were visited within a week of adoption of the method. The service of female health workers was much higher than that of male health worker. Almost all adoptors were satisfied with the follow-up care extended.

7. Non-acceptors: Knowledge of Family planning methods, reasons for not practicing Family Planning and utilisation of MCH services

In this study, a non-acceptor couple is a currently married couple with wife in the age-group of 15-44 years, having atleast one living child and not using any family planning method at survey. The respondent for interview was either the husband or the wife who was readily available at the time of visit of the Investigator. Of the 243 non-adoptors covered 181 ( 74 per cent ) were females and the remaining 62 ( 26 per cent ) were males.

The mean age of female respondents was 25 years and that of the male respondents was 31 years. The non-adoptors covered 82 per cent were Hindus ( 59 % caste Hindus and 23 per cent SCs ). Nearly two-fifths of the non-adoptors were from landless households while more than one-fourth belonged to households cultivating more than 5 acres of land. Nearly 44 per cent of non-adoptors were drawn from

with per capita income of over Rs. 1200/- per annum. About 68 per cent of wives and over 41 per cent of husbands were illiterates.

The knowledge of Tubectomy was universal both among male and female respondents. The knowledge of laparoscopy was also high ( 79 per cent ) but knowledge of vasectomy was far low ( 23 %). The knowledge of female temporary methods like oral pill and IUD was fairly high among male and female respondents; 40 per cent and 35 per cent respectively. Prior contraceptive practice was negligible among non-acceptors.

As regards reasons for non-acceptance of family planning over two-fifths of the non-adoptors ( 42%) desired additional children and another 31 per cent desired either a male or a female child. Health reasons and adverse effect of family planning methods was stated by over 16 per cent of the respondents. A majority of non-acceptors were willing to adopt a permanent method of family planning in future.

8. Utilisation of MCH services by non-acceptors

Among the non-adopter couples covered 40 per cent had given birth to a child during the one year period preceeding survey and 24 per cent were pregnant at survey. It is to be noted that though the MCH aspects are more specific to females, if the schedule was administered to a male respondent, he continued to be the respondent for this section as well and no attempt was made to analyse this section with respect to the sex of the respondent.

Among those who gave birth to a child during the one year period preceeding the survey over 83 per cent had registered their name in any health institution for ANC. Those who had not registered/<sup>reasoned</sup> that they had no knowledge of the availability of ANC services ( 23 %) and health workers not visiting them for ANC (61 %).

Among those who registered their names for ANC as high as 88 per cent had received atleast one dose of TT; 74 per cent of them atleast two doses. Among those not receiving ANC over 55 per cent had refused to avail TT facility.

Out of 98 deliveries reported to have taken during the year period preceeding the survey, 74 per cent had

taken place at home and 26 per cent at government and private dispensaries. A majority of 56 per cent deliveries were conducted by untrained personnel.

As regards child immunisation it was observed that 38 per cent of the children were not immunised with DPT and 30 per cent with polio vaccines. However, a little over one-third had received the DPT and Polio vaccine each three doses. Over 68 per cent of the children had received BCG vaccine, and 47 per cent were immunised against Measles.

Colostrum feeding was not known to most mothers and sizeable number of children who had crossed 6 months were not yet initiated supplementary feeding.

As regards pregnant mothers at survey, over 65 per cent had already registered for antenatal care and among these eligible for TT immunisation nearly 65 per cent were immunised.

#### Policy implications

1. The field verification of the sterilisation and IUD cases listed from the sample PHCs showed that all the cases of sterilisation were found to be genuine while 15 per cent of the cases of IUD were found to be not genuine adoptors. As large number of IUD insertions are done by paramedical staff, greater vigilance by the supervisory staff appear to be a must to avoid fictitious IUD cases.

2. It was observed that the grass root level programme personnel are in the habit of manipulating the information on the age of acceptors perhaps to ensure the so called quality of acceptors. This is wholly unwarranted in the context of the avowed policy of Family Planning programme to extend service to all eligible couples. The medical officers of the PHCs need to be oriented in this regard since they happen to be key personnel who can remedy the situation.

3. The evaluation study clearly shows that now-a-days even young couples are coming forward to accept family planning but they do so only after achieving a large family of 3 or more living children. Thus the promotion of Family Planning among young couples seem to be not a major factor but make them to accept family planning before they expand their family size is the real task. So, couples should be motivated to adopt a spacing method <sup>as</sup> soon as they



had their first child. It is believed that once the habit of contraception starts quite early in the reproductive life, couples would be tempted to have a small family either by continuing with the temporary method or by adopting a terminal method.

4. The socio-economic characteristics of the acceptors indicate that generally the adoptors are drawn from households of all socio-economic levels and this clearly implies that the programme can be vigorously implemented among all sections of the society irrespective of their social and economic standing.

5. Laparoscopy had the highest failure rate in the survey area and hence this needs to be looked into on a high priority basis.

6. A large number of adoptors were not subjected to premedical check-up before being sterilised or inserted with IUD. There is need to ensure proper screening of the clients volunteering for family planning especially IUD. Studies have shown that the IUD retention rate is often low because for a large number of acceptors the device is not suitable (Bhatia 1989) and hence they drop out the method early. In order therefore to prevent early dropouts a thorough medical checkup of the prospective cases for IUD insertion is a must.

7. A large number of acceptors reported complaint or side effects due to adoption of family planning method in spite of the fact that almost all adoptors were visited by the health workers soon after the adoption. The only inference that can be drawn is that follow-up visits were made but they were only casual visits without proper drugs and medicines. Therefore in order to ensure effective care the grass root level health workers should be provided with enough medicines to meet any eventualities in the field.

8. Knowledge of Tubectomy and laparoscopy is almost universal among non-acceptor couples. Sadly vasectomy which is relegated to background should receive the due attention it deserved in view of the simplicity of the operation and which incidentally does not involve hospital confinement. Knowledge of female temporary methods like oral pills and IUD was substantial. Efforts in this direction need to be further accelerated so that more and more women take to temporary methods.

9. The small family norm has not yet caught the imagination of the couples as was evidenced by the attitude of acceptors and non-acceptors towards family planning . 85 per cent of sterilised couples had adopted the method after having 3 or more living children while a majority of non-acceptors had stated that they intend to expand further their family size. Thus the study indicated that the desired family size was above the replacement level fertility. This is the major hindrance for the programme personnel and hence efforts should be directed to achieve a break through so that couples realise the advantages of a small family. Educational and motivational aspects of the programme should be given their due place of importance. The vicious circle of the idea of a large family can be broken only by means of constant persuasion of the couples to adopt small family norm.

10. Utilisation of MCH services by non-acceptors who had given birth preceding one year of survey and those who were pregnant at the time of survey was high. However, this is not matched by higher adoption rate. This implies that integration of family planning with MCH services has not yielded due fruits. This calls for the review of the functioning of family planning programme. Medical officers of health and family planning manning PHCs should ensure dissemination of family planning information to all those availing maternal services through para-medical staff who directly interact with the couples.

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Rho/Sum.