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CURRENT EVALUATION OF FAMILY WELFARE PROGRAMME IN BELGAUM DISTRICT (KARNATAKA STATE) 1982-83

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P R E F A C E

In order to monitor the ongoing family welfare programme, evaluation studies were initiated by the Ministry of Health and Family Welfare, Government of India way back in 1976. Since then the Population Research Centre of the Institute of Economic Research, Dharwad has been taking up evaluation of family welfare programme every year in one of the districts of the State. The present study is the sixth in the series of evaluation studies carried out in Belgaum district for the year 1982-83.

The study attempts to have first hand evaluation of the working of the programme. The report is divided into three Chapters. The first chapter is introductory which highlights the characteristics of the district and also provides the details of the methodology of the study. The second chapter gives the survey results relating to the performance of the family planning programme. The third chapter deals with communication, health and family welfare aspects. At the end the summary conclusions and policy implications are given.

I appreciate the services of Shri A.P. Katti former Deputy Director of the Population Research Centre who designed the study and initiated it. The major credit of the study is attributable to the field and tabulation staff for whatever merit this exercise may posses. In this connection I am happy

to place on record the services rendered by Shriyuts L.V.Talwai, A.S. Kulkarni, G.C. Jadar, R.M. Joshi, R.V.Deshpande and Smts. L.R. Savanur, P.R. Hukerikar and Chaya Gokhale. My thanks to Shri R.H. Onkar for neat typing of the report. My thanks are due to Dr. Krishnamoorthy the Director and Dr. P.M. Kulkarni the Deputy Director of the Population Research Centre who went through the first draft and made valuable suggestions.

I express my gratitude to District Health Officer, Belgaum District and Medical Officers of the selected Primary Health Centres and all other Health and Family Welfare personnel who supported the study. Thanks are also due to the respondents whose support we enjoyed through out the field work.

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C O N T E N T S

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CHAPTER I:

INTRODUCTION

This current evaluation of acceptors and non-acceptors in Belgaum district of Karnataka State is the sixth in the series of current evaluation of family welfare programme undertaken by the Population Research Centre of the Institute of Economic Research, Dharwad. The reference year of the study is; acceptors in the financial year 1982-83. Monitering the on going family welfare programme is the main objective of this current evaluation study.

Belgaum district is located in the northern part of the State bordering Maharashtra. According to 1981 census the district population was 2.97 million. The proportion of urban population of the district was 22.6 per cent. The district has 10 talukas/tehasils. As per the integrated index of development the district falls under the category of developing area.[1] Eighteen per cent of the sown area is irrigated. The district ranks second in terms of the number of factories. The district is experiencing a shift from rural to urban and from agricultural to non-agricultural occupation signaling the beginning of rural non-agricultural and urban industrial development.[2]

The Primary Health Centres (PHC) being the nodal points in the delivery of family planning services at the grass root level to the rural population; the district's entire rural population is served by 25 PHCs.

As for the family planning (FP) performance wwithin the district during the reference period of the study, the following observation can be made. In respect of Tubectomies the achievement of 76 per cent of the total annual targets was the same as that of the State. However, in respect of IUD insertions the district with only 40 per cent achievement lagged much behind the State's achievement of over 67 per cent of the total annual targets.

The Family Planning work in the rural areas of the State appear to be greatly handicapped by the insufficiency of the FP staff. The State level figures in respect of required staff and staff on position show that in the rural areas the insufficiency [3] was conspicuous amongst the grass root level FP workers. For instance, in respect of lady health visitors, Auxilory Nurse Midwives and Family Welfare Health Assistants, the insufficiency was 29 per cent, 40 per cent and 54 per cent respectively. The insufficiency in respect of medical officers and block level extension educators was 15 per cent each.

OBJECTIVES OF THE STUDY ARE

i) To study individual and household socio-economic and demographic characteristics of acceptors and non-acceptors.

ii) To evaluate the family planning services rendered to acceptors.

iii) To know the reasons for acceptance and non-acceptance.

iv) And finally to ascertain the genuineness of the cases of acceptors.

AREA OF THE STUDY

The State is divided into four main administrative revenue divisions viz; Bangalore, Mysore, Belgaum and Gulburga. The Population Research Centre, Dharwad is located in the Belgaum revenue division which comprises four districts viz; Dharwad, Belgaum, Bijapur and North Kanara. It was therefore decided to take up for evaluation all the four districts of the division one after the other spread over a period of four years. As a result the evaluation of FP programme was already carried out in Dharwad during 1980-81 and North Kanara during 1981-82. The present study is the third to be undertaken in Belgaum district during 198283.

The study refers to rural areas only. From within the district two PHCs with best performance were selected and they are Kagwad and Kakkeri. Detailed PHC wise performance is given in Table 1.2 . It may be noted from the Table that Kagwad and Kakkeri respectively being the 1st and IInd in the order of rank were selected for study purpose.

As quota sampling technique was resorted, a few villages within the selected PHCs with the concentration of a large number of acceptors were selected so as to fulfill the quota of 200 acceptors. Three villages from Kagwad PHC and two villages from Kakkeri PHC were finally covered.

As the quota for acceptors and non-acceptors was the same a total of 400 interviews were contemplated.

There were as many as 2783 acceptors in the two selected PHCs of which 2024 (73 per cent) were tubectomy acceptors and the remaining 759 (27 per cent) were IUD acceptors. It was therefore decided to cover 73 per cent of tubectomy acceptors out of the quota of 200 acceptors to be interviewed and the remaining were to be drawn from within IUD acceptors. Acceptors and non-acceptors were drawn from the same villages. The acceptors list was prepared from the list of acceptors for the accounting year 1982-83 provided by PHC while non-acceptors. The details of coverage are given in Table 1.3 .

DATA COLLECTION

Two separate structured questionnaires were designed one meant for acceptors and the other for non-acceptors.

An experienced field staff consisting of male and female interviewers conducted the field work from mid September to mid October, 1983.

Surprisingly there was not a single case of nonresponse.

TABLE 1.1 A PERFORMANCE OF FAMILY PLANNING PROGRAMME IN THE STATE, BELGAUM DISTRICT AND SELECTED PRIMARY HEALTH CENTRES DURING 1982-83

Area	Tubectomy	% of target coverage	IUD	% of target coverage
+ Karnataka state	232,966	76.0	68,750	67.4
+ Belgaum district	18,622	76.0	4,740	40.0
@ Kagwad PHC	1,326	NA	447	NA
@ Kakkeri PHC	698	NA	312	NA

Source + Monthly bulletin of family welfare programme, Karnataka State, March,1983.

@ Acceptors list prepared from PHC registers.

NA Not available

TABLE 1.1B LITERACY AND OCCUPATION;REVEALED BY 1981 CENSUS

	Rural	Urban	Total
1. Population (000)	2,309	671	2,980
2. Literacy rate	30.7	56.2	36.4
3. Main workers as percent of total population	37.9	29.5	36.1
4. (a) Cultivators	52.5	13.5	45.3
(b) Agricultural labourers	29.6	9.8	26.0
(c) Workers in household industry	4.0	8.6	49
(d) Other workers	13.9	68.1	23.8
	100.0	100.0	100.0

4 abcd as percent of total main workers

TABLE 1.2 FAMILY PLANNING PERFORMANCE OF PHCs 1982-83 IN RANK ORDER BELGAUM DISTRICT

Rank	PHC	No. of acceptors per 1000 population
1	Kagwad	12.89
2	Satti	11.49
3	Kakkeri	11.49
4	Aigali	9.55
5	Akkiball	9.54
6	Kanagali	8.98
7	Kabbur	8.90
8	Benadi	8.32
9	Hargeri	7.84
10	Hoskoti	7.61
11	Nandagad	7.47
12	Hosur	7.45
13	Bagewadi	7.43
14	Mudalagi	6.80
15	Ammeragi	6.80
16	Daddi	6.78
17	Uchagaon	6.78
18	Sadalga	6.70
19	Karadagi	5.73
20	Yargatti	5.60
21	Kittur	5.58
22	Nagnoor	5.05
23	Raibag	4.82
24	Kuligod	4.79
25	Sureban	1.58

TABLE 1.3 DETAILS OF COVERAGE OF FAMILY WELFARE ACCEPTORS IN THE SAMPLED PRIMARY HEALTH CENTRES (PHC) OF BELGAUM DISTRICT

PHC	Villages	Total number of acceptors		Number of acceptors covered		Total	No. of non-acceptors covered
		Tubectomy	IUD	Tubectomy	IUD		
Kagwad	Anantpura	46	55	24	18	42	42
	Ugarkhurda	63	20	38	9	47	48
	Kagwad	55	27	34	5	39	38
	Sub total	164	102	96	32	128	128
Bakkeri	Itigi	41	26	30	13	43	42
	Bidi	24	16	20	9	29	30
	Sub total	65	42	50	22	72	72
	Grand total	229	144	146	54	200	200

TABLE 1.4 DETAILS OF SAMPLE

PHC	Population served by PHC in 000	Family planning acceptors		Total	Sample of acceptors		Total	Sample of Non-acceptors
		Tubectomy	IUD		Tubectomy	IUD		
Kagawad	138	1326	447	1773	96	32	128	128
Kakkeri	88	698	312	1010	50	22	72	72
Total	226	2024	759	2783	146	54	200	200

CHAPTER II

SURVEY RESULTS

There were 229 tubectomy acceptors and 144 IUD acceptors in the sampled villages; vasectomy, oral pill or acceptors of other conventionals were not found in the sampled villages. Female sterilisation account for preponderant proportion of the acceptors. The male methods have been almost relegated to the back ground. The entire clientele thus constists of females only which is indicative of greater demand for female methods like IUD, Tubectomy etc. . The post emergency period is marked by the increasing popularity of female methods specially tubectomy. Compulsions or coercion that was imposed during the period of emergency year was directly responsible for the back lash from which the Fp programme is still suffering. While the drive of emergency is believed to be responsible for a less acceptability of vasectomy in the recent periods it seems to have increased the acceptability of tubectomy (Khoo, 1980; Shrinivasan, 1979; Visaria and Visaria, 1981).

AGE

Of the questions on family planning acceptance the most crucial for its impact on fertility is the one that relates to the stage in the process of family building activity at which Fp is accepted. In this regard the age of the acceptor is an important attribute that needs careful consideration. Column 2 of Table 2.1 A shows that there is a

concentration of tubectomy acceptors in the age group of 25-34 years. As high as 65 per cent of tubectomised women were found in this age category. It is interesting to note that the representation of acceptors in the age group of 20-24 being 18.5 per cent is sizeable. The median age of tubectomy acceptors is 28.5 years. Assuming that a woman remains fecund till her age of 44, the protection from the risk of pregnancy an average woman accepting tubectomy gets is 15.5 years. However the important snag is that within the reproductive span these person years like generally in a phase of receeding fecundity. The impact of acceptance on fertility therefore cannot be expected to be very large.

A comparison of median age of tubectomised and IUD acceptors show that IUD acceptors were comparatively younger by over four years. More than half of the IUD acceptors (57 per cent) belonged to the younger age category of 15-24 years. However it is intriguing to note that out of 54 IUD acceptors as many as ten were in the older age category of 30 years and above.

A comparision of the age distribution of tubectomy acceptors and female non-acceptors shows that obviously in the younger age group of 15-19 years. The female non-acceptors were more being 10.5 per cent as against 14 per cent of tubectomised women. It is significant to note that the

proportion of tubectomised women and female non-acceptors in the peak reproductive period (20-29 age group) was the same being 60 per cent. In the older age group of 30 years and above the tubectomy acceptors were 36.9 per cent while famale non-acceptors of the same age category were sizeable being 28.7 per cent.

A comparison of IUD acceptors and female non-acceptors shows that while 57.5 per cent of IUD acceptors are in the younger age group of 15-24 years. There are only 45.4 per cent of female non-acceptors in this age group. The proportion among IUD acceptors and among female non-acceptors in the age group of 25-29 were 34.1 and 25.9 per cent respectively. These indicate that IUD users are generally younger than non-acceptors.

A comparison of the pattern of age distribution of husbands of tubectomised women and male non-acceptors show that the former in the average were older by five years than the latter. However the age difference between husbands of IUD acceptors and male non-acceptors were marginal.

Number of living children at the time of acceptance of FP method is another important measure of the impact of FP on fertility. Table 2.2A gives the distribution of acceptors by number of living children. It may be noted that the mean number of living children to tubectomised women being 3.8 was

higher than the mean number of children living to IUD acceptors being 2.1. For the tubectomised women the number of surviving sons being 2 was slightly higher than the number of surviving daughters; 1.8. This is an indication that two surviving sons at the time of acceptance was the general norm. It is also worth noting that the distribution of tubectomy acceptors by male living children is concentrated around two living male children and that the distribution according to number of living daughters was relatively spread.

Table 2.2B gives the distribution of non-acceptors by the number of living children. Non-acceptors with an average of 2.6 living children belonged to lower parity group as compared to tubectomised for whom the mean number of living children is 3.8. On the other hand compared to IUD acceptors non-acceptors had slightly higher number of living children. By and large acceptors are largely drawn from higher parity.

Is it the presence of male or female children which facilitates the acceptance of family planning ? We have tried to examine this in view of the fact that desire for children means desire for both male and female children. The data in respect of those tubectomised alone is examined since Tubectomy happens to be a once for all method. Table 2.3 gives the distribution of tubectomised women by religion and number of daughters. In the last column of the Table the mean of sons are given for each category. It may be noted that there

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is a concentration of acceptors belonging to the three main religious denominations viz; Hindu, Muslims and Jains with one, two and three living daughters. All these acceptors, irrespective of the number of daughters they have, have accepted the terminal method on fulfilling their desire of having at least two living sons. In respect of the remaining 16 acceptors with four and five living daughters, it is likely that their families got expanded in their attempt to have at least two male children. Ultimately they might have accepted tubectomy due to economic compulsions. It is thus evident that it is the presence of two sons that tilts the balance in favour of acceptance. There is also a corresponding evidence that presence of daughters in the family too makes a difference in facilitating family planning acceptance. For example, those with no living daughters account for only 15.7 per cent.

LITERACY

Table 2.4A gives the distribution of acceptors (column 1 and 2) and female non-acceptors (column 4) by their educational level and in part "P" of the same Table the distribution of husbands of acceptors (Columns 1 and 2) and male non-acceptors (Column 4) by their educational level are given.

It may be noted from Table 2.4A that the prevalance of illiteracy was overwhelming being 69.9 per cent both among

tubectomy acceptors and female non-acceptors and the incidence of illiteracy being 57.4 per cent among IUD acceptors was much less than among other two categories. The proportion of literates below secondary school final among tubectomy and IUD acceptors and female non-acceptors was 27.4 per cent, 27.7 per cent and 23.1 per cent respectively. The proportion of those educated upto secondary school final and above was the highest being 14.8 per cent among the IUD acceptors when compared to 2.0 per cent among tubectomised and 7.0 per cent among female non-acceptors.

By and large the data suggests that education had had no influence in the acceptance of tubectomy. In respect of IUD acceptance literacy had had exerted considerable influence.

Similarly when we consider the education of husbands of respondents (Table 2.4B) the patteern of distribution is almost the same as was among the wives. For instance the number of illiterate being over 40 per cent was substantial among husbands of tubectomy acceptors and male non-acceptors while it was lower being 31.5 per cent among husbands of IUD acceptors. The proportion of those educated upto secondary school final and above was the highest being 35.1 per cent among the husbands of IUD acceptors as compared to 13.7 among the husbands of tubectomised and 22.1 per cent among male non-acceptors.

OCCUPATION

Table 2.5A gives the occupational distribution of acceptors and female non-acceptors. Table shows that a substantial portion of accepting clientele and female non-acceptors were not gainfully working. The proportion of not working among acceptors and non-acceptors was 64 per cent and 68 per cent respectively. This is presumably because both acceptors and non-acceptors were females. The data in respect of those working on family farm and those working as agricultural labourers among acceptors and non-acceptors shows only marginal difference. For instance the proportion of acceptors and non-acceptors engaged in agriculture (this includes both working on family farm and agricultural labourer) was 25.5 (column 3) per cent and 27.3 per cent (Column 4).

Table 2.5B gives the occupational distribution of husbands of tubectomised women and IUD acceptors. The proportion of husbands of tubectomised women and IUD acceptors engaged in agricultural sector both as cultivators and as agricultural labourers was 41.8 and 42.8 per cent respectively. More than half of the husbands of acceptors were drawn from non-agricultural sector. It is therefore likely that the prepondarance of non-agricultural occupations many at best be the reflection of the occupational distribution of the people in the area.

The occupational distribution among acceptors and non-acceptors show that in the agricultural sector the acceptors being 42 per cent (Column 3) were less than the non-accepors being 49.5 per cent (column 4).

RELIGION AND CASTE

In the foregoing paragraphs we have examined the individual characteristics of acceptors and in the paragraphs to follow, we intend to examine the family or the household characteristics to ascertain which of the two had greater influence on acceptance.

Among the family characteristics, we first take up the religion and caste. Table 2.6 gives the distribution of acceptors and non-acceptors by religion and caste. Four main religious denominations of Hindus, Muslims, Christians and Jains can be identified from the Table. Among all the acceptors Hindus constitute over 79 per cent, Muslims 15 per cent, Jains 5 per cent and Christians are negligible being less than one per cent.

It is to be noted that among acceptors the Hindus being 79 per cent are less than among non-acceptors (83 per cent). Among acceptors the proportion of Jains and Muslims being 5.5 per cent and 15 per cent respectively exceed the corresponding percentages among non-acceptors being 3.5 and 11.5 per cent.

The data in respect of the rate of acceptance among the various Hindu caste groups shows certain interesting trends. For instance among acceptors the very advanced Hindu caste groups viz; Brahmins and Lingayats (64) were less than among non-acceptors (72). On the contrary among acceptors the backward group viz; scheduled caste and scheduled tribes are 51 while among the non-acceptors they are 50. The other advanced Hindu caste groups are represented by 43 among acceptors and 45 among non-acceptors; the difference being marginal.

The excess of acceptors over non-acceptors can be taken as an indicator of the propensity to accept family planning. In this sense the two important minority groups viz; Muslims and Jains have shown a greater propensity to accept family planning than their Hindu counterparts. It is gratifying to note that the proportion of acceptors and non-acceptors among the Hindu scheduled caste was the same.

The family characteristics taken next for consideration is the economic position of household. Table 2.7 gives the distribution of acceptors by their annual household income. Out of 146 tubectomy acceptors 14 or 9.6 per cent of them were drawn from households in the lowest income of less than Rs.1500 per annum. About 31 per cent of the tubectomised were drawn from lower income group of Rs.2000-2999. Middle income group of less than Rs.5000/- but more than Rs.3000/- constitu-

ted of 25.3 per cent of the acceptors. Tubectomy acceptors belonging to higher income bracket of more than Rs.5000/- per annum were sizeable being 30.8 per cent of the acceptors.

The lowest income category was not represented by the IUD acceptors. The lower income households with income bracket of Rs. 2000-2999 covered 16.7 per cent of acceptors. Eleven acceptors belonged to the middle income of Rs.3000-4999 per annum. A majority of 57 per cent of IUD acceptors were drawn from the households in the higher income group of Rs.5000/ and more. A comparison of the distribution of tubectomy acceptors, IUD acceptors and non-acceptors according to annual household income suggests that while tubectomy acceptors are from relatively low income families than non-acceptors, the IUD acceptors are relatively better off than non-acceptors. Earlier it was noticed that IUD acceptors and their husbands are better educated than their counterparts. These suggest that in addition to limiting spacing is resorted more by better educated and economically well off couples while less educated and low income couples depend entirely on terminal methods and care less for spacing. Detailed investigation is called for to bring out reasons why spacing is not practical among the lower socio-economic strata for programme improvement.

Another important household characteristic considered is household type. Households are broadly classified as

nuclear or joint. The nuclear family is defined as comprising the two spouses and their unmarried children and all other households are said to be joint. Table 2.8 shows that nuclear families constitute over 63 per cent among acceptors and 66 per cent among the non-acceptors. The data does not suggest any significant difference between the two categories. However it should be noted that these data do not indicate that nuclearisation of family structure has any relation with family planning acceptance.

Table 2.9 gives the distribution of households of acceptors and non-acceptors by size. The average size of the household is 6.8 for acceptors and 7.3 for non-acceptors; the difference is 0.5 person. For the very small size of families of two or three members the acceptance obviously is on nominal scale. There is evidence of concentration of acceptors, from small to medium sizes with 4-6 members. The proportion of households with 4,5 or 6 members is the same among acceptors (49 per cent) and non-acceptors (48.5 per cent). But the proportion of households with a membership of seven or more is as high as 47.5 per cent among non-acceptors. The corresponding proportion among acceptors was less being 40.5 per cent. We have thus no evidence to support the view that acceptance of family planning is prompted by the desire to prevent the enlargement of household size.

The fore-going analysis suggests that household characteristics hold key to acceptance and individual characteristics have at best played a supporting role. For instance the occupation distribution of householdsof acceptors showed that households engaged in agricultural aector are lagging behind in acceptance and hence there is the need to intensify the motivational educational programme.

PREGNANCY STATUS AT THE TIME OF ACCEPTANCE

Table 2.10 shows that a majority (86.3 per cent) of the tubectomised women had accepted the method during the post-partum amenorrhea period. Only 12.3 per cent were menstruating at the time of acceptance. One of the acceptor was reported to be pregnant.

Among the IUD acceptors a majority of 72.2 per cent of them were menstruating at the time of acceptance while 22.2 per cent were in the post-partum amenorrhea period. Three IUD acceptors had reported that they were pregnant when IUD was fitted.

The interviewers diaries confirmed that one tubectomy acceptor and three IUD acceptors were pregnant at the time of acceptance. Therefore a detailed large scale investigation in this aspect is suggested.

EVALUATION OF DATA ON AGE AND LIVING CHILDREN

In this section it is proposed to compare the data on age and living children of the acceptors as found in the official registers of primary Health Centres with survey data. This is being done to assess the extent of ineligible cases if any enlisted for acceptance of various family planning methods.

Table 2.11 gives the age distribution of acceptors as per survey and registration. The median age of tubectomy as per survey data was 28.5 years and that of IUD acceptors 24.3 years. The corresponding figures as per registration data were 28.5 and 24.0 years. Thus we find that the two sets of data match closely on averages. Further both in survey and registration acceptors were found to be concentrated in the age group of 20-34 years. A careful examination of the data in the older age groups, however, reveals some variations in the two sets. In the older age group of 35-44 years, there were 22 acceptors as per survey while the registration shows only 6 acceptors.

A similar observation can be made with respect to IUD acceptors. The survey and registration show that there was a concentration in the age group 20-24 years. However, as per survey data there were 6 acceptors aged 35 and over but the registration shows one case in this age category. The data

by and large suggest that the acceptors were genuine.

Table 2.12 gives the distribution of acceptors and non-acceptors by number of living children as per survey and registration. The mean number of living children to the tubectomy acceptors being 3.8 as per survey is almost the same as per registration data (3.8). Thus we find that the two sets of data match closely on averages. Even a careful examination of the data shows that there were no discrepancies in reporting of ages and that data of two sets match each other. Among the tubectomy acceptors with a small family size of 1,2 or 3 living children the number of acceptors was 72 as per survey data and 77 as per registration data. The interviewers diaries show that this discrepancy in the survey data and registration data was due to slight over reporting of the living children of the acceptors with one or two living children so that the medical personnel would not reject the cases on grounds of too few children. Further we find that there were 78 tubectomy acceptors having more than three living children as per survey and only 68 as per registration. This is clear indication of under-reporting of living children in case of acceptors with large families by the hospital personnel.

THE COUPLE REGISTERS

No specific attempt was made to ascertain as to whether the couple registers were periodically updated or not. However

with the available scanty information we propose to make passing reference to couple registers. After listing the names of acceptors from the PHC registers, the investigating staff verified the couple registers to ascertain whether all the acceptors as per PHC registers were found in the couple register. Table 2.13 shows that a substantial number of acceptors (as high as 22 per cent) were from outside the couple registers. From amongst the tubectomy acceptors 16.4 per cent were not found in the couple register while the corresponding rate for IUD acceptors was as high as 37 per cent . It, therefore, appears that the updating of couple register is not seriously attended to.

IMPACT OF FAMILY PLANNING FERTILITY

Earlier analysis brings out that a large number of acceptors prefer a family size consisting of four living children. Under this situation it is difficult to expect a spectacular decline in fertility. The terminal method like tubectomy is normally accepted during the period of receding fertility as was evidenced by the study data and hence the family planning impact will be limited to averting the marginal births occuring to older women in the reproductive period.

TABLE 2.1 A DISTRIBUTION OF ACCEPTORS AND FEMALE NON-ACCEPTORS BY AGE

Age group	Tubectomy		IUD		Total Number		Non-acceptors	
	Number	percentage	Number	percentage	Number	percentage	Number	percentage
15-19	2	1.3	5	9.2	7	3.5	15	10.5
20-24	27	18.5	26	48.1	53	26.5	50	34.9
25-29	63	43.2	13	24.1	76	38.0	37	25.9
30-34	32	21.9	4	7.4	36	18.0	22	15.3
35-39	17	11.6	4	7.4	21	10.5	12	8.4
40-44	5	3.4	1	1.9	6	3.0	7	4.9
45-49	-	-	1	1.9	1	0.5	-	-
Total	146	100.0	54	100.0	200	100.0	143	100.0
Median age		28.5		24.2		27.6		28.8

TABLE 2.1b DISTRIBUTION OF HUSBANDS OF ACCEPTORS AND MALE NON-ACCEPTORS BY AGE

Age group	Tubectomy		IUD		Total number		Male non-acceptors	
	Number	percentage	Number	percentage	Number	percentage	Number	percentage
15-19	-	-	-	-	-	-	2	3.5
20-24	1	0.7	3	5.6	4	2.0	5	8.8
25-29	9	6.2	14	25.9	23	11.5	15	26.3
30-34	45	30.8	23	42.6	68	34.0	17	29.8
35-39	51	34.9	9	16.7	60	30.0	6	10.5
40-44	27	18.5	4	7.4	31	15.5	4	7.0
45-49	6	4.1	-	-	6	3.0	5	8.8
50 +	7	4.8	1	1.8	8	4.0	3	5.3
Total	146	100.0	54	100.0	200	100.0	57	100.0
Median age		36.8		32.2		35.4		31.6

TABLE 2.2 DISTRIBUTION OF ACCEPTORS AND NON-ACCEPTORS BY THE NUMBER OF LIVING CHILDREN

ACCEPTORS (A)

Number of living children	Males		Females		Total	
	Tub.	IUD	Tub.	IUD	Tub.	IUD
0	3	19	23	15	-	3
1	39	23	53	27	2	15
2	67	8	35	3	22	22
3	24	3	18	6	48	5
4	9	1	12	1	36	5
5 +	4	-	5	2	33	4
Mean	2.0	0.9	1.8	1.2	3.8	2.1

NON-ACCEPTORS (B)

Number of living children	Males	Females	Total
0	74	64	25
1	72	65	50
2	24	28	43
3	13	26	26
4	9	12	29
5 +	8	5	27
Mean	1.2	1.4	2.6

TABLE 2.3 DISTRIBUTION OF TUBECTOMISED BY RELIGION AND NUMBER OF DAUGHTERS

Number of daughters living	Hindus		Christians		Muslims		Jains		Total		Average No. of sons
	No.	%	No.	%	No.	%	No.	%	No.	%	
All daughters	3	3.2	-	-	-	-	-	-	3	2.4	Nil
1 daughter	42	45.2	-	-	7	36.8	4	40.0	53	43.1	2.1
2 daughters	24	25.8	1	100.0	6	31.6	4	40.0	35	28.4	2.1
3 daughters	13	14.0	-	-	2	10.5	1	10.0	16	13.0	2.1
4 daughters	10	10.7	-	-	2	10.5	-	-	12	9.8	1.8
5 daughters	1	1.1	-	-	2	10.5	1	10.0	4	3.2	1.0
Total	93	100.0	1	100.0	13	100.0	10	100.0	123	100.0	2.0

TABLE 2.4 A DISTRIBUTION OF ACCEPTORS AND NON-ACCEPTORS BY LITERACY LEVEL

Literacy level	Tubectomy		IUD		Total		Female non-acceptor	
	No.	%	No.	%	No.	%	No.	%
Illiterate	102	69.9	31	57.4	133	66.5	100	69.9
Literate upto IV Std.	12	8.2	6	11.1	18	9.0	14	9.8
V to VII Std.	27	18.5	7	12.9	34	17.0	14	9.8
High school but not passcd SSC	1	0.7	2	3.7	3	1.5	5	3.5
SSC and above	3	2.0	8	14.8	11	5.5	10	7.0
NR	1	0.7	-	-	-	-	-	-
Total	146	100.0	54	100.0	200	100.0	143	100.0

TABLE 2.4 B DISTRIBUTION OF HUSBANDS OF FEMALE ACCEPTORS AND MALE NON-ACCEPTORS

Literacy level	Husbands of				Total		Male non-acceptors	
	Tubectomy		IUD					
	No.	%	No.	%	No.	%	No.	%
Illiterate	59	40.4	17	31.5	76	38.0	24	42.0
Literate upto IV Std.	25	17.1	6	11.1	31	15.5	7	12.3
V to VII Std.	35	23.9	11	20.4	46	23.0	11	19.3
High school but not passed SSC	5	3.4	1	1.8	6	3.0	2	3.5
SSC and above	20	13.7	19	35.1	39	19.5	13	22.1
Total	146	100.0	54	100.0	200	100.0	57	100.0

TABLE 2.4 B DISTRIBUTION OF HUSBANDS OF FEMALE ACCEPTORS AND MALE NON-ACCEPTORS

Literacy level	Husbands of				Total		Male non-acceptors	
	Tubectomy		IUD					
	No.	%	No.	%	No.	%	No.	%
Illiterate	59	40.4	17	31.5	76	38.0	24	42.0
Literate upto IV Std.	25	17.1	6	11.1	31	15.5	7	12.3
V to VII Std.	35	23.9	11	20.4	46	23.0	11	19.3
High school but not passed SSC	5	3.4	1	1.8	6	3.0	2	3.5
SSC and above	20	13.7	19	35.1	39	19.5	13	22.1
Total	146	100.0	54	100.0	200	100.0	57	100.0

TABLE 2.5 A DISTRIBUTION OF ACCEPTORS AND NON-ACCEPTORS BY OCCUPATION

Occupation	Tubectomy		IUD		Total		Female non-acceptors	
	No.	%	No.	%	No.	%	No.	%
Working on family farm	12	8.2	5	9.3	17	8.5	13	9.1
Agricultural labour	25	17.1	9	16.7	34	17.0	26	18.2
Salaried work	1	0.7	4	7.4	5	2.5	-	-
Other workers	14	9.6	2	3.7	16	8.0	6	3.2
Not working	94	64.4	34	62.9	128	64.0	98	68.5
Total	146	100.0	54	100.0	200	100.0	143	100.0

TABLE 2.5B DISTRIBUTION OF HUSBANDS OF FEMALE ACCEPTORS AND NON-ACCEPTORS BY OCCUPATION

(Non-acceptors include male non-acceptors and husbands of female non-acceptors)

Occupation	Husbands of						Non-acceptors	
	Tubectomy		IUD		Total			
	No.	%	No.	%	No.	%	No.	%
Cultivators	29	19.9	14	25.9	43	21.5	57	28.5
Agricultural labour	32	21.9	9	16.7	41	20.5	42	21.0
Salaried work	33	22.6	14	25.9	47	23.5	35	17.5
Other workers	48	32.9	17	31.5	65	32.5	63	31.5
Non working	4	2.7	-	-	4	2.0	3	1.5
Total	146	100.0	54	100.0	200.	100.0	200	100.0

TABLE 2.6 DISTRIBUTION OF ACCEPTORS AND NON-ACCEPTORS (MALE + FEMALE) BY RELIGION AND CASTE

Religion/Caste	Tubectomy		IUD		Total		Non-acceptors	
	No.	%	No.	%	No.	%	No.	%
Brahmins	3	2.0	5	9.2	8	4.0	10	5.0
Lingayats	32	21.9	24	44.4	56	28.0	62	31.0
Advanced Hindus	34	23.2	9	16.7	43	21.5	45	22.5
Scheduled castes/ Tribes	45	30.8	6	11.1	51	25.5	50	25.0
Jains	10	6.8	1	1.8	11	5.5	7	3.5
Muslims	21	14.3	9	16.7	30	15.0	23	11.5
Christians	1	0.7	-	-	1	0.5	3	1.5
Total	146	100.0	54	100.0	200	100.0	200	100.0

TABLE 2.7 DISTRIBUTION OF ACCEPTORS AND NON-ACCEPTORS (MALE + FEMALE) BY HOUSEHOLD INCOME

Household income	Tubectomy		IUD		Total		Non-acceptors	
	No.	%	No.	%	No.	%	No.	%
Less than Rs.1500	14	9.6	-	-	14	7.0	14	7.0
Rs.1501 to 1999	16	10.9	5	9.3	21	10.5	17	8.5
Rs.2000 to 2999	29	19.9	4	7.4	33	16.5	28	14.0
Rs.3000 to 4999	37	25.3	11	20.4	48	24.0	55	27.5
Rs.5000 +	45	30.8	31	57.4	76	38.0	78	39.0
Data NR	5	3.4	3	5.5	8	4.0	8	4.0
Total	146	100.0	54	100.0	200	100.0	200	100.0

TABLE 2.8 DISTRIBUTION OF ACCEPTORS AND NON-ACCEPTORS BY HOUSEHOD TYPE

Type of family	Acceptors		Non-acceptors	
	Number	%	No.	%
Nuclear	127	63.5	132	66.0
Joint	71	35.5	68	34.0
Not reported	1	0.5	-	-
Total	200	100.0	200	100.0

TABLE 2.9 DISTRIBUTION OF HOUSEHOLDS OF ACCEPTORS AND NON-ACCEPTORS BY SIZE

Household size	Acceptors		Non-acceptors	
	Number	percentage	Number	percentage
2	4	2.0	-	-
3	17	8.5	9	4.5
4	40	20.0	22	11.0
5	22	11.0	35	17.5
6	36	18.0	40	20.0
7	19	9.5	29	14.5
8	13	6.5	15	7.5
9	15	7.5	12	6.0
10	7	3.5	9	4.5
11	7	3.5	7	3.5
12 +	20	10.0	21	11.5
Mean Size	6.8		7.3	

TABLE 2.10 PREGNANCY STATUS OF THE ACCEPTORS AT THE TIME OF ACCEPTANCE

Pregnancy status	Tubectomy		IUD		Total	
	No.	%	No.	%	No.	%
Pregnant	1	0.7	3	5.5	4	2.0
Menapause reached	-	-	-	-	-	-
Post-partum amenorrhoea	126	36.3	12	22.2	138	69.0
Others	1	0.7	-	-	1	0.5
Menstruating	18	12.3	39	72.2	57	28.5
Total	146	100.0	54	100.0	200	100.0

TABLE 2.11 VERIFICATION OF REGISTRATION DATA BY MEANS OF SURVEY DATA IN RESPECT OF AGE OF ACCEPTORS

Survey data						Age group	Registration data					
Tubectomy		IUD		Total			Tubectomy		IUD		Total	
No.	%	No.	%	No.	%		No.	%	No.	%	No.	%
2	1.4	5	9.1	7	3.5	15-19	-	-	2	3.7	2	1.0
27	18.5	26	48.1	53	26.5	20-24	23	15.7	31	57.4	54	27.0
63	43.1	13	24.0	76	38.0	25-29	71	48.6	14	25.9	85	42.5
32	21.8	4	7.4	36	18.0	30-34	46	31.5	6	11.1	52	26.0
17	11.7	4	7.4	21	10.5	35-39	6	4.1	1	1.8	7	3.5
5	3.4	1	1.8	6	3.0	40-44	-	-	-	-	-	-
-	-	1	1.8	1	0.5	45-49	-	-	-	-	-	-
146	100.0	54	100.0	200	100.0	Total	146	100.0	54	100.0	200	100.0
28.5		24.5		27.6		Median age	28.0		24.0		24.0	

TABLE 2.12 VERIFICATION OF REGISTRATION DATA BY MEANS OF SURVEY DATA IN RESPECT OF NUMBER OF LIVING CHILDREN TO ACCEPTORS

Survey data						Number of living children	Registration data					
Tubectomy		IUD		Total			Tubectomy		IUD		Total	
No.	%	No.	%	No.	%		No.	%	No.	%	No.	%
-	-	3	5.6	3	1.5	0	-	-	1	1.8	1	0.5
2	1.4	15	27.8	17	8.5	1	2	1.3	15	27.7	17	8.5
22	15.1	22	40.8	44	22.0	2	22	15.0	24	44.4	46	23.0
48	32.9	5	9.3	53	26.5	3	53	36.3	7	13.0	60	30.0
36	24.2	5	9.3	41	20.5	4	30	20.5	4	7.4	34	17.0
18	12.3	3	5.6	21	10.5	5	24	16.4	2	3.7	26	13.0
20	13.7	1	1.1	21	10.5	6 +	14	9.5	1	1.8	15	7.5
-	-	-	-	-	-	Data NR	1	0.6	-	-	1	0.5
146	100.0	54	100.0	200	100.0	Total	146	100.0	54	100.0	200	100.0
3.8		2.1		3.3		Mean	3.7		2.1		3.3	

TABLE 2.13 TABLES SHOWING THE ACCEPTORS LIST BEING CRIPTED WITH COUPLE REGISTERS

Method accepted	Acceptors found in the couple list		Acceptors not found in the couple register		Couples from outside the area		Total	
	Number	percentage	Number	percentage	Number	percentage	Number	percentage
Tubectomy	118	80.8	24	16.5	4	2.7	146	100.0
IUD	34	63.0	20	37.0	-	-	54	100.0
Total	152	76.0	44	22.0	4	2.0	200	100.0

CHAPTER III

COMMUNICATION, HEALTH AND FAMILY WELFARE

COMMUNICATION

Communication between neighbours, friends, relatives and those who have already accepted family planning has played an important role in disseminating family planning information in the rural areas. It is in this backdrop that an attempt is made to evaluate the existing net work of informal communication in rural areas.

Table 3.1 shows that 54.1 per cent of tubectomy acceptors and 68.5 per cent of IUD acceptors had not had any discussion with either friends, relatives or neighbours just prior to acceptance. However as a large number of tubectomies were done during the post partum amenorrhea it is just likely that tubectomised women must have had some discussion with FP personnel. In respect of IUD acceptance it can be said that as it is only a temporary method the acceptors might not felt it necessary to discuss with others. 42.2 per cent of the tubectomy acceptors and 31.5 per cent of IUD acceptors did consult their relatives and friends who advised them to accept family planning. Only 2.7 per cent of tubectomy acceptors reported that their relatives had opposed acceptance of family planning. 93.8 per cent of the tubectomised and 85.2 per cent of IUD acceptors had obtained the consent of their spouse prior to acceptance.

DECISION MAKING

Reasons for acceptance of family planning are detailed in Table 3.2. Two distinct patterns are discernible from the responses of acceptors : the acceptance of tubectomy has been in response to the economic compulsions while acceptance of IUD was for spacing. Desire to have a small family was the main reason for 12.3 per cent of tubectomy acceptors. The remaining acceptors had given such reasons as trouble during pregnancy and delivery, nobody to take care of their children during confinement, etc..

REASONS FOR NON-ACCEPTANCE

Reasons for non-acceptance of family planning are detailed in Table 3.3 . Desire for additional children is the reason given by large proportion (51 per cent) of the respondents for not accepting FP methods. Another 12.5 per cent of non-acceptors had apprehensions with regard to acceptance of terminal methods. While 4.5 per cent of them were just married, another 7.5 per cent were found to be childless. Opposition to family planning on religious grounds was negligible. Opposition from either husband or wife or other family members is reported by 4 per cent of the non-acceptors.

LEVELS OF MOTIVATION

It is widely held that the family planning acceptance

rate is low because of weak motivations. Table 3.4 gives the distribution of acceptors motivated by various agencies. It is significant to note that 65.7 per cent of tubectomy acceptors had volunteered to accept family planning. Does this imply higher levels of motivations ? As is known that tubectomy is accepted only after the family is sufficiently expanded and that tubectomy acceptors are prompted by the economic compulsions. A large number of couples with four and more living children continue to be non-acceptors. Even among the tubectomy acceptors it may be noticed that as many as 32.9 per cent of them were motivated by family planning personnel. There is thus no evidence to suggest that levels of motivations are high. Among the IUD acceptors, we find that as many as 74 per cent of them had volunteered. This is because of the reversible nature of the contraception and that it is easy to do away with the method accepted. It may thus be concluded that in order to raise the levels of motivation of younger couples, strengthening of educational and motivational programme as an important instrument of implementation of the family planning programme would be crucial.

REACTION OF ACCEPTORS

Whether or not the acceptors feel satisfied with the methods accepted depends on the side effects and physical discomfort which they experience on acceptance. The satis-

faction also depends on relief they get by limiting their family size. In Table 3.5 the respondents have been classified according to their responses towards satisfaction with acceptance. 85.6 per cent of tubectomy acceptors and 66.7 per cent of IUD acceptors reported that they felt happy to have accepted the method. Among the tubectomy acceptors the major reasons for feeling satisfied were; no post acceptance complications (41.8 per cent) and no further addition to the family (36.9). Among the IUD acceptors the major reason was no post acceptance physical discomforts, (66.7 per cent).

The major reason for not being satisfied was post operation complications reported by 9.6 per cent of tubectomy acceptors and the corresponding proportion among IUD acceptors was higher being 24.1 per cent. The other reported reasons for not being satisfied were negligible, but worth noting. One of the tubectomy acceptor had lost her son while the other had lost her daughter after sterilisation. Only one IUD acceptor had become pregnant after the device was fitted. In view of the fact that the dissatisfied clients can harm the programme, the proportion of dissatisfied among the acceptors appear to be sizeable.

PREVIOUS PRACTICE OF FAMILY PLANNING METHODS

Table 3.6 gives the distribution of acceptors by their previous practice of family planning. Among the tubectomy

acceptors the previous practice was negligible being 1.4 per cent. Among the IUD acceptors the incidence of previous practice was as high as 14.8 per cent. The methods previously practiced included Condom, Oral Pills and IUD.

POST ACCEPTANCE COMPLAINTS

Data regarding post acceptance complaints by the acceptors are given in Table 3.7A. It is observed that 64.4 per cent of tubectomy acceptors and 70.4 per cent of the IUD acceptors had reported no trouble at all. Among those who had any complaint the major complaints reported by (71.2 per cent) tubectomy acceptors was stomach, waist and back ache. Among the complaining IUD acceptors 75 per cent of them reported excess bleeding and white discharge. The other complaints reported by tubectomy acceptors were excess bleeding and white discharge, irregular menses, weakness and pus formation. The other complaints reported by IUD acceptors were back, waists and stomach ache and weakness.

In part (B) of the Table data regarding the duration of complaints is given. Out of 52 complaining tubectomy cases, 22 or 42.3 per cent of them reported that the complaint persisted for less than 3 months. The proportion of tubectomy cases where the complaint lasted between 3 to 6 months, 6 to 9 months and between 9 to 12 months was 23.1 per cent, 15.4

per cent and 11.5 per cent respectively.

It is only in respect of 3 tubectomy cases that complaints were reported persisting at the time of survey. Out of 16 IUD cases with complaint as many as 14 or 87.5 per cent of them reported that the complaint persisted for less than 3 months. Only in respect of two cases, it was found that the complaints lasted upto 9 months.

On the whole it appears that the post acceptance complaints of IUD cases were not found to be serious. However among the tubectomy cases a sizeable number of them have reported that the complaints lasted from over 3 months to the day of survey. The programme may receive a set back if these complaints remain unattended. The family planning personnel who are in charge of the follow-up should see that each case was investigated and rendered properly. Whether such complaints were psychosomatic or physiological is not very important. What is of significant consequence is that these perceptions are carried by the acceptors and they have to be cleared.

HEALTH AND FAMILY WELFARE

Primary Health Centres are the nodal points of family planning services to the rural populations and hence it is necessary to examine the nature of interactions between the family planning personnel and the rural clients (the acceptors and the prospective acceptors as well.). An attempt

was also made to ascertain the health and family planning services availed by the clients. This is given in Table 3.8. It was noticed that by and large both acceptors and non-acceptors were aware of the visit of para-medical staff of PHC to their homes. An important differential in their reported reasons for the visit of PHC staff was noticed. As many as 42.5 per cent of acceptors reported that PHC staff visited them to render family planning advice; the corresponding proportion among non-acceptors reporting the same reason was only 9.5 per cent. The data suggests that family planning motivational work was confined to those who would immediately accept the family planning (in other words those with higher age and parity) than among the younger couples. From the Table it was noticed that both acceptors and non-acceptors had availed PHC services in respect of maternal and child health care, almost in equal measures. The non-acceptors availing child care was much higher 14.5 per cent and it is only seven per cent among acceptors. Thus it appears that inspite of eligible couples being covered under the maternal and child care, a large number of couples remain non-contraceptors presumably because of lack of motivation work on the part of the family planning personnel.

The responses to a question aimed at the reasons for visit to PHC by the couples are given in Table 3.9. The proportion of couples visiting the PHC to avail health and family planning services was 69 per cent both among acceptors

and among non-acceptors. The major reasons reported by the couples for visiting - PHC were prenatal care, child care and other curative purposes. Among the acceptors the proportions visiting for prenatal care, child care and other curative purposes were 5.0 per cent, 27.5 per cent and 36.5 per cent respectively, the corresponding proportions among non-acceptors were 1.0 per cent, 39.5 per cent and 25.0 per cent respectively. The significant variation between acceptors and non-acceptors appear to be the proportion of couples availing prenatal care. Larger proportion of acceptors are availing this service than non-acceptors. The proportion of couples availing child care was almost the same among acceptors and non-acceptors. It appears therefore that increased prenatal care of the prospective female acceptors may enhance the rate of acceptance.

PRIOR MEDICAL EXAMINATION

Table 3.10 gives the distribution of acceptors and non-acceptors by whether they were medically examined or not prior to the extension of family planning services. Premedical check up not only helps to ascertain the suitability of the person to accept a particular method of family planning but also facilitates rejection of these cases for whom family planning may not be necessary. Surprisingly the screening examination appears to be not scrupulously followed as 15.8 per cent tubectomy cases and 22.2 per cent IUD cases report that they were not medically examined.

FOLLOW-UP CARE OF ACCEPTORS

Researchers have often pointed out that family planning programme received set backs because of lack of follow-up care of the acceptors of terminal methods. Therefore extension of follow-up care to all those acceptors of terminal methods assumes significance. It may be noted from Table 3.11 that 30.0 per cent of the tubectomy acceptors and 11.0 per cent of IUD acceptors had not received follow-up care from the family planning personnel.

TABLE 3.1 COMMUNICATION WITH OTHERS PRIOR TO ACCEPTANCE OF FAMILY PLANNING METHODS

	Tubectomy		IUD		Total	
	No.	%	No.	%	No.	%
Relatives and friends advised to accept FP	63	42.2	17	31.5	80	40.0
Relatives opposed to FP	4	2.7	-	-	4	2.0
Not discussed with anybody	79	54.1	37	68.5	116	58.0
Total	146	100.0	54	100.0	200	100.0

WHETHER SPOUSE'S CONSENT WAS OBTAINED

	Tubectomy		IUD		Total	
	No.	%	No.	%	No.	%
Yes	137	93.8	46	85.2	183	81.5
No	6	4.1	8	14.8	14	7.0
Not reported	3	2.1	-	-	3	1.5
Total	146	100.0	54	100.0	200	100.0

TABLE 3.2 DISTRIBUTION OF ACCEPTORS BY THE REASONS FOR ACCEPTANCE

Reasons	Tubectomy		IUD		Total	
	No.	%	No.	%	No.	%
Not to have any more children because of socio-economic compulsions	109	74.6	1	1.9	110	55.0
Advised by FP personnel	1	0.7	-	-	1	0.5
No body to take care of children during delivery confinement	3	2.1	-	-	3	1.5
Got children of either sex	2	1.4	1	1.9	3	1.5
Desired a small family	18	12.3	-	-	18	9.0
Spacing	-	-	50	92.6	50	25.0
Trouble during pregnancy and delivery	10	6.8	2	3.7	112	6.0
Data NR	3	2.1	-	-	-	-
Total	146	100.0	54	100.0	200	100.0

TABLE 3.3 DISTRIBUTION OF NON-ACCEPTORS BY REASONS FOR NON-ACCEPTANCE

Reasons	Number	%
Desire for more children	102	51.0
Recently married	9	4.5
Afraid of likely adverse effects	25	12.5
Not likely to have any more children due to oldage or secondary sterility etc.	3	1.5
Opposed the idea of FP on religious grounds	1	0.5
Acceptance involves prolonged confinement which we cannot afford	8	4.0
Already having physical ailment - hence not prepared to accept any method	10	5.0
Opposition from family members including husband/wife	8	4.0
Not seriously thought of it	5	2.5
No living children	15	7.5
Other miscelleneous reasons	9	4.5
No knowledge about FP	5	2.5
Total	200	100.0

TABLE 3.4 DISTRIBUTION OF ACCEPTORS BY TYPE OF MOTIVATION

Motivated/voluntary	Tubectomy		IUD		Total	
	No.	%	No.	%	No.	%
Motivated by FP personnel	48	32.9	12	22.2	60	30.0
Friends/Relatives/ Neighbours	2	1.4	1	1.8	3	1.5
Spouse motivated	-	-	1	1.8	1	0.5
Total motivated	50	34.3	14	25.9	64	32.0
Voluntary	96	65.8	40	74.1	136	68.0
Grand Total	146	100.0	54	100.0	200	100.0

TABLE 3.5 DISTRIBUTION OF [illegible] BY TYPE OF REACTION TO THE [illegible] ACCEPTED

Happy reasons	Sterilisation		IUD		Total	
	No.	%	No.	%	No.	%
Acceptance has caused no trouble/best method for spacing	61	41.8	36	66.7	97	48.5
No further addition of children	54	36.9	4	7.4	58	29.0
Relieved from the earlier delivery trouble	7	4.8	-	-	7	3.5
Happy but no reasons given	3	2.1	-	-	3	1.5
Total (Happy)	125	85.6	40	74.1	165	82.5
UNHAPPY REASONS						
Suffered a lot due to post acceptance complications	14	9.6	13	24.1	27	13.5
Death of a child	2	1.4	-	-	2	1.0
severe weakness	1	0.7	-	-	1	0.5
Because pregnant	-	-	1	1.9	1	0.5
Total(Unhappy)	17	11.6	14	25.9	31	15.5
Repenting	1	0.7	-	-	1	0.5
Indifferent	3	2.1	-	-	3	1.5
Total	146	100.0	54	100.0	200	100.0

TABLE 3.6 DISTRIBUTION OF ACCEPTORS BY THEIR PREVIOUS PRACTICES

Previous practice	Not practiced any method		Nirodha		IUD		Oral pills		Total	
Present method	No.	%	No.	%	No.	%	No.	%	No.	%
Tubectomy	144	98.6	-	-	-	-	2	1.4	146	100.0
IUD	46	85.2	2	3.7	3	5.6	3	5.6	54	100.0
Total	190	95.0	2	1.0	3	1.5	5	2.5	200	100.0

TABLE 3.7 A DISTRIBUTION OF ACCEPTORS BY POST-OPERATION COMPLAINTS

Nature of complaints	Tubectomy		IUD	
	No.	%	No.	%
No complaints	97	64.4	38	70.4
Back, waist and stomach ache	37	71.2	3	18.7
Excess bleeding and white discharge	4	7.7	12	75.0
Irregular menses	1	1.9	-	-
Weakness	7	13.5	1	6.3
Pus formation	3	5.7	-	-
Total complaining	52	100.0	16	100.0
Complaining as percent of total acceptors		36.6		29.6
Grand total	146		54	

TABLE 3.7 B

Duration of complaints	Tubectomy		IUD	
	No.	%	No.	%
Less than 3 months	22	42.3	14	87.5
3 to 6 months	12	33.1	-	-
6 to 9 months	8	15.4	2	12.5
9 to 12 months	6	11.5	-	-
Still persists	3	6.8	-	-
Not reported	1	1.1	-	-
Total	52	100.0	16	100.0

TABLE 3.8 REASONS FOR VISIT BY PARA-MEDICAL STAFF OF PHC TO THE DOORS OF ACCEPTORS AND NON-ACCEPTORS

Reasons	Tubectomy		IUD		Non-acceptors	
	No.	%	No.	%	No.	%
To enquire about the health status of the family	43	29.4	27	50.0	126	63.0
Care of the pregnant attending delivery	[illegible]	[illegible].3	-	-	13	6.5
For immunization of children	11	7.5	3	5.6	29	14.5
To motivate to accept FP	[illegible]	43.2	22	40.7	19	9.5
No body visited	13	8.9	2	3.7	11	5.5
Not reported	1	0.7	-	-	2	1.0
Total	146	100.0	54	100.0	200	100.0

TABLE 3.9 REASONS FOR VISIT TO PHC BY ACCEPTORS AND NON-ACCEPTORS

Reasons	Tubectomy		IUD		Non-acceptors	
	No.	%	No.	%	No.	%
For pregnancy check up	9	[illegible].2	1	1.9	2	1.0
For child care	52	[illegible].6	23	42.5	79	39.5
For other curative purposes	38	[illegible].0	15	27.8	50	25.0
Not visited	47	32.2	15	27.8	63	31.5
Do not know	-	-	-	-	6	3.0
Total	146	100.0	54	100.0	200	100.0

TABLE 3.10 DISTRIBUTION OF ACCEPTORS BY WHETHER OR NOT MEDICALLY EXAMINED

Whether medically examined prior to acceptance	Tubectomy		IUD		Total	
	No.	%	No.	%	No.	%
Yes	123	84.3	42	77.9	165	82.5
No	23	15.8	12	22.2	35	17.5
Total	146	100.0	54	100.0	200	100.0

TABLE 3.11 DISTRIBUTION OF ACCEPTORS BY NATURE OF FOLLOW-UP SERVICE RENDERED

Nature of follow-up care	Tubectomy		IUD		Total	
	No	%	No.	%	No.	%
Provided medical aid like tablets, injections, dressing in addition enquired about health	64	43.7	17	31.5	81	40.6
Enquired about the impact of acceptance of health	37	25.3	30	55.5	67	33.5
NA	1	0.7	1	1.9	2	1.0
Not visited	44	30.1	6	11.0	50	25.0
Total	146	100.0	54	100.0	200	100.0

SUMMARY AND CONCLUSIONS

THE SUMMARY

This study, Evaluation of family planning programme in Belgaum district 1982-83, is the sixth in the series undertaken by the Population Research Centre of the Institute of Economic Research, Dharwad.

The main objectives were to study the socio-economic and demographic characteristics of the acceptors and non-acceptors and to ascertain the reasons for acceptance and for non-acceptance. Verification of the genuiness of acceptors was another important objective of the study.

Quota sampling technique was resorted. The sample size was 200 acceptors and 200 non-acceptors. Two PHCs; Viz: (a) Kagawad and (b) Kakkeri serving the rural population of Belgaum district were selected. From within the two PHCs five villages were covered.

FINDINGS

The accepting clientele consists of females only. Tubectomy was the most popular method being accepted by as high as 73 per cent of the acceptors. The other female method preferred was IUD.

The median age of tubectomy and IUD acceptors was 28.5 years and 24.2 years respectively. 65 per cent of tubectomy acceptors were in the age group of 25.34 years. In the peak reproductive ages of 20-29 years, the proportion of acceptors and non-acceptors was the same being 60 per cent.

The number of living children to tubectomy and IUD acceptors and to non-acceptors was 3.8, 2.1 and 2.6 respectively. Among the tubectomy acceptors two living sons was a norm prior to acceptance. The presence of female child in the family very much facilitated acceptance.

The proportion of illiterates among tubectomy acceptors and female non-acceptors was as high as 69.9 per cent. Among the IUD acceptors the proportion of illiterates was relatively small being 57 per cent. Education has had no influence on the acceptance of tubectomy while it exerted some influence in the acceptance of IUD.

Since all acceptors were females, the data in respect of their occupation shows that as many as 64 per cent of them were not gainfully working. The corresponding proportion among female non-acceptors was 68 per cent. The proportion of acceptors and non-acceptors engaged in agricultural sector among acceptors and non-acceptors was 25.5 per cent and 27.3 per cent respectively.

A closer scrutiny of the occupational distribution of husbands of acceptors and female non-acceptors shows that nearly 58 per cent of the husbands of acceptors and 51 per cent of the husbands of non-acceptors were engaged in occupations falling outside the agricultural sector.

Among the acceptors the share of various religious denominators viz ; Hindus, Muslims, Jains, Christians was 79 per cent, 15 per cent, 5 per cent and 0.7 per cent respectively. The corresponding percentages among non-acceptors were 87 per cent, 11.5,3.5 and 0.5. The per cent of acceptors belonging to Jainism and Islam was more than among non-acceptors. Scheduled castes and backward group are equally represented among acceptors and non-acceptors. Rural Muslims had shown a greater interest in accepting family planning than their Hindu counterparts.

Fifty five per cent of tubectomy acceptors were drawn from the households with an annual income of Rs.3000 and above, the corresponding proportion among the IUD acceptors was 71.8 per cent.

Sixty three per cent of acceptors and 66 per cent of non-acceptors belonged to the nuclear family consisting of two spouses and their unmarried children and the rest belonged to joint families. The average household size of acceptor and

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Sixty three per cent of acceptors and 66 per cent of non-acceptors belonged to the nuclear family consisting of two spouses and their unmarried children and the rest belonged to joint families. The average household size of acceptar and

non-acceptors was 6.8 and 5.3 members respectively. The proportion of acceptors belonging to larger households consisting of 7 and more members was 40 per cent while the corresponding proportion among non-acceptors was as large as 47 per cent.

A comparison of survey and registration data in respect of age of acceptors showed that there was under-reporting of the ages of older couples to some extent. In respect of data on the number of living children also it was observed that as per the registration data couples with very large families or 7 or more living children were shown as having less number of children.

POLICY IMPLICATIONS

Sterelisation is given high priority in the implementation of the FP programme. Presently 28 per cent of the eligible couples are effectively protected by various family planning methods of which the share of sterilisation is as large as 25 per cent. But the working group on population policy in its interium report has recommended 60 per cent effective coverage of eligible couples under family planning programme so as to achieve a net reproductive rate of 1.00. That is by another twelve years from now the programme achievements especially in the field of sterilisation will have to be doubled.

The question remains whether at the present rate of coverage of couples, 60 per cent could be achieved in the next 12 years. Clearly the target appears to be beyond reach. However in order to step up the tempo of family planning programme an important step would be to allocate increased resources to expand the family planning service facilities. presently targets are tagged on to the available resources in men and material and hence unless this constraint is removed higher targets would be impossible to achieve. The increased expansion of family planning services greatly facilitates setting of higher targets. Demographers have been advocating setting up of higher targets. For instance Mukerji [4] pleads for an annual 3 million sterilisations instead of 2 million as at present.

Comparision of IUD acceptors and non-acceptors showed that non-acceptors were slightly older than IUD acceptors and hence with increased grass root level staff it should not be a difficult to extend IUDs and Oral pills to a larger number of non-acceptors who need to be helped in accepting family planning method.

Monetary incentives both for tubectomy and IUD acceptors should be enhanced so as to increase the number of acceptors.

Better follow up services would be another important aspect which needs to ensured to acceptors.

Persons engaged within agriculture such as cultivators and agricultural labourers are under represented among the acceptors and hence there is greater need to step up motivational and educational programme in respect of family planning among this important section of the rural society.

A sizeable number of non-acceptors were covered under maternal and child health care programme but family planning information was not disseminated and hence efforts to motivate them to accept family planning may yield rich dividends.

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