CHAPTER I

INTRODUCTION

1.1 Background

Planning in independent India in its very start recognized the inter-relationship between population growth and socio-economic development that India became the first country in the world to have an official family planning programme way back in 1951. Despite an impressive measure of success in spreading the programme, the overall growth of population has, however surged forward. As such there is still cause for serious concern and need for a renewed appraisal of various aspects of functioning of the programme as well as the essential developmental activities to be strengthened along with it. India being the second most populous country in the world and its contribution to world population growth being so significant that an effective solution to India's population problem will amount to a great measure in solving the giant task of world's population problem.

An examination of the demographic trends in a country as vast as India would indicate that the nature of the demographic problems varies from
one part of the country to another. There continued to be wide variations among the states and districts in terms of contraceptive use and fertility. Yet, as is well known, the Government had more or less adopted a uniform programme or strategy throughout the country in the past. However, a tentative beginning has begun in recent years to focus attention on those states or areas that are backward in family planning performance as well as developmental inputs. In this connection, the major Hindi belt area constituted by four states, Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh which are geographically, linguistically, socially and culturally more or less homogenous and containing 40 percent of India's population and contributing to more than 42 percent of the net increase of the population has been identified as the most vulnerable part demanding a thrust effort in family planning. The present study is an attempt to identify the role of key elements in the family planning programme strategy and examine their impact to achieve further increase in contraceptive use in one of these states, which is Madhya Pradesh.

Government has initiated several programmes and actions to curb population growth. Several programme efforts of the government and non-programme efforts through interdepartmental linkages, and linkages of NGOs are mentioned very briefly.
1.2 Programme efforts

During the five past decades India has gained the experience of experimenting with different strategies of popularizing family planning in an effort to increase the acceptance rate of various contraceptive methods among the reproductive couples. Started with a 'clinical approach' the programme has developed gradually into a community based service system through a vast network of Primary Health Centres (PHCs) and Sub-centres (SCs).

PHCs and Sub-centres were established throughout the country to provide curative, preventive, and promotive services in the community. The First Five Year Plan (1951-56) gave importance to the training of maternity and child welfare services were made an integral and important part of the primary health centre services. Each PHC had a staff of one health visitor and one auxiliary nurse midwife and a trained dai at sub-centre. The dai training was emphasised during the Second Five Year Plan (1956-61). Maternity and child welfare formed the basis of PHC services during Third Five Year Plan (1961-66). Public cooperation and maternity and child welfare operations in the rural areas including domiciliary services were incorporated into the Plan. The Fourth Five Year Plan (1969-1974) was significant in that an attempt was made to integrate maternal and child welfare services with family planning. The Ministry of
Health and Family Planning was designated the Ministry of Health and Family Welfare.

During the Fifth Five Year Plan period (1974-78, which was of four years' duration) nutrition services to deal with malnutrition in children of preschool age and expectant mothers, which had been introduced in the Third Five Year Plan, were strengthened. In 1975 the Integrated Child Development Service (ICDS) was launched in the rural areas. ICDS projects also helped in promoting family planning. The Sixth Five Year Plan (1980-85) laid emphasis on immunization programme and covered BCG, typhoid, polio, and DPT.

It can be mentioned that during the seventies, the Family Planning Programme focused mainly on terminal methods and the Programme received set back due to rigid implementation of a target based approach. The Programme has, however, remained fully voluntary and the main effort of the Government has been to provide services on the one hand and to encourage the people by information, education, and communication on the other hand to use such services. The experiences gained, within the country and outside, had amply established that the health of women in the reproductive age group and of small children (upto 5 years of age) is of crucial importance for effectively tackling the problem of growth of population which led to change in the approach
from Family Planning to Family Welfare. Since the Seventh Plan implemented during 1985-90, the family welfare programmes have evolved with focus on health needs of the women in reproductive age group and of children below the age of 5 years on one hand and provision of contraceptives and spacing services to the desirous people on the other hand. The main objective of the Family Welfare Programme for the country henceforth has been to stabilize population at a level consistent with the needs of national development.

The Universal Immunisation Programme (UIP) aimed at reduction in mortality and morbidity among infants and younger children due to Vaccine Preventable Diseases was started in 1985-86. The Oral Rehydration Therapy (ORT) was also started in view of the fact that diarrhoea was a leading cause of deaths among children. Various other programme under Maternal and Child Health (MCH) were also implemented during the Seventh Plan. The objectives of all these programmes were convergent and aimed at improving the health of the mothers and young children and to provide them facilities for prevention and treatment of major disease conditions. While these programmes did have a beneficial impact, separate identity for each programme was causing problems in its effective management and this was also reducing somewhat the outcomes. Therefore, in the nineties, that is, the Eight Plan
period, these programmes were integrated under Child Survival and Safe Motherhood (CSSM) Programme and were implemented from 1992-93.

The Approach Paper to the Ninth Plan brought out by the Planning Commission has brought out the inadequacy of the investment made for Family Welfare. This is a severe handicap, particularly when it is noted that in almost all respects, the health care system needs upgradation and it needs to reach out to many more people for the national goals to be achieved. While there is a steady improvement due to economic development, spread of education/literacy and female empowerment, substantial problems remain to be solved in the weak performing states.

The process of integration of related programmes initiated with the implementation of the CSSM Programme was taken a step further in 1994 when the International Conference on Population and Development in Cairo recommended that the participant countries should implement unified programmes for Reproductive and Child Health (RCH). The RCH approach in its definition hails the theme,

"People have the ability to reproduce and regulate their fertility, women are able to go through pregnancy and child birth safely, the outcome of pregnancies is successful in terms of maternal and
infant survival and well being and couples are able to have sexual relations free of fear of pregnancy and of contracting diseases."

This concept is in keeping with the evolution of an integrated approach to the programmes aimed at improving the health status of young women and children, which has been going on in the country. It is obviously sensible that integrated RCH programme would help in reducing the cost of inputs to some extent because overlapping of expenditure would no longer be necessary and integrated implementation would optimize outcomes at the field level. During the Nineth Plan, the RCH Programme, accordingly, integrates all the related programmes of the Eight Plan. The concept of RCH is to provide the beneficiaries need based client centred demand driven high quality and integrated RCH services. The programme incorporates the components covered under the Child Survival and Safe Motherhood Programme and includes two additional components, one relating to sexually transmitted diseases (STD), and other relating to reproductive tract infections (RTI).

1.2.1 IEC Policy and programme efforts

IEC efforts utilize a variety of channels of communication including mass media, folk media, as well as interpersonal media. The basic philosophy
underlying the communication strategy since 1965 was to focus on only a few meaningful messages and disseminate them in the same form using all available and possible channels. The communication experts, thus took a rather simplistic and linear view of the communication process at the policy level.

The population policy in 1977 led to the development of a population communication strategy for the guidance of media and extension personnel. The communication strategy emphasised the importance of the integrated role of the media and extension personnel. Following the communication policy of 1977, the planning commission set up a working group on population policy. The group evolved a three point motivational strategy – (i) Strengthening of the climate in favour of the programme through mass media (ii) Increasing acceptance through the group situation and interpersonal communication, and (iii) Promotion of population education through both formal as well as non-formal channel.

The group did not favour the use of high cost media. The increasing use of radio was recommended in view of its extensive outreach. Differential communication strategies for specific target group was again emphasised, and separate communication strategy for different states taking into consideration the demographic situation, the needs, resources and socio-cultural setting was also put forward.
The communication strategy for the Sixth Five Year Plan (1978-79 to 1983-84) advocated strengthening the credibility of the programme. Attention was given to positive factors other than contraception which influence fertility. Promotion of population education is emphasised to increase community participation in rural health schemes through formal and non-formal channels. The communication strategy from 1985-96 to 1989-90 (Seventh Five Year Plan) emphasised on frequency and reach, campaign on spacing method, norm of two children irrespective of sex composition. Stress is given to move to a broader base of social communication highlighting the various areas beyond family planning that impinge on its acceptance, with further emphasis on a people-sensitive and local-specific approach. Area specific campaigns and IEC training for health personnel is our consideration.

The communication strategy of 1991-92 further stressed to broadening the scope of the family welfare message from a macro-demographic stereotype with narrow emphasis on sterilization to a life cycle approach – population education for the young, raising the age of marriage, safe motherhood, spacing, child survival, antenatal, and post-natal care with stress on women’s status and promotion of male responsibility in sharing the contraceptive burden. Development of state media plans on differentials that exist among areas so as to optimize utilization of media resources. Special scheme for population not reached by any media is
planned. Greater emphasis is given on extension education. The National Population Policy, 2000 suggested to coverage IEC efforts across the social sectors. Emphasis is given to spread the messages through every possible media, including public transport, hoardings on road-sides, films, school dramas, public meetings, local theatres, folk songs etc. Stress is given to involve departments of rural developments, social welfare, transport, cooperatives, education with special reference to schools, to improve clarity and focus of the IEC effort, and to extend coverage and outreach. The field level functionaries need to be sensitized across diverse sectors (education, rural development, forest and environment, women and child development, drinking water mission, cooperatives) to the strategies, goals and objectives of the population sterilization programme. Funding of nagar palikas, Panchayats, NGOs and community organizations is suggested for interactive and participatory IEC activities.

**Mass media:** India has a fairly sophisticated communication system. The mass media consists of all other major elements viz. press, TV, and radio in a mix of both public as well as private sectors. The mass media was adopted as a vehicle for communication in the mass education and media (MEM) within the Ministry of Health in the late sixties and since then the family welfare programme has made exclusive use of radio, TV, film, posters, and other materials at both the national and state levels. Radio has proved to be the most predominant source of family welfare
information. More rural listeners discuss family welfare information with others than urban listeners. Although the reach of family welfare messages through radio is quite high, it is less effective, as the mode of presentation is generally in the form of talks, interviews and discussions.

**Interpersonal communication:** Interpersonal communication is an integral part of the IEC strategy, as this constitutes the communication channel for the service providers. The quality of contact between frontline field workers and clients is of strategic importance. Due to high illiteracy rate and poor access to the mass media, extension workers, village health guides (VHGs) and trained birth attendants (TBAs) are considered as non-programme personnel to boost the interpersonal communication infrastructure. The challenge for IEC planners is how to influence the quality of millions of transactions conducted every day between field workers and their clients in personalizing communication needs and motivating people.

**Training:** Training assumes higher priority in the IEC activities to implement objectives and to emphasise on creation of ‘demand generation’. Training programmes for workers are largely institution-based and such programmes mainly concentrate on imparting knowledge rather than skill development and problem solving. Few training programmes provide opportunities for on-the-job training. The workers need apart from
technical knowledge extension skills. It is essential that they should be trained to primarily address the issues of how and why to communicate, rather than what to communicate. Grass roots level workers and block extension educators (BEEs) need comprehensive training on extension methods, participation method of training, organizing group discussions and meetings.

**Interspouse communication:** A critical factor influencing the adoption of family planning is the quality and nature of inter-spouse communication on the subject. Several studies have shown that the correlation between family size limitation and factors such as at which stage in the life-cycle the couples discuss family planning with each other – before the first child, after one child, or only after having attained the desired family size and composition. The question of interspouse communication cannot be addressed in isolation of overall status of women concerns. Nevertheless, the importance of this need to be communicated to village-level functionaries, who could attempt to address the issue either at small group forums such as Mahila Mandals, or by calling on husband and wife together on household visits.
1.2.2 Availability and accessibility

Rural health and family planning services in India are provided mainly through a chain of sub-centres, primary health centres (PHCs), and community health centres (CHCs). According to the norms there is one sub-centre for every five thousand population, one primary health centre for every 30 thousand population, and one community health centre for every 100,000 – 120,000 population. Currently there are about 30,000 PHCs, and about 1,31,000 sub-centres throughout the rural areas in the country. Through these health centres a host of preventive, promotive and curative services are offered to the clients. At the grass roots level multi-purpose male and female workers play a very crucial role and provide an important linkage between service delivery system on one hand and the beneficiaries on the other.

Access to family planning services is the availability of people to obtain family planning from a service-delivery system. It is traditionally understood to encompass four dimensions, geographic, economic, administrative, and information access, all of which can be influenced by programme managers. Geographic access refers to the number, type and location of services; economic access refers to the costs of obtaining services incurred by prospective users; administrative access refers to programme norms and procedures that may facilitate or restrict a client’s
ability to obtain services; and information access refers to the amount of information available to prospective users about services. Some others referred about fifth dimension of access, psychosocial access, refers to factors such as social approval, stigmas, or individual attitudes that can facilitate or prevent potential clients from using programme services.

1.2.3 Quality of care

Quality of care helps to establish good rapport with the clients and to win their faith. Quality has always been a family planning programme issue, although it did not move to center stage until the nineties. Communication effectiveness also depends on effectiveness of health delivery services. Mass media or interpersonal communication will not provide the desired impact unless they are accompanied by quality of service provided by the health functionaries. Improved quality care is also an increasingly important goal of family planning programmes. The available studies show that people's perception on the quality of service is quite poor. In India where a few significant follow-up studies were undertaken, the IUD was simply dropped as a programme method after the first signs of any health problem leading to significant IUD discontinuation rates appeared and rumours circulated of horrendous side effects. The motto in Taiwan became, "Follow the woman not just the
method”. These careful follow-ups in Taiwan were illustrative of a considerable effort to stress quality of care.

Bruce (1990) has set up six elements of quality of care: Choice of methods, information given to clients, technical competence of service providers, interpersonal relationship, continuity of use or follow up services, and appropriate constellation of services.

Choice of methods refers both to the number of contraceptive methods offered on a reliable basis and their intrinsic variability. The method to be offered to serve to clients having different characteristics like different age-groups, contraceptive intentions, lactation status, health profile. Satisfactory choices of contraceptive need to be done for men and women who wish to space or who wish to limit.

Information given to clients refers to the information imparted during service that enables clients to choose and employ contraception with satisfaction and technical competence. It includes advantages and disadvantages of method, how to use a method, possible side effects etc.

Technical competence involves competence of the clinical techniques of providers. Interpersonal relations are personal dimensions of services.
Relations between providers and clients are strongly influenced by management style, and ratio of workers to clients. Follow-up services include forward appointments, home visits etc. to win the trust of the people so that they readily accept health and family planning services.

Appropriate constellation of services refers to situating family planning services so that they are convenient and acceptable to clients, responding to their natural health concepts, and meeting pressing pre-existing health needs. Services can be appropriately delivered through a vertical infrastructure, or in the context of MCH initiatives, postpartum services, comprehensive reproductive health services etc. (Bruce, 1990).

It has been argued that in assessing the quality of care the clients' perspective should form the focal point. In other words the degree of quality of care should be assessed in terms of what is received by the client than what is provided by the provider.

1.2.4 Social marketing

India is one of the first countries to develop a Social Marketing programme as a mechanism for delivery of contraceptive products. In 1968, Social Marketing programme was initiated under the name of the Nirodh Marketing Programme, with the help of giant consumer goods,
pharmaceuticals and oil companies both in the public as well as private sector. The Nirodh Marketing programme represented an unprecedented collaboration between Government and business designed to expand contraceptive usage among Indian Couples by distributing government subsidized condoms through the networks of private companies. Social Marketing of oral pills also is one more important dimension in this field. Launched in 1987, four pharmaceutical companies were involved on a regional basis.

A systematic publicity campaign through Radio, TV, AIR, and Cinema is being carried out by DAVP. Other publicity efforts such as hoardings, wall paintings, point of sale (POS) material, advertisements through local press, or ongoing displays are being carried out by marketing companies in their areas of operation.

1.3 Outside programme efforts

The National Population Policy (NPP 2000) mentioned comprehensive and multisectoral coordination of planning and implementation between health and family welfare on the one hand, along with schemes for education, nutrition, women and child development, safe drinking water, sanitation, rural roads, communications, transportation, housing, forestry
development, environmental protection, and urban development on the other hand.

1.3.1 Horizontal interactions

At the district/block level, a multitude of departments/development programmes operate, with the same fundamental objective of enhancing the overall quality of life and meeting certain basic unmet needs. The interaction between the health department and other departments (like ICDS, education, agriculture, revenue, post-office etc.) at the district, block, and village level exists. These forums were being regularly used to exchange ideas and disseminate information. Certain departments or programmes had the potential for developing a close link with family welfare IEC. The departments and programmes which are seen to have a linkage with health in some way, have been categorized into three groups, (i) Health Influence Programmes (WCD, DWCRA, IRDP), (ii) Health Improvement Programmes (Adult Education, Non-formal Education, TRYSEM), Health related Programmes (ICDS, Rural Water Supply, Sanitation). At district level, the interest, attention, and initiatives that district collector brings to bear on health and family welfare related issues is perceived to be an important element in the success of the programme.
1.3.2 Non-government organisations (NGOs)

NGOs have considerable potential in achieving family planning objectives. Many NGOs have demonstrated their potential by making a substantial impact on family planning adoption and fertility reduction in their target areas. NGOs are community-based, community oriented and often utilize community resources and run by community as well. Most of the NGOs draw their grassroots level workers from the community itself. Hence, they are able to establish a fair amount of credibility, support and rapport with the population. NGOs are flexible and region and culture specific. In conducting family welfare activities they are able to respond to the people’s needs, traditions, resistance and misconceptions in a better manner.

There is a need of more coordinated efforts between Government and NGOs so that the strengths of each are exploited in providing health care and family welfare services to the people. Also, it is important that all NGOs receive training and education on all aspects of family welfare so that they can completely address the people’s doubts and queries.

1.3.3 Role of organized sectors

The role of organized sector for the promotion of family planning has been well recognized. Today, in most of the large industries, population
education and family planning services are provided as routine welfare measures of the company. Many industries had taken this initiative long ago. TVS-Lukas group of companies in Madras took the earliest initiatives in 1938. The Tata Group of industries also embarked on family planning programme around 1950, other earlier starters were Alembic Chemicals (1956), Godrej & Boyce (1957), India Tea Association (1957 in Assam), Hindustan Spinning and Weaving Mills (1962), Indian Oil Corporation (Gujarat Refinery, 1964). At TISCO, a major industry of Tata which is located in Jamshedpur, special care was taken in planning and developing educational and motivational campaigns. These programmes included programme for family life education programmes for parents of tomorrows, opinion leaders' training, and special orientation programme for officers, staff, and trade union leaders. Apart from these, various channels of mass media, folk dance and other innovative approaches are also used to popularize family planning. In the public sector, the Defence Services, The Railways, Posts and Telegraphs and several large industrial undertakings followed.

1.4 Socio-cultural environment

Socio-cultural factors affect the demand for and the supply of children and thus, affect the motivation to use fertility control. While family planning is a sensitive issue, the present policy and socio-cultural
environment is positive. Although a few minority group express opposition to the programme, India remains to be one of the few countries where dominant cultural values do not pose any serious obstacle to adoption of contraceptives. Some socio-cultural factors do dampen programme initiatives included poor status of women, illiteracy, early marriage, son-preference, poverty, and agrarian economy. Despite these, most Indians approve the idea of family planning. A few are indifferent to family planning behaviour is perhaps more psychological than cultural and more sporadic than systematic. Doubts and misconceptions from the public also account for some resistance.

Economic utility of having a son arises since he is a wage earner, help in agricultural activity and above all as a security in old age. Religious utility stems from performance of sacred rites of lighting the funeral pyre of both parents by sons. In societies where son preference is strong, intension to use contraception will depend on number of living sons.

1.5 Objectives of the study

The objectives of the study is to have a comprehensive examination of the family planning programme in the state of Madhya Pradesh and to identify various factors influencing contraceptive use. In this context it tries to examine the various aspects of family planning programme and its linkages with other programmes in an effort to crystallize key strategic
issues that can effectively influence performance of contraceptive use.

Towards this the following specific objectives are pursued in the various chapters of the thesis

1. Regional variations in the contraceptive use in Madhya Pradesh and factors influencing the regional variation of use or non-use of contraceptives.

2. To study met and unmet need of family planning in Madhya Pradesh

3. The study aims to identify a comprehensive set of measurable indicators of programme effort, outside programme effort, and social setting factors which are influencing the use or non-use of contraception.

4. After identifying the programme input elements, the next step is to measure them in an effort to observe their impacts. Here, the linkages of the programme factors with non-programme factors and the individual characteristics are assessed.
5. A few key elements from the programme and non-programme factors that are determinant factors for the adoption or non-adoption of contraception are explored.

6. Finally, the mechanism of relationship among the selected factors with the contraceptive use is examined.

1.6 Location of the study

As mentioned earlier the present study is planned to be undertaken in Madhya Pradesh (old Madhya Pradesh, that is, present Madhya Pradesh and Chhattisgarh states together). As its name suggests, the state, Madhya Pradesh is situated in the middle of India. The state (before bifurcation in 2000) borders with seven states, namely Uttar Pradesh, Bihar, Orissa, Andhra Pradesh, Maharashtra, Gujrat and Rajasthan. Director of census operations, Madhya Pradesh mentions geographic feature of Madhya Pradesh as:

"Undulating topography characterized by low hills, narrow villages, plateaus and plains is the general physiography of the state which separates the fertile Gangetic plains of Uttar Pradesh in the north from the broad table land of
the Decant Plateau". Almost one-third of the state is forest area.

Madhya Pradesh, before bifurcation in 2000, was the largest state of India in terms of land area. As per the 1991 census, the state has 66 million population (according to 2001 census 81 million population for Madhya Pradesh and Chhattisgarh states together), 8 percent of the country's population and 14 percent of the country's land area. About 15 percent of the total population is scheduled castes and 23 percent scheduled tribe.

Madhya Pradesh is predominantly an agricultural state, with 77 percent of its population living in rural areas. The state is self-sufficient in the production of food grains. Industrially, the state is less developed. Jute goods (sacking bag), cement, sugar, vanaspati ghee etc. are the main industrial products. The state has rich mineral wealth, including bauxite, coal, copper, diamonds, dolomite etc. About 41 percent of the rural population and 20 percent of the urban population were estimated to be below the poverty line. Madhya Pradesh is one of the most educationally backward states in the country. According to NFHS-2 in 1998-99, 56 percent of females and 28 percent of males age 6 and over are illiterate.
The demographic situation in Madhya Pradesh shows a dismal picture. The estimated currently married women are about 14 million (in 1998). Only 6 million of them are current users of any method of family planning. According Sample Registration System (SRS, 2000), the crude birth rate and death rate were 31 and 11 respectively in 1998. The infant mortality was estimated as 98. Health conditions in Madhya Pradesh are poor. The NFHS-2 conducted in 1998-99 showed that only 30 percent of births in the state were attended by a health professional. Only 22 percent of children ages 12-23 months were fully immunized. About 45 percent of currently married women had a reproductive health problem. Contraceptive prevalence rate was 44 percent. About 65 percent of women age 20-24 married before age 18.

The state has initiated its own population policy and set the target to reach replacement level of fertility (TFR 2.1) by 2011. To reach the target the state needs immediately special developmental and programme efforts swung into action.

1.7 Data Used and methodology

The present study is based on both secondary and primary data.
**Secondary Data:** In 1998, Government of India initiated Rapid Household Survey (RHS) in all the districts of India to collect district level data on reproductive and child health (RCH) related information like utilization of the services provided by government health facilities and also people's perception of quality of services etc. Half of the districts in each state are covered under Phase-I in 1998, and the remaining districts are covered under Phase-II in 1999. For selection of districts in a state in Phase I, all districts of the state are alphabetically arranged. The first district was selected with a random start from either first or second district and then the alternative districts are selected. Following this procedure 23 districts are chosen in Phase-I and 22 districts in Phase-II.

In the selected districts, 50 Primary Sampling Units (PSUs, Village/Wards) were selected adopting probability proportional to size (PPS) sampling. The Village/Ward level population was taken as per 1991 census. The sample size for RHS-RCH was fixed at 1000 households, 20 households from each PSU. In order to take care of non response due to various reasons, an over sampling of 10 percent was done. In other words, 22 households from each PSU were selected following circular systematic random sampling. The data provides detail information on reproductive care of women and contraceptive use practices of 41,254 currently married women in the age-group 15-44 covering 45 districts of Madhya Pradesh. The number of women covered in each district is provided in Table 3.1.1.
Primary Data: In the RCH-RHS data detail information on programme inputs was lacking. So, the relevant information in this regard were collected in field survey undertaken during January-February, 2002 in three districts of Madhya Pradesh. For the selection of three districts, at first stage all districts are grouped into two categories. the first category comprised all those districts having good performance of contraceptive use. The second category included all those districts having poor performance of contraceptive use. Within the group the districts are arranged in descending order of performance of contraceptive use. From the first group the district having highest performance of contraceptive use, and from the second group, the district having lowest performance of contraceptive use is considered. From the first group, Indore district was selected representing good performance of family planning. From the second group, Panna district was selected representing poor performance of family planning districts. Further, since the proportion of scheduled tribe population in Madhya Pradesh is high, one district purposely was selected where dominance of scheduled tribe population exists. For this the district Jhabua was selected where proportion of scheduled tribe population is highest, more than 80 percent of the district population.
Again, from each of the selected districts, 3 PHCs were randomly selected. From each of the selected PHCs in the three districts, 5 villages, 1 PHC village, 2 Sub-centre villages, and 2 remote villages (having no health facility around 5 km.) are considered. From each selected village 15 to 25 married women (depending on population size of the village) in the age-group 15-44 years were interviewed. A care has been taken while selecting households from a village such that all sections of the community get a representation. In total 998 women are interviewed from 45 villages covering 15 PHCs in the three districts. The names of the villages, PHCs covered during the survey are presented in Appendix-5.1.

From each of the selected PHCs and sub-centres, detail information regarding availability of infrastructural facilities, staff, trained manpower, drugs and medicines, necessary instruments, vehicles, staff quarters, vacant posts etc. are taken. Apart from availability of resources, service providers from PHCs and sub-centres like doctors, LHVS, ANMs are interviewed to know about the trainings they have received, knowledge about RCH, work experience, supervision and monitoring work done, linkages with other departmental workers, involvement of NGOs and private doctors etc.
1.8 Conceptual framework of the study

The reproductive behaviour of couples is influenced, apart from biological factors, by social, cultural and physical environment in which they live. Hence without significant societal, economic and behavioural changes there can not be expected to have a substantial reduction in fertility. As discussed earlier the reduction of fertility through increased use of contraception requires simultaneous efforts from various quarters and for that matter the co-operations of various organisations and agencies are imperative. In short, linkages of programme efforts with outside programme efforts like inter sectoral co-operation, involvement of NGOs and local community leaders are to be established which will provide much credibility to the programme and hasten the acceptability of the programme as “people’s programme”. A conceptual framework outlinking Programme Efforts, Outside Programme Efforts and individual characteristics is shown in Chart-1.1.

1.9 Hypothesis

On the basis of conceptual framework of the study, it is conjectured that better programme efforts like more availability and accessibility of programme inputs, trained manpower, effective IEC activities etc. will lead to improved quality of services and will provide the beneficiaries
need based contraceptive services. Other non-programme efforts like interdepartmental cooperation and involvement of NGOs will help in motivating people in the acceptance of family planning. At individual level, couples having better socio-economic status, residential premises in progressive areas contribute to shape the attitudes, progressive outlook and behaviour in relation to contraceptive use. So, the following specific hypothesis have been formulated to be tested in the study.

1. Increased availability of infrastructural facilities, health personnel, contraceptive supplies and necessary instruments will lead to increased adoption of contraceptives.

2. Good knowledge and training of health functionaries on RCH services will help to promote contraceptive use

3. More supervision and monitoring work will lead to improved quality of services which in turn will induce contraceptive use.

4. More IEC activities, social and interpersonal communication will lead to more interspousal communication which in turn will lead to increased contraceptive use.
5. The more clients are satisfied with the quality of health delivery services, more will be use of contraception.

6. More linkages with other departments will help to promote contraceptive use.

7. The more cooperation of NGOs in health and family welfare programme, the more will be participation of clients in contraceptive use.

8. Clients belonging to better socio-economic group have more progressive outlook and behaviour and have more contraceptive use.

9. Clients residing in more progressive areas are more prone to contraceptive use.

1.10 Statistical methods for data analysis

At the first stage, information collected from the field survey were scrutinized and initial editing and coding of the information were done. Then coded information were entered into computer. The raw data were
edited further to remove any discrepancies or any possible error crept into during the data entry through range and consistency checks.

At the second stage, the variables were suitably categorized to suit different types of analysis. At the third stage, various statistical analyses were done through SPSS package. The various statistical analysis techniques employed include multiple regression analysis, hierarchal regression analysis, logistic regression analysis, multiple classification analysis (MCA), and path analysis.

Hierarchal regression has the advantage that it allows for causally prior variables in a regression when variables are arranged in a logical sequence. The MCA analysis gives mean values of different categories of predictors before and after adjustment for other factors. It also provides unadjusted and adjusted deviations from mean value, which show the extent of deviations from mean before and after controlling with respect to other variables. Also, an attempt has been made here to see the impact of influencing factors, on the contraceptive use through logistic regression. It provides the likelihood that a woman having particular characteristics practices contraception or not.

Path analysis helps to interpret the result of regression and MCA further. It elaborates the mechanism of relationship between a set of independent
variables and dependent variables. It enables in making the logic of regression calculations explicit and in identifying the indirect and spurious effect of the independent variables.

1.11 Chapterisation plan

This thesis is divided into nine chapters.

Chapter I which is the present chapter contains the background information about several factors which directly or indirectly influence contraceptive use. It also provides the objectives of the present study, hypotheses, and the various statistical methodology used for data analysis.

Chapter II deals with review of literature on various factors influencing contraceptive use or non use

Chapter III provides regional variation in contraceptive use. Also, factors responsible for regional variation are studied here.

Chapter IV focuses on met and unmet need of family planning. Here an effort is made to study proportion of total demand which was met and unmet, and also to assess factors responsible for it.
Chapter V presents clients perspectives on contraceptive use based on primary survey data.

Chapter VI describes roles and linkages of contraceptive use and measures various dimensions of programme, non-programme, and social setting factors, which are directly, or indirectly influencing contraceptive use. Here, contraceptive use differentials due to various programme, non-programme, and social setting factors are studied.

Chapter VII concentrates on impact assessment. Here, at first stage key elements, which had significant impact on contraceptive use, are identified. Then various impact assessments are carried out using various statistical techniques. Mechanism of the relationship is also assessed.

Chapter VIII provides a summary and conclusion of the study.

Reference is provided at the end.
Figure 1.1: A conceptual framework outlining programme efforts, non-programme efforts and individual characteristics