FINDINGS
SOCIO-ECONOMIC AND CULTURAL BACKGROUND

OF THE ACCEPTED GROUP.
The subject matter of this Thesis is "Socio-economic and cultural determinants of fertility and fertility control". To make an indepth study of this topic, as already stated, I have enrolled all total 850 women of which 400 women chosen from those who have accepted the fertility control methods. Again of these 400 women, 200 woman have accepted permanent method (Sterilisation) and 200 temporary methods.

This study was carried out with a view to isolate the socio-cultural factors associating with the acceptance of the fertility control methods, among sample group of women and also identify the socio-cultural barriers for the acceptance of the fertility control methods. I have discussed the findings under the following heads- Respondent's age, place of residence, size of the family, occupation, level of education, parity, preference of son etc. Socio-economic background of the respondents is a very important elements in the field of social research. Without knowing the background of the respondents, it is very difficult to proceed with the work of research and come to a conclusion. All total 400 cases have been interviewed personally to get actual ideas about their socio-economic and cultural background. First of all I had taken the idea of their attitude towards the family size norm. Socio-economic background of the respondents exercised a
great influence on their mental make-up and attitude towards different problems of society and life. A society with people having an ideology in mind sticking to more traditional and conservative ideas, new ideas and methods are never accepted. On the other hand a society having people with broad outlook and education is always prepared to march with the time. Society is an organism. According to August Comte1 'Society grew as a result of the extension of the family unit, families become tribes and tribes became nation. So that whole race might be conceived of as the gradual development of single families'. Society is a network of human relationship. It consists of relationship among the different individual. Every normal human being lives in a society. Long ago Aristotle remarked that 'he who does not need society is either a beast or a God'. He stated that 'man is by nature a social animal'. Individual is an unit of society but he feels the presence of the society within a group. Society and individual do not denote separate phenomenon but are simply collective and distributive aspect of the same thing. According to Lapier2 'the term 'society' refers not a group of people but to the complex pattern of the norms of interaction that animals among and between them'.

Ref.1 : August Comte - Positive Philosophy, 1855, New York.
In the present study, it seems to be very important to study the social background of the respondents as it is concerned with the socio-economic and cultural determinants of fertility and fertility control. The fertility level of a community has been observed as the outcome of a complex set of factors - biological, social, cultural, economic, demographic and political that are constantly operating on the population and these factors interact with each other with regard to their effects on fertility.

In the present study, the major correlates of differential interacts such as family, age, sex, marriage, religion, education, place of residence and economic condition of the families were discussed thoroughly.

**Family:**

Family is a commonly used word and in a general sense well understood. It refers to a universal permanent pervasive institution characterised by socially approved sexual access and reproduction, common residence, domestic services and economic co-operation. The family has passed through several stages of development since the time of 'Vedas'. Of all human groups the family is the most important primary group. It is a small social group consisting ordinarily of a father, mother and one or more children.
Historically it has undergone several changes. At the very outset it is important to explain the meaning in which the term 'family' is used. The word 'family' has been taken over from the Roman word 'Famulus' meaning a 'Servant'. In Roman law the word denoted the group of producers and slaves and other servants as well as members connected by common disent or marriage. Thus family is a group of people united by the ties of marriage, blood of adoption, constituting a single house-hold interacting and intercommunicating with each other. According to Summer and Killer 'Family is a biological unit implying institutionalised sex relationship between husband and wife'. It is both a institution and association. It is a universal institution found in every age and in every society. It is the primary cell out of which the community developed.

Preference of Family:

There may be two kinds of family joint and nuclear. Though the nuclear family is more typical in modern time, joint families are not died out as yet. In the modern India, too, the people have appreciation towards traditional norms and values. From this point of view we studied the preference of the respondents towards the both types


Ref. 4 : Summer and Killer- Folkways, 1940.
of families. As the attitude of the individual is generally coloured by the influence of the particular family setting, the study of various types of family and preference towards the nature of the family is very important. The following table will present the attitude of the respondents towards the nature of family.

Table - 1:
200 Sterilisation cases.
Study: Sterilisation.
Family.

<table>
<thead>
<tr>
<th>Nuclear</th>
<th>%</th>
<th>Joint</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>18</td>
<td>9</td>
<td>182</td>
<td>91</td>
</tr>
</tbody>
</table>

Table - 2:
200 Temporary method users.
Study: Other contraceptive (Temp. method).
Family of 200 women.

<table>
<thead>
<tr>
<th>Nuclear</th>
<th>%</th>
<th>Joint</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>10</td>
<td>180</td>
<td>90</td>
</tr>
</tbody>
</table>

From the above two tables it is clear that out of total respondents 91%, 90% were coming from the joint families and only 9%, 10% from nuclear families.
On the theoretical considerations, such sociologist like Frank Lorimer, Kingsley, Devis and Judith Black maintained that extended family system are a major cause of high fertility in pre-industrial societies. Under joint family system the financial and physical burden of rearing of children is shared by others and large families carry prestige, but this is not all, there are other factors which counteract this tendency. It is therefore necessary to study fertility in the context of family structure and kinship organisation.

Family size norm:

In Assam, family size norms varies between different caste groups. For low and high caste Hindus informants the ideal numbers of children are 6 and 5 respectively. The second All India Family Planning Surveys shows that at national level of family with 2-3 children is considered small and with 4-8 children as large. This indicates that the couples of rural areas were still in favour of a relatively larger family. This was particularly true among the lower caste Hindu couples. The concept of small family norm is developing among most of the caste Hindus and Muslims except the Harijans. But Muslims believe that norms itself is an anachronism to 'Islam'. There is no social sanction for this. But it is slowly degenerating. The old generation on an average had 6 children and never at any point of time they thought of limiting their
family size in all the cultural groups. However, the present generation would like to limit to two sons and a daughter and would like to go for a fourth child if all the first three children happened to be boys or vice versa. Therefore, the present family size norm is a range of three or four children depending upon the value of children. Thus they do not have a definite norm for a small family but the preference is conditioned by the value of children.

No doubt they have relatively greater value for son as against daughter. A number of studies have shown that husband-wife communication on these aspects plays a crucial role in accepting fertility control devices and limiting their family size. Because there is a predominant 'son bias' among the Indian couples. In India fertility pattern and control behaviour is significantly influenced by the dominant pattern of the family cycle. From the above discussion it is seen that the percentage of preference towards joint family is high. The respondents under study belong to both the families joint and nuclear.

**Age at Marriage:**

We can distinguish two events in premarital life of an Indian married couple which together constitute marriage. The formal wedding or 'Shadi' establishing the ritual union of the Indian couple, takes place as soon as
the families concerned can arrange a satisfactory match. This may occur at any time after birth until the girl has reached puberty or beyond. After the formal wedding, the bride remain in her parent's home for one or several years depending on her age, till she is judged to have passed her puberty and is ready for consumation of the marriage, generally there is a second ceremony called 'Gauna' or 'Vida' after which the girl will transfer her residence to her husband's home. The engagement 'Shadi' and 'Gauna' together make up Indian marriage. This renders determination of age at marriage problematic. There is of course high relation between the age at marriage and the age at cohabitation. Most of the demographer attempt to find out that the age at the shadi ceremony and assume that gauna follows in approximately one year (Andrew Collver "The family cycle in India and United States of America Sociological Review" xxviii, 1963). According to the B.B. Dixon early age at marriage can be attributed due to feasibility and desirability of marriage. Clotton S. Ford in his topic 'A comparative study on Human Reproduction' stated that increase effective age at marriage to 20 years of little use because fecundity before the age of 20 years is low which Ford called as 'Absolute sterility'. In our state, since the day of independence, the traditional system of Indian marriage comprising of 'Shadi' and 'Gamna' has been significantly degenerating almost to nil by 1960's.
the purpose of my investigation I shall refer the age at marriage to the age at 'Gauna' or 'Vida'. That the male age at marriage is negatively correlated with fertility has been held by Anand, 1967 and Ghurye, 1934. But it has been observed that the latey married male having children more quickly than the early married to complete their family. In the present study similar significant observation has also been observed with the male age at marriage.

It has also been observed in the present study that the women contracting more than one marriage are having higher fertility. Similar observation was also made by Namoria, 1961, 1957 and Raina, 1965. It is due to the more longer period of conjugal life. It has also been observed that duration of conjugal life is directly proportional to fertility rate.

Table 3 and 4 will show the distribution of the respondents according to their age at marriage.

Table No.3: Sterilisation group (200 women).

<table>
<thead>
<tr>
<th>Group (Age at marriage)</th>
<th>No. of Women</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upto 15 years</td>
<td>16</td>
<td>8</td>
</tr>
<tr>
<td>16 - 17</td>
<td>38</td>
<td>19</td>
</tr>
<tr>
<td>18 - 19</td>
<td>72</td>
<td>36</td>
</tr>
<tr>
<td>20 - 22</td>
<td>30</td>
<td>15</td>
</tr>
<tr>
<td>23 - 25</td>
<td>24</td>
<td>12</td>
</tr>
<tr>
<td>26 and above</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>200</td>
<td>100</td>
</tr>
</tbody>
</table>
Table No. 4: Temporary method users (200 women)

<table>
<thead>
<tr>
<th>Group</th>
<th>No. of women</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upto 15 years</td>
<td>16</td>
<td>8</td>
</tr>
<tr>
<td>16 - 17</td>
<td>36</td>
<td>18</td>
</tr>
<tr>
<td>18 - 19</td>
<td>54</td>
<td>27</td>
</tr>
<tr>
<td>20 - 22</td>
<td>70</td>
<td>35</td>
</tr>
<tr>
<td>23 - 25</td>
<td>14</td>
<td>7</td>
</tr>
<tr>
<td>26 and above</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>200</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

From the above two tables, it is observed that most of the women were married between 18 - 22 years (36%, 27%). But percentage of marriage below 18 years is not negligible (26.5%).

Age at marriage is also an important factor for individual difference. People grow, learn and mature with their age. The age at which women marry is raising much throughout the world. This means more time for education, more time to earn job, skill and more time to be more mature physically and socially before starting conjugal life. Around the world, women marry for the first time at different ages. In developed countries like East Asia and few Latin American countries, two third or more women do not marry until the age of 20 years or above. In contrast to the Indonesian.
countries, the majority of women marry before the age of 20. In all the regions, women from urban areas with schooling education, tend to marry later - sometimes much later than the women of the rural areas and women who have not been to school, marry earlier. Almost in all the developing countries, young women in rural areas marry earlier than the woman in cities. Urban women are more likely to go to school and to work outside the home. This may help to account for later marriage.

Whatever may be their education or employment, most of the young people are concerned about marriage and family. The decisions they make—whom they marry, how old they will be, when they marry, how many children they will have, when to use birth control methods etc. will greatly influence their own lives and the life of their children. In all the countries, men marry later than women, or to put it in another way, men tend to be 5 to 6 years older than their wives. As we have noted that the age is an important demographic variables. In our country, people prefer early marriage for both male and female and consequently, show the high fertility rate. In 1904 Infant Marriage Prevention Law in Baroda State define the age at which marriage is permissible - 12 years for girls and 16 years for boys. The child Marriage Restraint Act of 1929 came into force from 1st April, 1930 popularly known
as "Sarda" was enacted prescribing minimum age for marriage for males as 18 years and for females 14 years. In 1949 the Act was amended raising the age at marriage to 15 years for females. This Act was more often violated than practised because of the lack of an effective law enforcing machinery. Following the national population policy announce in April, 1976, the Government of promulgated the child Marriage Restrain Act in 1978, raising the age of marriage for males from 18 years to 21 years and for females 15 years to 18 years. The act came into force from 1st October, 1978. But the effectiveness of such Act is doubtful as because in my study it has been releaves that quite a good number of females get married below 18 years of age occupying 26.5% in both the acceptors and non acceptors groups.

**Sex Ratio:**

Sex ratio is said to have negative co-relation with fertility by Chandrasekhar, 1946, 1943, 1961, Gandotre, 1967, Ghose, 1946; India, 1954, Memoria, 1961, Mukherjee, 1961, Sen, 1965; and Jain et al. 1967 considered sex ratio as being of no importance. Economically son is to help father in earning and religiously to offer last rites to his parent for salvation. A daughter in a family at present is also not neglected she is to help mother in domestic affairs and to earned "Punna" by donating
her to a bridegroom. Our society is bias for son, couples are having high fertility rate waiting for a son on the other hand some couples are also desiring for a girl child resulting high fertility.

The present study is in the opinion that sex ratio has got an important influence on fertility rate. K. Srinivasan et al in 1983 have strongly held that social and cultural values with regard to marriage, fertility of couples and particularly the preference for a son. Richard Lannoy in 'The Speaking tree. A study of Indian culture and society page 105 stated that the esteem of newly married bride increases with the number of children she conceives, particularly sons. Sex composition of the family has important bearing on fertility decision. It has been observed in the present study, higher the number of surviving sons, lower the proportion of the couple progressing higher parity or lower the subsequent fertility. 'Surviving son' is expected to show the influence of sex composition of the surviving children on future fertility.

Table-5: Age of the respondents at the time of sterilisation.

<table>
<thead>
<tr>
<th>Sterilisation group (200 Women)</th>
<th>No. of Women</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upto 20 years</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>21 - 25</td>
<td>49</td>
<td>24.5</td>
</tr>
<tr>
<td>26 - 30</td>
<td>99</td>
<td>49.5</td>
</tr>
<tr>
<td>31 - 35</td>
<td>37</td>
<td>13.5</td>
</tr>
<tr>
<td>36 and above</td>
<td>13</td>
<td>6.5</td>
</tr>
<tr>
<td></td>
<td>200</td>
<td>100</td>
</tr>
</tbody>
</table>
From the above two tables, it is observed that most of the temporary methods users were from the age group of 21 to 30 years. 49.5% of the women have accepted tubal sterilisation i.e. permanent method.

**Occupation and percapita income:**

Occupation refers to engagement of a person for livelihood. More precisely 'occupation is a regular activity of an individual which implies payment of remuneration'. Thus the role of occupation is very significant. Again husband's occupation should have an inverse relationship with fertility. Similarly wife's occupation is important predictor of fertility. However, in India data do not show inverse relationship as the majority of the rural women is illiterate.

Ref.5: A status study on population research in India, Vol.2, Demography S.P. Jain, 1975, P.141.
and engaged in cultivation or labour work. To study the effect of husband's occupation, distinct occupational categories are made. It is expected that those who are engaged in cultivation and in related jobs have relatively higher fertility than the fertility of the service groups and professional. Fertility is considered as a very complex phenomena that is affected simultaneously by economic factor. The importance of social and economic factor is emphasized by many studies, not only because they directly influence fertility behaviour, but because they are also important influences on the level of modernisation of the individual couple.

The family income was measured by dividing the total income of the family by the number of adult members of the family. It is however noted that this variables to some extent may not be correct in the sense that the respondent may have given incorrect information, either because the respondent did not know the real income of the family or because the respondent did not want that. So the interviewer should know the correct income as they are from the lower income group.

**Table-No.7: Per capita income (Sterilisation 200 women)**

<table>
<thead>
<tr>
<th>Monthly per capita income (in Rs)</th>
<th>No. of women</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upto 50/-</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>51 - 100/-</td>
<td>66</td>
<td>33</td>
</tr>
<tr>
<td>101 - 200/-</td>
<td>111</td>
<td>55.5</td>
</tr>
<tr>
<td>201 and above</td>
<td>13</td>
<td>6.5</td>
</tr>
<tr>
<td></td>
<td><strong>200</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
Monthly income: Temporary method users (200 women)

Table No. 8:

<table>
<thead>
<tr>
<th>Per capita income (Rs.)</th>
<th>No. of women</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upto 50/-</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>51 - 100/-</td>
<td>128</td>
<td>64</td>
</tr>
<tr>
<td>101 - 200/-</td>
<td>32</td>
<td>16</td>
</tr>
<tr>
<td>201 and above</td>
<td>32</td>
<td>16</td>
</tr>
</tbody>
</table>

From the above tables, it shows that 5% of the sterilisation cases belonged to families with monthly per capita income ranging from Rs. 51/- to Rs. 200/- in 33.3% of the cases. 66.6% of the per capita income ranging from 51/- to 100/- and in 55.5% it ranged from Rs. 101/- to Rs. 200/- while it was above Rs. 201/- in only 6.5%.

Of the total 200 women of temporary methods users, 64% women were from the families with monthly income of Rs. 51/- to Rs. 100/-. Majority of the women were from the per capita income group of Rs. 51/- to Rs. 100/-. Thus in general it appears that fertility of women of lower economic level was higher in every age group. So very low income group have higher fertility.

Educational Standard:

Level of education is said to be a depressor of fertility. Education enhance the quality of human capital.
and is indispensable to modernization. Couple's education should have an independent effect on fertility. Couple's education should be inversely related to age at marriage, desired family size and in turn to fertility. Fertility also bears a direct relationship to education. More husband's education and wife's education were taken. Educational services are more better than health, family planning and other welfare services which are important for both men and women. An educated couple is having better ability to manipulate the environment and maintain health and family well-being. There is enough evidence to show that consciousness about health and family planning of an educated women is better than that of an uneducated women.

Education pulls the mankind from dark to light and push up to brightness. It is an enlightenment which helps an individual to develop his personality, which includes all the influence acting upon an individual during his passage from cradle to grave. One of the task of education is to make him conscious about cultural values and behavioural patterns of the society and infuse the same in its junior and matured members. By this means society achieves a basic social conformity and ensure that its traditional mode of life are adequately modernised. But modern society also needs critical and creative attitude to make new inventions and discoveries and to initiate social changes. Moreover from the development point of view the purpose of
education must be to nationalise attitude as well as to impart knowledge and skills to the members of the society. In turn more rational attitude may provide a motivational preparedness that can facilitate for attainment of goal. Again educational position of the individual of a particular place, village, districts or state is an index of social development and progress of the district or state. From the educational standard of the people, we may have an image of the total society. To indicate the relationship of education with the approval of principle of family planning, the investigator likes to quote the view of the Elizabeth Draper. "Less direct but increasingly important social condition is education".

It does equate in some measures with the approval of the principle of family planning and to some extent, with practice, though education alone, by no means, overcomes all the problems arising from emotional condition or intellectual and temporal capacity. But it is also true that among the literates there is a widespread failure at present to introduce the young people approximately to physiological and emotional factors, personal and social responsibilities and the interaction between their own and societies activities and well being. From such point of social significance of education, the investigator studied the respondents from different educational standard.

Ref.7: Draper Hund Report,1983.
But population education has been defined as 'an educational programme provides for a study of the population situation in the family, the community, nation and world with the purpose of developing in the students' rational and responsible attitudes and behaviour towards that situation'.

Formal 'population education' is designed to teach children in school about basic population issues and in many cases to encourage them eventually to have a smaller family. Population education takes various forms. The most comprehensive approach is through the Govt. operated primary and secondary school system. The study of educational standard is of sociological significance. Because interest, attitude and values are closely related to educational standard of an individual. Knowledge and attitude of respondents towards family planning is also very important.

Table-No. 9: Educational qualification (Sterilisation group) 200 women.

<table>
<thead>
<tr>
<th></th>
<th>Wife</th>
<th>Husband</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>None</td>
<td>14</td>
<td>7.0</td>
</tr>
<tr>
<td>Can read and write</td>
<td>18</td>
<td>9.0</td>
</tr>
<tr>
<td>Primary level</td>
<td>47</td>
<td>23.5</td>
</tr>
<tr>
<td>High school level</td>
<td>93</td>
<td>46.5</td>
</tr>
<tr>
<td>College level</td>
<td>24</td>
<td>12.0</td>
</tr>
<tr>
<td>University level</td>
<td>4</td>
<td>2.0</td>
</tr>
</tbody>
</table>

Ref.8: Family Planning—Edited by Mary Polock, 1966 (p. 147).
Table No.10: Educational qualification (Temporary methods users-200 women)

<table>
<thead>
<tr>
<th></th>
<th>Wife</th>
<th></th>
<th>Husband</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>Illiterate</td>
<td>10</td>
<td>5.0</td>
<td>4</td>
<td>2.0</td>
</tr>
<tr>
<td>Can read and write</td>
<td>14</td>
<td>7.0</td>
<td>20</td>
<td>10.0</td>
</tr>
<tr>
<td>Primary level</td>
<td>24</td>
<td>12.0</td>
<td>24</td>
<td>12.0</td>
</tr>
<tr>
<td>High school level</td>
<td>60</td>
<td>30.0</td>
<td>66</td>
<td>33.0</td>
</tr>
<tr>
<td>College level</td>
<td>60</td>
<td>30.0</td>
<td>64</td>
<td>32.0</td>
</tr>
<tr>
<td>University level</td>
<td>32</td>
<td>16.0</td>
<td>32</td>
<td>16.0</td>
</tr>
</tbody>
</table>

200 100 200 100

The table No.9 shows that 46.5% of the women and 44.5% of the husband were educated up to high school level and 7% and 2% were illiterate respectively.

Again out of the temporary method users majority of both husband and wife were from the high school level (30% and 33% respectively (Table No.10). In both the groups only 7% and 5% women were illiterate. It was observed that female education does not play any part in the acceptance of sterilisation, but of the permanent method users, 49.5% husband were educated up to high school level and 25% up to college level which were the decision maker. Of the temporary methods, like Intra uterine contraceptives devices, oral pill and Norplant users couples, 30% female were educated up to high school level, 30% up to college level, 16% up to university level,
33% husband upto high school, 32% upto college and 16% upto university. This indicates that acceptance of temporary methods were grown in popularity among the educated couples particularly among the educated females. Except in Bihar and Rajasthan, the acceptance of I.U.C.D. and oral pill were getting more popularity among the the couples of the relatively developed states.

Moreover as regards to the methods used by the other acceptors, it was found that the majority had used condom (Nirodh). Evidence of an inverse relationship between fertility and education is clear. The birth interval of literatures couples are distinctly longer in both urban and rural areas which indicates lower fertility. An illiterate below primary, wife gets more than six or seven children. There is a great need for studying indepth the topic of education of two generations and fertility of the younger generation. As per provisional census report of 1991 in Assam 62.34% male and 4.7% females are literate as against 63.86% and 39.42% all India basis respectively.

Religion and Caste:

Religion is the basis of human society. But we can accept it as unified system of belief and practices related to the sacred things. The moral and spiritual development of society is achieved through religion 10.

Religion thus constitute to the operation of the society through power and authority sacred meaning which it provides to the support of man's conduct and to his understanding of his place in the universe. The study of religion is important for the scholars of Indian demography because religions sanction, restriction, and practice persisting to marriage, reproduction, social mobility and migration persist, and number of religious cultural practices effect the fertility of the population, for example Taboos on sexual intercourse on certain auspicious day, puberty marriage and no remarriage system for the high cast Hindu widow.

Modern religion is secular in nature. But all religion primitive and modern have the base of belief and rituals. Moreover, Indian society seems to be more orthodox. In Hinduism, religious and social practices are so intertwined that it is difficult to separate the one from the other. The ancient science of Ayurveda is basically derived from the sacred texts like the Vedas. Legender Physicians like the Ashrahikuma and Vaidas like Manceswritie had the status of demigod in the medical world. Healing the sick was part of the 'dharma'. In ancient India a life of domesticity was regarded as the basis for the fulfilment of duty. The name

Ref: 11: Psycho-social factors affecting continuation and discontinuation of intrauterine device oral pill.
'patni' implies the women who accompanies the man in his performance of his religious duties. According to Hindu Sastras no man can complete religious activities without wife. In India sons preference is very strong and birth of a son enhances the status of a woman in the family.

The people of Assam are very religious minded. Yet due to the impact of industrialisation and modernization now the people of Assam marched toward the present environment and want to go against poverty. In course of my study I found that most of the respondents were Hindus. Again in different surveys report it is revealed that Muslims were not liberal in case of fertility control. There was a vast difference between Hindus and Muslims. But yet their birth rates are higher than those of the Christians. Other communities in rural and urban areas have high fertility rates. Compared to Hindus, Christian have lower fertility rates. But in my study it was observed that Hindus were very much conscious about family planning. Most of the villagers even remarked that it is not the devine power which is responsible for the birth of a child.

**Table-11 : Sterilisation group( 200 women).**

<table>
<thead>
<tr>
<th>Religion</th>
<th>No.of women</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hindus</td>
<td>184</td>
<td>92</td>
</tr>
<tr>
<td>Muslims</td>
<td>14</td>
<td>7</td>
</tr>
<tr>
<td>Christian</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>200</td>
<td>100</td>
</tr>
</tbody>
</table>

Ref.12 : Emile Durkheim. Elementary form of religions life Page 47
Ref.13 : Shapier- Man, Culture and Society.
Table No. 12: Temporary methods users (200 women)

<table>
<thead>
<tr>
<th>Religion</th>
<th>No. of women</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hindus</td>
<td>180</td>
<td>90</td>
</tr>
<tr>
<td>Muslims</td>
<td>14</td>
<td>7</td>
</tr>
<tr>
<td>Christian</td>
<td>6</td>
<td>3</td>
</tr>
</tbody>
</table>

The above tables have shown that respondents under study belong to three major religious groups. Amongst the sterilisation acceptors group 92% were Hindus, 7% Muslims and 1% Christian.

Again amongst other contraceptive users 90% were Hindus, 7% were Muslims and 3% Christian.

Caste is another important feature of Indian society. The caste system in India forms the most integrated and self-conscious system that has grown up in the country. It determines the religious, economic, social lives of the individual. Every caste is having its distinctive role and status in social framework. An individual is placed in social cadre according to his birth in a particular caste. But in the modern era status of an individual is not determined by birth but by merit or performance. But still, caste remains as an important aspect of social stratification which is found in rural areas to a great extent. In my investigation
I found different caste group in relation to belief or attitude towards population control. Out of all the caste groups Brahmans were occupying the highest percentage in relation to consciousness towards the fertility control programmes.

Like caste, class is more prevalent in an urban phenomena. The class stratification is borrowed from western society. Class is also another important aspect of social stratification. The class refers to any group of people that is found in the same situation. But the frame of reference of class position in India, in the present era is economic i.e. wealth and property. In my study it was observed that respondents do not belong to upper class, but to lower class, middle class and lower middle class people.

Fertility has declined mostly in the people of upper, lower middle and middle class; socio-economic conditions contribute to fertility decline.

In order to understand the religious differentials in fertility patterns two relevant hypotheses exist, one proposition suggests that the impact of religion on fertility related attitudes and behaviour operates with particular religious doctrine only affecting its social norms. Religion influences fertility by these norms. The second hypothesis suggest that the particular fertility levels of a religious group only indicate the social, demographic and economic attributes that characterized the group. Thus affiliation to a particular religion is not significant but

is the social demographic and economic characteristic that the religious affiliation indicates which determine fertility levels. Leela Visaria et al (1974) stated that the "inter-censal increase in the population of Hindus less than that of the either the Muslims or the Christians'. The difference in the growth rate of Hindus and the Muslims is partly explained by differential fertility, incomplete coverage of census and also due to differential use of contraception.

Number of the living children of the respondents:

**Table No.13:** Parity: Sterilisation (200 women)

<table>
<thead>
<tr>
<th>Living children</th>
<th>No. of women</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>2</td>
<td>5</td>
<td>2.5</td>
</tr>
<tr>
<td>3</td>
<td>11</td>
<td>5.5</td>
</tr>
<tr>
<td>4</td>
<td>65</td>
<td>32.5</td>
</tr>
<tr>
<td>5 and above</td>
<td>118</td>
<td>59.0</td>
</tr>
<tr>
<td></td>
<td>200</td>
<td>100</td>
</tr>
</tbody>
</table>

**Table No.14:** Temporary methods users (200 women)

<table>
<thead>
<tr>
<th>Living children</th>
<th>No. of women</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>18</td>
<td>9.0</td>
</tr>
<tr>
<td>2</td>
<td>38</td>
<td>19.0</td>
</tr>
<tr>
<td>3</td>
<td>70</td>
<td>35.0</td>
</tr>
<tr>
<td>4</td>
<td>54</td>
<td>26.0</td>
</tr>
<tr>
<td>5 and above</td>
<td>20</td>
<td>10.0</td>
</tr>
<tr>
<td></td>
<td>200</td>
<td>100</td>
</tr>
</tbody>
</table>
The above table No.14 shows that majority of the sterilized women had two or more living children. 2.5% women had only 2 children. 5.5% women had 3 children and 32.5% had 4 children and 59.0% women had 5 and above children.

Again out of 200 temporary method users as shown in table No.14, 26% had 4 children and 9% had one children.

The study of the number of living children indicates the pattern of family, standard of living etc. Again the study of number of living children of the people indicates the fertility rate and at the same time it helps us to know is the small family norm accepted by the respondent? From the above discussion we come into conclusion that the people under the field of study have accepted the small family norm to some extent. The couples controlled the fertility after completing their family. Only 0.5% accepted the permanent method after single child birth, 2.5% after two as they were medically unfit to carry next pregnancy. 9% females accepted temporary methods after one child birth and 19% after two as because either, clinically, financially or socially they were unable to conceive soon but not that they were aware about the various high fertility problems and fertility control programmes.
Place of dwelling:

The respondents under study were enquired of their native place. The table below will show the distribution of the respondents according to their place of dwelling.

Table No. 15: 200 sterilisation women.

<table>
<thead>
<tr>
<th>Place</th>
<th>No. of women</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban/semi urban</td>
<td>180</td>
<td>90</td>
</tr>
<tr>
<td>Rural</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>200</td>
<td>100</td>
</tr>
</tbody>
</table>

Table No. 16: 200 temporary method users.

<table>
<thead>
<tr>
<th>Place</th>
<th>No. of women</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban/Semi urban</td>
<td>132</td>
<td>66</td>
</tr>
<tr>
<td>Rural</td>
<td>68</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>200</td>
<td>100</td>
</tr>
</tbody>
</table>

From the above tables it was observed that of the total 200 sterilized women 90% were urban dwellers and 10% were villagers. Again of the total 200 temporary method users 66% were urban dwellers and 34% were villagers. Although 80% of our population is rural, sterilisation acceptors constituted only 10% probably because villagers scared to accept sterilisation due to improper knowledge. It has been observed that users were residing nearer to the hospitals or any other health institution, within 3 kilometers.
Indications:

More than 200 million women around the world are using fertility control devices. Permanent sterilisation both male and female is now one of the world's most popular methods of preventing unwanted pregnancy. Voluntary sterilisation is a vital preventive health measure, as it averts high order pregnancies and births which are associated with increased infant and maternal mortality. From the results of this prospective study it can easily be analysed the indications for sterilisation and temporary methods used.

Table No. 17: Sterilisation (200 women).

<table>
<thead>
<tr>
<th>Causes</th>
<th>No. of women</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Socio economic</td>
<td>189</td>
<td>94.5</td>
</tr>
<tr>
<td>Medical</td>
<td>6</td>
<td>3.0</td>
</tr>
<tr>
<td>Disincentive</td>
<td>5</td>
<td>2.5</td>
</tr>
<tr>
<td></td>
<td>200</td>
<td>100</td>
</tr>
</tbody>
</table>

From the above table it was observed that 94.5% of women got themselves sterilised because of socio-economic reasons, 3% were sterilised on medical ground, and 2.5% women were on disincentive ground.
It was observed from the above table that majority of women were using the methods either temporary or permanent on socio-economic ground. Thus the foregoing findings identify that a relatively larger percentage of target couples were belonging to socially or economically backward class of society. It was observed that use of contraceptives were more common when no more children are wanted and the couples became aware that they cannot afford any more children for health and economic reasons.

It has shown that contraception acceptance is influenced by the following four variables:

1. Desire for additional children.
2. Age of the wife.
3. Education of the women/couples.
4. Spread of propaganda about family planning programmes and various fertility control methods.
It was also observed that birth control practice is more strongly related to the variable 'desire for additional children' than to the ideal family size.

This study also confirms the hypothesis that the acceptance of fertility control methods are more frequent in the case of those couples who decide jointly about the number and spacing of their prospecting children. Such couples also have a distinctly lower level of fertility. In common per- lence it is clear that accepted women with adequate knowledge about the fertility control methods and willing to have less anxiety and having a stronger dominance than that of the non accepted women and accepted women without or inadequate know- ledge on fertility control methods. In my study it was obser- ved that most of the respondents were unaware about the faci- lities of 'small family size' as a result they could not take decision either to stop or space fertility much earlier. The respondents used fertility control devices only when they entered into the sufferings of repeated child birth, in the field of physical and mental health. The knowledge of the term 'fertility control' and sex variation are not clear and side. But for the individual and social welfare every couple should have limited number of children and their births are to be space properly(two or three years). This will surely raise the levels of their standard of living, education socio- economic condition and promote
health and happiness. Repeated pregnancies can harm mother's health and can cause economic as well as mental hardship for the entire family.
## DISTRIBUTION OF POPULATION, SEX RATIO, GROWTH RATE & DENSITY OF POPULATION

### INDIA

#### 1991 CENSUS

(Provisional Figures)

**India/State/Union Territory** | **Population 1991** | **Sex Ratio 1991** | **Density 1991** | **Growth Rate 1991** | **Growth Rate 1981-91** |
---|---|---|---|---|---|
**INDIA** | 1,338,034,522 | 565,217,491 | 772,817,031 | 2.26 | 3.10 |

### States

2. **Arunachal Pradesh** | 858,392 | 461,718 | 396,674 | 864 | 861 | 8 | 10 | 15.15 | 35.86 |
5. **Goa** | 1,168,622 | 593,561 | 575,059 | 924 | 925 | 277 | 116 | 26.74 | 15.96 |
6. **Gujarat** | 41,174,060 | 21,272,388 | 19,901,672 | 942 | 936 | 174 | 210 | 27.67 | 20.80 |
7. **Haryana** | 16,317,715 | 8,705,379 | 7,612,336 | 970 | 974 | 292 | 369 | 28.75 | 26.28 |
8. **Himachal Pradesh** | 5,111,079 | 2,560,894 | 2,550,185 | 971 | 976 | 777 | 116 | 76.74 | 16.96 |
9. **Jammu & Kashmir** | 7,718,700 | 4,014,100 | 3,704,600 | 971 | 973 | 59 | 76 | 29.69 | 20.92 |
10. **Karnataka** | 44,817,398 | 22,861,409 | 21,955,989 | 963 | 960 | 194 | 234 | 26.74 | 20.69 |
11. **Kerala** | 26,811,237 | 14,218,167 | 14,793,070 | 1,032 | 1,040 | 65 | 74 | 48.55 | 13.98 |
12. **Madhya Pradesh** | 14,714,060 | 7,352,048 | 7,362,012 | 941 | 936 | 174 | 369 | 28.75 | 26.28 |
13. **Maharashtra** | 41,174,060 | 21,272,388 | 19,901,672 | 942 | 936 | 174 | 210 | 27.67 | 20.80 |
14. **Manipur** | 1,168,622 | 593,561 | 575,059 | 924 | 925 | 277 | 116 | 26.74 | 15.96 |
15. **Meghalaya** | 1,168,622 | 593,561 | 575,059 | 924 | 925 | 277 | 116 | 26.74 | 15.96 |
16. **Mizoram** | 1,168,622 | 593,561 | 575,059 | 924 | 925 | 277 | 116 | 26.74 | 15.96 |
17. **Nagaland** | 1,168,622 | 593,561 | 575,059 | 924 | 925 | 277 | 116 | 26.74 | 15.96 |
18. **Orissa** | 31,512,070 | 15,979,904 | 15,532,166 | 981 | 972 | 169 | 207 | 20.17 | 19.50 |
19. **Punjab** | 20,190,795 | 10,695,116 | 9,495,659 | 879 | 888 | 111 | 401 | 24.06 | 20.26 |
20. **Rajasthan** | 20,190,795 | 10,695,116 | 9,495,659 | 879 | 888 | 111 | 401 | 24.06 | 20.26 |
21. **Sikkim** | 1,168,622 | 593,561 | 575,059 | 924 | 925 | 277 | 116 | 26.74 | 15.96 |
22. **Tamil Nadu** | 20,190,795 | 10,695,116 | 9,495,659 | 879 | 888 | 111 | 401 | 24.06 | 20.26 |
23. **Tripura** | 1,168,622 | 593,561 | 575,059 | 924 | 925 | 277 | 116 | 26.74 | 15.96 |
24. **Uttar Pradesh** | 13,870,795 | 7,174,527 | 6,696,268 | 898 | 898 | 111 | 401 | 24.06 | 20.26 |
25. **West Bengal** | 41,174,060 | 21,272,388 | 19,901,672 | 942 | 936 | 174 | 210 | 27.67 | 20.80 |

### Union Territories

1. **A & N. Islands** | 31,512,070 | 15,979,904 | 15,532,166 | 981 | 972 | 169 | 207 | 20.17 | 19.50 |
2. **Chandigarh** | 20,190,795 | 10,695,116 | 9,495,659 | 879 | 888 | 111 | 401 | 24.06 | 20.26 |
3. **Dadar & Nagar Haveli** | 20,190,795 | 10,695,116 | 9,495,659 | 879 | 888 | 111 | 401 | 24.06 | 20.26 |
4. **Daman & Diu** | 101,439 | 51,452 | 49,987 | 1,062 | 972 | 705 | 906 | 26.07 | 28.43 |
5. **Delhi** | 9,370,475 | 5,120,737 | 4,249,738 | 808 | 830 | 4,194 | 6,319 | 53.00 | 50.64 |
6. **Lakshadweep** | 60,000,000 | 30,000,000 | 30,000,000 | 808 | 830 | 4,194 | 6,319 | 53.00 | 50.64 |
7. **Pondicherry** | 789,416 | 348,174 | 431,242 | 985 | 982 | 1,729 | 1,605 | 28.15 | 24.60 |

**Note:**
1. In 1981, Census was not conducted in Assam. Based on the 1971 Census and the 1991 Census provisional results the population as of 1981 has been interpolated.
2. As a consequence of the revised estimates for Assam for the year 1981, the total population of India as of 1981 has been estimated at 681,329,097 as against earlier published figures of 685,184,692.
3. As a consequence of the revised figures the decadal growth rate for India during 1971-81 has been estimated as 24.66.
4. 1991 Census has not yet been conducted in J&K. The figures are as per projection prepared by the Standing Committee of Experts.

**Source:** Registrar General, India
## Distribution of Population, Sex Ratio, Growth Rate and Density of Population by Districts

<table>
<thead>
<tr>
<th>State/District</th>
<th>Population 1991</th>
<th>Sex-Ratio (Females per 1000 males)</th>
<th>Density of Population per Km²</th>
<th>Growth Rate of Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASSAM</td>
<td>22,274,562</td>
<td>11,570,693</td>
<td>10,714,869</td>
<td>806</td>
</tr>
<tr>
<td>1. Dhubri</td>
<td>1,325,853</td>
<td>639,335</td>
<td>686,518</td>
<td>930</td>
</tr>
<tr>
<td>2. Kokrajhar</td>
<td>196,880</td>
<td>410,272</td>
<td>386,608</td>
<td>913</td>
</tr>
<tr>
<td>3. Bongaigaon</td>
<td>806,857</td>
<td>415,635</td>
<td>390,837</td>
<td>926</td>
</tr>
<tr>
<td>4. Goalpara</td>
<td>661,801</td>
<td>119,321</td>
<td>542,478</td>
<td>919</td>
</tr>
<tr>
<td>5. Barpeta</td>
<td>1,107,715</td>
<td>717,831</td>
<td>669,884</td>
<td>912</td>
</tr>
<tr>
<td>6. Nalbari</td>
<td>1,012,608</td>
<td>522,655</td>
<td>489,953</td>
<td>923</td>
</tr>
<tr>
<td>7. Kamrup</td>
<td>1,987,662</td>
<td>1,056,525</td>
<td>931,137</td>
<td>855</td>
</tr>
<tr>
<td>8. Darrang</td>
<td>1,286,633</td>
<td>663,596</td>
<td>673,037</td>
<td>907</td>
</tr>
<tr>
<td>9. Smitpur</td>
<td>1,418,484</td>
<td>747,455</td>
<td>670,029</td>
<td>871</td>
</tr>
<tr>
<td>10. Lakhimpur</td>
<td>749,675</td>
<td>387,942</td>
<td>361,733</td>
<td>895</td>
</tr>
<tr>
<td>11. Udalguri</td>
<td>472,183</td>
<td>244,467</td>
<td>227,716</td>
<td>874</td>
</tr>
<tr>
<td>12. Marigaon</td>
<td>640,176</td>
<td>329,377</td>
<td>310,199</td>
<td>917</td>
</tr>
<tr>
<td>13. Nagaland</td>
<td>1,992,087</td>
<td>970,720</td>
<td>911,367</td>
<td>864</td>
</tr>
<tr>
<td>14. Majuli</td>
<td>401,140</td>
<td>141,214</td>
<td>259,926</td>
<td>883</td>
</tr>
<tr>
<td>15. Jorhat</td>
<td>849,445</td>
<td>459,001</td>
<td>390,444</td>
<td>886</td>
</tr>
<tr>
<td>16. Sibsagar</td>
<td>895,112</td>
<td>467,610</td>
<td>427,502</td>
<td>887</td>
</tr>
<tr>
<td>17. Dibrugarh</td>
<td>1,038,090</td>
<td>544,141</td>
<td>493,949</td>
<td>883</td>
</tr>
<tr>
<td>18. Tinsukia</td>
<td>963,176</td>
<td>508,703</td>
<td>454,473</td>
<td>855</td>
</tr>
<tr>
<td>19. Karbi Anglong</td>
<td>655,415</td>
<td>343,144</td>
<td>312,271</td>
<td>875</td>
</tr>
<tr>
<td>20. North Cachar Hills</td>
<td>149,346</td>
<td>79,536</td>
<td>69,810</td>
<td>841</td>
</tr>
<tr>
<td>21. Karimganj</td>
<td>825,551</td>
<td>424,118</td>
<td>401,433</td>
<td>930</td>
</tr>
<tr>
<td>22. Hailakandi</td>
<td>440,506</td>
<td>232,236</td>
<td>212,270</td>
<td>923</td>
</tr>
<tr>
<td>23. Cachar</td>
<td>1,215,952</td>
<td>627,202</td>
<td>588,750</td>
<td>918</td>
</tr>
</tbody>
</table>

Note: NA stands for area figures not available.

Proportion marrying

Age: 0-10-20-30-40-50-60
Proportion marrying by age of female in India
1931-1941 and 1951-1961
## 1991 CENSUS
### LITERACY

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Persons</td>
<td>Males</td>
</tr>
<tr>
<td>1. Assam</td>
<td>22,294,562</td>
<td>11,579,693</td>
</tr>
<tr>
<td>2. Dhubri</td>
<td>1,325,653</td>
<td>679,335</td>
</tr>
<tr>
<td>3. Kokrajhar</td>
<td>796,800</td>
<td>410,272</td>
</tr>
<tr>
<td>4. Bongaigaon</td>
<td>806,472</td>
<td>415,615</td>
</tr>
<tr>
<td>5. Goalpara</td>
<td>661,801</td>
<td>330,323</td>
</tr>
<tr>
<td>6. Barpeta</td>
<td>1,382,715</td>
<td>712,861</td>
</tr>
<tr>
<td>7. Nalbari</td>
<td>1,012,608</td>
<td>522,655</td>
</tr>
<tr>
<td>8. Kamrup</td>
<td>1,197,652</td>
<td>1,065,525</td>
</tr>
<tr>
<td>9. Darrang</td>
<td>1,286,633</td>
<td>661,596</td>
</tr>
<tr>
<td>10. Sonitpur</td>
<td>1,418,484</td>
<td>742,455</td>
</tr>
<tr>
<td>11. Lakhimpur</td>
<td>749,675</td>
<td>387,942</td>
</tr>
<tr>
<td>12. Dhemaji</td>
<td>472,183</td>
<td>244,467</td>
</tr>
<tr>
<td>13. Marigaon</td>
<td>640,376</td>
<td>329,977</td>
</tr>
<tr>
<td>14. Nagson</td>
<td>1,092,087</td>
<td>978,220</td>
</tr>
<tr>
<td>15. Golaghat</td>
<td>801,740</td>
<td>417,234</td>
</tr>
<tr>
<td>17. Sibsagar</td>
<td>895,112</td>
<td>467,610</td>
</tr>
<tr>
<td>18. Dubrughar</td>
<td>1,038,090</td>
<td>544,141</td>
</tr>
<tr>
<td>19. Tinsukia</td>
<td>963,176</td>
<td>508,703</td>
</tr>
<tr>
<td>22. Karimganj</td>
<td>825,551</td>
<td>424,118</td>
</tr>
<tr>
<td>23. Hailakandi</td>
<td>448,506</td>
<td>232,236</td>
</tr>
</tbody>
</table>

Note: * Literates exclude children in the age group 0-6 who are treated as illiterates in the 1991 Census.
Census 91 Literacy
figures in percentages

<table>
<thead>
<tr>
<th>Year</th>
<th>Total</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>1951</td>
<td>226.3</td>
<td>212.9</td>
<td></td>
</tr>
<tr>
<td>1961</td>
<td>548.2</td>
<td>284.1</td>
<td>264.1</td>
</tr>
<tr>
<td>1971</td>
<td>363.3</td>
<td>264.1</td>
<td></td>
</tr>
<tr>
<td>1981*</td>
<td>437.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1991†</td>
<td>406.3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* age 7 years and above; excludes Assam
† age 7 years and above; excludes J&K

Census 91 Population and Sex Ratio
figures in millions

<table>
<thead>
<tr>
<th>Year</th>
<th>Total</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>1961</td>
<td>439.2</td>
<td>226.3</td>
<td>212.9</td>
</tr>
<tr>
<td>1971</td>
<td>548.2</td>
<td>284.1</td>
<td>264.1</td>
</tr>
<tr>
<td>1981</td>
<td>683.3</td>
<td>363.3</td>
<td>320.</td>
</tr>
<tr>
<td>1991</td>
<td>843.9</td>
<td>437.6</td>
<td>406.3</td>
</tr>
</tbody>
</table>
NATIONAL INCOME & PER CAPITA INCOME IN INDIA
AT 1980-81 PRICES

INDEX
NATIONAL INCOME
PER CAPITA INCOME

YEARS
1980-81
1981-82
1982-83
1983-84
1984-85
1985-86
1986-87
1987-88

NATIONAL INCOME (IN RS. MILLIONS)
INDIA
AGE SPECIFIC FERTILITY RATES - RURAL
1972 & 1986

INDIA
AGE SPECIFIC FERTILITY RATES - URBAN
1972 & 1986
KNOWLEDGE AND ATTITUDE OF THE ACCEPTORS TOWARDS THE FAMILY PLANNING PROGRAMME
In this chapter an attempt has been made to assess the knowledge and attitude of women towards various types of fertility control programmes and method. In this interview I tried to evaluate their opinion about the family planning programmes. I also elicited their views on various fertility control methods and sterilisation. Knowledge and attitude of the respondents are examined as follows: such as the concept of family planning as they understand, sources of information, knowledge of different methods etc.

The degree of interests for the various birth control methods depends in part, upon the diffusion of knowledge of the birth control programmes and various techniques of birth control and upon the necessity either to stop or to space the births. Knowledge\(^1\) is that inferred capabilities which makes possible the successful performance of task that could not be performed before the learning was undertaken. With the development of medical science different birth control methods are invented. Out of the various birth control methods condom, oral pills, I.U.C.D. and female sterilisation are commonly practised in India. But in the qualified group, apprehension towards the newer devices like Norplant* injectable steroid**, post coital pill and once a week pill are also found quite promising.

---

Ref. 1: Anderson and Ausubel- Reading in Philosophy of cognition, Chicago, 1966.

Footnotes:
* Subdermal long acting reversible contraceptive Silastic material containing Levonorgestral.
** Progestogens. i) Depomedroxy progesterone acetate
   ii) Norethisterone enanthate.
In our present study no family evidenced total ignorance of birth control methods. Knowledge on birth control methods would appear to have definite bearing with the literacy of the couples. Awareness towards the newer methods is usually high among the urban and city dwellers with high literacy. On the contrary still there are a large number of men and women in the rural areas who do not know even the old methods like tubectomy, diaphragm, loop, jelley etc. can be use to get rid of unwanted conceives.

Knowledge, attitude and practice studies, aiming at measuring the attitude of the couples towards family size, towards the use of various family planning programmes and fertility control methods, preference for sons and etc. have been conducted in developing countries during the past two decades. It is evident that desire for no more children which is one of the several prerequisites for accepting birth control practices 'is generally understood by all. But in such cases the couples must have knowledge and motive to act accordingly. The contraceptions among the users who have favourable attitude, desire no more children and having adequate knowledge of various fertility control methods, yields good result. It has been clarified by several studies that knowledge and attitude are two important factors in
this respect besides desire for no more children. When (i) couple has knowledge of family planning programmes and fertility control methods (ii) shows favourable attitude and desires no more children then the condition is very conducive for the acceptance of one or other method of birth control. In case of absence of any one of the elements mentioned above, the acceptance process is likely to remain incomplete.

Knowledge:

Knowledge of family planning programmes and fertility control methods is acquired through the process of social learning and how couples go through the process is an important matter. Family planning usually means the "limitation of births". The respondents under this study are asked different questions to get informations about their knowledge on different aspect of birth control. On enquiry, it was found that cent per cent of the respondents have heard of family planning programmes and various fertility control methods. But they have given the interpretation of the term in a different way. But educated and intellectual group can plan their sex lives so as never to have an unwanted pregnancy. The couples who want no more children feel the necessity of collecting information regarding fertility control methods and required services from variety of

sources, because official communication channels are not sufficient to provide them even minimum information regarding the various family planning programmes, fertility and fertility control methods.

Level of knowledge about family planning programmes and fertility control methods:

With the development of medical sciences, different methods are invented to control births. The most common methods of birth control in India are oral contraceptive pills, sterilisation, loop, jelly, condom etc. It has been observed that almost all the respondents have heard about almost all these methods of fertility control. Many couples now a days space births and limit the size of their families by taking precautions against unwanted pregnancies. But it can be seen that the level of knowledge about when and how to use the methods was not upto satisfaction even in the case of popular methods, like vasectomy, I.U.C.D., tubectomy, condom etc. Even many couples do not know how to use the conventional birth control methods. It was observed that relatively larger proportion of these couples belong to socially and economically backward classes of the society. Further, such couples were less predisposed to rational thinking and were not at all prepared to face new experience. However, among the couples not desiring any more children, the use of contraceptives increased with the influence of modernization of the publicity through mass media. Among all,
education of the wife seems to be an important factor in narrowing the gap between the desire of additional children and practice of fertility control methods.

In the acceptor groups of this study it was found that the people from urban areas, having clear ideas as to how to stop or space fertility in view of population explosion were also aware of their physical fitness, health of the mother and child, economic condition of the nation and etc. They further realised that economic development is intimately associated with the growth of population.

It is generally viewed that knowledge, attitude and practice are closely related to each other and knowledge and attitude influence the degree of practice of birth control methods. In the findings of the empirical studies on this topic of family planning conducted on the different parts of the world, it is seen that knowledge and attitude have only some theoretical values, practically they do not lead the individual to practise birth control methods.

In this chapter I studied about the knowledge, attitude and practice of fertility control methods from the respondents of accepting group.

Table No.1: Place of enrolment (Accepted group)

<table>
<thead>
<tr>
<th>Place</th>
<th>Within</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Govt. Hospital</td>
<td>400</td>
<td>100</td>
</tr>
<tr>
<td>Private Hospital</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Private Chamber</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

400 100
I have registered all the women from the Department of Obstetrics and Gynaecology, Gauhati Medical College Hospital. Table No.1 shows that in the total sample cent per cent of the acceptors had adopted the fertility control methods in Gauhati Medical College Hospital.

**Table No.2 : Sources of knowledge.**

<table>
<thead>
<tr>
<th>Sources</th>
<th>Women</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>From husband</td>
<td>108</td>
<td>27</td>
</tr>
<tr>
<td>From Neighbour</td>
<td>80</td>
<td>20</td>
</tr>
<tr>
<td>From Users</td>
<td>60</td>
<td>15</td>
</tr>
<tr>
<td>From Radio</td>
<td>60</td>
<td>15</td>
</tr>
<tr>
<td>From Television</td>
<td>40</td>
<td>10</td>
</tr>
<tr>
<td>From Newspaper</td>
<td>32</td>
<td>8</td>
</tr>
<tr>
<td>Other books and journals</td>
<td>20</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>400</td>
<td>100</td>
</tr>
</tbody>
</table>

As there are different channel of sources like formal or official and non-official from which the respondents can acquire the knowledge of family planning programmes and fertility control methods. The respondents were asked from where they first knew about family planning programmes and birth control methods. The important sources of formal information are books,
journals, film, T.V. and Radio publications on family planning programmes, family planning clinic, birth control methods, other health problems, maternity and child welfare. But most of the women of my study were not well literate and the above sources were not easily assessable. Therefore they knew many things mainly from personal contacts and mass media was second source.

Table No.2 shows that 27% have got information about birth control methods from their husbands. And it was observed that most of the husband were literate and service holder, so they got information from publicity poster, discussion with their friends, colleagues. 20% of them have got information from neighbourhood and relative, 15% have got information from the users which were more relevant and accurate. Again 5% have got information from books and journals. But no respondents from the lower income group has knew from books, journals, movies etc. Again 8% respondents have acquired knowledge of family planning programmes and fertility control methods and other information from News paper.

Table No.3 : Accepted at will or forced.

<table>
<thead>
<tr>
<th>Will/force</th>
<th>Women</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accepted at own will</td>
<td>312</td>
<td>78</td>
</tr>
<tr>
<td>Accepted being influenced or forced by others.</td>
<td>88</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>400</td>
<td>100</td>
</tr>
</tbody>
</table>
Table No. 3 shows that 78% adopters accepted birth control methods willingly. On the contrary 22% accepted as forcefully influenced by the others.

Several reasons for not using any fertility control method are discussed in the later chapter. The respondents of present study are asked whether they have knowledge of fertility control methods or not. It was known from them that all the respondents have heard about various family planning programmes and fertility control methods from various sources by this way or that way.

Table No. 4 : Acceptance with favourable attitude/unfavourable attitude.

<table>
<thead>
<tr>
<th>Favourable/Unfavourable</th>
<th>Women</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Favourable</td>
<td>312</td>
<td>78</td>
</tr>
<tr>
<td>Unfavourable</td>
<td>88</td>
<td>22</td>
</tr>
</tbody>
</table>

400 100

Table No. 4 shows that 78% have favourable attitude towards the family planning programme. Only 22% of respondents accepted family planning devices under the influence or force from others. The causes of unfavourable attitude was due to the misinterpretations of religious aspect of the procreation system and apprehension of the side effects of the various fertility control methods. It was observed that respondents have favourable attitude towards the family planning programmes and birth control methods for the sake of wellbeing of the both mother and child and for
the maintainance of social status of the family. Economic and national and social interest come later.

Another cause of unfavourable attitude towards the acceptance of the birth control methods that may women had no real freedom in regard to the decision making for the type of birth control method to be used. Women in rural areas who have little education lagging behind in the acceptance of the fertility control method for such reasons.

Several studies conducted to assess attitude of the people towards family planning have revealed the following:

1. There is nothing in the tenets of religion which is opposed to family planning.
2. The poor people, both in the rural and urban areas do not have enough money to purchase contraceptives. They are not aware that the contraceptives are available free of cost.

<table>
<thead>
<tr>
<th>Table No. 5</th>
<th>Distribution of different fertility control methods users.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methods</td>
<td>Women</td>
</tr>
<tr>
<td>Sterilisation</td>
<td>260</td>
</tr>
<tr>
<td>Loop and Cu.T.</td>
<td>16</td>
</tr>
<tr>
<td>Norplant</td>
<td>40</td>
</tr>
<tr>
<td>Oral Pill</td>
<td>84</td>
</tr>
<tr>
<td>Nirodh</td>
<td>60</td>
</tr>
<tr>
<td></td>
<td>400</td>
</tr>
</tbody>
</table>

Table No. 5 shows that the respondents preferred five methods to control their fertility. Such as tubal sterilisation, I.U.C.D. condom, Norplant and oral pill. Among them a few respondents could not put their views certainly about their preference for a particular method. 4% preferred I.U.C.D. and 10% have preferred Norplant. Total 21% respondents have preferred oral contraceptive tablet and 15% respondents have preferred condom.

The respondents are asked about the medical termination of pregnancy (M.T.P.). It is a method to get rid of unwanted birth, as they stated, in their society, it was taken as a popular method and adopted by a section of their women. In the present study also, the respondents, though some of them viewed it as harmful had undergone M.T.P. for more than one before adopting birth control method.

The shortage of living accommodation coupled with the rise in cost of living for the education and other development of the children, have compelled the couples to restrict the births. Incidentally, these factors were also responsible for restricting the size of the family.

Medical Termination of pregnancy has an important place in fertility control programme. Induced abortion means termination of pregnancy on medical ground, specifically mentioned in the Medical Termination of Pregnancy Act of 1971 at or before 20 weeks of gestation measured by the size of the uterus for all purposes. The Medical Termination
of pregnancy Act (M.T.P.Act) was passed in Indian Parliament in April, 1971, assented by the President of India on October, 1971 and came into force throughout the country except in Jammu and Kashmir from 1st April, 1972. In Assam, M.T.P. started from 1st June, 1972. It is estimated that about 55,000,000 pregnancies are terminated throughout the world per year. In India in the year 1975-76, 214,200 and in 1978-79, 312,800 pregnancies have been terminated legally. In 1985-86 there was 0.56 million M.T.P. was performed. However, irrespective of cultural, religious, social, economic and educational differences, liberalisation of abortion laws had been readily accepted by women all over the world. The demand for termination of pregnancy for medical, eugenic humanitarian and social reasons has been steadily growing over the years in all the countries with liberalised abortion laws.

I have enrolled 200 women from the M.T.P. group. Among majority of Hindu women were in favour of abortion. Even now a days Christian and Muslim women seem to be more adherent to their religious principles, small proportion of well educated people favoured abortion (M.T.P.).

Marriage Act and Contraceptives delivery service in India:

India promulgated amended child Marriage Restrain Act from 1st October, 1978 raising the legal age of marriage from 15 to 18 years of females and from 18 to 21 years for males. The National Family Welfare Programme is available in 1982 through 554 urban post partum centres, 5428 rural family welfare centres in primary health centres, 18285 rural family welfare sub-centres and 1 lakh health centres. Nirodh and oral contraceptive are sold openly in India. Oral contraceptive is available on doctors' prescription. Nirodh, oral contraceptive, Lippes Loop, Cu.T. 200 are available in the Government Family Welfare clinic at free of cost.

Vasectomy and tubectomy are easily available at Government and Private Health Institution throughout the country. These are also available in rural health centres. In 1981-82, of total acceptors, 69% sterilisation acceptors and 52.9% I.U.C.D. acceptors were from rural areas. By 1980-81 average number of living children was 3.5 for vasectomy, 3.7 for tubectomy, 2.6 for I.U.C.D. acceptors. By the year tubectomy acceptor was 79.6% against 33.9% in 1970-71. During 1982-83, 4 million sterilisation were performed in India.

Ref. 5: Text Book of Gynaecology-C.S. Dawn, P. 294
It is fact that the majority of pill users in India are from urban areas and are educated women. Since 1956 till 1987-88 total birth averted was 85.2 million of which 68 million by sterilisation, 7.4 million by I.U.C.D. and 9.8 million by condom users.6

In Assam, since 1982 we have separate Directorate headed by a Director, designated as Director of Health Services, Family Welfare. Besides three Medical Colleges, we have got 26 Civil Hospitals, 73 Community Health Centres, 73 Thirty beded Hospitals, 73 Maternity and Child Welfare centres, 492 P.H.Cs., 366 State Dispensaries and 5109 Sub-centres throughout the Assam which are rendering Health, MCH, Family Welfare as well as Fertility control services to the 22.3 million people of Assam.

At present there are various fertility control methods which are practised by the people of Assam. Among those : Vasectomy, Tubectomy, I.U.C.D.s, Pills, Condoms, Norplant and etc. In Assam, I.U.C.D. was introduced in June, 1966. The insertion of loop does not require any hospitalisation. Total 1,44,519 loop were inserted in Assam during 1965-66 to 1968. In Assam 22,05,869 contraceptives (all varieties) were distributed from 1958 to 1968.

The oral contraceptives are harmless tablets interfere with ovulation and therefore check pregnancy if taken regularly. These tablets are required to be taken by a female everyday up to the 21st or 22nd day of the menstrual cycle. In my study only 10% accepted Norplant. The Norplant subdermal contraceptive implant system is a long acting reversible, low dose, progestin method. The drug is delivered by means of six or two Silastic rods placed subdermally in the medial side of the upper arm of the women by a trocar and a wide bore needle. The Norplant system was delivered by the International Committee of Contraception Research of the Population Council.\(^7\)

From these discussion it is observed that due to the fear of complications and side effects of the various fertility control methods are not liked by most of the couples. Majority of the respondents in my study had already exceeded the number of children they desired and some of them were on the verge of crossing their desired number at the time of interview. Thus from the sociological points of view the study of the causes of unfavourable attitudes towards the fertility control methods have much importance.

In order to study the nature of preference towards different methods, the investigator asked the respondents:

Ref. 7: The Population Council: South and East Asia.
whether they could maintain privacy for it or not. All most all of them have viewed that they could maintain privacy for these and the devices were not costly but due to various side effect and complications effected their sexual life. All most all the respondents have adopted the fertility control methods according to their own will. So it may be assumed that majority of the respondents affiliated the family planning programmes and fertility control methods.

In the present study it was observed that 22% of the women were afraid of various complications and side effects which may developed after adoption of fertility control methods. They came to know about the side effects and complications from the acceptors some times from publication and other individuals. So they developed unfavourable attitudes towards the fertility control methods and family planning as a whole. Yet they adopted some birth control methods. Question arises why they had adopted the methods. They were directly or indirectly forced by the others. When some of them medically, religiously or socio-economically unable to conceive any more they accepted permanent methods; while some other unable to conceive for the time being accepted temporary devices. Simply they were being forced to accept birth control methods against their will.
Family planning aims at making small family for the welfare of the family itself and for the country and the Nation. The success of these welfare programmes depends upon how far the people of the society accept the small family norm with an open mind and with broader ideas in shaping our society and National economy.

Ashok Kumar et al in 1983 in his article "Understanding of hinderance to use of Family Planning methods" opined that knowledge and attitude are two necessary conditions for the use of birth control devices.8

Ref.no. 8 ; Published in the proceeding of I C M K / civ Foundation workshop on child health, nutrition and Family Planning held at Jammu during December 5-7, 1983
Fig. Multihal Cu 250 AECO steps of insertion and removal.

Fig. Pomeroy tubectomy.
FiE. Various types of IUCDS used in the world.

A. Maguilies Loop (plastic spinal) - not used now. This is an open loop.
B. Lippes Loop is used worldwide. This is an open loop.
C. Birnberg bow (plastic) is a closed loop - not used now.
D. Soonawala Loop (plastic) is an open loop.
E. Antigon F made of plastic with a magnetic strip is a closed loop - not used.
F. M type made of steel not used.
G. Saf T Coil (plastic) is used worldwide.
H. Hall Stone ring.
I. Dalcon Shield.
J. Ota ring.
Fig. A. Cu. T. B. Cu 7. C. Cu loop.

Fig. CuT 380 carries two sleeves of solid copper on the transverse arm and a coil of copper wire around the stem.

Fig. Lippes loop and loaded applicator: Steps of introduction of loop.
WIDELY USED INTRAUTERINE DEVICES

Lippes Loop  Chinese 'Steel' Rings

TCu-200/200B  Multiload-250(MLCu-250)  TCu-350A

* 200B has a ball at the tip of the stem

TCu-220c  Nova T  Multiload-375(MLCu-375)
PERCENTAGE OF RURAL ACCEPTORS OF STERILISATION & IUD
1970-71 To 1988-89

YEAR

80
75
70
65
60
55
50
0

PERCENTAGE

STERILISATION
I. U. D.

SOURCE:
...
PERCENTAGE OF ACCEPTORS (WIVES) HAVING THREE OR LESS NUMBER OF LIVING CHILDREN—ALL INDIA (1977-78 TO 1987-88)
PERCENTAGE OF ACCEPTORS (WIVES) AGED BELOW 30 YEARS ALL INDIA (1973-74 TO 1987-88)
Couples effectively protected under family planning programme 1971 to 1989

YEARS AS ON 31st MARCH OF THE YEAR

PERCENTAGE
ACHIEVEMENT OF FAMILY PLANNING TARGETS
(1969-70 To 1988-89)

INDEX
TARGETS
ACHIEVEMENT

STERILISATION

I U D.

YEARS
C.C. USERS

X PROVISIONAL
O INCLUDING O.P. USERS
PERCENTAGE OF RURAL ACCEPTORS-STERILISATION (1988-89)

[Graph showing percentage of rural acceptors sterilisation by states: Madhya Pradesh, Gujarat, Karnataka, Maharashtra, Punjab, Haryana, Rajasthan, Tamil Nadu, Assam, Andhra Pradesh, Kerala, Uttar Pradesh, and All India.]
PERCENTAGE OF RURAL ACCEPTORS - I.U.D.
(1988-89)

PERCENTAGE

STATES

MADHYA PRADESH
ORISSA
ANDHRA PRADESH
UTTAR PRADESH
PUNJAB
GUJARAT
KARNATAKA
HARYANA
RAJASTHAN
MAHARASHTRA
KERALA
TAMIL NADU
ASSAM
ALL INDIA
IN MILLION
BIRTHS AVERTED DUE TO FAMILY PLANNING PROGRAMME
SINCE INCEPTION UP TO 1989

YEARS

* UP TO 31ST MARCH

IN MILLION
SOCIO-ECONOMIC AND CULTURAL BACKGROUND OF THE NON ACCEPTED GROUP
Fertility control or control of population is a key factor in today's health strategy. Unfortunately this aspect of the health welfare process has not been very successful amongst the people of the lower income group. The acceptance level of the available methods for restricting the number of conceptions has been very low. Apparently the efforts of introducing various modes to plan one's family in village areas have failed totally.

In this chapter an attempt has been made to outline the characteristics and demographic profile of the non-accepted women. To study on the topic of socio-economic determinants of fertility and fertility control. I had selected a total number of 850 women. Out of that 400 women belong to the group that did not accept any fertility control methods. Again out of these 400 women I had taken 200 women from delivery group and 200 from the Medical Termination of Pregnancy (M.T.P.) group.

The folk proverb that, 'the rich get richer and the poor get babies'. In general, a low birth rate is more characteristics of urbanised, well educated and high income group and a high birth rate is more opt to be found among the rural, less educated and low income group. In rural areas a large family has labour value. In the modern city child labour is prohibited and each additional child adds
to the family expenses without increasing income. The birth rate is high in the rural areas and among the less educated groups than the urban areas. Some of the objectives of the present study were to determine the socio-economic background of the women who did not use any fertility control methods.

Many attempts have been made to alter the course of fertility through various fertility control methods, but still it does not seem to have much impact in reducing birth among the people of lower income group and less educated group. This is a fact that not only in India but also in many other developing countries, the world's most comprehensive battle is the control of population growth. But the control of population growth is being waged on in India.

No research can be successful without having proper idea of the social and economical background of the respondents. My retrospective study was conducted in Gauhati Medical College Hospital where I have recruited 400 non-accepted women which was on the basis of stratified random sampling. I studied 200 women who were coming for repeated abortion under the provision of M.T.P. Act of 1971.

But in the delivery group, women were already having more than 3/4 children yet they were coming for repeated childbirth. Because our rural folk and less
privileged class did not accepted fertility control methods much. Repeated pregnancy, labour, lactation imposes serious effect on the health of mother which lead to increasing rate of maternal morbidity, pregnancy wastage, and high infant and maternal mortality. Amongst other factors socio-economic factor is an important one. Generally labour class believe that if they have more children there will be more hands to work and that would contribute towards the family income. If they have female children they wish for a male child to continue the family line, protection of paternal property and salvation of the parents.

Medical Termination of Pregnancy (M.T.P.) is generally accepted in increasing number. It is so popular that among the educated group it is known as "wash" and "khalash" or "saf" and in the middle lower and non-educated group. The women coming for repeated termination also opined that "wash" or "saf" was associated with some risk but it is for a "short while", while during in early weeks after abortion women were free after few minutes and could start working after a short while. But at present some of the developed countries have a medical or a surgical procedure performed on the women who has delayed menstrual period and do not wish to continue with the pregnancy. The most common procedure is vacuum aspiration of the uterine cavity. The most common procedure is vacuum aspiration of the uterine cavity, 1

Ref. 1 Birth Control - By Potts and P.Bhavandaswala.
Contraceptives are generally used first by the people with a higher cultural level as they have the means of acquiring information and obtaining suppliers of contraceptives. Thus couples that belong to the high socio-economic and cultural level, mainly use contraceptive. But women belonging to the medium level of socio-economic group are the largest acceptor of induce abortion. The lower level of socio-economic group has the highest fertility and makes the least use of birth control method or abortion. Woman of lower income group are generally apprehensive of the risk associated with abortion, and so they accept the risks of pregnancy. Abortion or M.T.P. is a 'curative' measure that solves an already existing problem as well as gives a definite result which is one of the most widely accepted, important, and riskless method to get rid of unwanted delivery.

Analysis of the reasons of the couples not using any fertility control method despite that they did not want any more children, shows that they were not practising birth control methods because of unawareness about the methods. As we have already seen that generally the couples did not have proper knowledge about the available methods to control births. After the influx of the knowledge, attitude and practice studies conducted in the 1950 and 1960\textsuperscript{2} world over, social scientists have directed

their efforts to understand not only the human motivations which contribute to fertility control but also the socio-psychological parameters as to why people want to have more children and what happens to those who do not accept modern fertility control measures.

Knowledge, attitude and practice (KAP) studies demonstrated that socio-demographic factors like education, religion, parity and age etc. contribute to the acceptance of fertility control methods. Now it is to be seen why some people in the same community, under similar socio-economic circumstances accept family planning programmes and birth control measures while others resist them, Subjects of study is, therefore, in the parameters of:

Demographic Profile:

1. **Age at marriage**:

   The higher the age at marriage the less is the fertility rate. Late marriage was one of the most important factor which declines the birth rate in India. On contrary, some other studies shows that delayed married couples have their child more quickly to complete their family size as they desire.
Table - 1 : Age at marriage.
Delivery group 200 women.

<table>
<thead>
<tr>
<th>Age in years</th>
<th>No.of women</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below</td>
<td>54</td>
<td>27.10</td>
</tr>
<tr>
<td>18-19</td>
<td>45</td>
<td>22.5</td>
</tr>
<tr>
<td>20-21</td>
<td>36</td>
<td>18.0</td>
</tr>
<tr>
<td>22-23</td>
<td>26</td>
<td>13.0</td>
</tr>
<tr>
<td>24-25</td>
<td>24</td>
<td>12.0</td>
</tr>
<tr>
<td>26-27</td>
<td>10</td>
<td>5.0</td>
</tr>
<tr>
<td>28 and above</td>
<td>5</td>
<td>2.5</td>
</tr>
</tbody>
</table>

Table - 2 : M.T.P.Group (200 women)

<table>
<thead>
<tr>
<th>Age in years</th>
<th>No.of women</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below 18</td>
<td>54</td>
<td>27.0</td>
</tr>
<tr>
<td>18 - 19</td>
<td>50</td>
<td>25.0</td>
</tr>
<tr>
<td>20 - 21</td>
<td>32</td>
<td>16.0</td>
</tr>
<tr>
<td>22- 23</td>
<td>25</td>
<td>12.5</td>
</tr>
<tr>
<td>24 - 25</td>
<td>24</td>
<td>12.0</td>
</tr>
<tr>
<td>26 - 27</td>
<td>9</td>
<td>4.5</td>
</tr>
<tr>
<td>28 and above</td>
<td>6</td>
<td>3.0</td>
</tr>
</tbody>
</table>
From the above two tables, it shows that 26.5% women got married before 18 years of age. Only 7.5% women got married at or after 26 years. Majority of the women got married within 21 years of age, exposing longer period for fertility and resulting high fertility.

**Table No. 3 : Delivery group (200 women)**

<table>
<thead>
<tr>
<th>Age in years</th>
<th>No. of women</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>22 - 23</td>
<td>104</td>
<td>52.0</td>
</tr>
<tr>
<td>24 - 25</td>
<td>66</td>
<td>33.0</td>
</tr>
<tr>
<td>26 - 27</td>
<td>22</td>
<td>11.0</td>
</tr>
<tr>
<td>28 and above</td>
<td>8</td>
<td>4.0</td>
</tr>
<tr>
<td></td>
<td>200</td>
<td>100</td>
</tr>
</tbody>
</table>

**Table No. 4 : M.T.P.Group (200 women)**

<table>
<thead>
<tr>
<th>Age in Yrs.</th>
<th>No. of women</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>22 - 23</td>
<td>106</td>
<td>53.0</td>
</tr>
<tr>
<td>24 - 25</td>
<td>72</td>
<td>36.0</td>
</tr>
<tr>
<td>26 - 27</td>
<td>18</td>
<td>9.0</td>
</tr>
<tr>
<td>23 and above</td>
<td>4</td>
<td>2.0</td>
</tr>
<tr>
<td></td>
<td>200</td>
<td>100</td>
</tr>
</tbody>
</table>

From the above two tables (Table-3 and 4) it shows that the number of women at or above 26 years of age coming for repeated childbirth or M.T.P. were less.
Table No.5: Qualification. Delivery group (200 women)

| Qualification       | Wife | | | | Husband | | | |
|---------------------|------|------|------|------|-----------------|------|------|------|------|
|                     | No.  | %    | No.  | %    | No.  | %    | No.  | %    | No.  | %    |
| Illiterate          | 16   | 8    | 8    | 4    | 16   | 8    | 8    | 4    | 16   | 8    |
| Can read and write  | 50   | 25   | 32   | 16   | 50   | 25   | 32   | 16   | 50   | 25   |
| Primary level       | 80   | 40   | 50   | 25   | 80   | 40   | 50   | 25   | 80   | 40   |
| High school level   | 40   | 20   | 80   | 40   | 40   | 20   | 80   | 40   | 40   | 20   |
| College level       | 14   | 7    | 30   | 15   | 14   | 7    | 30   | 15   | 14   | 7    |

Table No.6: M.T.P. Group (200 women)

| Qualification       | Wife | | | | Husband | | | |
|---------------------|------|------|------|------|-----------------|------|------|------|------|
|                     | No.  | %    | No.  | %    | No.  | %    | No.  | %    | No.  | %    |
| Illiterate          | 12   | 6    | 6    | 3    | 12   | 6    | 6    | 3    | 12   | 6    |
| Can read and write  | 56   | 28   | 40   | 20   | 56   | 28   | 40   | 20   | 56   | 28   |
| Primary level       | 60   | 30   | 64   | 32   | 60   | 30   | 64   | 32   | 60   | 30   |
| High school level   | 44   | 22   | 70   | 35   | 44   | 22   | 70   | 35   | 44   | 22   |
| College level       | 28   | 14   | 20   | 10   | 28   | 14   | 20   | 10   | 28   | 14   |

The above table No.5 and 6 shows that quite a good number of women were from the lower educational group 30% and 32% from the delivery and M.T.P. group respectively.
It was observed that females education does play an important part in the acceptance of the birth control methods. Similar trend was observed with the education of the husband.

Table No. 7: Occupation : Delivery group (200 women)

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Wife</th>
<th></th>
<th>Husband</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
<td>House wife</td>
<td>162</td>
<td>81</td>
<td>-</td>
</tr>
<tr>
<td>Govt. service</td>
<td>12</td>
<td>6</td>
<td>80</td>
</tr>
<tr>
<td>Semi Govt.</td>
<td>6</td>
<td>3</td>
<td>70</td>
</tr>
<tr>
<td>Private</td>
<td>6</td>
<td>3</td>
<td>30</td>
</tr>
<tr>
<td>Business</td>
<td>4</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Labour</td>
<td>10</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>200</td>
<td>100</td>
<td>200</td>
</tr>
</tbody>
</table>

Table No. 8: Occupation : M.T.P. Group (200 women)

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Wife</th>
<th></th>
<th>Husband</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
<td>House wife</td>
<td>160</td>
<td>80</td>
<td>-</td>
</tr>
<tr>
<td>Govt. service</td>
<td>14</td>
<td>7</td>
<td>76</td>
</tr>
<tr>
<td>Semi Govt.</td>
<td>4</td>
<td>2</td>
<td>68</td>
</tr>
<tr>
<td>Private</td>
<td>4</td>
<td>2</td>
<td>30</td>
</tr>
<tr>
<td>Business</td>
<td>8</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>Labour</td>
<td>10</td>
<td>5</td>
<td>14</td>
</tr>
</tbody>
</table>
Above two tables (Table No. 7 and 8) shows that as many as 81% and 80% of the women were housewife, only 2% and 4% were in business and 5% were daily labour. As regard to husband's occupation 40% and 38% in the two groups respectively were in Govt. service. 35% and 34% were in semi Govt. and 15% were in private organisation and only 5% and 6% were in business, 5% and 7% were daily labour.

Table No. 9: Parity - Delivery group (200 women).

<table>
<thead>
<tr>
<th>Parity</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>P4</td>
<td>110</td>
<td>55.0</td>
</tr>
<tr>
<td>P5</td>
<td>62</td>
<td>31.0</td>
</tr>
<tr>
<td>P6</td>
<td>28</td>
<td>14.0</td>
</tr>
<tr>
<td></td>
<td>200</td>
<td>100</td>
</tr>
</tbody>
</table>

Table No. 10: M.T.P. group (200 women)

<table>
<thead>
<tr>
<th>Parity</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>P4</td>
<td>104</td>
<td>52.0</td>
</tr>
<tr>
<td>P5</td>
<td>66</td>
<td>33.0</td>
</tr>
<tr>
<td>P6</td>
<td>30</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>200</td>
<td>100</td>
</tr>
</tbody>
</table>
Table No. 9 and 10 shows that in both the groups most of the women 55% and 52% respectively were having 4 to 5 children and, 14% and 15% were having 6 and above children. All the respondents of these two groups were multipara. A woman having more than 3 children is called multipara. They were already fit to accept either temporary or permanent method. M.T.P. or Medical Termination of Pregnancy is actually not a fertility control method. But the question is why they were coming for repeated childbirth or do M.T.P. but not taking any fertility control methods.

Table No. 11: Interval from one pregnancy to the other delivery group (200 women)

<table>
<thead>
<tr>
<th>Interval</th>
<th>No. of women</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>within 12 months</td>
<td>72</td>
<td>36.0</td>
</tr>
<tr>
<td>13 to 18 months</td>
<td>62</td>
<td>31.0</td>
</tr>
<tr>
<td>19 to 24 months</td>
<td>42</td>
<td>21.0</td>
</tr>
<tr>
<td>25 to 30 months</td>
<td>14</td>
<td>7.0</td>
</tr>
<tr>
<td>31 to 36 months</td>
<td>10</td>
<td>5.0</td>
</tr>
<tr>
<td></td>
<td>200</td>
<td>100</td>
</tr>
</tbody>
</table>
Table No. 12: M.T.P. Group (200 Women)

<table>
<thead>
<tr>
<th>Interval</th>
<th>No. of Women</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within 12 months</td>
<td>74</td>
<td>37.0</td>
</tr>
<tr>
<td>13 to 18 months</td>
<td>60</td>
<td>30.0</td>
</tr>
<tr>
<td>19 to 24 months</td>
<td>40</td>
<td>20.0</td>
</tr>
<tr>
<td>25 to 30 months</td>
<td>16</td>
<td>3.0</td>
</tr>
<tr>
<td>31 to 36 months</td>
<td>10</td>
<td>5.0</td>
</tr>
<tr>
<td></td>
<td>200</td>
<td>100</td>
</tr>
</tbody>
</table>

From the above two tables (Table No. 11 and 12), it was observed that quite a large number, 36% and 37% of women became pregnant within 12 months from their previous child birth which prove high frequency of fertility. Also 5% women in both the groups became pregnant within 31 to 36 months.

Table No. 13: Number of repeated M.T.P. (200 Women)

<table>
<thead>
<tr>
<th>No. of M.T.P.</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>52</td>
<td>26.0</td>
</tr>
<tr>
<td>2</td>
<td>40</td>
<td>20.0</td>
</tr>
<tr>
<td>3</td>
<td>30</td>
<td>15.0</td>
</tr>
<tr>
<td>4</td>
<td>26</td>
<td>13.0</td>
</tr>
<tr>
<td>5</td>
<td>24</td>
<td>12.0</td>
</tr>
<tr>
<td>6</td>
<td>16</td>
<td>8.0</td>
</tr>
<tr>
<td>7</td>
<td>12</td>
<td>6.0</td>
</tr>
<tr>
<td></td>
<td>200</td>
<td>100</td>
</tr>
</tbody>
</table>
Table No. 14: Number of M.T.P. done in relation to the parity.

<table>
<thead>
<tr>
<th>Parity</th>
<th>No. of women</th>
<th>No.of M.T.P.</th>
</tr>
</thead>
<tbody>
<tr>
<td>P4</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>P4</td>
<td>20</td>
<td>2</td>
</tr>
<tr>
<td>P4</td>
<td>14</td>
<td>3</td>
</tr>
<tr>
<td>P4</td>
<td>20</td>
<td>4</td>
</tr>
<tr>
<td>P5</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>P5</td>
<td>16</td>
<td>3</td>
</tr>
<tr>
<td>P5</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>P5</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>P6</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>P6</td>
<td>16</td>
<td>6</td>
</tr>
<tr>
<td>P6</td>
<td>2</td>
<td>7</td>
</tr>
</tbody>
</table>

The above table shows that majority of the women (57.5%) came for 5 or above times for M.T.P. and 42.5% came for 1 to 4 times.
**Table No. 15**: Reasons for not using any contraceptive methods.

Delivery group (200 women).

<table>
<thead>
<tr>
<th>Reasons</th>
<th>NO.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desire for more children</td>
<td>12</td>
<td>6.0</td>
</tr>
<tr>
<td>Left on God</td>
<td>22</td>
<td>11.0</td>
</tr>
<tr>
<td>Fear for side effect/after services</td>
<td>42</td>
<td>21.0</td>
</tr>
<tr>
<td>Unaware of fertility control methods</td>
<td>38</td>
<td>19.0</td>
</tr>
<tr>
<td>Wanted privacy/lady staff</td>
<td>44</td>
<td>22.0</td>
</tr>
<tr>
<td>Wanted male child</td>
<td>14</td>
<td>7.0</td>
</tr>
<tr>
<td>Non availability of the devices/specialised doctor</td>
<td>18</td>
<td>9.0</td>
</tr>
<tr>
<td>Want female child</td>
<td>10</td>
<td>5.0</td>
</tr>
</tbody>
</table>

**Table No. 16**: M.T.R. Group (200 women)

<table>
<thead>
<tr>
<th>Reasons</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of after services</td>
<td>30</td>
<td>15</td>
</tr>
<tr>
<td>Fear for side effects</td>
<td>44</td>
<td>22</td>
</tr>
<tr>
<td>Unaware of fertility control methods</td>
<td>58</td>
<td>29</td>
</tr>
<tr>
<td>Want privacy/lady staff</td>
<td>48</td>
<td>24</td>
</tr>
<tr>
<td>Non availability of devices/specialised doctor</td>
<td>20</td>
<td>10</td>
</tr>
</tbody>
</table>

200 100
From the above two tables (Table No. 15 and 16) it was observed that majority of the women (21% and 22% in both the groups) were afraid of various side effect like weight gain, menstrual abnormality, sexual displeasure, failure etc. In delivery group 6% wanted additional child. Again 11% and 15% in both groups did not accept any devices for fear of God or on religious ground. 22% and 23% of both the groups revealed that the women feel shy to express their difficulties in front of the male doctors. 9% and 15% of the respondents said that they could not get the methods easily and on the other hand they wanted female child and vice versa.

Social aspect:

After studying the table 15 and 16, the reasons which can be attributed to this unsuccessful venture may be explained as the socio-economic problems of the non accepted women which were some of the various important reasons of non-acceptance. Following were some of the factors which prevails in the non accepted women. However, apprehension for side effects of the various fertility control methods caused a substantial proportion of women in accepting the methods.

It is also clearly demonstrated that non-acceptance of birth control methods brings in more problems in their
social and family life than the acceptors. Respondents complained for bleeding irregularities resulting from the use of birth control methods for which they could not work. They were considered to be impure, while bleeding and were not allowed to serve food, cooking enter into the temples, to attend religious functions as a result family atmosphere were badly disturbed.

During discussion several women told us that due to the side effects of birth control methods they felt exhausted. Some others remarked that due to bleeding, they could not indulge in sexual act with their husband. It is a fact that for a very short time in some women during initial two to three months of use, certain mild side effects like headache, nausea, vomiting, heaviness of breast etc. can occur. But actually there are little or no chance of harmful side effects when used with advices of the medical staff.

To control birth, a number of methods are available. Among them the pill and condom are very simple, safe, effective and reversible methods for spacing pregnancy without any instrumental intervention. Once the methods are stopped the women exposed to conception. 

**Desire for additional children:**

From the interview with the respondents it was observed that 6% couples wanted more children. According
to them parents did not beget children merely for economic reasons. Child birth were considered to be a success in married life particularly for the females. Children, particularly sons for them were considered to be the cause of economic and old age security besides providing emotional satisfaction and salvation. In Indian society children, specially sons are more valued because they provide status to their mother and play an important role in religious performances to their family. So majority of the non users have been found to be reporting, desire of more children (especially sons) as reason for not accepting family birth control methods. According to them son could only give them salvation by offering *pinda* girls were not allowed to offer ‘Pinda’ in our society.

The people of lower socio-economic status are mostly superstitious and follow firmly the traditional ethics. The people of rural areas are more religious minded than the people of urban areas. For them pregnancy is believed to be God’s blessing. Exercising human attempts to prevent motherhood means denial of God’s gift. There is a great conviction that if such practices are allowed then curses of God would fall upon the whole community and that would be the end of every thing. Therefore, their outlook towards the whole affairs has remained unchanged
for ages. In some religious groups like Muslims and Christians use of contraceptives or to follow the birth control measures are said to be prohibited. Even Roman Catholics, although they agree with the idea of family planning, they found only certain methods of contraceptives acceptance. Even for some Hindu couples, adoption of family planning is a sinful act and going against nature and it amounts to killing of offspring. For them, it is up to God to decide about the fate of his/her life and nothing was left in their hands. Thus these couples stick to their traditional outlook, and do not show readiness to new innovations. Muslims are acknowledged to have a high fertility than the Hindus and their procreation in the overall population has been gradually rising. However, much progress has not been achieved inspite of various arrangement and wide propaganda. In the present study it was observed that 11% females did not used any fertility control method for fear of God.

Fear for side effects:

Several studies have shown that rumours play an important role in influencing the decision making in regard to the use of fertility control methods. But social norms relating to family size and norms relating to methods of birth control are important determinants of fertility
control behaviour. From the psychological point of view, the result shows that adopting couples tend to be less anxious, more intelligent and having a stronger need for dominance than the non-adopting couples. In the present study 21% females from delivery group and 22% from the M.T.P. group refused to use any contraception for fear of side effects. Various reasons advanced by the non-acceptors of the methods were classified in various categories – psychological, physical discomforts, social and others. Physiological problems like excessive bleeding, irregular cycle, white discharge were the major causes for non-acceptance of birth control measures.

Psychological reasons like nausea, bad mood, fear etc. Similarly social and family norms did not play any significant role for acceptance and non-acceptance of the birth control methods. Among the physiological reasons of non-acceptance of pill and other fertility control methods excessive bleeding and irregular cycle spotting were the main problems. However, the side effects of contraceptive methods caused a substantial affect in recent times. Quite a good number of women were complaining about non-availability of after services and absence of specialised doctor.

Unawareness of fertility control methods:

In my study 19.0% and 23% couples from both groups respectively reported that they were unaware of any family
planning programmes and fertility control methods and as such they did not practise. Thus in my study it was found that couples who did not want additional children but not practising any birth control methods were often found to have less husband-wife communication, apathy, less exposure to mass media and less perceived burden of children. As we had seen that generally those couples did not have proper knowledge about the various problems of excessive population growth also.

Integration of all these observations suggest that due to lack of systemic population education, couples did not have proper knowledge about the fertility and fertility control methods, as such their all the sensus were clouded by rumours and negative messages resulting misconception about the fertility and fertility control methods. As there were no body to remove the fears and misconceptions which seemed to have caused among the couples, the unfavourable attitude towards fertility control methods could not be removed.

Wanted Privacy/Lady staff:

In my study 23.5% women said that they felt shy to express to the male doctors. They wanted privacy. Most of the women reported that they did not like to go to the P.H.C.* as because there were no female doctors and they

Footnote: * P.H.C.: Primary Health Centre.
were also at a great distance. So due to shyness many women also felt that they should not discuss their health problems with other members of the family. Women especially from the rural areas and lower income group liked to postpone their visit to the clinics for various reasons including shyness and need of privacy.

Non availability of the devices:

12.5% women reported that they could not get the contraceptive devices easily. In my study it was revealed that contraceptives users were more among urban, better educated women, employed women and women close to any health institution's source of birth control services. Contraceptive users varies from place to place. A higher percentage of urban women and especially those living in the capital city used contraceptions in contrary to the rural women. As many women did not give specific reasons for non use, but only said that birth control methods were not available in their Health Centres. Supply of birth control methods to the all sections of rural and urban population were not regular. Thus one of the essential requirement for success of family planning programmes is to provide birth control methods at cheap rates and make them easily available.

Some other women did not give specific reasons for non use but only said that they did not want to or did not
like to use birth control methods, but it might be just to cheating themselves. Non-assessibility of the new methods and falastic attitude of the couples were also the important factors for non acceptance.

Besides these, some of present methods available for controlling fertility are not suitable to a great extent. For instance, it is impossible for adopting rythem methods for a village women. The women folk also feel shy to use other items of birth control like tablets, condom, foam tablets, creams, Cu.T etc. The coitus interruption affects badly a male sexual pleasure which may lead to psychological disturbances to the husband. The condom prevents the feeling of closeness and brings in dissatisfacation to a couple. The only method which can be comfortably adopted is the pill. Women having atleast one living child should be coerced to adopt any birth control methods.

**Failure of fertility control methods:**

Fertility control methods can fail to prevent pregnancy in percentage of women. The women may conceived while the couple is using the fertility control methods which is known as the contraceptive failure. Any method of birth control even the modern one also can fail. Oral contraceptive having the least failure rate while the withdrawal method having the highest. Failure may causes psycho-social affects to the couples. Again there may be serious social
problem when the woman conceived while the husband is using birth control method. Moreover, it is great resentment to the people in general. Thus due to the apprehension of contraceptive failure some couple exhausted to accept it.

After services and specialised doctors:

From this investigation it was observed that the after services were absolutely poor. The couples said that the health functionaries used to come before operation and used to motivate them with various 'sweety words' but surprisingly once their purposes were over no body were seen. Later on when they approached the health functionaries for any trouble they were not paying any interest for them. Even during the operation or while giving any birth control devices they were not properly behaved.

They were also saying that they did not have much faith on their doctor as they were not specialised on the subject of family welfare. They were also complaining that the doctors were not examining the patient at all 'just hear and write down the medicines' which indicate that the present system of the health institution is not at all satisfactory. After service means as per Government norms the health functionaries are suppose to give some services to the couples adopting birth control methods. They must
follow even the health functionaries are suppose to go to their home, collect information about their health and children's health and should advised accordingly for which government has appointed staff and sanctioned funds.
## Effectiveness of Contraceptives *

<table>
<thead>
<tr>
<th>Contraceptive</th>
<th>Pregnancy failure per 100 woman year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral contraceptive</td>
<td>0.1</td>
</tr>
<tr>
<td>Intrauterine contraceptive device (IUCD)</td>
<td></td>
</tr>
<tr>
<td>Copper T</td>
<td>2</td>
</tr>
<tr>
<td>Condom (Nirodh)</td>
<td>10</td>
</tr>
<tr>
<td>Vaginal diaphragm</td>
<td>15</td>
</tr>
<tr>
<td>Vaginal spermicide</td>
<td>15</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>35</td>
</tr>
<tr>
<td>Rhythm</td>
<td>35</td>
</tr>
<tr>
<td>Norplant</td>
<td>1-2</td>
</tr>
<tr>
<td>Tubectomy</td>
<td>0.4</td>
</tr>
<tr>
<td>Vasectomy</td>
<td>0.15</td>
</tr>
<tr>
<td>No contraceptive</td>
<td>60</td>
</tr>
</tbody>
</table>

* Source: Text Book of Gynaecology And Contraceptics
Abortion rights activists briefly covered the face of the Statue of Liberty and unfurled a banner recently in New York to protest regulations barring abortion counseling at federally funded family planning clinics. Members of WHAM (Women’s Health Action and Mobilization) hung two black banners, one from the crown and another from the top of the pedestal. No arrests were made.

AP/PTI
MEDICAL TERMINATION OF PREGNANCIES
(1972-73 TO 1988-89)
# The Six Steps of Counseling

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G</td>
<td>Greet each client warmly.</td>
</tr>
<tr>
<td>A</td>
<td>Ask the client about herself and why she has come.</td>
</tr>
<tr>
<td>T</td>
<td>Tell the client about each available family planning method. Then tell her more about the methods that most interest her.</td>
</tr>
<tr>
<td>H</td>
<td>Help the client choose the method that is best for her.</td>
</tr>
<tr>
<td>E</td>
<td>Explain how to use the method that the client chooses. Help her plan how she will use the method.</td>
</tr>
<tr>
<td>R</td>
<td>Return for follow-up. Agree on a time to meet again.</td>
</tr>
</tbody>
</table>
FLOW DIAGRAM FOR COUNSELLING A CONTINUING CLIENT

CONTINUING CLIENT

"Do you have any problems with your method?"

- No
- Yes

- Explore the reasons for dissatisfaction:
  - List the side effects:
    - Do they have any?
    - Misinformation
    - Lifestyle Issues

- Are they manageable?
  - Yes
  - Information, Education, Discussion

- No

- Do they need treatment or referral?
  - Yes
  - Provide treatment or referral

- No

- "Do you have any questions?"
  - Yes
  - Answer questions, review and discuss options

- No

- Will you continue your current method?
  - Yes
  - Provide method supplies
  - Give instructions
  - Verify correct use
  - Review side effects and warning signs
  - Plan return visit/after

- No

- "Do you want another method?"
  - Yes
  - Help the client select another method

- No

- Remove or stop method
- Refer if needed
NEIGHBOURHOOD  CONTROL  GROUP
In this part of the study, I have selected all total 50 couples and named as 'Neighbourhood control group study'. Many families living in houses near each other is called neighbourhood. They were living just within 4 K.M.s of the fertility control methods users. These 50 couples were not interested in accepting any methods of fertility control. As because of living near fertility control methods users, they must have adequate knowledge about the fertility control methods and also the effects and side effects of them. First of all I have picked up 10 respondents from accepted group whom I can contact easily. I have collected 50 couples from the neighbourhood of these 10 fertility control methods users, 5 neighbourhood couples against one acceptor.

In this chapter, an attempt has been made to throw light on the factors of not accepting any fertility control method by these 50 couples. Also I studied to find out whether the causes of not accepting any birth control method by these women of the neighbourhood control couples were similar or not to that of the non-acceptors. The fact that these 50 women have proper knowledge of all kinds of birth control methods. As because of living near the users, naturally they have been motivated by the acceptors, Moreover, the objectives of the present study is confined to make
a general assessment of the attitude, knowledge and reaction of the respondents of neighbourhood, who have not accepted any methods. The term family planning is used in many contexts and it is necessary to consider the economic, cultural, psychological and health factors. To study the demographic profile of the respondents, I have selected the respondents of neighbourhood control group from the same age, parity, qualification, occupation etc. of the respondents of non-acceptors. So I tried to find out the relationship of this result with that one found in the statement of the non-accepted women.

Table No.1 : Age of the respondents.

<table>
<thead>
<tr>
<th>Age in years</th>
<th>Against Temporary method users</th>
<th>Against permanent method users</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of women</td>
<td>%</td>
</tr>
<tr>
<td>Upto 20</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>21 to 25</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>26 to 30</td>
<td>15</td>
<td>60</td>
</tr>
<tr>
<td>31 to 35</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Above 36</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>25</td>
<td>100</td>
</tr>
</tbody>
</table>

In the above chart (Table No.1) I have shown that of these 50 women of the neighbourhood control group, 25
women were selected against the permanent method users and another 25 women against temporary methods users. From the above table, it was observed that majority of the women were from the age group of 26 to 30 years.

Table No. 2:

<table>
<thead>
<tr>
<th>Age at marriage in years</th>
<th>In the neighbourhood of sterilisation group</th>
<th>In the neighbourhood of temporary method users</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of women</td>
<td>%</td>
</tr>
<tr>
<td>Upto 15</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>16 to 17</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>18 to 19</td>
<td>11</td>
<td>44</td>
</tr>
<tr>
<td>20 to 22</td>
<td>6</td>
<td>24</td>
</tr>
<tr>
<td>23 to 25</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Above 26</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>25</td>
<td>100</td>
</tr>
</tbody>
</table>

The above table shows that (out of this 25 permanent and 25 temporary method users) majority of women were married at the ages of 18 to 19 years (44% and 40% respectively).
Table No.3: Monthly per capita income.

<table>
<thead>
<tr>
<th>Income</th>
<th>Sterilisation</th>
<th>Temporary method</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>Rs.20/- to 50</td>
<td>16</td>
<td>64</td>
</tr>
<tr>
<td>Rs.51/- to 100/-</td>
<td>6</td>
<td>24</td>
</tr>
<tr>
<td>Rs.101/- to 200/-</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Rs.201/- and above</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>

64% of the respondents belonged to families with monthly per capita income ranging from Rs.20/- to 50/-. In both the tables majority of the respondents came from families of whom monthly per capita income were below Rs.50/-.

Table No.4: Occupation.

Against sterilisation:

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Wife</th>
<th>%</th>
<th>Husband</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>House wife</td>
<td>15</td>
<td>60</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Govt. service</td>
<td>4</td>
<td>16</td>
<td>10</td>
<td>40</td>
</tr>
<tr>
<td>Semi Govt.</td>
<td>3</td>
<td>12</td>
<td>10</td>
<td>40</td>
</tr>
<tr>
<td>Private</td>
<td>3</td>
<td>12</td>
<td>5</td>
<td>20</td>
</tr>
</tbody>
</table>

25 100 25 100
Table No. 5:
Against temporary method users:

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Wife No.</th>
<th>Wife %</th>
<th>Husband No.</th>
<th>Husband %</th>
</tr>
</thead>
<tbody>
<tr>
<td>House wife</td>
<td>10</td>
<td>40</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Govt. service</td>
<td>5</td>
<td>20</td>
<td>10</td>
<td>40</td>
</tr>
<tr>
<td>Semi Govt.</td>
<td>5</td>
<td>20</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>Private</td>
<td>5</td>
<td>20</td>
<td>10</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>25</td>
<td>100</td>
<td>25</td>
<td>100</td>
</tr>
</tbody>
</table>

From both the tables as many as average 50% of the women were housewives, and average 40% of their husband from both the groups were Govt. servant. It is observed that as most of the respondent's husband were in Govt. service, they had chance to talk and discuss about the fertility and fertility control methods with their friends and colleagues. Then, naturally questions arises what inhibited them from accepting birth control services?

Table No. 6: Parity.

<table>
<thead>
<tr>
<th>No. of children</th>
<th>Against sterilisation (group) No.</th>
<th>Against sterilisation (group) %</th>
<th>Against temporary method users No.</th>
<th>Against temporary method users %</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>4</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>5</td>
<td>9</td>
<td>36</td>
<td>8</td>
<td>32</td>
</tr>
<tr>
<td>6 and above</td>
<td>14</td>
<td>56</td>
<td>10</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>25</td>
<td>100</td>
<td>25</td>
<td>100</td>
</tr>
</tbody>
</table>
From the table No. 6, it was observed that majority of the respondents of both the groups average 48% had six and above children and 82% from both groups had 5 and above number of children.

Table No. 7: Qualification.

Against sterilisation group:

<table>
<thead>
<tr>
<th>Qualification</th>
<th>Wife</th>
<th>Husband</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>Illiterate</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Can read and write</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Primary level</td>
<td>6</td>
<td>24</td>
</tr>
<tr>
<td>High school level</td>
<td>12</td>
<td>48</td>
</tr>
<tr>
<td>College level</td>
<td>4</td>
<td>16</td>
</tr>
</tbody>
</table>

Table No. 8:

Against temporary method users.

<table>
<thead>
<tr>
<th>Qualification</th>
<th>Wife</th>
<th>Husband</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>Illiterate</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Can read and write</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Primary level</td>
<td>6</td>
<td>24</td>
</tr>
<tr>
<td>High school level</td>
<td>12</td>
<td>48</td>
</tr>
<tr>
<td>College level</td>
<td>3</td>
<td>12</td>
</tr>
</tbody>
</table>

33 100 25 100
It was observed that, 49% of the husbands and wife in both the tables were illiterate. 48% of the women were educated up to high school level. On the other hand 40% of the husband against sterilisation group and 16% against temporary method users were up to college level.

Table No. 9:
Causes of not using any method:

<table>
<thead>
<tr>
<th>Causes</th>
<th>Against sterilisation</th>
<th>Against temporary method users</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>Wanted male child</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Left for God</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Fear of side effect/after services.</td>
<td>6</td>
<td>24</td>
</tr>
<tr>
<td>Unaware of birth control methods</td>
<td>4</td>
<td>16</td>
</tr>
<tr>
<td>Wanted privacy/Lady doctor</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>Wanted female child</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Non availability of method/specialised doctor</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Lack of faith</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>

25  100  25  100
In this chapter an attempt has been made to throw light on the causes of non accepting the birth control methods by the respondents in the neighbourhood control group. Already I had studied the causes of not accepting the birth control methods by the women of non-accepted group. First of all, I have noted down the addresses of those women who had adopted contraceptive devices. Among them I had selected 10 respondents. These 50 women had taken from their neighbours who were not taking methods inspite of having proper information and knowledge about fertility control methods. In probing, it was found that they avoided these methods mainly due to the fear of side effects. In some cases permanent method could not be accepted as it interfered with family responsibilities. It was observed that their neighbour who should have been useful as sources of information knowledge and motivation for promoting the use of the fertility control methods could not help them. The respondents did not desire to take up the birth control methods. These 50 respondents who were in the neighbourhood of accepted group had sources to remove some misunderstanding about birth control methods and the purpose for which family planning scheme has been taken up. They were in the neighbourhood of the acceptors group, yet they were having less
interest and apathy to accept fertility control methods. The women were traced out on the basis of addresses given by the acceptors. So I have selected 5 couples against each acceptor living around within a distance of 4 K.M. from the acceptors. These couple were selected and studied to know the various causes of not using the fertility control methods and to compare the results with that of the non acceptors who came for repeated child birth and M.T.P.

The various reasons advanced by non acceptors were psychological, social, economical and others. It was observed that temporary physiological problems, like excessive bleeding, irregular cycle, spotting and white discharge, left for God etc. were the major apprehensive causes. Psychological reasons like nausea, bad mood, fear, loss of sexual pleasure also may be added to the cause of their unwillingness to accept the methods. It was also observed that like non-accepted group the respondents of neighbourhood control group did not accept any fertility control methods due to the apprehension of side effects and lack of after services, 24% and 28% in both the groups respectively unaware of birth control methods by 16%, non-availability of the methods and specialised doctors by 8% and by left for God 12% and 8% in both the groups respectively.
The studies on the knowledge, attitude and reaction of this group of eligible couples shows that they knew family planning programmes and fertility control methods very well and were both possible and desirable but they were not using their knowledge as because they did not use the fertility control methods. Thus this demonstrated that with better social support the acceptance of birth control methods can largely be increased despite of the wrong information and apprehension for the side effects associated with them.
TECHNICO SOCIAL EVALUATION OF THE SURVEYED AREA
The state health functionaries is headed by the Government at the top. There are three Directorates - Director of Medical Education who is looking after the medical education, planning and research, Director of Health Services, who is looking after the health, treatment and health education and Director of Health Services, Family Welfare- is looking after the family welfare aspect of the health services.

In a district, Chief Medical and Health Officer is looking after the health and health education, the Addl. Chief Medical and Health Officer is looking after the family welfare aspect. In the present study a sample of 8 district, 16 P.H.C.s and 350 Sub-centres covering 160 remote villages and 1712779 population was carried out. The districts and P.H.C. are as follows:

<table>
<thead>
<tr>
<th>Name of districts</th>
<th>Name of P.H.C.s with population</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Kamrup</td>
<td>Soalkuchi - 68,874</td>
</tr>
<tr>
<td></td>
<td>Bihdia - 64,452</td>
</tr>
<tr>
<td>2. Barring</td>
<td>Sipajhar - 82,995</td>
</tr>
<tr>
<td></td>
<td>Jaljali - 120,000</td>
</tr>
<tr>
<td>3. Nowgong</td>
<td>Barapujia - 107,667</td>
</tr>
<tr>
<td></td>
<td>Jhargao - 17443</td>
</tr>
<tr>
<td>4. Nalbari</td>
<td>Kamarkuchi - 1,27,868</td>
</tr>
<tr>
<td></td>
<td>Gagharapar - 90,446.</td>
</tr>
</tbody>
</table>
5. Sonitpur  
Bihaguri - 2,05,965  
Dhekiajuli - 2,32,643

6. Barpeta  
Bhawanipur - 1,09,932  
Nityananda - 1,44,601

7. Karbialong (Hill district)  
Daskamukh - 60,325  
Manza - 75,229

8. Cachar  
Nilambazar - 1,33,920  
Soni - 1,82,419

None of the PHCs are functioning properly. Birth control services like vasectomy, tubectomy, and IUCD insertion are not done routinely but only by camp basis. None of them are admitting the patient regularly except in epidemic or emergency. 30% subcentres had existence on their own building, 50% in donated house and 20% had no existence and we found difficulties to find out the staff already appointed in this 20% subcentres.

I am afraid to say that none of the subcentres are functioning properly. The ANMs did not have any data of their respective area. We have surveyed 160 remote villages. During rainy season some villages were difficult to approach due to disruption of road communication. 30% villages were electrified with frequent disruption of current for hours and some time days together. Only 20% villages were having T.V. network facilities. None of the health institution followed the Bhor commission's recommendation. The health institution were hardly visited by their seniors.
The fellow relationship among the staff were very poor. I am surprised to say that the whole functioning system were principle oriented rather to be function oriented.

The functioning system of the health institutions were far below the level narrated in the curriculum. The contingency fund granted to each PHC were too less to cover the 200 sq. k.m. area even a small piece of paper to write prescription, for 200 patients attending daily in the O.P.D. in each PHC. Irregular payment of salary to the staff, non payment of allowances to the dais were also bitter feeling for the employees. Regularity of the staff were very hard to see. Life saving drugs were not available in any of the studied PHC. Supply of other essential drugs were also not sufficient and was irregular in supply. In none of the PHC single lady medical officer was seen. Sources of drinking water were unsafe. Supply of fertility control devices were irregular. Power supply was most irregular. Very often the vehicle remain out of the road for months together as the repair could not be done due to the lack of fund.

Hill Bribal

Total hill area of Assam is 15460 Sq. K.M. inhabiting 8,04,761 population of which 4,23,185 male and 3,81,576 female. Literacy rate is 47% male , 30.5% female and having annual growth rate of 4.23%. The density of population is 47 per Sq.K.M. which is due to vast area of
uncultivatable and uninhabitable hilly place. The growth rate is double the plain area. Culturally it is of composite in nature. 70% are Hindus following Sakta and Vaisnava and 30% are Christian. Marriage system they follow is of their traditional purchased and probationary type. 'Jum' cultivation is the main occupation. The women are mostly housewife and help their husband in day to day work. Economically they are far below the expected level. Poligamy and early marriage are more prevalent. The average family size is 8.5. Attitude to the birth control methods and family welfare programmes are quite unfavourable for fear of god and lack of knowledge regarding the birth control devices. Very few percentage of couple except birth control methods only after having the desired number of children. Water sources are unsafe as such communicable diseases are more common.

Plain Tribals

11% of total population of Assam is shared by the plain tribals. Mainly the Bodo and Kacharis. In my study there are 100 women from the plain tribals. Cultivation is main occupation for them but not to speak of modern agricultural amenities most of them do not have their own plough. Majority of them do not have their own land as such they used to cultivate on the Government land. Literacy rate is comparatively lower than the other plain
peoples, 40.2% male and 22.5% female. Growth rate is 4.12%. Culturally it is of composite in nature, 65% Hindus and 35% are Christian. They followed their traditional system of marriage irrespective of their religions. Economically they are poor, family size is 8.2 and the standard of living is far below the expectation. Death rates are doubled than the other plain population. Sources of water is unsafe. Communicable diseases are more common and frequent. Electrification is rare and the mass media is yet to cover vast area. 80% of the population do not have the knowledge about the family planning programmes and birth control methods. Hardly: they attend the health institution. Acceptance rate is very very low and those who have accepted only after completing their desired number of children. Some women used to terminate their unwanted pregnancies by the village quake. Some women right way refused to talk when they knew that I was approaching them to know about their attitude towards the birth control methods, which proves their complete apathy towards the family planning programme and birth control methods. The villages I have studied do not have any modern agricultural amenities though agriculture is the main source of economy. 80% of the cultivator do not have fund to buy modern plough, fertilises and seeds. The co-operative system is lying in the treatment bed as a crippled child. The people also do not have faith on the co-operative system as very often they are decieve by the co-operative system.
In a village there are 35 families with 350 population. The village is situated in the out skirt of a town with good road communication. Every house is connected by electric power and having T.V. and radio. Water sources safe, literacy rate is 100% and though the cultivation is the main sources of economy each family has got minimum one Government service holder and one graduate. The average family size is 10. 60 eligible couples are there having adequate knowledge about the problems of excessive population, family planning programmes and fertility control methods, yet the acceptance rate is only 10%. They are also accepting as because unable to carry further pregnancies. It has been observed that they are still strictly following the old traditional system in a air type manner for all purposes.