CHAPTER – VIII

SUMMARY AND CONCLUSION

SOCIO-ECONOMIC CHARACTERISTICS

The present study on the small size family norm and family planning practices was conducted in the seven villages, namely, Gularhi, Kanda, Rauri, Nahun, Dher Ke Bhed, Sihardi Musalmana and Sihardi Chamara, under the Dharampur Block of Solana District, Himachal Pradesh.

There are more nuclear families than joint families in all the villages. Religion is an important cultural factor that determines the contraceptive behaviour of the people. It plays an important role in forming the values, attitudes and action of the people regarding family planning. Though majority of the people are Hindus, there are also Sikhism and Islam where the percentage is low varying between 1.02 per cent to 11.72 per cent.

There are more pucca houses than the kaccha and semi-pucca houses in the villages. Those households having pucca type of houses will have RCC roof with a high percentage in the villages. The percentage is low in those households having kachcha/semi-pucca houses. In all the villages, most of the houses have more than 2 living rooms. Owning of houses is associated with one’s nativity. The percentage is high in all the village who own houses.

As for the sources of water supply and sanitation facilities, in all the villages there are both taps and bowries in the households with a high percentage. Also most of the households are having flushing toilets. There are households who are not in the position to have flush toilet or pit toilet, goes to the fields/bushes.

Most of the households have bathing facilities. For the location of bathing the percentage is high having attached bathrooms in Gularhi, Nahun, Dher Ki Bhed, Sihardi Musalmana and Sihardi Chamara. Those households having separate bathroom are found in Kanda and Rauri where the percentage is high.
In all the villages, they have separate kitchen for cooking with a high percentage. The type of fuel used for cooking are firewood, cowdung cakes, kerosene, LPG. The percentage is high where cowdung cakes are used as fuels for cooking. With modernity it has been replaced by LPG.

The highest education level achieved by the male in all the villages are graduates/postgraduates. In Dher Ki Bhed, Sihardi Musalmana and Sihardi Chamara, the respondent has both primary and secondary level of education. In Dher Ki Bhed, the maximum the male had achieved is middle school level. Most of the respondents have completed high school and higher secondary school level.

Those respondents whose income is less than Rs.100, males work as labourer and some have their own business and for females, they work as labourer, sewing teacher, angawadi workers. In the income group of Rs.100-2000, males work in agricultural fields, have their own business, works as masons. Females work as teachers, working in beauty parlour, as angawadi workers and din factories. Those whose income is Rs.4001-5000 to Rs.6000, males work in government offices, some working as milkman, teacher and females works as teachers. Thos in the income group of Rs.6001-7000 to Rs.9000 and above, males works as executives, pharmacists, government employed.

Higher occupational status is associated with higher education and income, which in turn, leads to higher rate of adoption of family planning methods. In professional categories (engineers, lawyers, scientist etc.) we see more males and females in Rauri, Dher Ki Bhed, Sihardi Musalma and Sihardi Chamara than in Gularhi, Kanda and Nahun. Only males are earning in the skilled category (furnace operator, broilers, fitters, dye makers etc.). But we see that in Dher Ki Bhed, Sihardi Musalmana and Sihardi Chamara females are also working. More males are seen in the farmers category because agriculture is their primary occupation and are done by males.
Age is an important demographic variable which not only determines an individual’s physical and mental maturity but also depicts his/her life experience. The distribution of the respondents according to different age categories indicates that majority of the respondents belongs to economically active age group.

The most prominent among the variable affecting the contraceptive behaviour in any society is the family size. Most women with living children ha have between 2 and 3 children in all the villages. In Gularhi, Kanda, Rauri and Nahun, most of the households has 2 or 3 children. There are less households also where they have 4 and 5 children or more.

In all the villages the percentage is high in the possession of durable goods. Most of the households possess radio, 2-in-1 and Television (B/W). those possessing VCP, TV (Colour) is attributed to those respondents who are in the higher income groups. Majority of the household possess bicycles who couldn’t afford to have automobiles. Hindi newspaper are read in all the villages except Nahun. English newspaper are read by respondents of Gularhi, Dher Ki Bhed, Sihardi Musalmana and Sihardi Chamara villages.

A high percentage of the households in all the villages are in possession of livestock such as cows, bullocks, buffaloes etc. Possession of livestock indicates secondary occupation of the respondents.

All the villages possess agricultural lands. Owning of agricultural land indicate that agriculture is their main occupation.

UNMET NEEDS FAMILY NORM AND REPRODUCTIVE BEHAVIOUR

Family Norm

In the age group of 15-24 years, more joint families have 3 to 4 children than the nuclear families. In 25-34 years age group, nuclear families shad 23 children. And in the age group of 35-4 years, more families have 5 children and some have 4, 3, and 2 children.
63.33 per cent of the respondents in the age group of 16-20 years, the age of consummation accounts for 76.67 per cent in regards to the wife’s age. 13.33 per cent of the respondents in the age group of 21-25 years, the age of consummation accounts for 16.67 per cent. But in the case of husband’s age it is the reverse pattern.

Regarding the family norm (generation wise), the size of the family norm was large, were literate, death percentage was slow, more unmarried males than females in the first generation. The size of the family norm was small, more males are married than females, literacy rate has gone up, but education had a setback in the second generation. The family size norm has increased, death rate has gone up, literacy rate came down resulting in the increase of illiteracy rate, and educational level has gone down in the third generation. The family size were small, age at marriage for females was low resulting in late marriages, illiteracy rate is high but death rate has come down in the fourth generation. There is a difference between the first and third generation. This is attributed to the knowledge of family planning.

Only 10.0 per cent in the first generation could trace their descent. The respondents could trace their descent in the second, third and fourth generation. It is the third generation where the joint/extended family could trace their descent and in second and fourth generation they could not trace their descent.

Only 33.3 per cent of the respondents availed facilities/treatment. 80.0 per cent of the respondents were satisfied with the treatment who availed PHC/Private treatment. 93.33 per cent of the respondents were satisfied with the treatment rendered by the government. 6.66 per cent of the respondents were dissatisfied with the treatment who availed private treatment. 80.0 per cent of the respondents were satisfied with the readily available of medical facilities. 76.63 per cent says no health personnel ever visited.
Respondents did faced problem in the family planning method. In the past, the problems were tubectomy and Copper T with a high percentage of 23.33 per cent. This is because of the inexperience handling by the nurse or midwives. In the present situation, 2 respondents had faced problem. This is because of unsuccessful operation. To avoid the problems, and to have a good success rate, trained personnel are employed to handle it.

In the present context, 73.33 per cent of the respondents were satisfied by using anyone of the family planning method. The users were satisfied to continue with the family planning methods. 6.66 per cent of the users like to change to other family planning methods. For future, 13.33 per cent of the respondents like to adopt the family planning method. 10.0 per cent of them will not go for adoption.

63.33 per cent of the user decisions is for the small family attitude and due to economic conditions. The user takes the help of the PHC/Government for family planning methods. The user goes for modern methods of family planning. They also have positive views towards commercials, and approval of family planning methods. They also prefer to watch family planning programmes.

21.6 per cent of the female respondents accounts for regular menstruation. 18.33 per cent of them experienced normal menstrual flow, 22.5 per cent of them have menses that last for 3 to 4 days. 16.67 per cent of the respondents experience no pain, 8.33 per cent have pain, 5.83 per cent have excess flow, 4.17 per cent have irregular period and 2.5 per cent have menses for more than 3 to 4 days.

In age group of 14 years, the frequency of wife’s at menarche accounts for 36.67 per cent; in age group of 15 years it accounts for 30.0 per cent and in age group of 16 years it accounts for 16.67 per cent.
40.0 per cent of the households have 3 live births, 23.33 per cent of the households have 2 live births, 10.67 per cent of the households have 4 live births, 13.33 per cent of the households have 5 live births and 3.33 per cent of the households have 8 live births. Taking the live birth sex-wise, 48.0 per cent of the households have 2 males live birth, 40.0 per cent of the households with 1 male live birth, 8.0 per cent of the households with 3 males live birth, 4.0 per cent of the households with 6 males live birth. In case of females, 33.33 per cent of the household have 3 females live birth, 29.17 per cent of the households each with 2 males and 1 female lived birth.

Most of the respondents had the knowledge of family planning methods. This is attributed to literacy and mass media. The common methods are tubectomy/vasectomy, sterilization, condom, oral pills and copper T. Those who named after naming them are condom, oral pills, copper T, tubectomy/vasectomy. Those who are not aware are the withdrawal method, rhythm method, natural method, copper T and condom.

96.97 per cent of the spouses are in favour of adopting family planning and 3.33 per cent of the spouses are not in favour. 40.0 per cent of the respondents adopted the family planning method to avoid pregnancy. 76.67 per cent of the respondents were not given advise about family planning method. 66.67 per cent of the respondent had no problem with family planning method, 77.33 per cent of the respondents are aware about the effective and safe period. All the respondents has the knowledge relating to pregnancy.

There were 16.67 per cent cases of abortion to 13.33 per cent of the respondents ands were spontaneous abortion, 13.33 per cent of still births, 16.67 per cent of miscarriages and 26.67 per cent of premature deliveries.

There were 26.67 per cent of premature deliveries of which 6.67 per cent were males and 20.0 per cent were females. As for live births and still
births, there were 3.33 per cent each for live birth and still birth for females and 6.67 per cent cases of live births and 13.33 per cent of still birth for females.

To avoid future pregnancy operation was the method. All the respondents who underwent sterilisation considered not only good but also the last resort to save oneself from having pregnancies. 70.0 per cent of the respondents have undergone sterilisation. Besides, sterilisation, other methods use are copper T (33.67 per cent), condom (23.33 per cent), oral pills (10.0 per cent) and natural method (6.66 per cent) respectively.

96.67 per cent of the respondents are cognizant of family planning methods. 56.67 per cent of the respondents were not advised. Mass media played an important role to the respondents that they became aware of the family planning method. 50.0 per cent of the respondents are aware of family planning method, 43.33 per cent of the respondents aware of incentives. There were respondents who wanted to restrict the number of children to 2 (46.67 per cent), 3 (36.67 per cent), 4 (10.0 per cent) and more than 4 (6.66 per cent). Towards family planning practices, it is the decision of both the spouses (56.67 per cent), husband alone (23.33 per cent), wife alone (16.67 per cent and others (3.33 per cent).

The co-efficient of correlation is positive. It implies that with the increase of age of the respondents, the income increase. The degree of correlation is small between variable age and income.

The age group for the ever married was taken between 13-49 years and for unmarried girls, the age group was divided into two groups. One between 12-19 year, and, the other between 20-22 years. In Gularhi, single married spouse staying together is found in 23 households, 4 married spouses in 2 households and 3 married spouses in 6 households. In Kanda, there are single married spouses staying together in 28 households, 2 married spouses staying

For the unmarried girls, in the age group of 12-19 years, single unmarried girls staying together in 6 households, 2 unmarried girls in 3 households in Gularhi. In Kanda, single unmarried girls staying together in 3 households, 2 unmarried girls in 4 households. In Rauri, single unmarried girls staying together in 5 households, and 3 unmarried girls in 2 households. In Nahun, single unmarried girls in 4 households, 2 unmarried girls in 2 households and 3 unmarried girls in 2 households.

In the age group of 20-22 years, in Gularhi, single unmarried girl staying together in 2 households, 2 unmarried girls in 3 households, 3 unmarried girls in 1 household. In Kanda, single unmarried girls staying together in 2 households, 2 unmarried girls in 3 households. In Rauri, single unmarried girls staying together in 3 households, 2 unmarried girls in 3 households. In Nahun, single unmarried girls staying together in 2 households, 2 unmarried girls in 4 households.

More ever married women experience menarche between the age of 16 to 18 years. And for unmarried girls, they experience at 15 years and 17 years respectively in Gularhi. In Kanda, ever married women experience menarche between 15 to 19 years and unmarried girls at 17 and 18 years respectively. In Rauri, ever married women experience between 15 to 18 years and unmarried girls between 13 to 15 years. In Nahun, ever married women experience it between 15 to 16 years and unmarried girls at 16 years.

The percentage of the respondents who underwent tubectomy is high in all the villages. IUDs is the next preferred method followed by oral pills/foam tablets. Preference of IUDs is seen in Gularhi and Kanda village. The percentage of preference is low for oral pills/foam, tablets.
All currently married women had discussion in practicing family planning. The percentage is high in Gularhi (65.31 per cent), Kanda (72.50 per cent), Rauri (70.27 per cent) and Nahun (85.29 per cent).

The percentage is high in Gularhi (59.18 per cent), Kanda (57.50 per cent), Rauri (56.76 per cent) and Nahun (70.57 per cent) of the respondents who did not have any reproductive problems.

The respondents have preferences in using contraception for future intention to delay/avoid pregnancy. The percentage is high which varies from 55.10 per cent to 67.57 per cent.

To delay/avoid pregnancy the percentage is high as they are aware of family planning method. The percentage is also high of the respondents who have used the family planning method for more than 5 years.

For the satisfaction with the services care they received during/immediately after the adoption of family planning, the percentage is high for excellent service.

The methods used in family planning to avoid contraception are traditional method, mechanical method, chemical method and surgical method. The response given by the respondents for traditional method was spontaneous and the percentage is high. Whereas the percentage was low of those respondents whose responses was probed.

For mechanical method the percentage of the respondents is high when their response was probed. The percentage for spontaneous response was low. For chemical method, the percentage of the respondents response for spontaneous was high. And the percentage was slow in case of the probed response. Same is the case with surgical method.

For the sources of information about the knowledge of practicing family planning, the percentage is high in Gularhi, Kanda and Nahun, who discuss with relatives and in Rauri with neighbours. The percentage is high in
Gularhi and Rauri who discuss it with friends and in Kanda and Rauri they discuss with neighbours. The percentage ism also low in Kanda and Nahun who discuss with friends, in Gularhi with neighbours and in Rauri with relatives.

The respondents knowledge of getting HIV(AIDS) from an infected person like shaking hand, sharing needles, eating utensil their responses was negative.

As for the respondents knowledge if RTI/STI/HIV(AIDS) if it is curable, the percentage is high where their response was positive.

The respondents awareness of RTI/STI/HIV(AIDS), the percentage is high where they are aware of it.

Communication through mass media plays an important role in the field of family planning. It is seen that the percentage is high on the information about HIV(AIDS). This has been attributed through the influence of mass media. It also shows then same result that the percentage is high when the respondents consulted the doctors about HIV(AIDS).

For the respondents if they have suffered any type of reproductive problem, the percentage is high where they did not have any reproductive problems.

The respondents discussed with the household members about the reproductive problem, thee percentage is high except in Kanda village.

All the respondents are aware of avoiding HIV(AIDS) where the percentage is high.

The unmarried girl respondents are aware of HIV(AIDS) but not RTI/STI and the percentage is high.

For the unmarried girl respondents about the knowledge of RTI/STI/HIV(AIDS) the percentage is high where they do not have the knowledge of RTI/STI. But for HIV (AIDS) the respondents did have the knowledge.
The unmarried girl respondents about the knowledge if one can get HIV (AIDS) from an infected person, the percentage is high. The percentage is also high of the respondents of unmarried girl where they say that one cannot get infected with HIV (AIDS) by sharing needles, eating utensils etc.

Regarding the sources of information/person about RTI/STI/HIV(AIDS), the unmarried girl respondents did have the knowledge of HIV(AIDS) rather than RTI/STI through mass media. So also the other sources the respondents got about HIV(AIDS) is from doctors.

The Family Planning programme in India launched in 1951, evolved through a number of stages and has changed its direction, emphasis and strategies. Dramatic changes in the family welfare policy and programme was witnessed in the 1990s. The target-oriented approach was replaced with the target-free approach in 1996. In 1997 in order to direct the programme more towards clients’ needs, the target-free approach was recast as the community needs assessments approach. The Reproductive and Child Health programme was launched in 1997. The Reproductive and Child Health programme espouses the principles of client satisfaction and high quality in delivering comprehensive and integrated health services.

The National Population policy adopted in February 2000, further legitimized the shift towards incorporating quality of care within public sector services. For achieving the twin objectives of population stabilization and promoting reproductive health within the wider context of sustainable development the National population policy provides a policy framework. The objective of the policy is to address the unmet need for contraception and to provide integrated service delivery for basic reproductive and child health care. The policy affirms the government’s commitment to the provision of quality services, information and counseling, and expanding contraceptive method choices in order to enable people to make voluntary and informed choices.
The literature reviewed makes it clear that unmet need for contraception is not a monolithic or undifferentiated concept. The nature of unmet need varies from couple to couple and from place to place. Some women have unmet need primarily because they have ambiguous fertility preferences. Others opines contraception is too costly in the widest sense, compared with the benefits of avoiding a next pregnancy. Thus, some couples will start using contraceptives if certain costs are decreased, while others will respond only slightly to such changes.

In recent years unmet need for family planning has been one of the most widely discussed family planning concepts. In developing countries addressing unmet need through family planning programmes has been proposed as a major strategy for fertility reduction.

The National Population Policy 2000's stated goal is to achieve net replacement levels by 2010, by meeting people's 'reproductive and child health needs'. To establish a health infrastructure and provide a package of contraception, maternal and child health services, the government plans to work with the private sector and voluntary organizations. This approach is to result in population stabilisation (Total Fertility Rate of 2.1) by the year 2045. It aims at developing an infrastructure for the RCH package, providing and ensuring education till age 14; reducing infant mortality to below 30/1,000 live births and maternal mortality to below 100/100,000 live births; universal immunisation, delayed marriage, institutional or supervised deliveries; 100 per cent registration of births, deaths, marriage and pregnancy; tackling communicable diseases, integrating Indian systems of medicine in these services, reaching out to households, promoting the small family norm, and linking family planning to other social sector programmes.

The National Health Policy -2002 (NHP-2002) envisages the identification of specific programmes targeted at women's health. The Policy
notes that women, along with other under-privileged groups, are significantly
disproportionately low access to health care. The principal common features covered under the National Population Policy-2000 and NHP-2002 include universal immunization of children against all major preventable diseases, addressing the unmet needs for basic and reproductive health services and supplementation of infrastructure. Reproductive ill health is associated not only with mortality but also morbidity which can be prevented by providing safe and effective methods of fertility control, preventing and treating complications of pregnancy and unsafe sex, making abortion safer and treating infertility and other reproductive tract diseases/infections.

Though it is yet to be implemented in all parts of the country the Reproductive and Child Health Programme was launched in India on October 15, 1997. The earlier programme was target-oriented, focussed on women in the reproductive age-group, and catered only to their family planning and maternal and child health needs. The Reproductive and Child Health programme was meant to provide high quality, integrated, client-centred services based on people's needs and the local demand, and at all stages of the life cycle.