Improving Health Status of Women and Institutional Delivery of Public Reproductive Health Services in Rural West Bengal (Phase-II)

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PREFACE

Project Title: Improving health status of women and institutional delivery of public reproductive health services in rural West Bengal (Phase-II)

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Chapter 1

Introduction

1.1 Background

India has the second largest population and the first national family planning programme in the world. Family planning refers to the use of birth control methods to attain the desired number of children and ensure the desired timing of conceptions and spacing between births. Birth control is an umbrella term for techniques and methods used to prevent fertilization, or to interrupt pregnancy at various stages. In addition to the traditional (natural) methods such as rhythm and withdrawal, modern contraceptive methods include all hormonal methods (i.e., the pill, injectable and implants), IUDs, male and female sterilization, condoms, modern vaginal methods (e.g., the diaphragm and spermicides) and emergency contraceptive pills (ECP).

Access to and utilization of family planning service care essential to achieve the Millennium Development Goals (MDGs) (Cleland et al., 2006; Potts and Fotso, 2007; Allen, 2007). One of the MDGs is to improve maternal health (Goal 5), a key means to which is to increase contraceptive prevalence rates. While family planning programs had considerable impact on increasing the voluntary use of family planning and reducing fertility in many parts of the world during second half of the twentieth century, they have received less attention at the global level in recent years. As a consequence, contraceptive use remains low in much of Sub-Saharan Africa and parts of South Asia despite high levels of unmet need (Cleland et al., 2006). A recent study estimates that round 215 million women in the developing world as a whole have an unmet need for modern contraceptives (Singh et al., 2009). Acceptance and sustained use of family planning especially of modern spacing methods have generally been low in developing countries, particularly in India. The use rate for modern spacing methods was only 6 per cent among the eligible couples in India in 1992 (International Institute for Population Sciences, 1995).

Although a multitude of social, religious and economic factors play a role in the decision to begin contraceptive use, there are various other factors, especially women's status, which affect the use of contraception. The indicators of female status include the level of education (Chatterjee, 1991; Sathar & Kazi, 1990), employment (Dharmalingam & Morgan, 1996; Sathar

& Kazi, 1990; Shapiro & Tambashe, 1994), mobility, and involvement in political activity (Vlassoff, 1992; Mason,1983; Balk, 1994; Murthi et al., 1995). Greater autonomy for women is shown to lead to greater contraceptive use (Morgan and Niraula, 1995).The ICPD also "stressed gender equity as a precondition for health and to address women's subordination in reproductive health programmes" (Sciortino, 1998). It was also observed that the use of birth control and the kinds of contraceptives employed vary with parity (Bledsoe et al., 1994; Dang, 1995; Shah et al., 1998). The number of sons among the offspring influences couples' decisions to use contraception as well as their method of choice (Dang, 1995). The easy availability and accessibility of contraception through local health centres promotes the use of birth control (Akin and Rous, 1997; DeGraff, 1991). Female education in particular is known to affect a host of social, economic and demographic variables such as marriage, employment status, and fertility (Cochrane and Bean, 1983; Martin, 1995) and is positively related to the use of contraceptives (Islam, 1991). Even small improvements in educational attainment could result in substantially greater contraceptive use (Mamlouk, 1982; Shapiro and Tambashe, 1994). It was also found that Muslim women are less likely to use contraception (Dutta et al., 1990).

Family planning and adoption of birth control measures such as greater use of condom reduce the transmission of HIV and other sexually transmitted diseases (STDs), reduce unintended pregnancies and the incidence of unsafe abortions, and leads to a decline in the number of women facing complications due to unsafe pregnances. This would decline and averts maternal and newborn deaths. Use of contraceptive methods also delays the first pregnancy of girls married at an early age and limits the numbers of children, improving thereby their health status. Spacing of births also helps to improve pregnancy outcomes by lowering the proportion of underweight children, reducing neonatal and infant mortality and thus save the lives of children.

1.2 History of family welfare programme in India

Although Family Welfare Programme in India was launched in 1951 primarily with the objective of reducing birth rates to the extent necessary to stabilize population at a level consistent with the requirements of the national economy, the programme has experienced significant directional changes, emphasis and strategies since then. Family planning was considered more as the means of improving maternal and child health than as a method of population control over the first

decade. During the second decade, however, with the growing concern about population growth rate and its undesirable impact on socioeconomic development, the emphasis of the programme shifted to fulfil the objective of population stabilization. In addition to the replacement of 'clinic-centred' approach by 'extension-education' approach, time-bound method specific targets were introduced within the programme. Sterilization camps began to be used to promote vasectomy. This 'target-oriented' approach became highly coercive during the Emergency period (1975-77) and the idea of making family planning compulsory for the citizen was envisaged in the National Population Policy of 1976. Due to the backlash against the coercion, the subsequent governments were compelled to stress the voluntary nature of family planning acceptance and emphasised the need of motivational and educational approach in National Population Policy of 1977. The time-bound and target-oriented approach was revived during 1980s and efforts were made to popularise the use of reversible modern methods through incentive payments.

After the International Conference on Population and Development (ICPD) 1994 and Beijing Women's Conference in 1995, the government made a 'paradigm-shift' in the programme by abolishing the method-specific targets to monitor and evaluate the programme performance, which was in place for decades. It replaced the former with target-free approach (later renamed as Community Needs Assessment Approach (CNAA) in 1997. This programme was directed more towards addressing clients' needs determined and identified at the community level by the grass root level health workers. Later it was subsumed in the Reproductive and Child Health Programme (RCH), launched in 1997. It advocated the principles of client satisfaction and comprehensive health services with high quality of care integrating the aspects of prevention and management of unwanted pregnancy, reproductive tract infection and sexually transmitted infections (RTI/STI), promotion of safe motherhood and child survival and male involvement in reproductive health. The aim of the programme was expanded to meet the needs of underserved and socio-economically marginalized sections of the society. The National Population Policy, 2000, further legitimised the client-oriented approach in order to achieve the objectives of population stabilization and promoting reproductive health in the context of sustainable development.

However, the emphasis of 'cafeteria approach' adopted by the programmes since the 1960s, whereby clients were provided with a range of contraceptive methods, remained heavily skewed towards promoting permanent methods, particularly female sterilization (and vasectomy

during the 1970s) until recently, in addition to its focus on the poor population. The Population Policy of 2000 clearly underscores that the couple below poverty line, who marry after legal age of marriage, have the first child after the mother reaches 21 years of age and adopt a terminal method after the birth of second child, will be rewarded. Nationally, data from National Family Health Survey (NFHS-3), 2005-06, show that female sterilization accounted for 77% of the contraceptive prevalence due to modern method and 66% of overall current contraceptive prevalence (International Institute for Population Sciences (IIPS) and Macro International 2007). It may be noted that in the National Welfare Programme the emphasis was given to popularise 'modern' methods (permanent or reversible), while 'natural' family planning methods were largely ignored. Although modest sums of money were allocated to research into the rhythm method during 1950s, Tim Dyson argued that 'it is easy to dismiss such early efforts as cautions and ineffectual' (Dyson and Moore, 1983). Due to the perceived inefficiency of the natural family planning method, nationally, use of traditional methods was reportedly low, accounting for just about 14% of current contraceptive use (International Institute for Population Sciences (IIPS) & Macro International 2007). It may also be noted that although nationally the use of modern contraceptive method rises with increase in wealth quintile, use of permanent modern methods was higher among lower wealth groups (IIPS & ORC Macro, 2000; IIPS & Macro International, 2007), which is in line with the Population Policy, 2000. Thus, arguably, the efforts to improve maternity care ignored the social context of maternity and traditional practices in the control of birth.

1.3 Gender and contraception

Studies have shown that women face opposition from their male partner while deciding to use contraception (Bankole and Singh, 1998; Becker, 1999; Biddlecom et al., 1997; Speizer, 1999; Speizer et al., 2005).Researchers have documented that educated males are more likely to support their partners in decisions on contraceptive use and family planning (Grady, 1996; Wegner et al., 1998; Wilkinson, 1997).

However, it is worth noting that the control of women's fertility rather than that of men became the target of population control programmes. The government commitment was questioned in order to improve maternal mortality and morbidity and pregnancy outcomes even within the narrow perspective of women's biological reproductive role as envisaged in the

population and health policies of the state. It may be mentioned that although the onus of contraception is placed on women, her voice is never heard on contraceptive decision making. Moreover, the depiction of women in the government reproductive health and HIV/AIDS control programmes reiterates women's low social image and reinforces patriarchy in spheres of women's fertility, sexuality and health behaviour.

In addition, critical analysis of the promotion of reproductive technology argued that modern contraceptive methods 'medicalize' every aspects of women's life and lead to a wide range of complications such as wound infection, pyrexia, urinary tract infection, intense weight gain, menstrual disorder, abnormal discharge and so on and may lead to permanent sterility. Some researchers pointed out the unethical trials of contraceptive methods such as Norplant, Depo-Provera and Net-en by the Indian Council of Medical Research (ICMR) during 1980s and 1990s were conducted among women particularly from poor households and without their informed consent. It was argued that the research on contraception focused on the surgical methods over the safer barrier methods, demonstrating a greater concern for 'efficacy' than 'safety' in contraception and thus these technologies and related practices violate women's rights to life, reproductive rights in particular, safety and dignity, as well as codes of medical ethics. Also, there are anecdotal evidences indicating sterilizations have taken place without informed consent. Critically speaking, all these practices go against the *Indian Women's Health Charter 2007* where women's right to health was articulated as an agenda of addressing basic needs through a human development approach in a wider context and stated that women's reproductive right and health incorporates the idea of women's economically productive and cultural roles in addition to their biological reproductive function.

1.4 Contraceptive morbidity

In addition to gynaecological and obstetric morbidity, contraceptive morbidity may also have severe consequence on women's reproductive and psychological health and well-being. Contraceptive morbidity refers to morbidity caused by the use of specific contraceptives. Obviously, contraceptive morbidity does not include the protective effects that contraceptives have against a variety of adverse conditions, but the concept of "contraceptive health" does include the absence of these diseases, which include ovarian and endometrial cancer, anemia, and STDs. Contraceptive morbidities are of the following broad types:

1. Local effects of contraceptives include irritation from or allergic reactions to barrier contraceptives, IUD-associated bleeding, or infection at wound sites (implants, tubal sterilization).

2. Systematic effects include impact on the cardiovascular and hormonal systems and carcinogenicity (Fortney, 1995).

Ram and Rangaiyan (1997) studied the prevailing contraceptive morbidity pattern among the contraceptive users by method for all India and some selected states. Community based studies in India on reproductive health have consistently shown that the prevalence of self-reported symptoms of RTIs is relatively high among contraceptive users than non-users (Bhatia and Cleland, 1995). Contraceptive users often attribute any reproductive tract infection (RTI) or any common health problems to the method. The absence of adequate pre-acceptance counselling including information on potential side-effects and complications, post-acceptance follow-up by contraceptive provider results in discontinuation of the method. Studies have shown that a comparatively higher proportion of sterilized women reportedly suffered illness related to contraceptive use than reversible method users. The differentials in terms of type of service providers, source of the service availed of and quality of care in terms of care during the intra uterine device (Copper-T) insertion and sterilization and follow-up care have significant relation with the illness related to contraceptives' use.

1.5 Current level of contraceptive practices in West Bengal

The third rounds of National Family Health Survey (NFHS), 2005-06 and District Level Household Survey (DLHS), 2007-08 show that the knowledge of contraception is almost universal in West Bengal. Female sterilization is the most widely known method, known by virtually all married women and men. The acceptance of modern methods of contraception is high in southern states as well as in West Bengal. It may be noted that the use of traditional (natural) family planning methods, namely, rhythm and withdrawal, is the highest in West Bengal compared to all other Indian states (21.3%) (DLHS-3, 2007-08).Conspicuously, the traditional method use is higher in urban areas, (25.6%) than rural (19.6%) (IIPS & Macro International 2007).It may be noted that the fertility rate in West Bengal is lower than the national average.

1.6 Objectives

Against this backdrop, the Institute of Development Studies Kolkata (IDSK) with the help of Rosa Luxemburg Stiftung (RLS), Germany, conducted the Project 'Improving health status of women and institutional delivery of public reproductive health services in rural West Bengal (Phase-2)' in 2012. The present study would like to assess the level of contraceptive knowledge, factors determining contraceptive method choice, extent of gender inequality in contraceptive decision making, prevalence of contraceptive morbidity and associated treatment seeking behaviour among marginalized sections living in underdeveloped regions of West Bengal. Since utilization of traditional contraceptive method has been found to be higher in the state of West Bengal compared to all-India level, special emphasis will be given to understand the factors associated with the preference for using such methods. Specifically, the objectives of the present study are:

(1) To assess the level of knowledge of different contraceptive methods and its variations according to socioeconomic status among the respondents

(2) To explore the extent of gender inequality in contraceptive decision making

(3) To understand the role of socio-economic factors influencing contraceptive choice (or non-choice) in general and choice of traditional contraceptive methods in particular, among the respondents

(4) To assess the prevalence of contraceptive morbidity by different socioeconomic factors among the respondents

(5) To investigate the treatment seeking behaviour for contraceptive morbidity by different socioeconomic factors among respondents

(6) To explore the issues related to contraceptive supply, contraceptive counselling, informed method choice and contraceptive uses among health care and contraceptive providers.

1.7 Study settings

Birbhum district is one of the typical backward districts of West Bengal. Although ethnically the people are proportionately heterogeneous, a large proportion of the population belongs to marginalized sections of the society. According to 2001 Census of India, 29.5% were scheduled caste, 6.7% were scheduled tribe and 35.1% were Muslim. Moreover, more than 90% of the

population lives in the rural areas and earn their livelihood through agriculture, mining and quarrying, and related activities (RGI, 2001). A few key indicators of the study district, and the state where it is located, are presented in Table 1.1.

Table 1.1: Profile of the study district (Birbhum) vis-à-vis state (West Bengal)

Characteristics	Birbhum	West Bengal
Population (in '000)$^{\$}$	3,502	91,347
Population/KM$^{2\$}$	771	1029
Overall sex ratio$^{\$}$	956	947
Child sex ratio (0-6 years)$^{\$}$	952	950
% of SC to total population[*]	29.5	23.0
% of ST to total population[*]	6.7	5.5
% of Muslim to total population[*]	35.1	25.2
Male literacy (%)$^{\$}$	77.4	82.7
Female literacy (%)$^{\$}$	64.1	71.2
Literacy among SC (%)[*]	45.7	59.0
Literacy among ST (%)[*]	31.2	43.4
Institutional delivery (%)[@]	48.7	49.2
Current contraceptive use (%)[@]	74.8	72.7
Mothers who had at least three antenatal check-ups for the last birth (%)[@]	59.1	67.0
Mothers who received postnatal care within two days of delivery for their last birth (%)[@]	41.8	56.9

Sources: $ Provisional population total, Census 2011; *Census 2001; @ District level household survey (DLHS)-3, 2007-08.

The current study was conducted in the rural settings in Birbhum district, namely, in Saithia, Mohammed Bazar and Suri-I blocks which have the lowest, medium and highest proportions of agricultural labourers according to 2001 Census.

1.8 Study design and sample selection

A multistage sampling design has been adopted in selecting respondents. **At the first stage**, proportion of agricultural labourer will be used as sampling stratification frame. It may be mentioned that the proportion of agricultural labourer in a certain area has been regarded as one of the developmental indicators in the sampling stratification frame in various national level surveys and has direct implication on the level of development in that area. High presence of agricultural labourer implies that agriculture is the predominant occupation and the area is

economically less developed. In order to maintain socioeconomic variation in the sample, three blocks of the district comprising the lowest, medium and the highest proportions of agricultural labourers according to 2001 Census (since the block level data of 2011 Census is still not available), have been selected for the study.

Since data on the family size, number of girls in a family etc. are not available at the village or even at the block level, **at the second stage**, 15 villages have been selected by probability proportional to size (PPS) sampling from each block. A rapid house listing exercise was conducted in each of the 45 selected villages. In order to maintain the variations in the exposure to the length of childbearing period among currently married women, the respondents have been divided according to their age- 15-24 representing younger, 25-34 representing middle aged and 35-44 representing older at the next stage of stratification. Age of the women has direct implication on contraceptive use since younger are more likely to use the spacing method (or even not use any contraceptive method) for the future intention of child bearing, while older women are more likely to use permanent method as desired family size and sex composition might have already been achieved.

At the final stage, from each village 30 respondents, who are currently married, non-menopausal, not pregnant at the time of survey or did not deliver a baby within 6 months preceding the survey (lactational amenoria period), have been selected on the basis of proportional representation of their age through simple random sampling. Thus, the targeted sample size was 1,350. Of this, finally, 1,348 currently married respondents were selected and interviewed in the study.

In order to fulfil the objective regarding the issues related to supply of contraception, contraceptive counselling and informed method choice semi-structured interviews have been conducted among 48 selected village and block level healthcare and contraceptive providers from these three blocks.

1.9 Questionnaire

Questionnaires were prepared and pretested to obtain data - (1) to assess the contraceptive knowledge, use, morbidity and associated treatment seeking behaviour; (2) to acknowledge the village level facilities; and (3) to understand the issues related to supply of contraceptive methods and counselling among contraceptive providers. Three types of questionnaires were

prepared. These are related to the Individual Questionnaire (Structured), the Village Questionnaire (Semi-Structured) and the Contraceptive Provider's Questionnaire (Semi-Structured).

The Individual Questionnaire was employed to interview currently married women age 15-44 who are currently not pregnant or did not deliver a live/still birth six months preceding the survey and did not attain menopause. The following information was collected.

Background characteristics: age, marital status, caste/tribe, religion, education, employment status, husband's background, household assets, exposure to mass media.

Contraceptive knowledge, attitude and practice: knowledge and use of specific contraceptive methods, first age of contraceptive use, duration, reasons for discontinuity, source of contraceptive choice, informed choices, advice to use, contraceptive decision, husband approval, contraceptive morbidity and associated treatment seeking behaviour across various contraceptive methods and reasons for non-using contraception among non-users and intention to future use.

Reproductive history: number of times conceived, length of pregnancy interval, contraceptive use during pregnancy interval, live/still birth and age of child.

Future fertility intention: future intension of childbearing specifying numbers and sex composition, future intention to use contraception by method type.

The Village Questionnaire was administered to the *Panchayet Prodhan* (or any other knowledgeable member) or village level functionaries in each of the 15 surveyed villages of each block. It was designed to elicit information about accesses and privileges present in the village area in terms of electrification, drinking water, sanitation facility, drainage facility, cultivation of main agricultural crops. Besides, information regarding presence of educational institutions and health centres in the village, awareness camps about the family planning through mass media and the implementation of various government programmes etc. were also collected.

The Contraceptive Provider's Questionnaire was administered to any of the following depending upon their availability: ANM, MPW, ASHA worker, PHC doctor, PHC nurse, BPHC/Rural Hospital's gynaecologist, BPHC/Rural Hospital's nurse, informal providers or *Anganwadi* workers. This questionnaire was prepared keeping in mind the contraceptive provider's attitude towards informed choice, supply, role in generating awareness of various contraceptive methods and their importance to use by couples.

1.10 Field work and sample coverage

As mentioned earlier, after house listing operation in each of the sampled villages, respondents were selected from each age group on the basis of proportional representation of their age through simple random sampling. Then a team comprising 5 investigators and 1 supervisor in each block (15 investigators and 3 supervisors) were trained to collect data from each selected respondent through door-to-door visit. The supervisors were responsible for coordination and to monitor data collection activity for quality control. Additionally, the supervisors also conducted interviews of the contraceptive providers and local health workers.

1.11 Data processing

The field level data which were collected by the investigators through door-to-door visit were edited by the supervisors. After the data was editing by the supervisors, it was re-checked by the associate at the IDSK. Then the raw field data was entered by 2 data entry operators at IDSK under the supervision of the associate. The data were entered in specially designed computer software (CSPro) by both the operators. The cross-checking of the data entry was also be conducted to ensure quality. Finally, after converting the data from CSPro to SPSS software, it was cleaned by the associate and the primary data were ready for further analysis. Data have been analysed in standard statistical software SPSS.

1.12 Sample weights

Sample weights were calculated in order to provide block level estimates of the various indicators. The calculation of weight combines two weights:

1. Village weight i.e. inverse of selection probability of a village within a block and
2. Individual weight i.e. inverse of selection probability of an individual of a particular age-group in a particular village.

First stage: Inverse of Selection probability of a village (Village Weight)

Weight of the ith sampled village

$$VW^i = M/n.m_i$$

Where, n= number of the sampled villages

m_i= measure of size (total population) for the ith village and

$M = \sum_{i=1}^{N} m_i$, N=total number of villages in a stratum (block in this case)

Second stage: Selection probability of an individual (Individual Weight)

Assuming there is no non-response, selection probability of an individual in kth age-group in the ith village will be

$$IP^{k.i} = H^{k.i}/S$$

Where, $H^{k.i}$ = is the selection probability that an individual of kth age-group in the ith village

S=constant

Individual Weight $IW^{k,I} = 1/IP^{k.i}$

Therefore, Total Weight = Village Weight * Individual Weight

$$= VW^i * IW^{k,I}$$

CHAPTER 2

Background and Village Characteristics of the Respondents

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Background and Village Characteristics of the Respondents

This section describes the background characteristics of the surveyed respondents across three blocks. The demographic and socioeconomic behaviours of the respondents vary, influenced by various characteristics such as age, marital status, educational attainment, work status, media exposure etc. as well as the characteristics of their households such as household composition, standard of living, religion, caste etc. Further, it extends to highlight the characteristics of the surveyed villages primarily in terms of the availability of health facilities and education facilities.

2.1 Background characteristics of women

Table 2.1 presents the distribution of respondents by age, education, employment status, religion/castes, exposure to mass media and wealth index. It has been observed that more than 3 out of 10 women were more than 35 years of age in all surveyed villages. However, the proportion of the respondents within the age group 25-34 was the highest in Suri-1 (42.2%) compared to other blocks (41.1% in Md. Bazar and 39% in Saithia). Women's education has a strong bearing on contraceptive behaviour and fertility. The distribution of the respondents according to completed numbers of years of education revealed a low level of educational attainment among the surveyed respondents. A little more than 4 out of 10 women in Md. Bazar block (41%) were illiterate. Compared to Md. Bazar, the percentages of illiterate respondents were lower in Suri-1 (36%) and in Saithia (34%). The proportion of women who completed their primary school did not vary much across blocks; on an average 16% have attended primary schools. However, the number of women who went for middle schooling was higher compared to the primary schooling across the blocks (25% in Md. Bazar, 24% in Suri-1 and 30% in Saithia). It may also be noted that about one-fifth of the women across blocks attended higher education (more than middle level of schooling).

Employment of women in wage earning sector activities has been recognized as an important determinant for achieving the goal of population stabilization in India (Ministry of Health and Family Welfare, 2000). However, more than half of the respondents (56%) across the three blocks were found to be unemployed currently. The majority of the working women were

agricultural labourers (21% in Md. Bazar, 23% in Suri-1 and 40% in Saithia). The religion and caste composition vary across blocks. The majority of the respondents (43%) in Suri-1 belonged to SC and 33% are from Hindu upper castes. 37% of the women in Md. Bazar block belonged to the Hindu upper castes and the remaining belonged to the marginalized community comprising 35% SC, 15% ST and 13% from minority community. A greater proportion of minority respondents has been found in Suri-1 (19%).

Table 2.1 Background characteristics of the women across the blocks (N: 1348)

Background Characteristics	Md. Bazar	Suri-1	Saithia	Total
Respondent's age				
15-24	21.1	25.8	27.0	24.6
25-34	41.1	42.2	39.1	40.8
35-44	37.8	32.0	33.9	34.6
Maternal Education				
Illiterate	41.1	36.4	34.2	36.4
Primary	15.1	16.7	15.6	16.7
Middle	24.9	24.4	30.4	24.4
>Middle	18.9	22.4	19.9	22.4
Women employment status				
Not working	62.4	55.1	50.9	56.2
Working as agriculture self-employed	4.4	1.6	0.7	2.2
Working as other skilled self-employed	1.8	10.4	3.3	5.2
Working as agriculture labour	21.1	23.3	39.5	28.0
Working as skilled labour	7.1	4.2	1.1	4.2
Working in secondary/tertiary sector	3.1	5.3	4.4	4.3
Religion/Caste				
Hindu SC	34.9	42.7	42.2	39.9
Hindu ST	5.1	9.3	16.1	13.5
Hindu Other/Other Minority	36.9	29.3	33.0	33.1
Muslims	13.1	18.7	8.7	13.5

Read Newspaper				
Almost everyday/At least once a week	13.9	13.2	9.5	12.1
Less than a week/never	86.1	86.8	90.5	87.9
Listen Radio				
Almost everyday/At least once a week	11.1	2.2	8.7	7.3
Less than a week/never	88.9	97.8	91.3	92.7
Watch TV				
Almost everyday/At least once a week	48.9	58.4	41.5	49.6
Less than a week/never	51.1	41.6	58.5	50.4
Standard of Living				
Poor	21.8	34.7	43.5	33.3
Middle	39.1	33.1	27.9	33.4
High	39.1	32.2	28.6	33.3
Total no of observations	**450**	**450**	**448**	**1348**

Exposure to mass media was measured by asking the respondents about the frequency of reading newspaper or magazine, watching television and listening to radio (categories are: almost a day; at least once a week; less than once a week; or not at all). The most common form of media for the respondents was television (49% in Md. Bazar, 58% in Suri-1 and 42% in Saithia). However, more than 9 out of 10 women across the 3 blocks were not regularly exposed to radio.

Combining household amenities, assets and durables, a wealth index is computed by employing factor analysis and divided into 3 quintiles, namely, poor, middle and rich. A little more than two-fifth of the respondents (22%) in Md. Bazar belonged to the lowest quintile. However, in Suri-1 35% of women were in the lowest quintile and 33% were in middle quintile. A greater proportion of poorer women were observed at Saithia block (44%).

2.2 Household composition

Table 2.2 shows the distribution of the surveyed households according to sex of the head of the household and according to the number of usual members of the household, separately for Md. Bazar, Suri-1 and Saithia block, and also for the whole study area. Almost 11% of the

households in Saithia were headed by females. The proportion of female headed households was lower in Md. Bazar and Suri-1 block (4% and 5% respectively).

The mean number of household members did not vary across blocks. In Md. Bazar and Suri-1 block one-fifth of the households comprised two to three usual members. It may also be noted that majority of the households comprised four usual members in each of the study block (27%, 34% and 34% in Md. Bazar, Suri-1 and Saithia blocks respectively). Although the household size is shrinking; more than two-fifths of the households in the surveyed area were still comprised 6 or more members.

Nuclear household is defined as household that comprised a married couple or a man or a woman living alone or with unmarried children (biological, adopted, or foster), with or without unrelated individuals. In all the 3 blocks more than three-fifth of the families (60% in Md. Bazar, 62% in Suri-1 and 64% in Saithia) were nuclear in nature.

Table 2.2 Household composition across the blocks

Background Characteristics	Md. Bazar	Suri-1	Saithia	Total
Sex of the Household head				
Male	96.3	94.7	89.5	91.7
Female	3.7	5.3	10.5	8.3
No. of Member				
2	3.8	4.3	3.9	3.9
3	17.2	16.0	23.0	20.5
4	28.6	33.6	34.3	33.3
5	22.4	21.6	16.5	18.6
6+	28.0	24.4	22.3	23.7
Mean of the no. of member	**4.83**	**4.6**	**4.59**	**4.69**
Household Structure				
Nuclear	60.4	62.6	63.8	63.0
Extended	39.6	37.4	36.2	37.0
Total no of observations	**450**	**450**	**448**	**1348**

2.3 Household characteristics

Access to basic amenities, such as access to electricity, proper housing, safe drinking water and sanitation, and clean cooking fuel, is not only an important measure of the socio-economic status of the household but is also linked to fundamental necessities of life and health. This section of the household characteristics provides information on several household characteristics that affect living conditions.

Information on housing characteristics such as availability of electricity, type of house, number of sleeping rooms, type of fuel used for cooking and lighting, main source of drinking water, toilet facility and drainage system are given in Table 2.3. A little less than 8 out of 10 households among the surveyed population have electricity. However, the proportion of households having electricity varied across the three blocks. The least number of households having electricity is observed in Md. Bazar block (68%) compared to Suri-1 (74%) and Saithia (84%). The housing quality of sampled households was more or less uniformly distributed across the 3 blocks. It has been observed that a majority of the households were *kachha* (73.3% in Md. Bazar, 63.3% in Suri-1 and 67% in Saithia). More than 1 out of 10 households in Md. Bazar block, one-fifth of households in Suri-1 and almost 19% of the households in Saithia lived in *kachha-paccha* (or *semi-pucca*) house.

To assess the residential crowding, data were collected on the number of rooms that were used for sleeping. It was found that more than half of the households in Md. Bazar (57%) and Saithia (55%) have more than three rooms to sleep. However, majority of the households in Suri-1 (65.5%) have less than three sleeping rooms. Overall, the vast majority of the households used electricity as a source of lightning. The highest has been observed in Saithia where 84% of the households used electricity and the lowest is in Md. Bazar block where 67% of the household used electricity as the source of lightning. Most of the households in the surveyed population have access to an improved source of drinking water i.e., own/neighbour/government pipe or tube well or covered well. The improved sources of drinking water were the government piped water or tube well or covered well and were accessible to at least 78% of the households in Md. Bazar, 83% of the households in Suri-1 and 63% of the households in Saithia.

Table 2.3 Housing characteristics across the blocks (N: 1348)

Housing Characteristics	Md. Bazar	Suri-1	Saithia	Total
Household Goods				
Yes	66.8	73.7	84.1	79.0
Type of House				
Kachha	73.3	63.3	67.0	67.1
Kachha- Pacca	11.0	20.3	18.7	17.9
Pacca	15.7	16.4	14.3	15.0
No. of Sleeping Rooms				
1	6.8	29.5	12.9	15.7
2	36.7	36.0	32.0	33.7
3+	56.5	34.5	55.1	50.6
Source of Lighting				
Electricity	67.0	71.4	84.1	78.6
Kerosene	33.0	28.6	15.9	21.4
Main Source of Drinking Water				
Own/Neighbour Pipe/Tube well/Covered Well	13.4	16.3	34.2	26.9
Own/Neighbour Uncovered Well	4.4	0.2	2.7	2.4
Govt Water Pipe/Tube well/Covered well	75.7	83.1	63.0	69.6
Govt Uncovered Well	5.8	0.5	-	1.0
Pond/River/Lake/Dam/Surface Water	0.7	-	-	0.1
Source of Cooking Fuel				
Wood/Cow dung/Coal	94.0	91.6	92.3	92.4
Kerosene	0.1	0.3	1.0	0.7
Electricity	-	0.1	0.3	0.2
Gas (L.P.G)	5.1	8.0	4.9	5.6
Biogas	0.8	-	1.5	1.1

Toilet Facility				
Own Flash Toilet	15.7	10.4	19.4	16.8
Shared Flash Toilet	0.6	6.3	1.7	2.6
Own Pit Toilet	0.1	0.8	0.9	0.8
Shared Pit Toilet	-	0.2	-	-
No Toilet Facilities	83.5	82.3	78.0	79.8
Drainage System				
No Drainage Facility	25.3	56.3	59.2	53.3
Open Drainage Facility	73.5	42.9	32.6	41.3
Covered Drainage Facility	1.1	0.7	7.9	5.2
Underground Drainage Facility	0.1	0.1	0.2	0.2
No. of Household	**450**	**450**	**448**	**1348**

A large proportion of the households used solid cooking fuel such as wood, coal, cow dung etc. It has been observed that, more than 9 out of 10 households in the sample population used solid fuel for cooking; 94% in Md. Bazar, 92% in Suri-1 and 92.3% in Saithia. However, 5% of households in Md. Bazar and Saithia used L.P.G as cooking fuel. In Suri-1, 8% of households used L.P.G as cooking fuel. The use of an improved sanitation facility among the sampled households were found to be less; only 16% in Md. Bazar, 10.4% in Suri-1 and 19.4% in Saithia have access to own flush toilets. It is important to note that more than 8 out of 10 households in Md. Bazar (83.5%) and Suri-1 (82.3%) did not have toilet facilities. The proportion of the household in Suri-1 having no toilet facility was found to be 78%. A majority of the household in Suri-1 (56.3%) and Saithia (59.2%) have no drainage facilities. However, in Md. Bazar more than 7 out of 10 households (73.5%) have open drainage facility.

2.4 Household possessions

In order to assess the living standard of the surveyed population further, information was collected on household ownership of 16 durable goods and four different means of transport, ownership of agricultural land (irrigated and non-irrigated) and possession of farm animals. Among farm animals, information was obtained about the possession of cows, bullocks, goats, ducks, hens and sheep.

Table 2.4 represents that out of the above listed items, only a few are owned by a majority of households; cot/bed (23%), a watch/clock (80%), a mattress (94%), a chair (48%), a pressure cooker (28%) and an electric fan (61%). More than half of the households in Md. Bazar have a chair (58%). Fewer than 4 out of 10 households in Md. Bazar owned a pressure cooker (39.1%). Various forms of media or means of communication were owned by a minority of the households. Only 38% of the households have a colour television, 8% owned a radio or a transistor, and 17%possessed a mobile phone. Almost 13% of the households in Suri-1 possessed a radio or a transistor and almost 79% of the respondents in Suri-1 have a mobile phone for communication. Only a minority of the surveyed households own a computer (1.3%),possession of which is significantly higher in Md. Bazar block (3.2%). It may also be noted that only 8% of the households have a refrigerator and 3% have a sewing machine. The household possession of sewing machine is the highest in Suri-1 (6%). Only a small proportion of the households have a water pump (8%).In Saithia block the presence of water pump is found to be lower (6%) compared to other blocks. A thresher is owned by 15% of the households but a tractor is owned by only 1% of the households.

Table 2.4 Housing assets across the blocks (N: 1348)

Housing Characteristics	Md. Bazar	Suri-1	Saithia	Total
Household Goods				
Mattress	87.9	96.8	94.6	94.1
Pressure cooker	39.1	25.6	26.2	28.1
Chair	58.1	44.5	46.0	47.6
Cot or bed	35.5	21.3	20.0	22.7
Electric Fan	56.2	56.0	63.8	60.8
Radio or Transistor	12.7	5.6	8.4	8.4
Television (black and white)	8.1	4.7	6.5	6.3
Television (colour)	33.2	37.4	39.9	38.3
Sewing Machine	5.7	1.7	2.7	2.9
Mobile Telephone	78.5	72.1	67.9	70.5
Computer	3.2	0.7	1.1	1.3

Refrigerator	8.9	6.6	7.8	7.7
Watch or Clock	80.4	77.2	77.5	77.9
Water Pump	13.6	11.5	5.5	8.1
Thresher	17.6	14.3	14.4	14.8
Tractor	1.7	1.1	0.7	0.9
Means of Transport				
Bicycle	84.7	86.6	80.0	82.2
Motorcycle or Scooter	18.0	13.4	11.5	12.9
Animal-drawn cart	17.7	20.6	17.4	18.2
Car/Jeep	3.6	0.3	1.1	1.3
Agricultural Land				
Own Irrigated Land	30.7	32.1	37.9	35.5
Shared Irrigated land	8.3	17.3	13.1	13.3
Own Un irrigated Land	15.3	11.2	14.1	13.6
Shared Un irrigated Land	3.5	6.1	10.2	8.2
Farm Animals				
Cow	64.4	57.1	56.7	58.0
Bullock	5.5	3.7	11.8	9.0
Goat	37.8	27.3	37.4	35.2
Duck	16.4	20.1	36.6	29.7
Hen	22.0	7.6	13.4	13.4
Sheep	4.3	8.4	6.3	6.5
No. of Household	**450**	**450**	**448**	**1348**

Bicycles continue to be the most commonly owned means of transport, owned by more than 8 out of 10 households (82%). The share of bicycle is more in Sathia block (87%) compared to other blocks. It may be observed that 13% of the households owned motorcycle/scooter, 18% owned an animal driven cart and only 1.3% owned a car or a jeep. More than one-fifth of the households in Suri-1 have animal driven cars and 3.6% of the households in Suri-1 owned cars or jeeps.

Almost 36% of the households in the surveyed population have their own irrigated land, the proportion is higher in Saithia (38%) compared to Suri-1 and Md. Bazar. 13% of the households owned shared irrigated land and 8.2% of the households across the surveyed population have shared un irrigated landholdings. The households of Suri-1 are more likely to hold a shared irrigated land (17%) and the proportion of shared un irrigated land are more likely owned by the households of Saithia block (10.2%).

More than half of the households owned a cow (58%) and a household at Md. Bazar is more likely to possess a cow (64.4%). 35% of the households have goat and almost 3 out of 10 respondents have duck as their livestock. The possession of duck is significantly higher in the households of Saithia blocks (37%). 13% of the households in the study population have hen and the possession of hen is the highest in the households of Md. Bazar block (22%). Only 9% and 7% of the surveyed households owned bullock and sheep respectively.

2.5 Village infrastructure

Information has been collected on health, educational, communication and other facilities available in the surveyed blocks. The respondent for the village questionnaire was either 'Sarpanch' or 'Prodhan' or any other member of the Panchayat, or any other knowledgeable person in the village. To assess the accessibility of sampled villages specific questions have been asked on whether these facilities are located within the village and, if not, the distance of the facilities from the sampled villages. Table 2.6 provides the distance of the sampled population from the nearest educational facility.

Table 2.5 Distance from the nearest educational facility (N: 1348)

Educational Facility	Within village	Distance from the village		
		<5km	6-9 km	10+ km
Primary School	96.1	3.9	-	-
Middle	29.2	66.3	4.5	-
Secondary	22.8	70.5	4.5	2.2
Higher Secondary	11.4	75.7	6.7	6.2
College	-	31.9	8.8	59.3

Madrasa	24.7	40.4	8.9	26.0

Most of the surveyed villages have primary schools (96.1%).Percentage of villages having middle, secondary, higher secondary school and *madrasa* respectively are 29.2, 22.8, 11.4 and 24.7%. The proportion of villages having middle school facility in less than 5 km was 66.3%. It has been observed that 71% villages have secondary school within 5 km distance from the village, while location of higher secondary school was less than 5 km for 76% of villages. College was not present within any of the village and 32% of colleges were located within 5 km from the village. However, almost 6 out 10 colleges were beyond 10 km from the village. One-fifth of the Madrasa Schools were situated within the village, 4 out of 10 Madrasa schools were located within 5 km from the village.

Table 2.6 provides the summary of accessibility of health facilities in terms of distance categorized as within the village, within 3 km, from 4 to 5 km, from 6 to 10 km and beyond 10 km from the villages.

Table 2.6 Distance from the nearest health facility (N: 1348)

Health Facility	Within Village	Distance from the village			
		> 3km	4-5km	6-10km	10+km
Subcentre	35.8	50.8	13.4	-	-
Primary Health centre	13.1	41.5	30.5	8.2	6.7
BPHC/RH	6.8	12.9	29.4	20.3	30.6
District/sub-divisional Hospital	6.8	6.7	14.1	8.8	63.7
Government Allopathic Dispensary	6.8	26.3	27.5	13.4	26.0
Private Clinics	18.0	37.4	16.2	17.7	10.6
Private Hospital	3.3	11.9	11.9	20.1	52.7
Ayush Hospital	11.1	13.1	9.6	8.9	57.3

From the above Table it may be noted that 36% of the villages have sub-centres within the village itself and more than half of the sub-centres are located within 3 km from the village. 13% of the villages have primary health centres (PHCs), while 42%, 31%, 8.2% and 7% of the villages have PHCs within 3km, 4 to 5 km, 6 to 10 km and beyond 10 km from the village respectively. The proportion of villages having block primary health centre (BPHC) or Rural Hospital (RH) (higher level from PHC) within village the villages was 7%. The location of BPHC/RH was more than 10 kms for more than 30% of the villages. As expected, only about 7% villages have access to tertiary level health facility. It may be noted that 18% and 3% villages have private clinics and private hospitals (or nursing homes)respectively, while 11% villages have *Ayush* hospitals.

CHAPTER 3

Awareness, Ever-use and Current Use of Contraceptive Methods

Chapter 3

Awareness, Ever-use and Current Use of Contraceptive Methods

In India, young couples conceive at an early age, face the problem of unintended pregnancies which sometimes result into unsafe abortions. A multiplicity of factors such as lack of awareness, conservative views about contraception, son-preference, high cost and inaccessibility affect the use of such methods to stop or delay pregnancy. Furthermore, one of the most important reasons for such low contraceptive usage was the search for the so-called 'ideal' contraceptive method due to lack of informed choice. Each method differs from the other in terms of individual's requirements. Therefore, it is important for women to have a wide knowledge about contraceptive options to maximize their benefits and minimize their risks.

This chapter presents information on the awareness of different contraceptive methods, the level of utilization i.e., ever-use and current-use of contraceptive methods among the study participants across the surveyed blocks. Information was also collected about the age of first contraceptive use and timing of sterilization. Further, a brief account of contraceptive method-mix is presented in this section.

3.1 Awareness of contraceptive methods

Awareness plays a critical role in the use of family planning methods. The provision of adequate contraceptive information is fundamental for the ability of women to make informed choices about reproductive health decisions. In the survey, the women were asked about their knowledge of each of 10 methods of contraception comprising modern spacing methods, modern permanent methods and traditional (natural) methods. Table 3.1 highlights the knowledge of the respondents on the awareness of female and male sterilization, pill, IUD, injectables, condom/*nirodh*, female condom, two traditional methods (rhythm and withdrawal) and emergency contraception across the background characteristics. Information on knowledge of contraception was collected in two ways. First, respondents were asked to spontaneously mention all the methods of contraception that they had heard of. For methods not mentioned spontaneously, the interviewer described the method and probed as to whether the respondent could recognize it.

Table 3.1 Awareness of contraceptive methods by background characteristics (N: 1348)

Background characteristics	Any method	Any modern method	Female sterilization	Male sterilization	Pill	IUD	Injection	Condom	Female condom	Any modern reversible method	Any traditional method	Calender method	With-drawal	Emergency contraceptive	No. of women
Age															
15-24	99.8	99.8	99.4	84.5	98.9	68.1	66.9	91.2	39.3	98.9	75.9	69.5	65.3	45.5	332
25-34	99.9	99.9	99.9	77.8	98.4	64.2	61.0	86.1	42.2	98.4	74.0	68.4	61.6	38.6	550
35-44	99.9	99.9	99.8	77.4	97.4	68.1	59.7	79.3	43.1	98.7	73.5	68.9	61.2	35.4	446
Women's education															
Illiterate	99.6	99.6	99.4	74.2	94.9	64.3	53.1	73.8	31.1	96.6	54.2	45.5	39.6	28.5	502
Primary	100	100	100.0	72.6	99.7	63.5	63.7	91.4	43.5	99.7	79.5	75.3	64.8	29.4	213
Middle	100	100	99.8	82.4	99.6	64.9	61.0	85.5	38.6	99.6	78.7	74.2	28.4	42.6	358
>middle	100	100	100.0	87.4	99.7	74.9	74.9	95.2	60.7	99.7	94.2	91.5	86.2	56.9	275
Partner's education															
Illiterate	99.9	99.9	99.8	71.2	94.2	60.7	52.2	72.5	27.5	96.3	55.2	46.9	42.3	27.3	375
Primary	99.4	99.4	99.1	79.0	98.5	67.7	60.5	80.1	39.7	98.5	69.4	61.1	57.2	29.5	268
Middle	100	100	100	79.7	99.5	62.7	58.2	92.3	42.1	99.5	83.6	79.5	72.2	44.0	245
>middle	100	100	99.8	85.1	100	72.9	72.2	91.6	53.3	100	84.8	82.4	73.7	49.6	460
SRC															
Hindu SC	100	100	100	78.8	97.2	67.7	52.6	82.0	36.8	97.9	70.1	63.4	57.4	27.0	538
Hindu ST	99.2	99.2	98.3	70.7	97.4	60.8	60.4	77.8	35.6	98.0	51.6	43.1	37.3	38.2	182
Hindu other/Other minority	100	100	100	82.8	99.3	66.3	71.7	90.1	49.1	99.6	88.5	85.4	79.2	50.9	446
Muslim	100	100	100	82.8	98.7	82.0	65.5	87.2	45.1	98.7	64.9	61.7	44.8	45.1	182
Women work															
Primary	99.7	99.7	99.5	78.3	97.4	67.3	54.7	78.7	35.7	98.0	56.8	48.4	43.1	29.8	433

Self-employed/tertiary	99.8	99.8	99.6	79.3	95.6	73.4	68.8	82.9	55.9	95.9	72.2	66.6	64.5	47.7	158
Not working	100	100	99.9	80.0	99.1	64.8	65.8	89.4	43.5	99.7	87.0	83.8	75.6	44.0	757
Men work															
Primary/not working	99.8	99.8	99.6	74.6	97.4	67.8	56.9	78.4	37.1	97.9	64.9	57.7	50.3	32.6	809
Self-employed/tertiary	99.9	99.9	99.9	85.3	99.0	65.1	68.5	93.1	48.1	99.7	86.4	83.3	77.9	47.4	539
Media exposure															
Regular	100	100	100	83.9	99.6	70.5	66.1	89.1	47.2	99.6	86.6	82.6	75.5	43.5	723
Irregular	99.7	99.7	99.4	73.3	96.1	61.5	56.6	79.2	34.9	97.4	58.2	51.0	45.4	33.3	625
Wealth index															
Poor	99.8	99.8	99.7	79.8	95.1	69.3	57.1	80.1	35.8	96.6	56.2	47.3	41.6	32.3	449
Middle	99.8	99.8	99.4	69.7	99.7	59.1	55.0	79.2	32.1	99.7	73.5	68.0	59.6	29.0	450
Rich	100	100	100	86.6	99.8	70.1	72.4	94.0	55.9	99.8	92.9	91.1	85.3	54.0	449
Block															
Md. Bazar	100	100	99.5	95.4	97.9	56.0	45.3	66.5	27.2	99.1	51.1	46.4	40.5	30.1	450
Suri-1	99.5	99.5	99.5	95.2	99.3	79.1	72.8	96.8	43.2	99.3	90.0	89.5	74.5	54.3	450
Saithia	100	100	99.9	69.3	97.8	64.7	62.2	84.9	45.0	98.3	74.3	66.9	63.4	35.7	448
Total	99.9	99.9	99.7	79.3	98.1	66.6	61.9	84.8	41.8	98.7	74.2	68.8	62.3	39.1	1348

Awareness about any method and any modern method of family planning was universal across the surveyed respondents. However, awareness of certain specific methods varied considerably. Looking into the responses of the women, it may be noted that 79.3% were aware of male sterilization as compared to almost universal knowledge (99.7%) of female sterilization.

Knowledge about modern spacing methods is important from the point of view of increase in birth spacing. Almost 99% of respondents were aware of such methods. Awareness of pill was the highest among all the modern spacing methods of family planning across the study respondents. About 98% of currently married women reported knowledge about contraceptive pills followed by male condom (84.8%). More than two-third respondents were aware of intra-uterine device (IUD) (66.6%), while 61.9% women were aware of injections as a method of birth spacing. It is quite interesting to note that 39.1% of the respondents knew about emergency contraceptive pill which has recently been introduced in the national family welfare programme.

More than 7 out of 10 women (74.2%) in the surveyed population were aware of traditional methods. Among the traditional methods, rhythm or calendar method was widely known as a method of family planning. 68.8% of women knew about calendar/rhythm methods and 62.3% of women knew withdrawal techniques as a method of family planning.

Table 3.1 also presents the percentage of currently married women who were aware about the use of specific contraceptive methods across selected background characteristics. Awareness about any method and any modern method of family planning was universal across the background characteristics. It was true for female sterilization as well. In contrast, awareness about male sterilization was relatively high for younger women (84.5%), Muslims and Hindu upper caste (82.8%), women who were not working at the time of survey (80.0%) and women belonging to the highest wealth quintile (86.6%).

In the case of modern spacing method, the knowledge of pill is also universal across the background characteristics. About 7 out of 10 women of younger and older age groups were aware of IUD. The awareness of IUD was highest among those women who had studies beyond the middle level (75%), women belonging to Muslim community (82%), respondents engaged in tertiary or self-employed work (73.4%) and women belonging to the highest wealth quintile (70.1%). Educational attainment was found to be strongly associated with awareness about injections as a modern spacing method. It was observed that around 75% women with higher than middle-school education knew about injections. The level of awareness across the socio-religious

community is the highest for Hindu upper castes and among Muslim or other minority communities (71.7%). It may also be noted that 72.4% women from affluent sections of the society knew about injections as a method of family planning.

Awareness level of condom was relatively high among younger women (91.2%) compared to older women (79.3%). More than 9 out of 10 women from the Hindu upper caste knew about condom. The knowledge of condom as a method of family planning was relatively high for women who have at least some education compared to illiterate women. Respondents who were not-working at the time of survey knew about condom than others (89.4%). 94% of women belonging from the affluent sections of the society were aware of condom. The awareness level of female condoms among the respondents was very low compared to the male condoms. Visible differentials were observed by age, education and wealth index. It was found that respondents belonging to the older age group (43.1%) were well aware of female condom and women with higher educational attainment (61%) knew about female condoms as a family planning method. A less than half of the women (49.1%) belonging to Hindu upper caste knew about female condoms. Almost two-third of the women belonging to the highest wealth quintile were aware of female condoms (55.9%).

Knowledge of traditional (natural) method of contraception also varies widely across educational attainment of the respondents and their partners, and according to religion/caste affiliation, work status, media exposure and household wealth. Overall, three-fourth of respondents knew about traditional method. Although there was not much variation across age-groups, the younger women were found to be more aware about traditional methods (75.9%) compared to older women. The level of awareness about traditional methods was high in the Hindu upper caste compared to other castes (88.5%). Women who were not-working at the time of survey were more aware about traditional methods (87%) compared to their working counterparts. Women from the higher wealth quintile were more aware about traditional methods (92.9%) compared to the poorer sections.

3.2 Ever use of contraceptive methods

Ever use of contraceptive method can provide an idea about the accessibility of family planning method. It is also an instrument in assessing the current level of contraceptive use and acceptance of

various contraceptive methods in different background characteristics. Table 3.2 gives the level of any family planning method ever used by selected background characteristics.

Table 3.2 Ever use of contraceptive methods by background characteristics (N: 1348)

Background characteristics	Any method	Any modern method	Female sterilization	Male sterilization	Pill	IUD	Injection	Condom	Any modern reversible method	Any traditional method	Calender method	With-drawal	Emergency contraceptive	No. of women
Age														
15-24	81.1	75.2	35.4	0.0	44.6	0.6	0.3	3.5	47.4	11.9	5.5	7.4	2.3	332
25-34	92.1	88.5	64.6	0.0	36.4	0.7	0.1	2.9	37.8	13.0	6.8	6.8	0.5	550
35-44	95.9	93.5	79.9	1.7	23.3	2.6	0.0	2.6	26.1	13.5	5.5	8.1	0.1	446
Women education														
Illiterate	87.8	85.5	74.1	0.2	19.0	0.2	0.0	1.0	20.2	5.5	4.1	1.5	0.0	502
Primary	91.2	90.0	74.1	0.0	21.5	0.5	0.0	0.3	22.3	8.6	2.6	6.3	2.4	213
Middle	90.5	86.5	62.0	1.9	36.4	1.6	0.1	2.5	37.9	12.3	5.8	6.9	0.5	358
>middle	95.9	88.3	41.8	0.0	59.4	3.6	0.3	8.2	65.1	27.7	11.4	17.8	1.3	275
Men education														
Illiterate	88.9	87.0	74.5	0.3	20.6	0.1	0.0	0.3	21.0	5.3	4.1	1.4	0.2	375
Primary	88.9	87.3	72.0	0.0	19.2	0.2	0.2	1.6	21.1	7.3	2.5	5.2	0.0	268
Middle	92.1	88.7	66.2	2.6	36.2	0.5	0.0	1.2	37.5	13.2	4.0	9.8	0.9	245
>middle	92.7	86.4	49.3	0.0	48.3	3.6	0.2	6.6	52.7	21.2	10.4	11.6	1.4	460
SRC														
Hindu SC	98.2	89.9	72.6	0.0	24.4	0.2	0.0	1.8	26.1	10.3	5.3	5.7	0.3	538
Hindu ST	81.1	80.3	64.8	0.3	26.7	1.0	0.2	1.4	28.4	2.4	1.1	1.1	0.0	182
Hindu other/Other	94.2	88.8	59.6	1.5	43.8	2.9	0.1	4.8	46.9	20.1	8.5	12.3	1.5	446

minority														
Muslim	78.4	71.6	30.7	0.0	47.3	0.6	0.0	0.9	49.0	9.5	7.8	2.5	0.0	182
Women work														
Primary	87.9	85.6	70.4	0.2	23.0	0.5	0.0	1.6	25.0	5.9	3.7	2.2	0.2	433
Self-employed/tertiary	92.9	89.2	66.4	0.0	33.0	0.2	0.0	1.1	34.1	8.3	3.9	4.4	0.3	158
Not working	92.9	88.0	57.9	1.1	40.8	0.3	0.2	4.2	43.5	18.8	8.1	11.7	1.3	757
Men work														
Primary/not working	88.6	85.5	67.5	0.1	25.3	0.8	0.1	1.8	26.9	10.8	5.6	5.4	0.5	809
Self-employed/tertiary	93.9	89.5	58.2	1.3	43.9	2.2	0.1	4.3	47.1	15.7	6.5	10.1	1.2	539
Media exposure														
Regular	93.7	88.9	59.3	1.0	39.2	2.1	0.1	3.6	41.7	17.9	7.2	11.3	1.3	723
Irregular	87.3	85.0	68.8	0.2	29.5	0.5	0.1	2.0	27.8	6.5	4.5	2.4	0.1	625
Wealth index														
Poor	87.4	84.0	70.6	0.2	22.9	0.1	0.0	0.9	24.0	7.7	4.7	3.0	0.1	449
Middle	92.8	89.2	69.2	0.0	26.8	1.2	0.1	1.5	28.0	11.1	6.8	5.1	1.2	450
Rich	92.9	88.8	51.5	1.6	49.3	2.9	0.2	6.1	52.9	19.6	6.7	13.8	1.2	449
Block														
Md. Bazar	82.0	72.7	50.6	0.4	30.8	1.0	0.2	2.9	33.7	15.6	12.7	4.6	0.0	450
Suri-1	93.0	86.2	61.5	0.0	35.9	1.8	0.3	4.1	37.5	26.8	13.9	14.2	1.5	450
Saithia	92.4	91.2	67.4	0.9	33.2	1.4	0.0	2.5	35.5	7.1	1.4	5.7	0.0	448
Total	90.9	87.2	63.4	0.6	33.4	1.4	0.1	2.9	35.7	12.9	6.0	7.4	1.3	1348

Almost 91% of women used a method of family planning. Women above 35 years of age (95.9%), of high educational level (96%), women belonging to Hindu SC (98.2%) and women engaged in either tertiary or self-employed (92.9%) as well as not working at the time of survey (92.9%) were more likely to use any method of contraception.

Women in the lowest wealth quintile category were less likely to use any method of family planning (87.4%). Almost 87.2% of the respondents across the surveyed population ever used any modern contraceptive methods. Education plays a significant role in the ever use of modern methods among the women (88%).As expected, women aged above 35 were more likely to ever use any modern methods of contraception.

Amongst the type of contraceptive method, female sterilization was the most ever used (63.4%). On the contrary, male sterilization was ever used by only 0.6% of the respondent's partner. This indicates not only the dominance of female-oriented contraceptive methods but also emphasized the adoption of permanent method of family planning. The modern spacing methods of family planning were used by 35.7% of the respondents. Among the temporary modern methods, pill was ever used by 33.4% of the women; IUD was ever used by only 1.4%. The least ever used contraception was injections (0.1%). It is quite surprising that being a reliable contraceptive method that plays very important role to prevent transmission of STI/HIV, the use of male condom was very low (2.9%). Further, the use of female condom has not been found among study population. It is also important to note that only 1.3% of women in the surveyed population ever used emergency contraception.

Although the utilization of traditional (natural) method of contraceptives is high (about 20% according to NFHS-3, 2005-06), the utilization is not so high in the study population. Nevertheless, almost 13 percent of the respondents had ever used traditional methods. Majority of them prefer the withdrawal technique (7.4%) compared to calendar/rhythm method (6%).

As expected, ever used of any contraceptive methods was more significant among women aged 35-44 (95.9%). Significant difference was not observed among the literate and illiterate regarding ever-use of contraceptive methods. Muslim women had less ever used (78.4%) any method compared to Hindu. Women who were engaged in tertiary sector or were self-employed and not working had ever used any contraceptive method (92.9%) compared to those who were working as agricultural labourers. The poorer women were less likely to ever use any method (87.4%) compared to the better-off sections of village community.

It is important to note that almost 8 out of 10 women of older ages have undergone female sterilization. On the other hand, the majority of illiterate women and women who attained only primary schooling have undergone female sterilization (74% respectively). Across the socio-religious groups it may be noted that female sterilization was higher among Hindu SC

(73%) and least among the Muslim women (30.7%). Also, women involved in primary sector activities (70.4%) and women belonging to the poorer sections have undergone sterilization (71%) more compared to others. In contrast the male sterilization across the selected background characteristics was very low; only about 0.6% of women's current living partners have undergone vasectomy.

In case of modern spacing method, the ever use of pill was relatively high for younger women (44.6%), greater proportion of women with more than middle level schooling (60%), Muslim women (47.3%), women who were not working at the time of survey (40.8%) and belonging to higher wealth quintile (49.3%). The ever use of IUD was found to be higher among women aged more than 35 years (2.6%), women with middle level of schooling (3.2%), women from Hindu upper caste (2.9%) and among the women belonging to higher wealth quintile (2.9%). Significant difference in the ever use of condom was noticed across socioeconomic characteristics of respondents. The use of condom was found to be higher among the educated women (8.2%), upper caste Hindu women (4.8%) and also among the women belonging to the higher wealth quintile (6.1%).

Visible differences were not observed regarding the ever use of traditional method by age groups. However, respondents who completed their middle schooling (12.3%) and pursued higher education (28%) were more likely to ever use traditional methods. Almost one-fifth of the Hindu upper caste women ever used traditional methods compared to other socio-religious groups. The utilization of traditional method was also found to be higher among women who were not working at the time of survey (18.8%) and belonging to the affluent sections of the society (19.6%).

3.3 Current use of contraceptive methods

The current level of contraception use i.e., the contraception prevalence rate (CPR) is defined as percentage of married women aged 15-44 years who are using a contraceptive method or whose spouses are using a contraceptive method. As literature on this subject suggests, CPR is one of the principal determinants of fertility and also an indicator of the success of family planning programmes. During the survey, we have collected information about women using a family planning method to delay or avoid pregnancy. This section focuses on the levels and differentials in current use of contraceptive methods in the surveyed population.

Fig. 3.1 shows a pie-chart representing the percentage of various contraceptive methods currently used by the respondents in the study population. It is to be noted that 82% of the women in the surveyed village were using modern contraceptive methods to prevent birth. Among them a majority of the married women have undergone female sterilization (64%), which implies that they do not want to bear any risk of pregnancy possibly after attaining the completed family size. It may be noted that only a minority of women currently rely on modern reversible method (18%), in which majority using oral pill (17%). The reliance on traditional (natural) methods comprising rhythm/calendar method and withdrawal technique was also found to be low; only 6% of the respondents were using traditional methods. It may also be noted that 12% of the surveyed women were not using any contraceptive methods to delay or stop pregnancy.

Fig. 3.1 Percentage of married women currently using contraceptive methods (N: 1348)
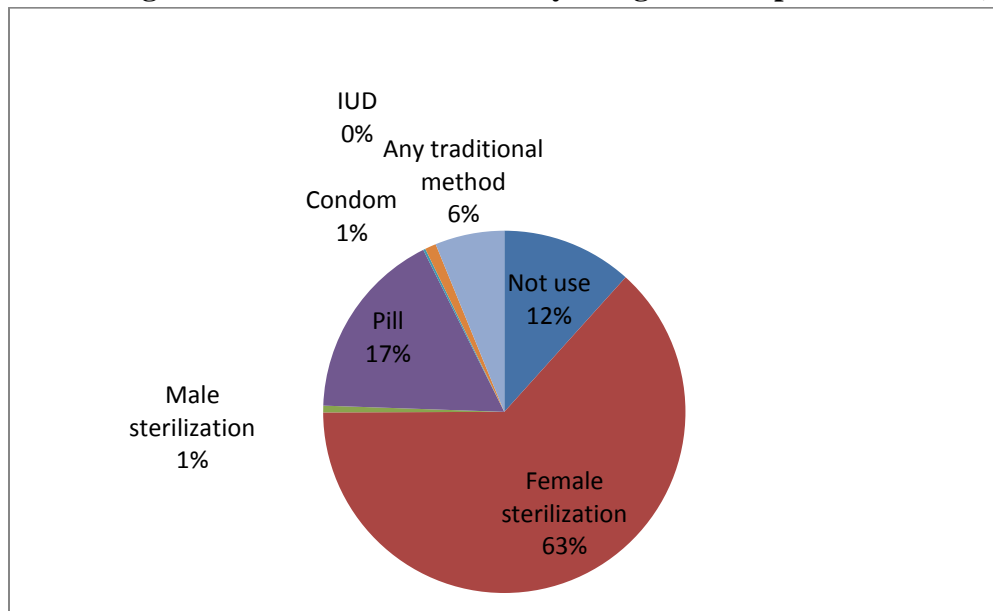
The current use of different methods of family planning among the married women across the selected background characteristics is shown in Table 3.3. The Contraceptive Prevalence Rate (CRP) was 88.2% for any method. As expected, the younger women were less likely to use contraceptive methods (79%) compared to their older counterparts due to their desire to attain the ideal number of children. The illiterate women were less likely to use any

contraceptive method (84%) compared to their literate or higher educated counterparts (93%). Muslim women were the least likely to use any contraceptive methods (68%), while women belonging to Hindu upper caste were more likely to use any contraceptive methods (92%). It may also be pointed out that a higher proportion of self-employed or those engaged in the tertiary sectors activities were more likely to use any contraception method (91%) compared to others. Women belonging to the middle or higher wealth quintile (almost 90%) using any contraceptive methods more compared to the poorer women. Current use of any contraceptive measure is universal among women having 3 female children and women with 4 children, one being a boy compared to other categories as given in the Table 3.3.

The CPR for any modern method can be assumed as an indicator of performance of the family planning programme. It may be noted that more than 8 out of 10 respondents (82%) were using modern contraceptive methods. It is important to mention that use of any modern method of family planning by sex composition is an indicator of sex preference. Women with no living sons are less likely to use any modern method of contraceptive except among them having 3 living girl children and no son (96%). Only 77% of women having one surviving female child use contraceptive methods whereas 85% of women having one surviving male child use contraception. The prevalence of modern contraceptive methods was common among the Hindu upper caste (81%) compared to others. As observed earlier, younger women were less likely to use any contraception (72%) compared to their older counterparts.

Among the modern permanent methods, female sterilization was the most common means of contraception (63%). The sex composition of children has a huge impact on the acceptance of female sterilization. Among the women with two living daughters, sterilization is low (77%) as compared to women with two sons (92%). It is interesting to note that illiterate women (74%) and primary educated women (74%) were more likely to female sterilization compared to higher educated women. Fewer Muslims women have undergone sterilization (31%), while more women from lower wealth quintile (71%) adopted female sterilization.

Table 3.3 Current use of contraceptive methods by background characteristics (N: 1348)

Background characteristics	Any method	Any modern method	Female sterilization	Male sterilization	Pill	IUD	Condom	Any modern reversible method	Any traditional method	Calender method	With-drawal	Not use	No. of women
Age													
15-24	78.8	71.8	35.4	0.0	34.7	0.2	1.3	36.3	6.7	3.7	3.0	21.2	332
25-34	89.7	84.7	64.6	0.0	18.6	0.1	1.5	20.1	6.5	4.2	2.2	10.3	550
35-44	92.8	86.7	79.9	1.7	4.5	0.4	0.3	5.1	5.7	1.7	4.1	7.2	446
Women education													
Illiterate	83.8	82.5	74.1	0.2	7.3	0.1	0.8	8.2	1.3	2.1	0.1	16.2	502
Primary	89.9	87.5	74.1	0.0	12.8	0.5	0.1	13.4	2.3	0.8	1.5	10.1	213
Middle	89.2	83.6	62.0	1.9	19.3	0.0	0.4	19.6	5.6	2.4	3.2	10.8	358
>middle	92.5	76.7	41.8	0.0	31.9	1.6	2.8	34.9	15.8	6.1	9.7	7.5	275
Men education													
Illiterate	84.1	82.6	74.5	0.3	7.8	0.1	0.0	7.9	1.8	1.3	0.5	15.8	375
Primary	88.6	88.6	72.0	0.0	13.1	0.2	1.4	14.6	2.0	1.2	0.8	11.4	268
Middle	90.0	86.4	66.2	2.6	17.2	0.2	0.1	17.5	4.6	2.1	2.5	9.1	245
>middle	89.3	77.5	49.3	0.0	26.1	0.4	2.1	28.3	12.6	6.0	6.6	10.5	460
SRC													
Hindu SC	90.2	78.0	72.6	0.0	13.6	0.1	0.7	14.3	3.6	2.4	1.2	10.1	538
Hindu ST	78.2	77.4	64.8	0.3	11.0	0.5	0.9	12.3	0.8	0.7	0.1	21.7	182
Hindu other/Other minority	92.2	81.7	59.6	1.5	22.0	0.3	1.4	23.4	11.0	4.6	6.5	7.5	446
Muslim	67.7	61.1	30.7	0.0	28.8	0.8	0.9	30.5	6.6	5.4	1.2	31.0	182
Women work													
Primary	84.3	81.8	70.4	0.2	10.3	0.2	0.8	11.3	2.8	1.9	0.9	16.2	433
Self-	91.0	88.0	66.4	0.0	20.6	0.2	1.0	21.6	3.0	1.9	1.2	9.2	158

employed/tertiary													
Not working	90.4	81.6	57.9	1.1	21.3	0.3	1.1	22.6	9.2	4.2	5.0	9.0	757
Men work													
Primary/not working	85.6	81.8	67.5	0.1	13.3	0.2	0.8	14.2	4.0	2.5	1.6	14.6	809
Self-employed/tertiary	91.5	83.0	58.2	1.3	22.1	0.3	1.2	23.6	9.0	4.0	5.1	8.0	539
Media exposure													
Regular	91.2	83.1	59.3	1.0	21.7	0.3	1.0	22.8	8.7	3.6	5.1	8.9	723
Irregular	84.3	81.4	68.8	0.2	11.3	0.2	1.0	12.4	3.0	2.5	0.5	15.4	625
Wealth index													
Poor	85.5	82.3	70.6	0.2	10.5	0.1	0.8	11.4	3.5	2.5	0.9	15.2	449
Middle	89.6	84.9	69.2	0.0	14.9	0.4	0.4	15.7	4.8	3.2	1.6	10.3	450
Rich	89.8	80.3	51.5	1.6	25.5	0.2	1.7	27.2	10.1	3.6	6.6	9.5	449
Living children													
No children	19.4	9.4	1.5	0.0	5.5	0.0	2.4	7.9	6.5	10.0	3.5	80.6	85
1 Child1 son	85.0	69.5	25.7	0.0	42.1	0.0	2.1	43.7	7.3	15.5	8.4	15.0	215
1 Child 0 son	77.3	67.5	18.1	0.0	45.9	1.1	2.4	49.4	3.8	9.9	6.0	22.7	141
2 children 2 sons	96.3	96.2	92.0	0.0	4.1	0.0	0.0	4.1	0.6	0.6	0.0	3.2	178
2 children 1 son	95.1	91.6	83.3	2.7	4.7	0.1	0.8	5.6	0.3	3.5	3.1	4.9	293
2 children 0 son	97.9	92.8	77.2	0.0	13.9	0.7	0.9	15.5	1.9	5.1	3.2	2.1	109
3 children 3 sons	95.5	94.2	94.2	0.0	0.0	0.0	0.0	0.0	1.3	1.3	0.0	4.5	22
3 children 2 sons	97.1	97.1	93.3	0.0	3.9	0.0	0.0	3.9	0.0	0.0	0.0	2.9	90

3 children 1 son	94.7	94.1	86.4	0.0	7.7	0.0	0.0	7.7	0.6	0.6	0.0	5.3	99
3 children 0 son	100.0	95.7	70.1	0.0	25.6	0.0	0.0	25.6	3.6	4.3	0.8	0.0	24
4+ children 2+ sons	87.0	82.1	65.6	0.0	16.0	0.6	0.0	16.6	3.0	4.8	1.2	13.0	59
4+ children 1 son	100.0	96.9	88.2	1.9	3.4	3.4	0.0	6.8	3.1	3.1	0.0	0.0	27
4+ children 0 son	43.6	43.6	39.9	0.0	3.7	0.0	0.0	3.7	0.0	0.0	0.0	56.4	6
Block													
Md. Bazar	79.2	70.0	50.6	0.4	16.4	0.7	2.0	19.0	9.5	8.0	1.6	20.4	450
Suri-1	91.3	80.0	61.5	0.0	17.1	0.3	1.0	18.5	12.3	6.6	5.7	9.6	450
Saithia	89.3	86.3	67.4	0.9	17.3	0.1	0.7	18.0	3.1	0.6	2.5	10.3	448
Total	88.2	82.3	63.4	0.6	17.1	0.2	1.0	18.3	6.2	3.1	3.1	11.7	1348

Although majority of the respondents were using modern methods, only 18% of women were using modern reversible (spacing) method. A high proportion of the women (44%) having one surviving child irrespective of gender use pill. Married women of younger age use pill more to delay pregnancy (35%) compared to women of higher ages. Education plays an important role in determining the usage of pills where more of higher educated (32%) use pill. More Muslim women (29%) were using pill compared to Hindu upper caste (21%). One-fourth of couple from higher wealth quintile use pill. The prevalence rate of IUD (0.2%) and condoms (1.0%) was abysmally low in the surveyed population.

The use of traditional method is amongst 18% in the study population. Majority of women with higher education (16%) were using traditional methods. Hindu upper caste women (11%) rely on traditional methods compared to Muslim (7%) women. It is important to note that 12% of the respondents in the surveyed population were not using any contraceptive methods. The greater proportion amongst them were the women aged 15-25 years (21%), illiterate women (16%), Muslims women (31%) and significantly 81% of those women who do not have any surviving child.

3.4 First age of contraceptive use

The age at which women first used contraceptive methods to delay or stop child bearing has been reported in Table 3.4 as collected during respondents' interviews. The mean and median age distribution of the respondents is represented on the table 3.4. Out of 1348 respondents, 1197 respondents have ever used any contraceptive method and the remaining 151 did not ever use any contraceptive method. The mean age of first contraceptive use across the study population was 21 years. At Md. Bazar and Suri-1 block the mean age of first use of contraception was 21 years, while in Saithia it was 22 years. The mean age of first use of contraception among the Muslims and STs (23 years) was higher as compared to Hindu women (21 years). The mean age of first contraceptive across the number of living children ranges within an interval from 20 to 27 years.

Table 3.4 First age of contraceptive use by background characteristics (N: 1197)

| Background characteristics | First age of Contraception Use | | No. Of women |
	Mean age	Median age	
Women education			
Illiterate	22	22	435
Primary	21	20	187

Middle	20	20	321
>middle	21	20	254
Men education			
Illiterate	22	22	327
Primary	22	20	232
Middle	20	19	213
>middle	21	20	425
SRC			
Hindu SC	21	20	493
Hindu ST	23	23	137
Hindu other/Other minority	21	20	418
Muslim	23	22	149
Women work			
Primary	22	21	376
Self-employed/tertiary	22	21	141
Not working	21	20	680
Men work			
Primary/not working	22	21	701
Self-employed/tertiary	21	20	496
Media exposure			
Regular	21	21	662
Irregular	22	20	535
Wealth index			
Poor	22	22	387
Middle	21	20	398
Rich	21	20	412
Living children			
No children	20	18	23
1 child 1 son	20	20	187
1 child 0 son	21	20	116
2 children 2 sons	21	20	177
2 children 1 son	21	20	275
2 children 0 son	21	20	104
3 children 3 sons	22	22	21
3 children 2 sons	23	23	88
3 children 1 son	23	23	96
3 children 0 son	21	20	24
4+ children 2+ sons	27	27	54
4+ children 1 son	25	25	27
4+ children 0 son	24	21	5
Block			
Md. Bazar	21	21	390
Suri-1	21	20	413
Saithia	21	21	394
Total	21	20	1197

The median age of the first use of contraceptive in the study population was 20 years. For women belonging to Md. Bazar and Saithia block the median age was 21 years, while it was 20 years among women in Suri-1 block. The median age of first use of contraception was the highest among STs (23 years) compared to others. The median age of first contraceptive use across the number of living children varies marginally. Among the respondents, those who have 4 or more living children with no living male child used their first contraceptive method at the age of 21 years while women who have 4 or more living children with 2 or more living sons used their first contraceptive method at the age of 27 years.

3.5 Age of sterilization

The age of women at the time of acceptance of sterilization is one of the refined indicators of programme performance as the age at the time of sterilization is also directly linked with the effectiveness of the family planning programme in terms of fertility reduction. Table 3.5 provides the mean and median age of sterilization which is 23 years and 22 years respectively for the study population as a whole. Out of 1348 respondents 766 women had undergone sterilization. Among these 766 women, 756 women reported had undergone tubectomy, 7 women had undergone hysterectomy and 3 respondents could not report the type of sterilization they had undergone.

Education plays a vital role in determining the age of sterilization across the surveyed population. The mean age of sterilization among the educated women who completed higher middle education was 24 years as compared to illiterate women (23 years). The mean age of sterilization among the Muslim women is 25 years as compared to Hindu upper caste (23 years). Moreover, women who had 4 or more number of living children, amongst whom 2 or more sons underwent sterilization at the mean age of 28 years and women with no living son underwent sterilization at the mean age of 27 years. It shows a clear cut picture of a preference for a male child.

Table 3.5 Age of sterilization by background characteristics (N: 766)

Background characteristics	Age of Sterilization		No. Of women
	Mean age	Median age	
Women education			
Illiterate	23	23	351
Primary	22	21	132
Middle	22	21	197
>middle	24	24	89

Men education			
Illiterate	23	23	267
Primary	23	21	164
Middle	22	21	141
>middle	23	22	197
SRC			
Hindu SC	22	20	373
Hindu ST	24	24	100
Hindu other/Other minority	23	21	235
Muslim	25	23	61
Women work			
Primary	23	22	299
Self-employed/tertiary	23	23	82
Not working	23	21	388
Men work			
Primary/not working	23	22	492
Self-employed/tertiary	23	21	277
Media exposure			
Regular	23	22	384
Irregular	23	21	385
Wealth index			
Poor	23	23	292
Middle	23	21	267
Rich	23	21	210
Living children			
No children	29	29	1
1 child 1 son	22	22	29
1 child 0 son	21	21	13
2 children 2 sons	22	22	157
2 children 1 son	22	21	235
2 children 0 son	23	22	71
3 children 3 sons	24	23	20
3 children 2 sons	24	23	77
3 children 1 son	24	23	85
3 children 0 son	24	25	17
4+ children 2+ sons	28	27	36
4+ children 1 son	26	25	22
4+ children 0 son	27	26	3
Block			
Md. Bazar	23	23	249
Suri-1	23	22	238
Saithia	23	22	282
Total	23	22	766

The median age of sterilization for the study population is 22 years which is same for Suri-1 and Saithia. The median age of sterilization among women with higher middle education is 24 years. Except for the number of living children, other selected background characteristics

did not provide any clear cut pattern the age at which they were sterilized. Among the women who had 4 or more living children adopted sterilization at the age of 27 years and those who had 4 or more living children and 1 son or no living son adopted sterilization at the age of 25 years and 26 years respectively.

Among the 1348 respondents, 3 women reported that their husband had undergone male sterilization (vasectomy). The mean age of vasectomy is 29 years and the median age of sterilization is 28 years.

3.6 Method mix pattern

While contraceptive prevalence has been a central part of family planning objective over the past few decades, there has been surprisingly little consideration of method mix, an important aspect of quality of care. Almost all the countries in the world offer family planning clients a range of contraceptive methods. "Method mix" refers to the distribution of contraceptive methods used by the population (i.e., the percentage that uses each method). There is no "ideal" method mix recognized by the international community; however, there is reason for concern when one or two methods predominate in a given country. Indeed, conventional wisdom holds that there is no single "best" contraceptive; rather, couples are encouraged to adopt the method with the most benefits and the fewest drawbacks or side-effects, based on their individual perceptions.

In this analysis 'method mix' refers to the distribution of seven categories of contraception: pill, IUD, condom, female condom, withdrawal, calendar or rhythm method and any other method. Broadly, the focus was on the method mix among the respondents that is, those who were using modern reversible (spacing) method and traditional methods. Here we are not employing any "standard" or "ideal" model of method mix; only a bivariate frequency analysis among the respondents across the study population was carried out. However, the results were not reported in tabular form.

Among the 84 respondents who utilized the modern spacing and traditional methods simultaneously, majority of them (25 respondents) combine pill with withdrawal technique. Significantly, pill is the most dominating contraceptive method that couples combine with various other methods to delay pregnancy (68 respondents). 16 respondents preferred to combine pill with condom together as a method of family planning. The most widely used

method mix pattern is modern spacing with traditional methods (65 respondents) as compared to the mix of various modern spacing methods (19 respondents).

It has also been found that there is hardly any definite pattern of method mix in the study population. However, by and large, it has been observed that couples never went for method mix before conceiving. In between the gap of marriage and conceiving for the first time, among 1282 cases only 7 couples followed the mixed method of contraceptive use. The use of an alternative contraceptive method along with a main method is more prominent in between the delivery of the first child and conceiving the second. In fact, 16 out of 983 respondents in this group practiced such mixed method of contraception. But after the delivery of the second child a majority of the respondents underwent sterilization and the remaining of either used one of the various available contraceptive methods or did not use any contraceptive method at all.

CHAPTER 4

Modern Spacing Methods

Chapter 4

Modern Spacing Methods

It has already been noted in the previous section that an overwhelming majority of respondents in the study population were aware of modern spacing methods (98.7%). Although 36% of the respondents had used modern spacing method, only 18% of the couple were currently protected by such methods. It is also important to note that predominantly oral pill was the most popular method amongst all spacing methods.

The present section tries to explore various aspects associated with the use of modern spacing methods among married respondents across the selected background characteristics. It includes a vivid description o the duration of use, reasons for discontinuity, source of such method, incidence of contraceptive morbidity and associated treatment-seeking behaviour of the respondents who were either using modern reversible methods or ever had used such method. Women were also asked questions about the persons who informed them to use such methods, whether they were well-acquainted with the side-effects of such method and received advice regarding what should be done whenever they face side-effects. One of the most important factors in the contraceptive choice is the decision making i.e. person who have taken the final decision about contraceptive method. It is also associated with the consequences such as husband's opposition to use such method and the levels of satisfaction among the respondents while adopting modern spacing methods.

4.1 Duration of modern reversible methods

Duration of regular use of a modern spacing method is another indicator of programme effectiveness and quality. Table 4.1 depicts the mean number of years during which such modern spacing methods of family planning was used. In the surveyed population 7 out of 15 IUD users were using the method for more than 7 years and 8 women who earlier had inserted IUD used it for less than 2 years. It may be noted that 44% of the women who were currently using pill have been using such method for 4 continuous years. There were 48 such women who were previously and have been currently using pill for more than 7 long years. Women, whose partners were using and also previously used condom, have been using it for 8 years. However, it may be noted that less than half of the numbers of respondent's husband were currently using such methods for almost 5 years.

Table 4.1 Mean number of years using modern spacing methods by the respondents

(N: 541)

Duration	Pill (468)		IUD (15)		Injection (3)		Condom (55)	
	Mean no. of years	No. of women	Mean no. of years	No. of women	Mean no. of years	No. of women	Mean no. of years	No. of women
Currently	3.80	205	7.12	7	0.50	1	4.75	24
Previously	2.33	215	1.76	8	0.33	2	0.86	27
Currently &Previously	7.30	48	0	0	0	0	8.08	4

4.2 Sources of modern reversible methods

Family planning services and supplies in India were provided primarily through a network of secondary and tertiary level government hospitals and Urban Family Welfare Centres in the urban areas, and Primary Health Centres (PHC), Sub-Centres (SC) and *Anganwari* Centres (AWC) in the rural areas. The major sources of modern reversible contraceptive method in the study blocks are shown in the Table 4.2. Since our surveyed areas consist of rural areas of the Birbhum district, SCs and PHCs should have been the most prominent sources of obtaining modern spacing methods in the study population. However, we found that medical shops were the predominant sources of obtaining family planning services followed by the AWCs.

Table 4.2 Sources of modern reversible methods (N: 506)

Background Characteristics	Sub-centre	PHC	Anganwadi /ICDS	Medical Shop	Others*	No. of women
Age						
15-24	12.4	4.9	13.5	53.2	16.1	160
25-34	9.7	6.9	9.3	66.7	7.4	242
35-44	4.5	3.7	16.3	62.5	13.0	104
Women education						
Illiterate	19.0	7.3	28.3	32.7	12.6	114
Primary	14.8	9.5	11.0	51.2	13.5	72
Middle	9.3	5.2	16.1	56.5	12.9	158
>middle	3.1	3.5	3.2	80.4	9.9	162
Men education						
Illiterate	11.8	13.2	37.1	30.4	7.5	85
Primary	33.7	5.7	10.0	33.8	16.8	83
Middle	7.2	4.6	12.8	58.0	17.3	96
>middle	4.2	3.3	5.8	77.2	9.5	242
SRC						
Hindu SC	15.0	10.3	18.8	37.1	18.8	161
Hindu ST	14.8	8.0	30.2	43.9	3.0	55
Hindu other/Other	3.3	2.3	3.3	82.4	8.7	203

minority						
Muslim	20.4	1.3	27.5	28.2	22.6	87
Women work						
Primary	20.5	9.3	33.9	26.1	10.1	117
Self-employed/tertiary	2.5	16.5	8.4	70.1	2.6	67
Not working	5.5	2.1	4.5	74.2	13.7	322
Men work						
Primary/not working	17.0	5.4	23.8	38.8	15.0	257
Self-employed/tertiary	3.3	5.3	4.3	77.9	9.2	249
Media exposure						
Regular	6.3	4.6	5.4	72.7	11.0	316
Irregular	14.6	6.8	26.5	38.9	13.1	190
Wealth index						
Poor	17.7	6.4	27.0	28.4	20.5	124
Middle	12.8	10.4	14.4	51.2	11.2	156
Rich	3.6	2.6	5.2	80.7	7.9	226
Block						
Md. Bazar	27.1	4.4	3.0	60.7	4.7	159
Suri-1	5.9	11.3	5.5	57.1	20.2	197
Saithia	6.1	3.3	17.6	62.9	10.1	150
Total	9.1	5.3	12.6	61.2	11.7	506

*includes Rural/BPHCs Hospitals, District/Sub-divisional Hospitals, Public and Private Mobile Centre, ASHA workers, Public and Private Ayush hospitals, other governmental community health centres, other NGOs or trust hospitals, private hospitals or doctors, unqualified doctors or pharmacists, other shops, relatives or friends, other non-governmental sources or any other sources.

It may be noted that overall 61.2 % of women received spacing methods from medical shops. Relatively better-off women (81%) obtain such methods from medical shops compared to women belong to the poorer segment of economic strata (28%). The majority of illiterate women obtain spacing methods from government facilities such as sub-centres, PHCs and AWWs (54.3%) compared to educated women, who obtain such methods mostly from medical shops (81%). The public facilities were not commonly used by the Hindu upper caste (9%), while only one-fifth of Muslim women receive spacing methods from sub-centres.

4.3 Reasons for discontinuity of modern spacing contraception

A major concern for family planning programme managers is the discontinuation of contraceptive methods, either voluntarily because of the need for more children or due to method failure resulting in unwanted pregnancy. Table 4.3 provides the percentage of recently married women who had used modern spacing methods as a family planning method in the past, but discontinued for some reasons. It was found that around 56% of the

respondents discontinued using spacing contraceptives. The most frequently mentioned reason for discontinuing reversible method was fertility-related i.e. need for child (77%), followed by concerns about side effects or health concern (17%) and 6% of the respondents also cited 'other' reasons. 'Other' reasons include lack or shortage of supply, lack of satisfaction, memory loss, inconvenience, high cost, opposition from husband/family, husband away and infrequent sex.

Table 4.3 Major Reasons for discontinuity of modern reversible method (N: 284)

Background Characteristics	Birth related	Side-effect related	Others reasons	No. of women
Age				
15-24	87.5	5.2	7.2	63
25-34	72.6	18.0	9.4	144
35-44	75.8	23.1	1.1	77
Women education				
Illiterate	72.7	25.0	2.3	67
Primary	93.1	6.7	0.2	33
Middle	81.6	9.9	8.5	95
>middle	72.5	20.8	6.6	89
Men education				
Illiterate	69.1	28.4	2.5	53
Primary	91.1	8.9	0.0	44
Middle	86.1	9.6	4.3	53
>middle	72.8	18.4	8.7	134
SRC				
Hindu SC	76.3	18.8	4.9	94
Hindu ST	83.6	15.0	1.4	33
Hindu other/Other minority	76.7	15.7	7.6	126
Muslim	63.0	37.0	0.0	31
Women work				
Primary	75.2	20.6	4.2	73
Self-employed/tertiary	80.1	18.8	1.1	33
Not working	77.1	17.2	5.8	178
Men work				
Primary/not working	75.8	17.9	6.4	138
Self-employed/tertiary	77.8	16.8	5.4	146
Media exposure				
Regular	77.7	15.2	7.1	179
Irregular	75.5	21.1	3.3	105
Wealth index				
Poor	71.3	26.2	2.5	61
Middle	77.0	15.5	7.5	86
Rich	79.0	14.6	6.4	137
No. of living children				

No children	81.2	0.0	18.8	6
1 child 1 son	73.0	22.4	4.6	43
1 child 0 son	32.3	31.9	36.9	28
2 children 2 sons	68.5	29.2	2.2	41
2 children 1 son	85.5	13.7	0.9	84
2 children 0 son	91.2	8.3	0.5	32
3 children 3 sons	100.0	0.0	0.0	6
3 children 2 sons	87.5	12.5	0.0	14
3 children 1 son	87.8	4.0	8.2	13
3 children 0 son	100.0	0.0	0.0	6
4+ children 2+ sons	75.3	7.5	17.2	8
4+ children 1 son	0.0	100.0	0.0	2
4+ children 0 son	100.0	0.0	0.0	1
Block				
Md. Bazar	81.0	16.8	2.3	92
Suri-1	67.3	17.3	15.4	109
Saithia	79.4	17.3	3.3	83
Total	77.0	17.2	5.8	284

There was not much variation in the reasons for discontinuation by background characteristics except for women's age and number of living children. A higher percentage of young women below 24 years (88%) and couples with no living child (81%) reported wanting of a child was the reason for discontinuation. Although very small in number, strikingly all the couples with 3 living male children (with no living female child), 3 living female children (with no living male child) and 4 or more living female children (with no living male child) reported need for another child as the only reason for discontinuing reversible methods.

4.4 Informed choices before the use of modern spacing methods

Women who knew about the whole range of available options and who were well-informed about the side-effects and problems associated with various methods were in a better position to utilize spacing methods. Women who have been using modern spacing methods or used these previously were asked whether they were informed about the range of other methods at the time of adoption of the current method. Moreover, they were also asked whether they were informed about the possible side effects or the problems they might have to face with the method and whether they were informed what to do if they experienced side effects. Table 4.4 shows the percentage of women who received informed choices. It is disheartening to know that only around 31% of women were informed about other contraceptive methods to delay pregnancy. Moreover, a minority of the respondents (26%) were informed about the

side-effects of the methods at the time of adoption. However, among them majority of the women (80%) were informed what to do in case of any problem they may face while using such methods. Variations in background characteristics in informed choice were observed to be negligible except for the socio-religious group. It is important to note that women belonging to STs and minority communities were deprived of informed choices. Such variations were also observed by block as well as by gender-parity.

Table 4.4 Informed choices before modern reversible method (N: 506)

Background Characteristics	Percentage who were informed about the side effects or problems of method used	Percentage who were informed about what to do if experienced side effects	Percentage who were informed by a health or family planning worker about other methods that could be used	No. of women
Age				
15-24	26.1	81.9	22.8	160
25-34	26.4	72.2	22.4	242
35-44	24.9	82.8	25.8	104
Women education				
Illiterate	18.5	88.5	36.5	114
Primary	36.0	69.6	27.3	72
Middle	27.9	84.3	17.5	158
>middle	25.2	79.9	21.1	162
Men education				
Illiterate	22.5	100	39.7	85
Primary	32.9	100	25.8	83
Middle	22.0	100	10.3	96
>middle	27.1	100	24.0	242
SRC				
Hindu SC	40.1	91.8	32.3	161
Hindu ST	8.2	35.0	35.6	55
Hindu other/Other minority	22.8	72.9	15.0	203
Muslim	19.6	100	29.7	87
Women work				
Primary	28.1	87.8	35.7	117
Self-employed/tertiary	25.0	80.6	27.3	67
Not working	25.1	78.0	17.9	322
Men work				
Primary/not working	27.3	79.9	30.9	257
Self-employed/tertiary	24.8	82.0	18.5	249
Media exposure				
Regular	28.0	75.4	20.9	316

Irregular	21.7	95.4	28.6	190
Wealth index				
Poor	28.6	84.3	32.7	124
Middle	21.4	81.6	25.9	156
Rich	26.7	79.3	18.2	226
No. of living children				
No children	24.5	100.0	5.0	14
1 child 1 son	28.1	75.1	27.4	130
1 child 0 son	28.2	88.1	13.8	89
2 children 2 sons	34.8	90.3	24.1	50
2 children 1 son	25.5	87.1	24.8	97
2 children 0 son	17.1	45.9	10.0	49
3 children 3 sons	57.9	56.0	0.0	6
3 children 2 sons	26.5	88.9	44.8	22
3 children 1 son	20.8	100.0	35.3	19
3 children 0 son	5.4	100.0	49.6	9
4+ children 2+ sons	9.2	100.0	54.0	15
4+ children 1 son	11.8	100.0	52.7	4
4+ children 0 son	6.5	100.0	100.0	2
Block				
Md. Bazar	28.1	98.8	32.7	159
Suri-1	36.3	44.0	23.7	197
Saithia	21.3	100	21.2	150
Total	25.9	79.6	30.6	506

Table 4.5 represents the variety of seven family planning methods that were informed by the health workers at the time of adoption of the respective methods. These were female sterilisation, male sterilization, pill, IUD, injections, condoms and female condoms. The most popular method which was informed by the health workers to the couples was condom (53%) followed by IUD (49%) and female sterilization (35%). Significantly, health workers did not inform the clients much about female condoms (11%) resulting in a lack of awareness and use of such methods. As seen earlier, variations across background characteristics were minimum in informing modern spacing methods. The proportion of older aged women above 35 years (54%), illiterate women (73%), women from Hindu ST (84%), women who were engaged in primary activity (60%) and belonged to poorer strata (51%) were informed about female sterilization. All the women having more than 4 living children but no living son or 1 living son were informed to adopt female sterilization as a method of family planning methods.

Table 4.5 Informed choices before modern reversible method (N: 155)

Background	Female	Male	Pill	IUD	Injecti	Condo	Female	No. of

Characteristics	Steriliz ation	Steriliz ation			on	m	Condo m	women
Age								
15-24	15.1	4.9	64.6	44.4	26.8	62.3	10.0	57
25-34	37.0	7.8	84.2	41.2	22.1	45.4	11.8	72
35-44	53.7	1.9	100	65.1	17.1	54.5	11.4	26
Women education								
Illiterate	72.5	1.5	100.0	41.4	21.0	26.1	3.0	37
Primary	16.6	3.5	100.0	56.6	20.4	78.7	32.4	26
Middle	35.4	9.2	100.0	43.0	14.6	41.8	0.8	42
>middle	11.9	5.9	84.2	55.7	28.1	74.2	12.2	50
Men education								
Illiterate	62.1	0.0	100	48.6	20.3	33.6	0.0	26
Primary	45.7	3.1	100	21.7	27.5	57.4	26.9	29
Middle	20.7	6.7	100	64.4	29.8	64.4	29.8	24
>middle	22.8	7.8	85	52.9	20.2	60.1	9.6	76
SRC								
Hindu SC	27.3	3.2	93.7	51.5	17.9	46.8	8.1	57
Hindu ST	84.3	5.1	29.1	27.4	18.0	26.3	0.0	20
Hindu other/Other minority	15.1	6.4	92.5	59.9	27.5	76.6	17.7	51
Muslim	42.2	10.4	100	49.7	31.3	56.9	28.1	27
Women work								
Primary	59.9	1.7	82.2	46.7	15.7	27.0	2.7	43
Self-employed/tertiary	17.2	4.8	82.1	17.9	47.6	86.9	21.5	23
Not working	19.4	8.0	91.2	59.1	21.4	67.3	15.6	89
Men work								
Primary/not working	51.5	2.2	86.7	45.0	23.9	44.6	13.2	91
Self-employed/tertiary	15.6	8.7	89.8	54.8	19.7	64.1	8.6	64
Media exposure								
Regular	18.0	6.8	91.5	50.2	24.7	66.3	13.2	98
Irregular	59.9	2.7	80.5	48.3	18.2	35.1	8.1	57
Wealth index								
Poor	50.7	1.2	78.5	38.0	14.4	30.9	5.7	41
Middle	40.3	5.8	100	64.4	26.1	52.2	9.6	43
Rich	19.7	7.9	90.6	49.2	25.6	72.4	16.5	71
No. of living children								
No children	0.0	0.0	100.0	0.0	61.9	100.0	0.0	14
1 child 1 son	6.8	1.3	75.7	44.5	34.7	66.6	16.3	130
1 child 0 son	15.0	1.7	100.0	38.2	43.9	84.6	19.0	89
2 children 2 sons	71.2	11.2	100.0	28.7	6.0	51.6	4.3	50
2 children 1 son	16.3	5.3	18.2	75.9	2.3	59.0	3.2	97
2 children 0 son	53.9	43.1	100.0	33.6	17.0	56.0	27.0	49
3 children 3 sons	0.0	0.0	0.0	0.0	0.0	0.0	0.0	6

3 children 2 sons	67.7	0.0	0.0	51.7	0.0	25.4	16.3	22
3 children 1 son	81.6	0.0	100.0	17.1	4.6	4.6	0.0	19
3 children 0 son	95.1	0.0	100.0	4.9	10.8	10.8	10.8	9
4+ children 2+ sons	85.2	0.0	0.0	89.0	79.5	14.8	5.2	15
4+ children 1 son	100.0	0.0	100.0	100.0	0.0	0.0	0.0	4
4+ children 0 son	100.0	0.0	0.0	93.5	6.5	6.5	6.5	2
Block								
Md. Bazar	42.2	11.2	15.6	42.1	36.2	67.9	33.0	65
Suri-1	19.1	11.8	11.5	39.0	26.2	77.6	16.8	53
Saithia	39.8	0.0	18.0	55.5	15.0	37.6	0.6	37
Total	35.3	5.1	16.0	48.8	22.0	53.4	11.1	155

4.5 Advice on the use of modern spacing methods

Apart from medical and paramedical personnel, women also sought advice from their husbands, mothers in law, mothers, friends, relatives and neighbours about the adoption of correct family planning methods. Table 4.6 clearly indicates that 84% of women have strong inclination towards seeking advice from their husbands about the use of modern spacing methods, while 57% of the women adopt their own modern reversible methods to delay conception. It seems that women were somewhat reluctant to seek advice from the medical and para-medical personnel which includes public or private doctor, anganwadi, MPW, ANM and ASHA workers (43%) about the correct modern spacing methods that they could have adopted.

Table 4.6 Persons given advice regarding modern reversible method (N: 506)

Background Characteristics	Medical/Para-medical Personnel	Husband	Wife	Mother in law	Mother	No. of women
Age						
15-24	44.5	80.5	51.3	13.6	6.7	160
25-34	41.6	81.6	60.6	3.6	6.3	242
35-44	41.9	89.7	57.0	3.2	2.7	104
Women education						
Illiterate	68.4	73.9	50.1	8.0	8.0	114
Primary	52.2	71.7	34.1	4.0	6.0	72
Middle	43.5	86.4	56.3	6.0	4.7	158
>middle	27.9	88.6	65.5	7.3	4.6	162
Men education						
Illiterate	66.0	73.1	65.7	9.4	7.5	85
Primary	62.7	68.3	34.2	1.2	12.8	83
Middle	32.5	91.1	44.0	8.1	5.1	96
>middle	36.1	86.3	64.1	6.3	3.5	242

SRC						
Hindu SC	56.7	70.4	49.4	12.8	13.2	161
Hindu ST	66.9	84.4	70.0	3.0	0.4	55
Hindu other/Other minority	29.4	93.1	57.9	4.6	2.8	203
Muslim	37.3	59.7	53.0	1.8	0.8	87
Women work						
Primary	74.1	68.1	50.9	9.4	9.3	117
Self-employed/tertiary	22.0	72.7	76.0	13.1	5.4	67
Not working	32.9	91.4	56.1	4.6	3.8	322
Men work						
Primary/not working	59.3	78.3	47.2	6.3	6.2	257
Self-employed/tertiary	30.2	87.3	63.7	7.0	4.9	249
Media exposure						
Regular	36.5	88.1	59.6	6.1	4.6	316
Irregular	54.6	74.5	50.9	7.7	7.1	190
Wealth index						
Poor	59.3	74.2	45.1	4.9	6.2	124
Middle	53.7	77.5	51.3	13.0	9.4	156
Rich	30.1	90.4	64.3	4.6	3.3	226
Block						
Md. Bazar	53.0	76.9	51.4	3.4	0.0	159
Suri-1	52.2	86.7	61.7	5.8	11.1	197
Saithia	36.4	83.8	55.9	7.8	4.5	150
Total	42.6	83.5	56.7	6.7	5.4	506

The variation across background characteristics shows that 9 out of 10 women from richer wealth quintile consulted their husbands, while only 3 out 10 women from the above group went to medical personnel regarding the adoption of correct modern spacing method. Greater proportion of illiterate women sought advice from medical personnel (68%), while 89% of educated women consulted their husbands about adopting spacing methods. Lesser proportion of Muslim women went to the medical personnel (37%) and majority of the Hindu upper caste women consulted their husbands (93%) while adopting reversible methods.

4.6 Final decision in the adoption of modern spacing methods

Final decision regarding choice of contraception is an important indicator of the extent of gender equality in household decision-making. Table 4.7 depicts the final decision-making in contraceptive choice by background characteristics. It highlights the fact that although husbands alone are the final-decision maker regarding contraceptive choice (about 74%), a substantial proportion of respondents also have reported that they have participated in the

decision-making along with their husbands (about 62%). However, a handful of women decided on their own regarding the use of spacing methods (8%).

Table 4.7 Final decision to use modern reversible method (N: 506)

Background Characteristics	Wife	Husband	Together Husband & Wife	Mother /Mother in law	No. of women
Age					
15-24	5.9	71.4	58.3	2.6	160
25-34	9.0	70.2	61.5	0.0	242
35-44	2.3	75.6	52.8	0.0	104
Women education					
Illiterate	6.3	67.2	51.8	0.1	114
Primary	11.4	79.1	48.8	0.0	72
Middle	9.8	63.5	64.9	2.6	158
>middle	2.0	79.1	58.0	0.0	162
Men education					
Illiterate	9.5	62.6	49.8	0.0	85
Primary	5.7	68.2	56.6	0.0	83
Middle	6.7	74.7	62.3	3.7	96
>middle	5.0	74.5	58.9	0.0	242
SRC					
Hindu SC	8.2	49.6	66.0	2.8	161
Hindu ST	9.0	67.0	67.9	0.0	55
Hindu other/Other minority	3.5	87.2	51.9	0.0	203
Muslim	14.2	59.8	51.3	0.2	87
Women work					
Primary	6.4	58.5	54.9	3.1	117
Self-employed/tertiary	0.9	62.5	89.9	0.1	67
Not working	6.8	79.1	54.6	0.0	322
Men work					
Primary/not working	10.0	62.4	57.8	1.9	257
Self-employed/tertiary	3.3	79.2	58.3	0.0	249
Media exposure					
Regular	5.2	75.0	62.1	0.0	316
Irregular	7.9	66.4	50.3	2.4	190
Wealth index					
Poor	7.3	64.6	64.8	0.0	124
Middle	3.9	65.5	53.1	3.4	156
Rich	6.6	78.4	57.3	0.0	226
Block					
Md. Bazar	14.6	68.8	20.4	0.0	159
Suri-1	2.9	99.8	98.3	0.0	197
Saithia	5.4	62.1	51.5	1.3	150
Total	7.9	73.7	61.9	0.4	506

Looking across the selected background characteristics, a significant variation was observed across the socio-religious group regarding decision-making in contraceptive method choice. 87% of the Hindu upper caste women accept husband's final approval of modern reversible contraceptive use, while two-third of women belonging to the Muslim community reported that their husband took the final decision regarding choice of reversible contraceptive methods (60%). 65% of the women from poor wealth quintile reported that they together with their husbands took the final decision, while around 78% of the women from the rich wealth quintile reported that their husbands were final decision maker regarding choice of method. The above Table also depicts the fact that not only the partners were actively involved in decision making but also a significant extent of women's participation in contraceptive decision making does exist in the study population.

4.7 Husband opposition on the use of modern spacing methods

Although partners actively participated in the contraception decision making yet a total of 136 husbands did not take the final decision to adopt modern spacing methods. However, majority of them did not oppose their partner to the use of such family planning methods. Women did not report any case of husbands' opposition at the Md. Bazar block.

Table 4.8 Husband oppose to use modern reversible method (N: 136)

Background Characteristics	Husband Oppose	No. of women
Age		
15-24	7.3	40
25-34	6.4	68
35-44	20.3	28
Women education		
Illiterate	0.0	31
Primary	24.9	17
Middle	4.5	47
>middle	20.1	41
Men education		
Illiterate	7.0	21
Primary	3.7	24
Middle	2.2	24
>middle	16.1	67
SRC		
Hindu SC	5.3	52
Hindu ST	0.0	23
Hindu other/Other minority	23.8	36
Muslim	11.6	25

Women work		
Primary	3.7	40
Self-employed/tertiary	8.2	15
Not working	15.4	81
Men work		
Primary/not working	2.3	85
Self-employed/tertiary	20.5	51
Media exposure		
Regular	12.3	84
Irregular	7.0	52
Wealth index		
Poor	7.7	40
Middle	4.8	35
Rich	15.2	61
Block		
Md. Bazar	0.0	60
Suri-1	18.5	4
Saithia	12.0	72
Total	5.1	136

Across the background characteristics, the husbands' opposition is the most among the Hindu upper caste (24%), older women (20%), belonging to the rich wealth index (15%), among the not-working women (15%) and among primary level educated women (25%).

4.8 Morbidity due to the use of modern reversible method

Women who are using the modern spacing methods including pill, IUD, injectables etc. may face some of the common problems such as headache, body ache, nausea etc. Table 4.9 gives the proportion of women who faced health problems due to the usage of modern reversible methods. It may be noted that the ailments reported here are not clinically diagnosed and simply based on 'self-reporting'. 27% of the women reported that they have faced some problems while using or adopting spacing methods. Headache was the most common health problem (64%) faced by the rural women of three Birbhum blocks, followed by inability to work (39%), body ache (26%) and nausia (25%).

Table 4.9 Morbidity due to the use of modern reversible method (N: 145)

Background Characteristics	Any problem	Inability to Work	Body Ache	Head-ache	Vomit	Cramps	No. of women
Age							
15-24	19.6	35.6	11.7	77.5	35.1	10.3	38
25-34	30.2	40.9	20.9	62.4	16.2	13.9	77
35-44	29.4	39.2	46.0	55.7	29.0	33.5	30

Women education							
Illiterate	39.7	32.2	21.8	72.7	38.0	19.8	37
Primary	14.7	33.0	11.8	90.8	3.3	10.7	15
Middle	27.7	38.9	22.9	61.6	20.1	7.0	42
>middle	22.7	45.9	35.7	54.7	21.5	31.0	51
Men education							
Illiterate	44.9	30.6	14.8	66.8	50.8	19.1	28
Primary	18.0	30.3	24.2	72.2	8.4	7.8	16
Middle	23.3	42.6	12.2	77.4	19.4	16.6	31
>middle	24.4	43.6	39.0	55.4	15.0	21.7	70
SRC							
Hindu SC	29.3	49.4	18.7	87.5	23.5	11.1	42
Hindu ST	28.8	6.8	12.4	57.5	65.6	2.1	18
Hindu other/Other minority	23.7	42.7	39.1	52.8	16.3	25.9	63
Muslim	34.5	31.7	5.2	40.8	3.5	43.7	22
Women work							
Primary	33.2	31.6	20.2	70.6	39.7	19.7	34
Self-employed/tertiary	19.5	55.1	9.0	56.5	11.8	3.4	22
Not working	25.0	41.3	31.8	61.1	17.9	20.5	89
Men work							
Primary/not working	31.2	28.8	20.8	67.4	33.3	11.9	69
Self-employed/tertiary	23.2	49.5	32.0	60.4	15.9	26.1	76
Media exposure							
Regular	25.4	39.8	32.0	58.0	18.3	18.3	93
Irregular	28.9	38.0	16.9	73.9	35.3	20.4	52
Wealth index							
Poor	36.7	26.6	10.4	59.9	28.5	18.9	40
Middle	23.6	54.4	28.9	87.8	24.8	9.2	39
Rich	23.4	41.1	36.6	55.8	21.7	23.6	66
Block							
Md. Bazar	18.9	8.2	13.5	59.6	0.0	0.0	35
Suri-1	35.4	58.6	28.9	68.6	11.1	30.7	62
Saithia	25.0	34.1	27.4	62.0	36.4	16.1	48
Total	26.6	39.1	26.4	63.9	24.6	19.0	145

Substantial variations in reporting of contraceptive morbidity were observed according to the background characteristics of the respondents. Although older women are more likely to report any contraceptive morbidity, younger women below the age of 24 years faced more headache (78%) and nausea (35%) compared to others when they adopted the said spacing methods. However, majority of women of old age faced the problem of headache (56%) and body ache (46%). Around 4 out of 10 illiterate women reported problems using modern spacing methods. Muslim women were most likely to report any contraceptive morbidity compared to others (35%). Women from the poor wealth quintile (37%) and women who

engaged in primary sector (33%) are more likely to report such ailment compared to others. A little less than one-fifth of the women in Md. Bazar block reported any problem (19%) and 6 out of 10 women of the same block have the problem of headache (60%). However, one-fourth of the women in Saithia faced any problem (25%) and reporting of headache was found to the highest (62%) among the respondents.

4.9 Treatment-Seeking behaviour for contraceptive morbidity (modern reversible method)

Treatment of morbidity arising due to use of modern spacing methods is another important indicator to assess the quality of programme. Table 4.10 shows the proportion of respondents who sought any treatment from various sources viz. public, private qualified and private un-qualified for contraceptive morbidity. Among the 145 respondents who faced any problem for using spacing methods, only 37% sought any treatment. The main source in receiving treatment was from the private unqualified providers (56%). However, a significant proportion of women received treatment for contraceptive morbidity from government hospitals or clinics (40%).

Table 4.10 Treatment Sought for contraceptive morbidity (modern reversible method)

(N: 52)

Background Characteristics	Any treatment	Public	Private	Private unqualified	No. of women
Age					
15-24	37.4	48.0	0.0	58.7	12
25-34	38.1	46.1	12.4	47.2	30
35-44	34.4	24.4	8.6	66.9	10
Women education					
Illiterate	25.3	33.9	15.4	66.1	10
Primary	5.0	100.0	0.0	0.0	3
Middle	36.4	50.7	0.0	48.5	17
>middle	51.0	35.0	11.3	57.1	22
Men education					
Illiterate	37.6	25.0	11.2	75.0	11
Primary	36.1	92.9	0.0	7.1	4
Middle	19.3	56.2	0.0	43.8	11
>middle	43.8	38.2	9.6	54.7	26
SRC					
Hindu SC	28.1	42.0	11.8	58.0	13
Hindu ST	48.7	13.7	0.0	86.3	5
Hindu other/Other	39.1	44.0	10.9	47.9	21

minority					
Muslim	38.2	77.4	0.0	22.6	13
Women work					
Primary	36.1	35.7	9.2	64.3	10
Self-employed/tertiary	44.5	89.4	0.0	10.6	10
Not working	36.3	35.8	9.1	57.4	32
Men work					
Primary/not working	41.5	37.5	6.8	62.5	23
Self-employed/tertiary	32.1	42.5	9.6	50.3	29
Media exposure					
Regular	38.6	45.6	12.6	48.3	34
Irregular	33.8	30.1	0.0	69.9	18
Wealth index					
Poor	31.1	32.2	10.6	67.8	11
Middle	30.3	59.2	17.0	23.8	14
Rich	43.8	38.5	4.5	59.5	27
Block					
Md. Bazar	9.4	71.9	0.0	18.7	5
Suri-1	31.9	64.7	0.0	41.2	24
Saithia	44.4	29.5	11.9	62.7	23
Total	36.8	40.3	8.3	55.6	52

It was found that education plays a significant role in obtaining treatment for the problem faced by the respondents. Compared to the illiterate women, educated women are twice more likely to receive any treatment for such ailments (51% among educated against 25% among illiterate). However, a substantial proportion of women irrespective of their educational attainment sought treatment from unqualified providers. Variations were also observed across the socio-religious community in seeking treatment. It was observed that majority of the Hindu upper caste respondents sought any treatment (39%). Women involved in the tertiary sector or self-employed (45%) were the most who received treatment and among them almost 90% received it from public sources. It was also observed that a greater proportion of women from the richer wealth quintile (44%) sought any treatment for contraceptive morbidity.

4.10 Level of satisfaction after receiving treatment for contraceptive morbidity

As depicted in Table 4.11, more than 35% of the respondents who sought treatment for contraceptive morbidity due to the use of modern spacing methods rated the treatment as very good. Majority of the women who rated treatment as very good were from Md. Bazar block (65%) followed by Suri-1 (55%) and Saithia (27%).

Table 4.11 Level of satisfaction after seeking treatment of contraceptive morbidity

(N: 52)

Background Characteristics	Very Good	Good	Not so good/Bad	No. of women
Age				
15-24	14.4	43.9	41.8	12
25-34	37.3	30.9	31.8	30
35-44	49.0	36.9	14.1	10
Women education				
Illiterate	19.7	48.6	31.7	10
Primary	68.4	31.6	0.0	3
Middle	24.8	51.6	23.6	17
>middle	47.8	20.0	32.2	22
Men education				
Illiterate	12.8	35.2	52.0	11
Primary	22.9	77.1	0.0	4
Middle	36.8	56.0	7.2	11
>middle	46.8	27.1	26.1	26
SRC				
Hindu SC	12.0	33.8	54.2	13
Hindu ST	13.7	44.9	41.4	5
Hindu other/Other minority	59.5	27.1	13.4	21
Muslim	2.9	77.8	19.3	13
Women work				
Primary	11.7	47.8	40.5	10
Self-employed/tertiary	45.8	18.6	35.6	10
Not working	46.4	31.6	22.0	32
Men work				
Primary/not working	11.4	46.3	42.3	23
Self-employed/tertiary	53.6	27.5	18.9	29
Media exposure				
Regular	45.5	32.8	21.7	34
Irregular	15.2	41.4	43.5	18
Wealth index				
Poor	11.8	38.7	49.5	11
Middle	40.0	56.2	3.8	14
Rich	45.5	27.7	26.8	27
Block				
Md. Bazar	64.5	35.5	0.0	5
Suri-1	54.5	23.5	22.0	24
Saithia	26.5	40.5	33.0	23
Total	35.2	35.7	29.1	52

It may be observed from the Table that a greater proportion of the older women (49%), women belonging to the Hindu upper caste (60%) and richer section of women (46%)

reported that they were completely satisfied with the treatment they received from the healthcare centres. Further, majority of the Muslim women (78%) and respondents from the middle wealth quintile reported the treatment obtained by them as good. However, it is worth noting that more than half of the women belonged to the SC community (54%) and women from the poorer section of the society (50%) reported that the quality of treatment was not so good.

4.11 Satisfaction using modern reversible method

Table 4.12 demonstrated the level of satisfaction among users of reversible methods of contraception according to the background characteristics. It may be noted that more than half of the women (54%) across the study population reported their absolute satisfaction regarding the particular reversible method they are currently using A greater percentage of women from the Md. Bazar block (59%) were fully satisfied with the use of spacing methods followed by Saithia (54%) and Suri-1 (51%).

Table 4.12 Satisfaction using modern reversible method (N: 506)

Background Characteristics	Fully Satisfied	Partial Satisfied	Not at all Satisfied	No. of women
Age				
15-24	58.6	35.2	6.2	160
25-34	58.5	27.2	14.3	242
35-44	43.6	50.4	6.0	104
Women education				
Illiterate	38.5	54.0	7.5	114
Primary	71.3	26.5	2.2	72
Middle	57.7	28.7	13.6	158
>middle	54.9	36.2	8.9	162
Men education				
Illiterate	40.0	50.4	9.6	85
Primary	70.0	23.8	6.2	83
Middle	59.0	30.8	10.2	96
>middle	53.5	36.9	9.7	242
SRC				
Hindu SC	56.2	33.1	10.7	161
Hindu ST	46.2	49.7	4.1	55
Hindu other/Other minority	54.5	35.0	10.5	203
Muslim	62.5	32.7	4.8	87
Women work				
Primary	49.3	40.1	10.7	117
Self-employed/tertiary	70.1	23.3	6.5	67

Not working	54.1	36.6	9.3	322
Men work				
Primary/not working	51.5	37.5	10.9	257
Self-employed/tertiary	56.5	35.2	8.3	249
Media exposure				
Regular	54.9	35.4	9.7	316
Irregular	53.4	37.7	8.9	190
Wealth index				
Poor	46.7	40.9	12.4	124
Middle	59.5	33.3	7.2	156
Rich	55.6	35.4	9.0	226
Block				
Md. Bazar	59.3	36.3	4.4	159
Suri-1	51.4	28.4	20.2	197
Saithia	54.4	39.2	6.4	150
Total	54.4	36.2	9.4	506

Variations across the selected background characteristics were found to be minimal except for socio-religious community and women's educational attainment. More than half of the illiterate women in the study group (54%) reported that they were partially satisfied with the to use of modern reversible methods. However, more than 7 out of 10 (71%) respondents who attained primary education were fully satisfied with the use of spacing methods. Also, a greater percentage of Muslim women (63%) mentioned that they were fully satisfied using modern spacing methods.

Conclusion

The present chapter has described various aspects related to the use of modern reversible methods in the study population. Although policy documents such as National Population Policy (NPP) of 2000 and National Health Policy (NHP) of 2002 emphasized the need for expansion of the basket of contraceptive choices, particularly of modern reversible methods, our field level experience suggests that it is not entirely happening in the ground. However, it is important to address the unmet need for contraception, particularly for spacing by providing access to safe, effective and reversible methods. Thus, the concerned agency in the government must evaluate the interrelation between policy and practice.

Traditional Methods and Not Using Any Method at Present

Chapter 5

Traditional Methods and Not Using Any Method At Present

<u>Traditional Methods Users</u>

This section tries to explore the demographic and socioeconomic predictors determining the use of traditional methods viz. withdrawal and calendar or rhythm method. It also tries to investigate the reasons for the choice of such methods even if modern spacing methods are accessible and available. Although the use of traditional method is the highest in overall West Bengal in rural as well as in urban areas, its use was found to be less in rural Birbhum and at par with previous surveys (for example, District Level Household and Facility Survey -3, 2007-08). It was found that the contraceptive prevalence rate for traditional method was 6 percent in the study population. In this section the behaviour of the respondents using traditional methods were explored according to the selected background characteristics.

This section also explores the demographic and socioeconomic background characteristics of the currently married women who have never used any modern contraceptive methods. Moreover, the reasons for not adopting any modern family planning methods were also assessed. One of the major aspects was whether women who were using traditional methods were aware of modern method or not, and if informed, what are the contraceptive methods made known to them by the community level health workers.

5.1. Informed choices before traditional method

Current users who have adopted traditional methods were asked whether the community level health workers had informed them about the wide range of modern (spacing or permanent) methods. Table 5.1 represents the proportion of respondents who reported that they were informed about other modern methods of contraception. It was observed that less than half of the women (46%) were kept informed about any modern family planning method and majority of them were belonging to the Md. Bazar block women (55%). The most popular methods informed by the health/family planning workers were pill (93%) followed by condom (77%), IUD (39%) and female sterilization (26%).

Table 5.1 Informed choices before traditional method (N: 105 cases)

Background Characteristics	Any Inform	Female Sterilization	Male Sterilization	Pill	IUD	Injection	Condom	Female Condom	No. of women
Age									
15-24	48.2	12.0	1.4	87.8	34.7	8.9	48.1	1.4	24
25-34	49.3	16.0	6.1	93.9	33.1	22.5	89.4	6.7	45
35-44	41.7	46.2	2.4	94.3	49.1	5.2	80.5	14.2	36
Women education									
Illiterate	53.9	14.1	3.8	94.8	18.2	4.3	55.6	3.8	21
Primary	51.9	28.1	12.7	75.6	31.9	17.7	67.6	30.2	18
Middle	48.6	30.6	1.9	94.1	42.6	19.0	71.6	9.1	31
>middle	41.0	26.6	2.4	95.7	47.0	11.2	90.7	2.9	35
Men education									
Illiterate	53.9	7.7	2.5	97.9	23.7	3.1	45.7	2.5	14
Primary	64.3	25.6	6.3	83.4	13.5	11.7	61.9	17.5	21
Middle	43.4	17.0	4.3	86.4	46.5	12.9	82.1	18.7	21
>middle	42.4	33.9	3.1	96.3	46.8	16.0	85.7	3.0	49
SRC									
Hindu SC	44.4	17.4	3.2	97.8	42.2	7.8	58.1	11.8	40
Hindu ST	53.9	7.3	0.0	92.7	14.6	0.0	38.1	0.0	4
Hindu other/Other minority	46.8	28.8	3.9	90.8	40.7	16.0	90.0	6.3	53
Muslim	39.7	86.7	10.1	76.8	0.0	25.7	25.2	22.6	8
Women work									
Primary	43.7	10.1	3.9	98.4	45.2	5.8	51.2	11.6	19
Self-employed/tertiary	58.8	7.7	3.0	100.0	22.6	20.5	61.7	3.0	7
Not working	45.5	31.3	3.8	90.7	39.7	13.9	83.7	8.0	79
Men work									
Primary/not working	45.4	23.9	2.6	94.8	37.4	6.3	61.0	11.7	54
Self-employed/tertiary	46.6	27.7	4.7	90.9	40.8	19.1	90.2	5.2	51
Media exposure									
Regular	45.1	27.1	4.0	93.3	37.6	13.4	83.9	5.6	73
Irregular	49.4	22.3	2.6	90.5	44.4	12.2	53.0	16.5	32
Wealth index									
Poor	40.8	13.3	0.0	96.3	23.8	2.4	59.6	0.0	18
Middle	47.8	19.1	2.4	89.2	36.7	13.2	70.0	9.4	27
Rich	47.3	33.4	5.6	93.1	45.6	16.7	85.5	10.4	60
No. of living children									
No children	38.9	0.0	0.0	100.0	9.3	43.8	53.1	0.0	3
1 child 1 son	36.5	11.2	3.9	88.8	16.5	30.2	73.4	5.0	28

1 child 0 son	39.5	5.6	2.6	100.0	65.7	6.1	68.3	2.6	10
2 children 2 sons	60.4	2.0	2.0	100.0	38.7	8.1	74.0	7.2	15
2 children 1 son	62.4	56.0	4.9	94.1	63.6	3.6	85.4	13.4	21
2 children 0 son	44.2	30.4	4.9	84.7	29.6	7.4	95.0	8.8	12
3 children 3 sons	77.4	25.3	0.0	92.1	0.0	0.0	74.7	0.0	3
3 children 2 sons	28.6	100.0	0.0	0.0	100.0	0.0	0.0	0.0	1
3 children 1 son	28.0	100.0	0.0	100.0	0.0	0.0	0.0	0.0	1
3 children 0 son	58.9	0.0	0.0	100.0	53.9	0.0	54.5	0.0	5
4+ children 2+ sons	48.3	100.0	17.5	67.5	17.5	32.4	35.1	16.8	5
4+ children 1 son	63.5	100.0	0.0	100.0	0.0	0.0	100.0	35.1	1
4+ children 0 son	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0
Block									
Md. Bazar	54.8	31.8	13.9	96.7	31.0	42.2	70.6	35.4	46
Suri-1	48.2	16.3	1.2	90.4	37.6	6.7	89.8	0.5	47
Saithia	38.2	38.1	0.0	93.3	48.5	1.4	58.6	0.0	12
Total	46.0	25.9	3.7	92.7	39.2	13.1	76.6	8.2	105

Majority of the respondents belonging to the young and middle age-groups were kept informed about other modern birth control measures (48.2% among young and 49.3% among middle aged) and majority of them were informed about pill, condom and IUD. More than half of illiterate women (54%) were kept informed about modern methods. A greater proportion of women who have attained middle school education (31%) were informed about female sterilization. However, respondents who attained higher education were informed about modern spacing methods, namely, pill (96%), IUD (47%) and condom (91%). Muslims were the least informed by the health workers about contraceptive methods (40%), though a majority of them (88%) reported that they were informed about female sterilization by the health workers. However, a greater proportion of Hindu upper caste were informed about pill (91%) followed by condom (90%). A little less than two-third (59%) of the respondents engaged in tertiary sector activities or self-employed were advised to adopt any modern methods and the information regarding pill was universal (100%). It is important to note that women belonging to the poorer sections have reported to be least informed about any modern use compared to the better-off (41%).

5.2. Reasons for not using any modern methods (currently/previously)

Table 5.2 depicts the major reasons reported by the current users of traditional methods for not using any modern family planning methods (currently or previously). Around 42% reported 'other' reasons which include shortage of supply, difficulty in access, hard to remember, inconvenience, high cost, opposition from husband or family members, infrequent

sex or husband away from home etc. for not using any modern methods currently. More than 3 out of 10 women (33%) stated reasons related to fertility and 25% mentioned fear of side effects.

Table 5.2 Reasons for not currently/previously using modern method (N: 234 cases)

Background Characteristics	Birth related	Side-effect related	Others reasons	No. of women
Age				
15-24	34.7	11.9	53.4	56
25-34	37.0	26.6	36.4	97
35-44	28.4	30.1	41.5	81
Women education				
Illiterate	40.7	16.1	43.2	51
Primary	47.3	15.7	37.0	33
Middle	40.0	16.9	43.1	62
>middle	23.6	33.8	42.5	88
Men education				
Illiterate	38.6	18.3	43.1	35
Primary	57.1	12.3	30.6	33
Middle	32.7	14.5	52.8	48
>middle	28.0	32.0	40.0	118
SRC				
Hindu SC	42.6	9.9	47.5	87
Hindu ST	62.7	37.3	0.0	9
Hindu other/Other minority	27.6	32.0	40.4	115
Muslim	13.2	21.1	65.6	23
Women work				
Primary	46.9	13.4	39.5	37
Self-employed/tertiary	45.4	23.7	30.8	21
Not working	28.9	27.3	43.7	176
Men work				
Primary/not working	46.8	16.1	37.1	112
Self-employed/tertiary	20.9	32.4	46.7	122
Media exposure				
Regular	35.2	22.3	42.5	165
Irregular	25.4	33.6	41.0	69
Wealth index				
Poor	44.5	16.7	38.8	46
Middle	44.7	19.3	36.0	68
Rich	23.2	30.4	46.4	120
No. of living children				
No child	18.2	0.0	81.8	8
1 child 1 son	30.6	29.3	40.1	64
1 child 0 son	28.7	20.7	50.7	31
2 children 2 sons	59.7	2.1	38.2	23

2 children 1 son	38.3	36.9	24.8	45
2 children 0 son	23.8	26.0	50.2	24
3 children 3 sons	71.3	10.7	13.0	5
3 children 2 sons	19.4	31.2	49.4	5
3 children 1 son	27.9	17.2	54.8	7
3 children 0 son	26.3	18.5	55.2	7
4+ children 2+ sons	8.5	48.3	43.3	10
4+ children 1 son	63.5	0.0	36.5	4
4+ children 0 son	0.0	0.0	100.0	1
Block				
Md. Bazar	14.1	40.8	45.2	80
Suri-1	38.1	19.4	42.5	127
Saithia	36.6	23.2	40.1	27
Total	33.1	24.7	42.2	234

There was not much variation according to background characteristics except for women's age, affiliation to socio-religious community, employment and wealth quintile. More than half of the women (53.4%) below 24 years, 66% of women from minority group, 44% of the women who were not engaged in any work and women from the richer wealth quintile (46%) tend to report reasons other than fertility and side-effects. However, a greater proportion of respondents from the poor (46%) and middle (46%) wealth quintile mentioned want of children as the reason. A greater proportion of women belonging to the Hindu ST (63%) reported birth-related reasons.

5.3. Persons advice to use traditional methods

Table 5.3 clearly indicates that almost 81% of the women received advice from their husbands and 66% of the women themselves have strong inclination towards using traditional methods. 3 out of 10 respondents (30%) (Those who were currently using traditional methods) went to the medical/para-medical personnel to seek advice about the use of traditional methods. Medical/para-medical personnel include doctor (public/private), *anganwadi* workers, MPW, ANM and ASHA workers. 11% of the respondents mentioned 'other' persons such as relatives, friends, *dai*, NGO workers etc. also advised them to use traditional methods.

Table 5.3 Persons advice traditional method (N: 234 cases)

Background Characteristics	Medical/ para- medical personn	Husba nd	Wife	Mother in law	Mother	Other	No. of women

	el						
Age							
15-24	44.6	89.7	56.2	2.0	8.5	12.7	56
25-34	37.0	87.1	69.9	1.5	8.1	9.6	97
35-44	15.7	71.7	68.0	5.3	1.4	12.1	81
Women education							
Illiterate	24.4	79.0	61.3	6.3	9.8	14.1	51
Primary	58.1	65.7	52.9	0.0	1.3	18.5	33
Middle	44.0	84.1	51.5	3.7	3.6	12.9	62
>middle	17.7	84.4	79.0	2.6	6.4	7.9	88
Men education							
Illiterate	18.5	78.5	73.3	8.2	12.8	19.8	35
Primary	61.8	73.1	49.9	1.5	1.4	17.4	33
Middle	39.2	74.4	43.9	2.0	6.6	13.4	48
>middle	23.5	86.3	76.1	2.9	4.6	7.7	118
SRC							
Hindu SC	40.0	75.9	46.4	7.9	7.4	19.0	87
Hindu ST	28.4	66.6	84.3	0.0	0.0	15.7	9
Hindu other/Other minority	26.4	86.0	75.7	0.9	5.1	6.7	115
Muslim	6.7	65.9	61.6	0.0	0.0	19.4	23
Women work							
Primary	37.5	83.2	48.3	5.1	7.3	16.0	37
Self-employed/tertiary	47.3	52.9	57.6	0.0	10.8	17.3	21
Not working	27.2	83.6	70.8	2.9	4.7	9.7	176
Men work							
Primary/not working	37.3	76.7	50.9	3.1	3.8	12.1	112
Self-employed/tertiary	24.0	85.9	79.7	3.1	7.1	10.5	122
Media exposure							
Regular	31.8	83.5	66.9	2.0	4.6	11.3	165
Irregular	24.7	74.7	63.4	6.9	8.8	11.2	69
Wealth index							
Poor	43.2	82.1	46.5	6.2	7.9	18.7	46
Middle	47.6	75.7	60.1	1.7	4.6	8.1	68
Rich	17.1	84.1	76.6	2.6	5.1	9.8	120
Block							
Md. Bazar	20.3	78.7	71.0	0.8	0.8	12.0	80
Suri-1	42.6	83.8	74.5	4.0	11.5	10.9	127
Saithia	18.8	80.2	51.9	3.2	0.0	11.3	27
Total	24.8	79.5	66.7	3.0	6.4	16.7	234

A greater proportion of younger women (below 24 years) received advice from their husbands (90%) or consulted the medical/ para-medical personnel (45%). Majority of the higher educated women either consulted their husbands (84%) or decided themselves (79%). Muslim women were the least to consult medical/para-medical personnel compared to their counterparts belonging to other socio-religious affiliations (7%). However, a majority of the

Hindu upper caste women (86%) consulted their husbands. Irrespective of the household affluence, women consulted mainly their husbands regarding the current use of contraceptive methods. It may be noted that a greater proportion of women from the Suri-1 block consulted the health workers regarding such method (43%).

5.4 Final decision to use traditional method

Table 5.4 shows that husband's approval regarding the use of family planning methods by the wives' was nearly universal. In majority of the cases final decision to adopt traditional methods was taken by the husband (84%) followed by husband and wife together (67%). It is evident from the table that couples relied on their own regarding the use of traditional methods, unlike adoption of other modern methods where mother, mother-in-law, relatives, friends etc. also participated as final decision makers.

Table 5.4 Final decision to use traditional method (N: 234)

Background Characteristics	Wife	Husband	Together Husband & Wife	No. of women
Age				
15-24	3.0	81.5	66.4	56
25-34	2.6	96.5	65.8	97
35-44	6.9	73.3	67.9	81
Women education				
Illiterate	6.6	82.2	81.6	51
Primary	10.8	73.5	59.5	33
Middle	4.9	84.7	59.3	62
>middle	2.0	86.5	68.5	88
Men education				
Illiterate	5.0	77.9	84.6	35
Primary	7.2	71.9	68.6	33
Middle	8.4	81.7	50.6	48
>middle	2.3	88.1	69.4	118
SRC				
Hindu SC	5.3	75.9	68.1	87
Hindu ST	11.8	80.3	62.7	9
Hindu other/Other minority	2.6	89.6	66.9	115
Muslim	23.4	58.7	55.6	23
Women work				
Primary	6.3	81.9	68.2	37
Self-employed/tertiary	0.0	47.3	91.1	21
Not working	4.3	87.6	64.4	176
Men work				
Primary/not working	7.8	79.9	58.8	112

Self-employed/tertiary	1.4	87.7	73.9	122
Media exposure				
Regular	3.0	86.8	60.4	165
Irregular	9.3	73.9	57.7	69
Wealth index				
Poor	3.2	88.0	73.1	46
Middle	7.8	75.5	63.7	68
Rich	3.3	86.4	65.8	120
Block				
Md. Bazar	17.5	72.6	10.7	80
Suri-1	1.9	97.9	98.1	127
Saithia	0.6	71.1	54.5	27
Total	4.4	84.0	66.8	234

Across the selected background characteristics it may be observed that 67% of young women, 87% of the respondents who attended higher level of education, 90% of women from the Hindu upper caste and 88% of women belonging to poorer households followed their husbands final decision to use traditional methods. 56% of the couples from Muslim community together took the final decision. However, a greater proportion of women from minority community (23%) decided themselves. One important fact to report here is that there was no incidence of husband's opposition to use traditional methods.

5.5 Problem faced due to the use of traditional methods

Out of 234 women ever used traditional methods, only 24 of them faced problem. In Table 5.5 numbers were depicted.

Table 5.5 Problem faced due to the use of traditional methods (N: 24)

Components	Yes	No. of Women
Any problem	24	234
Lack of skill to withdraw	14	24
Lack of knowledge about safe period	13	24
Got pregnant	19	24
Once	18	19
More than Once	1	19
Induced Abortion	2	19
Private Hospital	1	2

Private Doctor	1	2

14 women reported that their husbands lacked the skill to withdraw at the appropriate time during climax. 13 women mentioned that they do not have correct knowledge about safe (infertile) period. Out of 24 women who faced any difficulty, 19 of them got pregnant. 18 women conceived for once and one woman became pregnant more than once. 2 women out of 19 did go for induced abortion to a private source (1 at private nursing home and 1 at private doctor).

5.6 Satisfaction after using traditional method

Table 5.6 shows that 75% of the women following traditional methods were fully satisfied with it. Only 5% reported they were not at all satisfied with the use of traditional methods.

Table 5.6 Satisfaction after using traditional method (N: 234)

Background Characteristics	Fully	Partial	Not at all	No. of women
Age				
15-24	81.7	17.6	0.7	56
25-34	69.9	23.4	6.7	97
35-44	74.9	18.5	6.5	81
Women education				
Illiterate	79.7	19.5	0.9	51
Primary	85.1	14.0	1.0	47
Middle	65.4	25.8	8.8	112
>middle	95.7	4.3	0.0	24
Men education				
Illiterate	86.5	12.4	1.1	35
Primary	93.9	6.1	0.0	33
Middle	73.0	26.3	0.7	48
>middle	69.5	21.8	8.8	118
SRC				
Hindu SC	79.5	20.0	0.5	87
Hindu ST	88.2	7.9	3.9	9
Hindu other/Other minority	70.3	21.5	8.1	115
Muslim	93.0	7.0	0.0	23
Women work				
Primary	84.2	15.1	0.7	37
Self-employed/tertiary	80.4	19.6	0.0	21
Not working	71.8	21.4	6.8	176
Men work				
Primary/not working	67.1	27.2	5.7	112

Self-employed/tertiary	81.1	14.0	5.0	122
Media exposure				
Regular	72.5	21.3	6.2	165
Irregular	81.6	16.3	2.1	69
Wealth index				
Poor	74.9	24.6	0.6	46
Middle	81.4	17.7	0.9	68
Rich	71.1	19.6	9.3	120
Block				
Md. Bazar	70.9	24.6	4.5	80
Suri-1	77.9	17.4	4.7	127
Saithia	71.7	21.7	6.7	27
Total	74.5	20.2	5.3	234

The variation across the selected background characteristics was found to be minimal. 82% of the women from the age group 15-24 years, 93% of Muslim women and 81% of the women belonging to middle wealth quintile mentioned that they were fully satisfied with the use of traditional methods.

5.7 Knowledge of modern methods among those who are the users of only traditional method

Among 1348 cases, we have 79 women who have never used any modern methods. Out of those 79 respondents who followed only traditional methods (withdrawal or calendar/rhythm) 9 of them mentioned that they did not know about any modern methods. However 70 women reported they have knowledge about the use of modern methods.

When they were asked about the source of modern family planning methods, more than half of them (58%) informed that either their husbands informed them or they themselves came to know about such method. A little less than one-fourth (24%) of the women came to know about modern methods from medical/medical personnel which includes doctors, *anganwadi* workers, MPW, ANM and ASHA workers. 18% of women reported that mother, mother-in-law, relatives, friends, *dai*, NGO workers etc. informed them about modern methods.

Table 5.7 Knowledge of modern methods among users of only traditional method

(N: 70)

Background Characteristics	Medical/Para medical personnel	Husband/Wife	Others	No. of women

Age				
15-24	32.5	54.2	13.3	24
25-34	17.1	64.7	18.2	23
35-44	20.8	53.8	25.4	23
Women education				
Illiterate	50.4	35.0	14.6	11
Primary	37.3	13.7	49.0	4
Middle	30.6	59.5	9.9	20
>middle	12.1	66.1	21.9	35
Men education				
Illiterate	57.7	32.2	10.1	9
Primary	41.3	41.3	17.5	9
Middle	38.3	45.6	15.9	8
>middle	11.7	67.9	20.4	44
SRC				
Hindu SC	23.1	60.0	10.9	17
Hindu ST	100.0	0.0	0.0	2
Hindu other/Other minority	17.1	60.1	22.8	41
Muslim	63.5	24.9	11.7	10
Women work				
Primary	43.9	52.5	3.6	8
Self-employed/tertiary	0.0	68.5	31.5	7
Not working	22.9	57.4	19.7	55
Men work				
Primary/not working	38.0	51.6	7.1	28
Self-employed/tertiary	14.8	59.7	25.4	42
Media exposure				
Regular	19.2	61.5	15.5	48
Irregular	35.8	48.7	19.3	22
Wealth index				
Poor	31.4	51.3	17.3	14
Middle	14.9	72.1	13.0	22
Rich	26.2	51.1	22.7	34
Block				
Md. Bazar	29.7	63.7	6.6	33
Suri-1	46.7	52.4	30.9	28
Saithia	27.2	55.0	17.9	9
Total	24.2	57.7	18.1	70

66% of the higher educated women came to know about modern methods either from their husbands or by themselves. However, more than half of the illiterate women (51%) received knowledge form the medical/para-medical staff. A greater proportion of women from the Hindu ST (100%) and Minority community (64%) acquired knowledge from the medical/paramedical personnel. However, two-third of the Hindu upper caste women (60%) came to know about modern methods from either their husbands or by themselves.

5.8 Reasons for not using modern method by women who have never used any modern methods

Table 5.8 depicts the major reasons according to various background characteristics regarding non-use of modern family planning methods among those who have only followed traditional methods. Each of the 24 women reported that they did not adopt modern methods due to fertility considerations, fear of side-effects and reasons related to these modern methods. 17 women also mentioned 'other' reasons and 14 women stated opposition from husbands, family, religion and lack of knowledge about modern methods for not adopting any modern birth control measure.

Table 5.8 Reasons for not using modern method by women who have never used any modern methods (N: 79)

Background Characteristics	Fertility/ Side-effects	Opposition/ Lack of knowledge	Method related	Other reasons	No. of women
Age					
15-24	10	5	10	4	29
25-34	8	2	8	7	25
35-44	6	7	6	6	25
Women education					
Illiterate	5	5	2	2	14
Primary	1	0	2	3	6
Middle	6	2	8	4	20
>middle	12	7	12	8	39
Men education					
Illiterate	5	2	3	1	11
Primary	2	5	2	2	11
Middle	4	0	2	4	10
>middle	13	7	17	10	47
SRC					
Hindu SC	6	4	7	3	20
Hindu ST	2	0	0	1	3
Hindu other/Other minority	12	4	16	11	43
Muslim	4	6	1	2	13
Women work					
Primary	3	1	3	2	9
Self-employed/tertiary	2	3	2	1	8
Not working	19	10	19	14	62
Men work					

Primary/not working	12	6	10	5	33
Self-employed/tertiary	12	8	14	12	46
Media exposure					
Regular	14	9	17	13	53
Irregular	10	5	7	4	26
Wealth index					
Poor	6	3	5	2	16
Middle	10	5	5	5	25
Rich	8	6	14	10	38
No. of living children					
No child	3	1	3	1	8
1 child	15	7	17	10	49
2 children	5	1	4	4	14
3 children	1	1	0	0	2
4+ children	0	4	0	2	6
Block					
Md. Bazar	15	0	15	5	35
Suri-1	5	11	6	12	34
Saithia	4	3	3	0	10
Total	24	14	24	17	79

A greater number of younger women (29) did not follow modern methods and majority of them reported fertility or fear of side-effects (10) and method related (10) problems. A large number of women who attained higher education (39) and women from Hindu upper caste (43) also reported that they did not use modern methods due to fertility or fear of side-effects (12) and method related (12) problems. Women from affluent households did not use modern methods (38) due to method (14) related problems. Women with only 1 living child irrespective of the sex tend not to use any modern methods primarily due to method related reasons (17).

Currently Not Using Any Method

The questionnaire not only deals with the questions related to the behavioural patterns among the respondents who are (were) currently (previously) using (used) any contraceptive methods but also tries to highlight the issues related to those who have never used any contraceptive methods. In this section such facts are being highlighted according to the selected background characteristics. However, while interpreting the results one must keep in mind the very low number of samples.

5.9 Reasons for not using any methods by women who have never used any methods

Out of 1348 respondents surveyed across three blocks of Birbhum district, only 182 women have never used any contraceptive methods. The reasons for not using any method are given in the Table 5.9. It consists of only three major reasons for currently not using any methods, namely, fertility reasons, fear of side-effects of contraceptive methods and opposition from various sources such as from husband or from in-laws, religion or society.

Majority of the respondents reported fertility i.e. desire for more children (48%) as the prime factor for not using any methods followed by 'other' reasons (29%) like opposition from husband, mother mother in law, religion or lack of knowledge about the modern methods (16%) and fear of side-effects (7%). 'Other' reasons include husbands do not stay or stay afar, infrequent sex, no involve in sex, menopause, citing God as the reason, etc. and has been reported by 72% of women of Suri-1 block reported birth related reasons, while 42% of the respondents each from the Md. Bazar and Saithia block cited such reasons.

Table 5.9 Reasons for not using any methods by women who have never used any methods (N: 182 cases)

Background Characteristics	Fertility reasons	Side-effects	Opposition/ Lack of knowledge	Other reasons	No. of women
Age					
15-24	66.6	8.0	7.8	17.6	82
25-34	35.6	4.7	20.1	39.6	51
35-44	30.4	9.3	25.5	34.8	49
Women education					
Illiterate	45.4	11.5	19.1	24.0	76
Primary	71.5	2.0	2.1	24.4	29
Middle	45.9	0.0	11.0	43.1	45
>middle	35.7	12.0	29.6	22.6	32
Men education					
Illiterate	49.8	7.0	21.0	22.3	57
Primary	58.6	9.4	5.9	26.1	39
Middle	58.0	6.2	11.5	24.2	38
>middle	34.3	6.7	18.6	40.5	48
SRC					
Hindu SC	47.9	8.5	16.2	27.4	56
Hindu ST	69.0	5.8	6.1	19.1	49

Hindu other/Other minority	26.8	8.9	20.1	44.2	38
Muslim	38.2	2.7	34.2	24.9	39
Women work					
Primary	49.6	10.0	13.6	26.8	68
Self-employed/tertiary	60.1	0.0	12.3	27.6	21
Not working	43.1	4.9	19.9	32.1	93
Men work					
Primary/not working	52.8	7.3	15.8	24.1	126
Self-employed/tertiary	35.8	7.0	16.7	40.5	56
Media exposure					
Regular	50.1	6.4	14.9	28.6	82
Irregular	46.0	7.7	16.9	29.3	100
Wealth index					
Poor	51.8	8.2	16.7	23.2	70
Middle	45.6	7.8	15.7	30.9	61
Rich	43.3	4.9	15.3	36.5	51
No. of living children					
No child	75.6	6.7	7.3	10.5	68
1 child	46.7	0.0	14.8	38.4	64
2 children	9.5	26.6	31.4	32.6	31
3 children	48.9	0.0	29.4	21.7	8
4+ children	0.0	15.6	22.1	62.3	11
Block					
Md. Bazar	41.9	5.8	28.8	23.4	68
Suri-1	71.9	0.8	5.6	21.7	46
Saithia	42.4	10.0	13.3	34.2	68
Total	47.8	7.2	16.1	29.0	182

According to the background characteristics, a greater percentage of young women in between the age of 15 to 24 years of age (67%), illiterate women (45%), women belonging to Hindu ST (59%) and also from Hindu upper caste (58%) and women from the poorer households (52%) mentioned birth-related reasons such as they have not yet conceived, they want more children etc. However, although 38% of the women from the Muslims community reported fertility reasons, 34% of Muslim women reported opposition from husbands, in-laws, society or religion to use any birth control measures. A greater proportion of the older women from 35 to 44 years of age (35%) reported 'other' reasons for not using any contraceptive measure.

5.10 Future intension to use modern methods among the women who have never used any methods

The respondents were also asked whether they are interested in using any modern contraceptive methods in near future or not. Out of 182 respondents, only 30 of them reported that they would adopt modern methods in future, while 68 women stated 'no' to use any modern methods in future also and 44 women have not decided as yet. Also, 41 respondents reported that they either had menopause or do not have any child yet. Fig 5.1 shows a diagram indicated the above stated facts.

Fig. 5.1 Future intension to use modern methods among the women who have never used any methods (N: 182)
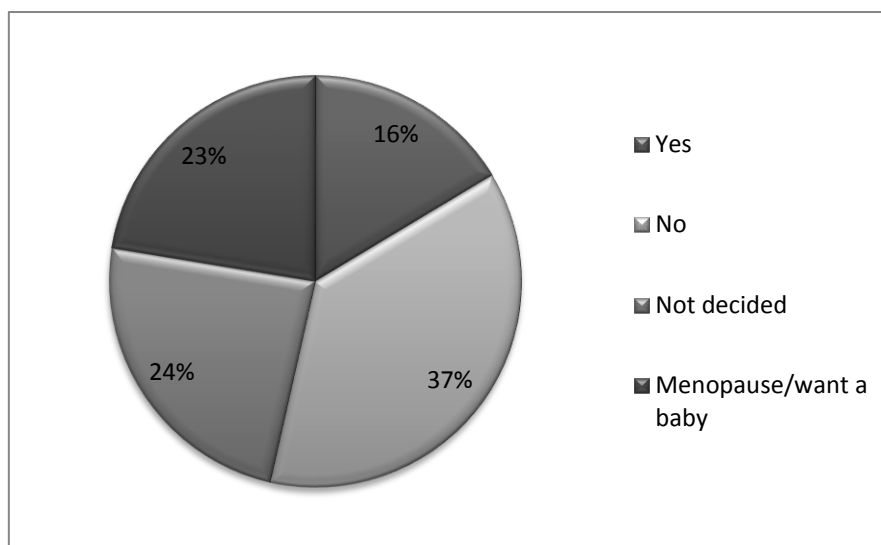
Women, who stated that they would use modern methods in future, were also asked about whether they would use any modern permanent or modern reversible methods. Out of 30 women 20 reported that they will use spacing methods in future and the remaining mentioned limiting methods. Also, respondents were asked after how many months would adopt their selected methods. It was divided into 2 intervals - one is within 1 year and another is after 1 year. Out of 30 respondents, 10 of them decided to use within one year, 5 of them wished to adopt methods after one year and 15 of them have not yet decided. Since the numbers of respondents are less, so percentage couldn't be reported in Table 5.10.

Table 5.10 Future intension to use modern methods among women who have never used any methods (N: 30)

Background Characteristics	Spacing	Limiting	<12 Months	>12 Months	Undecided	No. of women
Age						

15-24	6	13	6	3	10	19
25-34	4	6	4	2	4	10
35-44	0	1	0	0	1	1
Women education						
Illiterate	3	8	5	2	4	11
Primary	2	7	4	1	4	9
Middle	5	5	1	2	7	10
>middle	0	0	0	0	0	0
Men education						
Illiterate	3	6	5	2	2	9
Primary	3	5	3	0	5	8
Middle	2	1	1	0	2	3
>middle	2	8	1	3	6	10
SRC						
Hindu SC	5	6	4	3	4	11
Hindu ST	0	9	4	1	4	9
Hindu other/Other minority	3	3	1	1	4	6
Muslim	2	2	1	0	3	4
Women work						
Primary	5	11	6	4	6	16
Self-employed/tertiary	1	1	0	0	2	2
Not working	4	8	4	1	7	12
Men work						
Primary/not working	6	15	8	4	9	21
Self-employed/tertiary	4	5	2	1	6	9
Media exposure						
Regular	4	8	4	3	5	12
Irregular	6	12	6	2	10	18
Wealth index						
Poor	5	10	5	2	8	15
Middle	3	6	3	3	3	9
Rich	2	4	2	0	4	6
Block						
Md. Bazar	5	6	6	1	4	11
Suri-1	2	2	0	2	2	4
Saithia	3	12	4	2	9	15
Total	10	20	10	5	15	30

It may be noted that variations according to background characteristics in reporting were found to be minimal since the total number of cases were very low.

Conclusions

As mentioned earlier, the users of traditional method were found to be low in our sample as found in the Birbhum district as a whole by the national level surveys. Thus, it would be wise not to generalize the interpretations. Among the users of traditional method, it was observed that less than half of the respondents were informed by the health workers about any modern spacing method. The information mainly provided to the respondents confined itself to oral pill and condom. Fear of side-effects regarding the use of modern spacing methods among respondents needs to be addressed by the programme planners. Those who do not have any intention to use any contraceptive measures need appropriate counselling regarding necessity to adhere to small family norms.

CHAPTER 6

Modern Permanent Methods

Chapter 6

Modern Permanent Methods

As mentioned in the earlier chapters, permanent method of family planning, especially, female sterilization i.e. tubectomy, dominated Indian Family Planning Services. This section deals with the adoption of modern permanent methods by either couple. Sterilization is considered as a permanent method of birth control that a man or woman adopts. It has been regarded as full-proof measure of birth control and theoretically the safest measure. However, sterilization, or a tubal ligation, for women and vasectomy for men can sometimes be reversed. It has been observed from the data that it is the most popular method adopted by either of the couple as a birth control measure. Among 88% of the respondents mentioned to have currently used any family planning methods, 63.4% of the women have undergone female sterilization and 0.6% of the respondents' partner did male sterilization.

The women were asked about the type of sterilization they undergone in order to stop child bearing permanently. Out of 766 women who underwent sterilization, 756 reported to adopt tubectomy and 7 of them adopted hysterectomy procedure. However, 3 women were unaware about the procedure of sterilization. Since our study group consisted of currently married women from 15 to 44 years of age, questions regarding male sterilization were asked, that is whether their husband or current partner had undergone vasectomy operation and also about the nature of vasectomy operation. 3 of the respondents whose partner had undergone male sterilization reported that all of them had undergone regular vasectomy and no one performed non-scalpel vasectomy (NSV). The mean age of women at the time of sterilization as reported in the earlier chapter was approximately 23 years and the mean age of men at the time of vasectomy was approximately 29 years.

In the following analysis female and male sterilization are combined and we find that altogether 769 persons (766 women and 3 males) adopted modern permanent method.

6.1 Time and place of sterilization

Table 6.1 includes information about the time and place where the respondents underwent sterilization operation. Nearly than two-third of the respondents (64%) have undergone sterilization soon after childbirth or after spontaneous abortion. Almost half of the respondents (50.4%) have undergone sterilization at the place where their last child was born.

It was found that 75% of the respondents at the Md. Bazar block have undergone sterilization soon after child birth or pregnancy wastage and majority of them (73%) have undergone sterilization at the place where their last child was born. However, 55% of the respondents in Suri-1 block underwent sterilization at any other time which was not related to childbirth or pregnancy. When the question was asked about the place of sterilization, 61% reported that they went to the Rural Hospital for sterilization. While 17% of the respondents went to either District or Sub-Divisional Hospital, 16.6% went to Primary Health Centres. It implies that the majority of the respondents utilized public facility to undergo sterilization.

Table 6.1 Time and place of sterilization (N: 769)

Background Characteristics	Time		Place				Sterilised at the place of last child birth		No. of obs
	After delivery/Wastage	Other time	Rural Hospital	District/ Subdivisional Hospital	PHCs	Other	Yes	No	
Age									
15-24	47.5	52.5	62.8	17.5	14.6	5.1	47.6	52.4	99
25-34	64.9	35.1	58.3	17.1	18.1	6.5	49.3	50.7	323
35-44	66.8	33.2	62.8	17.1	15.9	4.3	51.9	48.1	347
Women education									
Illiterate	64.6	35.4	59.4	17.7	20.4	2.5	50.6	49.4	351
Primary	60.6	39.4	65.8	12.2	18.8	3.2	46.3	53.7	132
Middle	60.6	39.4	58.4	20.1	14.1	7.4	47.6	52.4	197
>middle	70.6	29.4	64.5	16.1	8.7	10.7	60.6	39.4	89
Men education									
Illiterate	65.1	34.9	61.4	17.2	19.7	1.8	50.7	49.3	267
Primary	61.7	38.3	57.1	13.9	25.1	3.9	45.3	54.7	164
Middle	57.3	42.7	64.2	19.4	13.1	3.2	46.8	53.2	141
>middle	68.6	31.4	60.8	17.5	9.9	11.8	56.8	43.2	197
SRC									
Hindu SC	72.8	27.2	58.3	19.7	19.7	2.3	60.5	39.5	373
Hindu ST	45.1	54.9	65.2	7.2	25.3	2.3	27.4	72.6	100
Hindu other/Other minority	60.5	39.5	64.1	18.0	8.8	9.1	48.3	51.7	235
Muslim	59.1	40.9	33.3	23.5	16.0	27.3	44.9	55.1	61
Women work									
Primary	64.9	35.1	54.6	17.7	25.8	2.0	46.9	53.1	299
Self-	72.9	27.1	65.4	9.1	22.1	3.5	59.9	40.1	82

employed/tertiary									
Not working	60.5	39.5	65.6	18.4	7.5	8.5	51.3	48.7	388
Men work									
Primary/not working	63.1	36.9	58.9	17.8	19.4	3.9	50.0	50.0	492
Self-employed/tertiary	64.3	35.7	64.2	16.1	12.4	7.3	51.0	49.0	277
Media exposure									
Regular	59.4	40.6	58.4	22.4	12.0	7.3	49.0	51.0	384
Irregular	68.3	31.7	64.0	11.2	21.8	3.0	51.9	48.2	385
Wealth index									
Poor	62.5	37.5	55.8	15.7	25.4	3.1	45.1	54.9	292
Middle	66.7	33.3	64.3	14.9	17.7	3.1	54.3	45.7	267
Rich	61.6	38.4	64.5	21.4	3.6	10.5	53.2	46.8	210
No. of living children									
No children	100.0	0.0	100.0	0.0	0.0	0.0	100	0.0	1
1 child 1 son	49.4	50.6	61.0	13.7	22.8	2.5	47.9	52.1	29
1 child 0 son	68.1	31.9	61.7	11.6	24.8	1.9	66.5	33.5	13
2 children 2 sons	61.8	38.2	64.2	15.2	13.5	7.0	50.0	50.0	157
2 children 1 son	67.1	32.9	59.0	22.4	13.6	5.0	52.1	47.6	237
2 children 0 son	67.0	33.0	65.2	13.9	12.0	8.9	51.5	48.5	71
3 children 3 sons	47.6	52.4	59.5	13.8	24.8	1.8	34.6	65.4	41
3 children 2 sons	60.5	39.5	59.8	16.8	21.0	2.4	45.1	54.9	92
3 children 1 son	62.8	37.2	55.3	11.7	28.0	4.9	47.3	52.7	108
3 children 0 son	86.8	13.2	62.9	30.3	5.7	1.1	63.7	36.3	20
Block									
Md. Bazar	74.9	25.1	59.3	10.0	22.8	7.9	67.1	32.8	249
Suri-1	44.7	55.3	49.9	41.8	1.1	7.2	52.6	47.4	238
Saithia	67.7	32.3	65.1	10.3	20.5	4.1	46.5	53.5	282
Total	**63.6**	**36.4**	**61.0**	**17.1**	**16.6**	**5.3**	**50.4**	**49.7**	**769**

It may be observed from the table that a greater proportion of older respondents (67%), respondents with higher than middle educational level (70%), women belonging to the Hindu SC (73%), women involved in either tertiary sector or self-employed (73%),respondents from the middle wealth index (67%) and respondents with 3 female children (87%) underwent sterilization after childbirth or pregnancy wastage. The place where the respondents had

undergone sterilization did not vary much. It was observed that respondents from the Muslim community were the least likely to undergo the sterilization operation in the higher level public sector hospitals (33% in RH), while more likely they were to undergo such operation from private sources (27%) compared to others.

A higher percentage of older respondent (52%), respondents with higher than middle level of education (61%), belonging to Hindu SC community (61%), involved either in tertiary sector activities or self-employed (60%), belonging to the middle wealth quintile (54%) and have 3 female children (64%) preferred to undergo sterilization at the place of their last childbirth.

6.2 Informed choices before sterilization

Respondents were asked whether they were informed by the health or family planning workers about other modern reversible methods before undergoing sterilization. It was found that only 12% of the respondents were informed about any other modern spacing methods. Among them half of them were informed about condom (50%) and one-fourth of them were informed about pill (25%) by the health workers. During the survey it was also asked whether concerned health workers informed the respondents that sterilization is a terminal method of contraception i.e. the couple would further not be able to have a child. A little less than 9 out of 10 respondents (89%) reported that they were informed in this respect by the health workers.

Table 6.2 Informed Choices before Sterilization (N: 769)

Background Characteristics	Any method	No child aft Sterli zation	No. of obs	Pill	IUD	Inject ion	Condo m	Fema le Cond om	No. of wome n
Age									
15-24	22.7	13.7	99	15.2	6.4	68.3	28.2	7.1	19
25-34	48.2	37.5	323	58.7	49.3	0.0	49.2	43.4	55
35-44	29.1	48.7	347	26.2	44.3	31.7	22.6	49.5	48
Women education									
Illiterate	29.7	37.0	351	43.5	56.6	4.4	19.9	36.3	45
Primary	32.1	18.1	132	32.2	6.4	0.0	38.4	34.7	39
Middle	23.8	30.1	197	16.0	27.2	68.3	23.2	21.6	25
>middle	14.4	14.8	89	8.2	9.8	27.3	18.6	7.5	13
Men									

education									
Illiterate	31.9	29.1	267	40.6	28.9	72.7	24.8	27.3	39
Primary	15.3	20.4	164	15.7	14.5	0.0	10.1	40.2	35
Middle	29.8	23.3	141	33.4	9.8	0.0	37.2	17.8	25
>middle	23.0	27.1	197	10.3	46.8	27.3	27.9	14.7	23
SRC									
Hindu SC	51.4	44.4	373	45.5	37.4	4.4	57.8	64.3	65
Hindu ST	18.3	15.4	100	34.6	25.6	68.3	8.7	0.0	14
Hindu other/Other minority	28.2	38.9	235	16.9	37.0	27.3	31.7	32.2	36
Muslim	2.0	1.4	61	3.0	0.0	0.0	1.7	3.4	7
Women work									
Primary	51.3	39.1	299	70.7	49.3	100.0	42.7	42.8	55
Self-employed/tertiary	9.5	9.7	82	5.8	3.0	0.0	15.0	3.4	8
Not working	37.3	51.2	388	23.5	47.7	0.0	42.3	53.8	59
Men work									
Primary/not working	68.5	59.2	492	70.1	43.5	100.0	65.3	77.8	82
Self-employed/tertiary	31.5	40.8	277	29.9	56.5	0.0	34.7	22.2	40
Media exposure									
Regular	50.7	53.3	384	44.3	53.2	0.0	63.8	33.0	55
Irregular	49.3	46.7	385	55.7	46.8	100.0	36.2	67.0	67
Wealth index									
Poor	47.5	37.8	292	48.3	52.8	72.7	58.2	8.2	35
Middle	25.3	31.2	267	33.5	30.8	27.3	13.4	49.9	48
Rich	27.2	31.0	210	18.2	43.4	0.0	28.4	41.9	39
No. of living children									
No children	0.0	0.1	1	0.0	0.0	0.0	0.0	0.0	0
1 child	6.3	10.6	42	8.6	0.0	0.0	7.5	3.4	5
2 children	67.0	67.1	465	62.5	43.6	72.7	75.2	55.3	73
3 children	21.7	18.1	199	18.9	56.4	27.3	15.2	30.6	34
4+ children	4.9	4.1	62	10.0	0.0	0.0	2.1	10.6	10
Block									
Md. Bazar	22.9	85.0	249	13.2	11.9	0.0	20.0	54.7	68
Suri-1	9.2	91.2	238	7.9	1.3	0.0	90.8	0.0	17
Saithia	10.1	89.4	282	34.8	7.1	8.7	49.7	0.0	37
Total	11.5	89.2	769	24.8	7.0	5.3	49.5	13.4	122

Informed choices before sterilization also vary according to the selected background characteristics such as age of the respondents, educational attainment, affiliation to socio-

religious community and household affluence. A little less than half of the women in between the age of 25 to 34 years (48%), more than half of the Hindu SC women (51%) and 48% of the poorer women were informed about other modern methods before sterilization. A very low proportion of women belonging to the ST and Muslim community (18% and 2% respectively) were informed about other modern methods. Further, women with two living children were the most informed about any other reversible methods by the health workers (67%). Condom was the most popular informed choice among the middle aged respondents (49%), respondents who attained primary schooling (38%), belonged to the Hindu SC community (58%), women belonging to poorer households (58%) and couples with 2 living children (75%). Pill was also advised primarily to the middle aged women (59%), illiterate women (44%), women belonging to the Hindu SC community (46%), women involved in primary sector activities (71%), women belonging to the poor wealth quintile (48%) and women with more than 2 living children (63%). It may be noted that the information regarding sterilization or permanent sterility was provided by the health workers across all the selected background characteristics.

6.3 Reasons for not using modern spacing methods

Table 6.3 depicts the reasons for not using other modern spacing methods that were told by the health workers before resorting to sterilization. More than half of the respondents reported that a major cause for the adoption of modern permanent method was to stop child bearing permanently (53%). It may be noted that 24% of the respondents expressed fear of side-effects of modern spacing methods or that spacing method may not be full-proof, if not used properly. In addition, less than one-fourth (24%) of the respondents mentioned various supply-side factors such as difficulty in obtaining spacing method, difficulty to remember using such method and high cost etc. for not adopting of spacing methods.

Table 6.3 Reasons for not using modern spacing methods (N: 122)

Background Characteristics	Side-effects/ Not safe	Not Want Baby	Difficult to get/expensive/ difficult to remember	No. of obs
Age				
15-24	18.1	26.2	19.3	19
25-34	36.6	49.8	56.3	55
35-44	45.3	24.0	24.4	48
Women education				

Illiterate	40.8	29.8	18.3	45
Primary	25.6	20.3	64.9	39
Middle	20.6	36.0	0.0	25
>middle	13.0	13.9	16.7	13
Men education				
Illiterate	45.8	31.7	18.3	39
Primary	12.4	17.5	13.2	35
Middle	4.7	31.3	51.7	25
>middle	37.1	19.5	16.7	23
SRC				
Hindu SC	49.7	47.2	62.4	65
Hindu ST	31.2	11.4	20.8	14
Hindu other/Other minority	16.9	38.5	16.7	36
Muslim	2.2	2.9	0.0	7
Women work				
Primary	49.4	42.4	80.7	55
Self-employed/tertiary	26.6	6.1	0.0	8
Not working	24.0	51.4	19.3	59
Men work				
Primary/not working	67.5	68.2	70.1	82
Self-employed/tertiary	32.5	31.8	29.9	40
Media exposure				
Regular	40.9	57.0	46.7	55
Irregular	59.1	43.0	53.3	67
Wealth index				
Poor	32.4	46.1	66.0	35
Middle	34.5	24.7	17.3	48
Rich	33.2	29.2	16.7	39
No. of living children				
No children	0.0	0.0	0.0	0
1 child	0.0	12.0	0.0	5
2 children	55.3	68.3	76.2	73
3 children	40.2	13.6	21.3	34
4+ children	4.5	6.2	2.6	10
Block				
Md. Bazar	10.7	84.3	4.9	68
Suri-1	18.8	81.2	0.0	17
Saithia	30.8	30.7	38.6	37
Total	23.7	52.7	23.5	122

Almost half of the women from the age group of 25-34 years of age (50%), 36% of the women having middle level of education and 46% of the poor women mentioned no intention

of future fertility as the reason for resorting to sterilization in spite of knowing modern reversible methods. Majority of the Hindu SC women (47%) followed by Hindu upper caste women (39%) reported that they did not want a baby in future. More than half of the women who were unemployed (51%) also reported the reason for sterilization as an intention to conceive in the future. It is noticeable from the above table that a greater proportion of the women in Md. Bazar (84%) and Suri-1 (81%) mentioned fertility related reasons for adoption of permanent method. However, a lesser percentage of Saithia (31%) reported fertility reasons and majority of them (39%) stated that since modern spacing methods were not available all the time at the health centres or in the medical shops or these methods were costly and were difficult to remember etc., they have resorted to permanent method.

6.4 Care after sterilization

Table 6.4 represents the nature care after sterilization according to selected background characteristics. Two-third of them reported the care they received after sterilization was 'very good' followed by more than one-third of the respondents (33%) reported as 'all right' and the remaining handful reported that the care after sterilization as 'not so good' or even 'bad' (8%). Majority of the respondents from Suri-1 (79%) mentioned that the care was 'very good'.

Table 6.4 Rate the care after sterilization (N: 766)

Background Characteristics	Very Good	All Right	Not so Good/Bad	No. of obs
Age				
15-24	57.4	39.5	3.0	99
25-34	58.6	34.7	6.7	323
35-44	61.3	28.9	9.8	344
Women education				
Illiterate	49.6	35.8	14.6	349
Primary	72.3	21.6	6.1	132
Middle	60.9	35.8	3.3	196
>middle	67.9	31.8	0.3	89
Men education				
Illiterate	54.7	31.3	14.0	265
Primary	45.6	49.1	5.3	164
Middle	67.6	25.5	6.9	140
>middle	69.3	27.7	3.0	197
SRC				
Hindu SC	59.0	29.5	11.4	373
Hindu ST	62.6	30.4	7.1	99

Hindu other/Other minority	60.6	36.0	3.4	233
Muslim	37.2	59.9	2.8	61
Women work				
Primary	59.7	28.1	12.3	297
Self-employed/tertiary	53.7	34.2	12.1	82
Not working	61.1	36.1	2.7	387
Men work				
Primary/not working	58.4	31.0	10.5	490
Self-employed/tertiary	61.8	34.9	3.4	276
Media exposure				
Regular	63.2	31.0	5.8	383
Irregular	56.0	34.3	9.8	383
Wealth index				
Poor	59.7	28.0	12.3	290
Middle	52.8	39.4	7.8	267
Rich	67.5	31.2	1.3	209
Block				
Md. Bazar	32.7	53.7	13.6	247
Suri-1	79.2	7.6	13.2	238
Saithia	58.3	37.0	4.7	281
Total	59.8	32.6	7.7	766

It may be noted that a greater proportion of older women (61%), women who attained primary level of education (72%) and women from the higher wealth quintile (68%)reported the level of care as 'very good'. The variation across the socio-religious community is almost negligible except for the Muslim women, where a lesser proportion of women reported the level of care was 'very good' (37%) and almost two-third of them (60%) mentioned the care after sterilization was 'all right'.

6.5 Persons Advise Modern Permanent Methods

Table 6.5 highlights the persons who suggested adopting of modern permanent methods. Majority of the respondents themselves decided to undergo sterilization (46%). 27% of the respondents received suggestion either from their mother or mothers-in-law and 15% of them received suggestion from their husband to undergo sterilization. Only 5% of the respondents received suggestion from the medical or para-medical personnel for adopting sterilization. 48% of respondents from Suri-1, 46% of respondents from Saithia and 40% of respondents from Md. Bazar herself decided to adopt modern limiting methods.

Table 6.5 Persons advice modern permanent methods (N: 769)

Background Characteristics	Medical staff	Husband	Wife	Mother-in-law/Mother	Others	No. of obs
Age						
15-24	50.0	4.4	13.8	14.6	19.2	99
25-34	37.0	35.4	38.3	46.5	16.6	323
35-44	44.2	60.2	47.9	38.9	64.2	347
Women education						
Illiterate	57.0	39.4	38.2	36.3	32.6	351
Primary	14.9	14.6	17.9	20.0	27.3	132
Middle	25.7	28.3	27.7	32.3	28.0	197
>middle	9.4	17.7	16.2	11.4	12.1	89
Men education						
Illiterate	36.6	27.4	27.9	35.0	28.3	267
Primary	24.9	18.6	21.3	13.2	34.5	164
Middle	18.0	28.6	20.4	27.2	16.6	141
>middle	20.5	25.5	30.4	24.6	20.6	197
SRC						
Hindu SC	48.8	42.2	42.2	52.9	44.3	373
Hindu ST	16.6	14.8	14.5	22.1	9.3	100
Hindu other/Other minority	27.8	40.9	41.5	23.8	45.3	235
Muslim	6.8	2.1	1.9	1.1	1.1	61
Women work						
Primary	55.0	34.1	39.1	47.1	38.7	299
Self-employed/tertiary	7.6	12.4	9.7	12.5	4.8	82
Not working	37.4	53.5	51.2	40.3	56.5	388
Men work						
Primary/not working	67.8	64.8	53.4	64.3	66.0	492
Self-employed/tertiary	32.2	35.2	46.6	35.7	34.0	277
Media exposure						
Regular	39.5	57.9	56.9	49.4	40.8	384
Irregular	60.5	42.1	43.1	50.6	59.2	385
Wealth index						
Poor	53.3	34.1	33.8	43.5	57.0	292
Middle	31.2	30.8	30.9	34.6	26.5	267
Rich	15.4	35.1	35.3	21.9	16.5	210
Block						
Md. Bazar	13.3	22.1	39.6	24.6	0.4	249
Suri-1	6.4	13.9	47.7	19.6	12.2	238
Saithia	2.2	13.9	46.4	30.4	7.2	282
Total	4.5	14.9	45.9	27.3	7.5	769

Looking across the selected background characteristics the variation has been minimal except for women's age, women's education, socio-religious community and wealth quintile. Majority of the old aged women (48%), women from the Hindu upper caste (42%) and SC (42%), women who received more than middle level of education (30%) and women belonging to highest wealth quintile (35%) herself decided to undergo sterilization. However 50% of the young women were asked to undergo sterilization by the para-medical personnel.

6.6 Final decision and husband opposition to adopt modern permanent methods

Table 6.6 indicates the persons who took the final decision to adopt modern permanent method and whether husband's disapproval was involved regarding such a decision. It is clear from the table below that more than half of the respondents (52%) underwent sterilization only after joint decision of husband and wife together to adopt modern limiting methods. In 44% cases either the respondent or her partner took the final decision to undergo sterilization. Since majority of the sterilization across the study population were adopted after the final decision taken either by the couples jointly or by any one of them, the opposition from their husband regarding sterilization was minimal. Only 23 respondents out of 769 reported that they had faced husband's opposition regarding adoption of modern limiting methods.

Table 6.6 Final decision and husband opposition to adopt modern permanent methods

(N: 769)

Background Characteristics	Husband/ Wife	Husband & Wife	Others	No. of obs	Husband Opposition (in nos.)	No. of obs
Age						
15-24	34.9	56.8	8.3	99	2	28
25-34	44.6	53.2	2.3	323	10	100
35-44	45.4	49.3	5.3	347	11	109
Women education						
Illiterate	44.3	49.6	6.0	351	12	102
Primary	43.4	53.1	3.5	132	4	45
Middle	46.8	49.5	3.8	197	4	63
>middle	36.1	60.4	3.4	89	3	27
Men education						
Illiterate	46.6	43.2	10.2	267	10	90
Primary	47.1	51.4	1.5	164	7	57
Middle	53.2	46.4	0.4	141	1	27

>middle	29.7	66.3	3.9	197	5	63
SRC						
Hindu SC	42.3	52.1	5.6	373	10	108
Hindu ST	38.3	55.9	5.7	100	4	42
Hindu other/Other minority	47.4	49.8	2.7	235	6	69
Muslim	52.8	45.8	1.4	61	3	18
Women work						
Primary	36.6	57.7	5.7	299	14	120
Self-employed/tertiary	41.9	53.8	4.4	82	1	22
Not working	50.1	46.3	3.7	388	8	95
Men work						
Primary/not working	41.8	51.4	6.7	492	15	168
Self-employed/tertiary	46.5	52.3	1.1	277	8	69
Media exposure						
Regular	37.9	59.7	2.5	384	15	104
Irregular	50.2	42.9	6.9	385	8	133
Wealth index						
Poor	39.8	53.2	7.0	292	9	101
Middle	51.8	45.4	2.8	267	8	80
Rich	40.1	56.7	3.2	210	6	56
Block						
Md. Bazar	78.6	18.6	2.8	249	3	88
Suri-1	11.7	83.4	5.0	238	9	21
Saithia	47.8	47.6	4.6	282	11	128
Total	43.7	51.8	4.5	769	23	237

It may be noted that 79% of the respondents from Md. Bazar block took the final decision of sterilization either herself or jointly her husband, while 83% of respondents from Suri-1 together with their husbands took the final decision to undergo sterilization.

It may be observed that a greater percentage of the respondents within the age group of 15 to 24 years of age (57%), women who attained more than middle level of education (61%), women belonging to the Hindu ST community (56%), women involved in primary sector activity (58%) and women belonging from the highest wealth quintile (57%) underwent sterilization after jointly taking decision with their husbands.

6.7 Health problems after sterilization

Table 6.7 represents the health problems faced by the respondents after they adopted sterilization. It was observed that 15% of the respondents reported any problem after

sterilization. Majority of the women from Saithia block (16%) followed by Suri-1 block (13%) and Md. Bazar block (10%) reported such problems. Among the respondents who reported any problem after sterilization, majority of them reported either about body ache (15%) or headache or abdominal pain (14%). Also, there are other causes (15%) such as weight gain, breast tenderness, excessive periods, spotting, decreased libido, sex related diseases etc.

Table 6.7 Health problems after sterilization (N: 143)

Background Characteristics	Any problem	Body Ache	Abdom in Pain	Head-ache	Irregula r Period	Others	No. of obs
Age							
15-24	15.0	19.2	10.4	30.7	2.6	5.4	15
25-34	14.5	16.7	7.0	12.5	5.4	18.3	67
35-44	15.0	12.2	20.4	11.0	16.1	15.8	61
Women education							
Illiterate	22.2	17.3	14.7	7.9	15.7	13.3	76
Primary	14.5	4.4	16.7	39.8	2.1	3.5	27
Middle	6.6	2.7	10.6	15.6	2.1	0.0	25
>middle	12.1	31.5	10.1	4.0	5.3	0.0	15
Men education							
Illiterate	18.8	11.6	18.7	16.8	7.3	8.7	59
Primary	16.5	1.7	15.4	7.5	29.6	21.8	30
Middle	11.2	22.0	0.0	14.8	1.6	28.1	27
>middle	12.0	27.9	15.5	15.9	2.9	10.3	27
SRC							
Hindu SC	13.7	23.0	11.8	14.3	8.6	14.1	67
Hindu ST	30.9	1.4	14.1	18.4	17.5	14.2	24
Hindu other/Other minority	8.2	21.2	19.9	5.6	3.1	21.0	33
Muslim	27.4	9.7	5.3	22.7	1.1	7.9	19
Women work							
Primary	19.8	12.2	13.1	13.7	13.8	16.0	60
Self-employed/tertiary	10.0	15.5	3.4	44.3	0.6	8.4	12
Not working	11.6	18.6	17.3	9.3	7.0	15.6	71
Men work							
Primary/not working	19.5	14.4	14.1	17.2	13.1	13.5	107
Self-employed/tertiary	7.9	16.4	13.6	3.3	0.0	22.1	36
Media exposure							
Regular	12.1	21.7	13.0	6.6	6.8	23.4	67
Irregular	17.9	9.6	14.8	20.0	12.9	9.2	76
Wealth index							
Poor	20.8	14.5	16.3	14.7	15.3	10.1	65
Middle	10.9	13.7	9.1	10.3	1.3	28.5	46
Rich	11.1	17.0	13.3	17.1	7.0	14.5	32
Block							

	9.8	50.4	16.2	8.0	4.3	2.4	27
Md. Bazar	9.8	50.4	16.2	8.0	4.3	2.4	27
Suri-1	13.4	44.2	6.6	7.0	0.2	21.4	34
Saithia	16.2	2.8	15.8	16.9	13.7	15.1	82
Total	**14.8**	**14.8**	**14.0**	**14.2**	**10.3**	**15.3**	**143**

Substantial variations according to background characteristics were observed in reporting such ailments, especially for women's education, socio-religious community and wealth quintile. A greater proportion of illiterate women (22%), women belonging to the Hindu ST community (31%) and women from the poorer households (21%) reported health problem after sterilization. A lesser proportion of the women with higher level of education (7%) and women belonging to Hindu upper caste (8%) mentioned any problem after sterilization operation. A greater percentage of Muslim women reported headache as one of the major problem (23%) and majority of women belonging to the Hindu SC community (23%) and Hindu upper caste (21%) reported body ache as one of the major problems after sterilization.

6.8 Treatment seeking for problem and satisfaction after treatment

Table 6.8 indicates the proportion of respondents who sought treatment for the problems that arose after sterilization. The respondents were also asked about the source of seeking such treatment viz. public, private qualified or private unqualified. Further, the respondents were also asked about their level of satisfaction after seeking treatment.

More than 7 out of 10 respondents (74%) received treatment for the problems that arose after sterilization and among them more than half of the respondents (52%) did seek treatment from the public health centres, followed by private qualified sources (28%) and private unqualified sources (20%). The satisfaction after treatment seeking did not vary much, hovering between 'very good' (44%) and 'all right' (40%).

Table 6.8 Treatment-seeking for problem & satisfaction after treatment (N: 99)

Background Characistics	Any Treatment	Public	Private	Private-unqualified	Very Good	All right/ Not very good	No. of Obs
Age							
15-24	66.2	13.7	44.6	41.7	37.7	62.3	10
25-34	68.3	53.2	22.3	24.5	43.0	57.0	46
35-44	80.4	59.9	27.1	12.9	46.7	53.3	43
Women edu							
Illiterate	71.6	54.1	27.5	18.4	45.4	54.7	49
Primary	80.8	55.6	13.6	30.6	53.3	46.7	22

Middle	72.4	56.0	31.7	12.4	44.8	55.1	17
>middle	76.5	33.0	45.9	21.0	24.7	75.3	11
Men education							
Illiterate	71.7	26.9	41.9	31.3	29.0	71.0	39
Primary	58.3	77.2	4.2	18.7	61.2	38.8	22
Middle	67.2	81.4	13.3	5.3	66.4	33.6	18
>middle	71.9	43.9	41.3	14.8	34.5	65.5	20
SRC							
Hindu_SC	71.5	61.5	13.9	24.6	46.7	53.3	45
Hindu_ST	73.8	47.5	30.2	22.3	52.9	47.1	16
Hindu_other	77.5	42.4	47.3	10.2	33.8	66.2	24
Muslim/Other	85.5	43.9	39.8	16.2	3.1	96.9	14
Women work							
Primary	76.2	58.9	14.3	26.8	50.8	49.2	42
Self-employed/tertiary	48.7	93.0	7.0	0.0	81.4	18.6	8
Not working	75.4	37.0	49.5	13.5	30.4	69.6	49
Men work							
Primary/not working	73.7	45.9	30.9	23.2	41.9	58.1	74
Self-employed/tertiary	75.0	73.9	15.6	10.5	52.9	47.1	25
Media exposure							
Regular	79.6	55.3	31.5	13.2	46.0	54.0	47
Irregular	69.7	49.2	24.1	26.7	42.9	57.1	52
Wealth index							
Poor	70.9	65.6	17.2	17.1	56.4	43.6	42
Middle	80.4	38.0	28.9	33.1	34.6	65.4	33
Rich	74.9	35.7	50.4	13.8	27.0	73.0	24
Block							
Md. Bazar	41.0	32.9	50.6	16.6	40.5	59.5	12
Suri-1	64.4	71.4	7.1	21.5	49.7	50.3	22
Saithia	80.3	48.9	30.7	20.4	43.4	56.6	65
Total	74.0	52.0	27.6	20.4	44.3	55.7	99

Across the study block, treatment-seeking was the highest among the respondents belonging to the Saithia block (80%) as compared to Suri-1 (64%) and Md. Bazar block (41%). At Saithia and Suri-1 block majority sought treatment from public health centres (50% and 71% respectively). However, at Md. Bazar, a greater proportion of respondents sought treatment from private qualified sources (51%). Looking through the selected background characteristics, a greater proportion of older women sought treatment from public health centres (60%), whereas majority of the younger respondents visited private qualified doctors (45%). It may be noted that the women from the Hindu SC community were more likely to visit public sector hospitals or clinics (62%) compared to others. As expected, a greater

percentage of women belonging to the affluent households (50%) sought advice from private qualified sources such as private doctors, private clinics etc., while women belonging to the lowest segment of economic strata visited public sector units (66%).

6.9 Satisfaction or regret after sterilization

The study participants who adopted modern permanent method were asked the following questions simultaneously:

1. Whether the respondents were satisfied after undergoing sterilization operation and

2. Whether they have any regret after sterilization since they would not be able to bear any child in future even if they wish to.

Table 6.9 depicts replies to both these questions. Although 94% of the respondents were reported to be satisfied after sterilization, 9% mentioned that they do have regret after sterilization.

Table 6.9 Satisfied or regret after sterilization (N: 769)

Background Characteristics	Satisfied	Regret	No. of obs
Age			
15-24	13.0	19.9	99
25-34	38.9	26.1	323
35-44	48.1	54.1	347
Women education			
Illiterate	38.4	53.2	351
Primary	19.4	4.8	132
Middle	27.1	31.6	197
>middle	15.1	10.4	89
Men education			
Illiterate	30.3	43.2	267
Primary	20.2	13.4	164
Middle	22.9	16.3	141
>middle	26.6	27.1	197
SRC			
Hindu SC	45.6	62.1	373
Hindu ST	16.9	9.8	100
Hindu other/Other minority	35.8	26.3	235
Muslim	1.7	1.8	61
Women work			
Primary	41.6	41.3	299
Self-employed/tertiary	10.8	6.7	82
Not working	47.7	52.0	388

Men work			
Primary/not working	60.2	68.2	492
Self-employed/tertiary	39.8	31.8	277
Media exposure			
Regular	52.0	51.5	384
Irregular	48.0	48.5	385
Wealth index			
Poor	39.6	59.3	292
Middle	32.1	11.1	267
Rich	28.2	29.5	210
Block			
Md. Bazar	87.4	5.5	249
Suri-1	98.4	7.5	238
Saithia	94.2	9.5	282
Total	94.3	8.6	769

According to the selected background characteristics, a greater proportion of middle aged women (48%), illiterate women (38%), women from Hindu SC community (46%) followed by Hindu upper caste (36%), women who were not engaged in any kind of activity outside household (48%) and women belonging to the lowest wealth quintile (40%) were satisfied after sterilization. However, a greater proportion of women amongst the older cohort (54%), illiterate women (53%), belonging to the Hindu SC (62%) and women belonging to the lowest wealth quintile (59%) reported that they do regret after sterilization.

Conclusion

The modern permanent methods, particularly female sterilization, were the most popular methods of family planning adopted by the rural respondents of the Birbhum district as found in other parts of India. However, choices given to them regarding other modern reversible methods by the medical and para-medical personnel were found to be very low, especially to the women belonging from the marginalised section such as scheduled tribes and Muslims. Majority of the respondents either by herself or with her husband took the final decision to adopt sterilization. The number of women suffering from any problem after sterilization operation was found to be low. Majority of the respondents sought treatment for their problems they faced after adopting modern limiting methods and primarily they sought treatment from the public health centres. Hence a greater emphasis should be given to inform women on other modern spacing methods before adopting modern permanent methods by the programme managers.

CHAPTER 7

Views of Healthcare & Contraceptive Providers

Chapter 7

Views of Healthcare & Contraceptive Providers

This section of the report tries to explore the issues related to contraceptive supply, contraceptive counselling, informed method choice and contraceptive uses among health care and contraceptive providers by using a semi-structured questionnaire in the three study blocks. The respondents comprise the healthcare and contraceptive providers including grass root level health workers such as Auxiliary Nurse Midwives (ANM), Multipurpose Workers (MPW), Accredited Social Health Activists (ASHA), doctors and nurses from Primary Health Centres (PHC) and gynaecologists and nurses from Block Primary Health Centre (BPHC) /Rural Hospitals (RH). Additionally, trained Rural Health Care Providers (RHCP) and informal (or unqualified) providers were also interviewed.

The questionnaire was designed to explore the involvement of the health workers in various issues regarding supply, counselling and distribution of family planning methods at the local level. The present analysis is purely based on qualitative research method. Qualitative research was especially effective in obtaining culturally specific information about the views, behaviours, opinion and social context of the study population. It was also effective in identifying intangible factors, such as socio-economic status, gender issues, society knowledge etc.

7.1 Background characteristics of the healthcare and contraceptive providers

This study aimed to interview 50 health workers who were basically responsible for providing or counselling about various methods of family planning that couples can use to delay or stop pregnancy. However, we could interview 48 such respondents since 2 doctors declined to appear in such interview. Out of 48 respondents, 31 of them were *para-medical personnel* comprising nurses from BPHC/RH/DH and ANM/MPW/ASHA from sub-centres, 12 of them were unqualified private practitioners and remaining 5 respondents were *medical personnel* including the BPHC/RH/DH doctors/gynaecologist.

The mean years in the service were 14 and the median years spent in service were 10 among para-medical professionals. However, the mean and median years in service of the medical personnel were less; 7 and 6 years respectively. The private unqualified providers were engaged in providing health services including contraceptive methods to the couples in

the villages longer than the medical as well as para-medical personnel (13 mean numbers of years and 11 median numbers of years). It may be noted that the para-medical personnel have been working in their respective health centres for 9 mean years and 6 median years, while medical professionals have been working in the hospitals for 3 years (mean and median both). The private unqualified practitioners have their own clinics or shop for 10 years (mean and median both).

Out of 48 respondents, 65% of them were women and majority of the women (97%) were para-medical personnel. Out of 35% male respondents, 71% were private unqualified providers and 24%were medical personnel. Almost 9 out of 10 respondents were Hindu (90%) and the majority belonged to the Hindu upper castes (71%). Among the para-medical personnel 76% were from Hindu upper castes and out of 5 medical staff only 1 belonged to Hindu scheduled castes. One-fourth of the surveyed private unqualified providers were Muslims (25%) and majority of the rest of them were from Hindu upper castes.The mean level of education of the para-medical professionals was 12 years (with median 11 years). As expected, the mean years of education were 17 years among medical graduates (with median 18 years). It is important to note that the private unqualified respondents have completed 13 mean years of education (14 median years).

7.2 Provision and counselling of contraceptive methods

All the respondents reported that if any husband, wife or if both husband and wife together came to seek advice about family planning methods, the providers always encouraged the couples to use/adopt birth control measures. It is worth noting that 85% of the providers did ask the couples about their ideal family size when they came to seek advice regarding contraceptive methods. But only 22 out of 48 i.e. less than half of the providers advised women to conceive according to their age at marriage. It is important to note that every surveyed provider advised women not to conceive before 18 years of age if she got married at a tender age. However, if a woman got married at/after the legal age of marriage then the providers suggest them to conceive after at least 2 to 3 years of marriage.

Out of 48 respondents, 11 of the para-medical personnel (i.e. a minority of 23%) encouraged only women to adopt contraceptive methods. Rest of the providers (i.e. a majority of 77%) not only encourage women but also their partners to use family planning methods. Among the providers, 79% of the respondents felt that it was fairly difficult to convince husbands to use contraceptive methods compared to their wives. Out of the 10 providers who

felt that husbands readily adopt birth control measures, five of them were private-unqualified practitioners, two were medical graduates and three of them were para-medical personnel. It is interesting to note that all providers except one para-medical personnel were of the opinion that husband and wife together should bear the responsibility of adoption of family planning methods. They were of the view that husband should actively take part in the decision-making regarding contraceptive use and emphasized 'Planned Parenthood'.

When the providers were asked regarding the appropriate method a couple should use after their marriage and prior to the first conception, the most common choices reported by them were pill and condom. Additionally, a majority of the para-medics and private unqualified providers suggested that couples should also use traditional methods such as withdrawal or calendar/rhythm methods. However, none of the qualified medical professional suggested the use of traditional methods. Interestingly, one private unqualified provider advised couples to seek guidance from a gynaecologist. Almost all providers, except two para-medics, informed couples about the side-effects of the contraceptive methods that they have suggested them to adopt. 96% of the surveyed providers reported that they advised couples what to do in case they faced any problem while using birth control measures. About two-third of the respondents (63%) also provide follow-up services after suggesting a particular method to a couple.

The time gap between the first two successive pregnancies, which result into live-birth, should be at least 3 years as reported by the providers. However, 5 out of 12 surveyed informal providers advise couple to maintain the gap of 5 years in successive conception. When the respondents were asked, what contraceptive methods they advise couples to use in between the first and second child, majority of them answered pill, condom and IUD (copper-T). One of the private unqualified also suggested that couples can use emergency pills in between two pregnancies.

If couples do not want any more children after having 2 or 3 living children then overwhelming majority (46 out of 48) of providers advise couple to adopt modern permanent methods in order to avoid the risk of further pregnancy. Only 2 of the para-medical personnel advise couples to use modern spacing methods even if the couple attained their desired number of children.

46 out of 48 respondents advised couples to maintain small family norm if couples wished to have more than two or three children. If couples have future fertility intention 29% of the respondents advise them to maintain small family and advise them to undergo sterilisation. However, the remaining 71% told couples to use spacing methods like pill,

IUD/copper-T, condom etc.If couples do not want to have any children after attaining the desired family size then 96% providers asked them to adopt permanent methods such as female or male sterilization.

88% of the providers reported that the awareness about the use of various modern spacing methods among the couples was not satisfactory. All the providers agreed that the awareness about the use of various modern spacing should be enhanced and improved in the study population. It is important to note that 85% of the providers acknowledged induced abortion as a kind of family planning method to stop unwanted pregnancy.

7.3 Prescription regarding modern permanent methods

The providers who advise couples to undergo sterilization also inform them that the women will not be able to bear any more child in future. All the 46 providers emphasised tubectomy operation. After tubectomy operation all the medical personnel provide follow-up services at the health centre/hospitals. Moreover, more than half of the para-medical healthcare providers and the private unqualified providers (54%) even provide home visits in case of some problem or in emergency after tubectomy operation.

All the providers reported that it was very difficult to convince husbands to adopt sterilization (vasectomy). 79% of the para-medics and two-third of the medical personnel revealed that they do not fix any target about the number of tubectomy/vasectomy operation that were to be conducted in their catchment area within a certain year. They advise couples to adopt tubectomy/vasectomy operation according to the necessity of the couples. 1 out of 10 para-medics and 4 out of 10 medical personnel reported that they were informed from the block or district level health administration to fix a *target* regarding the number of tubectomy/vasectomy operation to be conducted in a particular area within a year.

Only 9 out of 46 providers, who emphasised sterilization operation, have advised couples to use condoms/*nirodh* at the time of sexual intercourse even after tubectomy operation. 85% of the respondents reported that they do not believe tubectomy/vasectomy methods take away the right of procreation from couple. None of the private unqualified providers regarded that sterilization procedure prevents couple's right of procreation. However, 1 out of 5 medical personnel and 6 out of 29 para-medical professionals believed that adoption of sterilization restricts the child bearing capacity of the couples.

7.4 Modern spacing methods

It was found in the present study that providing information to the clients about the side effect of modern spacing methods was minimal. Out of 48 providers only two contraceptive providers inform couples about the side effects of using spacing methods. The providers were of the opinion that modern reversible methods are 100% safe and their accessibility, particularly of pills, copper-T, male condom etc., is universal. The providers have also reported that couples usually do not face any difficulty in obtaining the spacing methods. The providers also provide follow-up services after prescribing any modern spacing method to know whether couples are facing any problem while using such modern spacing method. It may be noted that prescribing condom as a contraceptive method as well as a method to prevent STI/HIV is minimal among the surveyed providers. Out of 48 providers, only one provider reported that couples should use condom/*nirodh* during sexual intercourse to prevent the spread of STI/AIDS irrespective of using modern permanent or spacing methods.

7.5 Traditional methods

46% of the surveyed providers do not advise couples to adopt natural (traditional) methods, namely, withdrawal and rhythm (calendar) methods because 96% of them felt that men and women in the study population lack awareness and skills which are adequately required in using traditional methods. The surveyed providers suggested that awareness generation campaign through outreach activities by the health workers should be conducted not only for the women but also their intimate partners to enhance knowledge and skills of using traditional methods. It may also be noted that 67% of the surveyed providers were of the opinion that traditional method is 100% safe if one uses these methods with proper knowledge and skills. Even four out of five medical personnel were also provided the same opinion. Due to limited knowledge and skills about the traditional methods among the couple of these underdeveloped remote villages, the providers do not suggest these methods.

7.6 Emergency contraception

Although the guideline of World Health Organization suggests that emergency contraceptive pills do not have any long-term side effects and has been included in the National Rural Health Mission (NRHM) to avoid unplanned pregnancy, half of the para-medical and medical personnel were of the view that emergency pills are detrimental for the women's health. However, private unqualified providers were of the opinion that emergency contraceptive

pills are effective against to avoid unplanned pregnancy and are not injurious to the women's health. During the last six months preceding the survey the unqualified providers advised 30 women (out of which 28 married and 2 unmarried) to use emergency pills in order to prevent unwanted pregnancy. However, the medical personnel have neither reported emergency pills are good nor they advised women to use such methods to stop pregnancy. Interestingly enough, 4 out of 23 respondents who do not know whether emergency pills are bad or good for the women's health have advised 4 women to use it. Majority of the para-medical staff did not remember how many women they have advised to use emergency pill during last six months preceding the survey.

7.7 Adoption of family planning method: Provider's perspectives

All the surveyed providers in the study population agreed on the point that couples who belonged to these villages should adopt family planning methods. The most common reasons reported by majority of the providers were as follows:

1. Adopting contraceptive method can control birth and avoid the increase in population.
2. By using family planning methods the couples in the villages can maintain small and happy family.
3. Accepting birth control measures would improve the health conditions of child and mother. It is also beneficial not only for the family but also for the country as a whole.

Other reasons include that use of contraceptive method can reduce poverty and improved educational facilities among the children.

It is important to note that 96% of the providers irrespective of their status and affiliation suggested that couples should adopt modern permanent methods. Some of the major reasons reported by them as why they advised couples to undergo tubectomy/vasectomy operation are:

1. If spacing methods are not used correctly or properly, then women can become pregnant. Such methods cannot negate the risk of unwanted pregnancy.
2. Permanent methods are safe and the perfect family planning method to control birth.
3. Family size becomes complete after having two to three living children and therefore couple should adopt sterilization.

The preference for modern permanent method also includes the fact that modern spacing methods are costly; couples are generally less aware about such methods and women can become pregnant unintentionally.

Although the present Reproductive and Child Health (RCH) programme of the Government of India envisaged a *target free* approach regarding adoption of family planning among couples, 11% of the surveyed providers reported that they receive *target* from block/district level managers regarding the number of sterilization that should be conducted in an area in a particular year. Instructions reported by the block level community health care providers are as follows:

1. After the birth of 2 living children district and block level programme managers suggest women to go for tubectomy operation.
2. Letters containing area-specific target are sent from the Office of the Chief Medical Officer of Health from time to time.

Conclusion

The present survey of 48 health and contraceptive providers suggest that while all of them were in favour of using contraception to reduce fertility, particularly unintended childbirth, a substantial majority of them prefer the permanent method. They also emphasised the lack of awareness and skill among couple about the natural (traditional) method as well as modern reversible method. According to them, well designed outreach activities by the grassroot level health providers are required for awareness and skill generation about traditional and modern spacing methods.

CHAPTER 8

Intervention

Chapter 8

Intervention

The previous sections reflected the level of awareness, utilization and behavioural patterns associated with different contraceptive methods in the study population. Moreover, study participants were asked about their future fertility intentions and also about the possible use of any birth control measures in the future. The current section would try to highlight the design of the intervention, however, in very small-scale and time period, which was carried out in the study site.

It is well-known that in 1951, India became the first country in the world to launch a family planning programme to check the population growth. Since then, the family planning programme in India has undergone a variety of forms. From the passive or "clinic-based" approach of 1950s the "time-bound' and "target-oriented" approach was pursued in 1960s. The "camp approach" was given tremendous emphasis to promote male sterilization during 1970s. The excesses of these campaigns lead to a severe backlash and re-christened as Family Welfare Programme in 1978. In 1990s, the government began to re-orient the programme, especially to address the concerns expressed at the International Conference on Population and Development held at Cairo in 1994.

During 1994-95, with the support of World Bank and other agencies, method-specific contraceptives targets were abolished and the emphasis shifted to decentralize planning at the district level based on the assessment of the needs of the local community. The implementation of programmes particularly aimed in fulfilling the unmet needs of family planning. It is important to address the unmet need for contraception, particularly for spacing, by providing access to safe, effective and reversible methods. Hence, it is necessary to expand the basket of contraceptive choices. Social marketing of contraceptives and availability of the range of methods would help to meet the needs of couples who are not ready to accept sterilization.

There is a large pool of formally or informally qualified Rural Health Practitioners (RMPs) who meet the day-to-day health care needs of the rural masses. It was recommended by the Working Group of Population Stabilization for the Eleventh Five Year Plan (2007-12) of the Planning Commission of the Government of India to use them in the delivery of non-

clinical methods of contraception and referring the clinical cases to the PHCs or First Referral Units, for a nominal fee.

On the basis of the findings from the questionnaire and the aforesaid recommendations, the design of intervention was outlined.

To carry out intervention among the study population of 1348 samples, first the population sub-group was identified. Altogether 259 women and their husbands were identified for the intervention programme from the three study blocks. 93 women and their husbands from Suri-1, 97 women with their husbands from Md. Bazar and 69 women with their husbands from Saithia were selected for the intervention. The selection criteria were as follows:

1. Women who were not aware of any contraceptive method to prevent the incidence of pregnancy.
2. Women who were unaware about modern reversible (spacing) methods.
3. Women who do not want any child in future and yet still not using any birth control measures.
4. Women having more than 2 living children and want more children in future.
5. Women with more than 2 living children and want more children in future but currently not using any contraceptive methods.
6. Women following only traditional methods viz. calendar or rhythm and withdrawal method.
7. Women who in future want to adopt modern permanent methods (sterilization).

Altogether 6 personnel - two trained unqualified providers (renamed as Rural Health Care Provider (RHCP) i.e. those who received training from West Bengal Liver Foundation (WBLF) and four members of community based organization (CBO) such as Self Help Group (SHG) - were inducted for the intervention activities. In the group, three members were females and the rest were males. Females were supposed to communicate with the respondents while males were supposed to talk with the husbands. The selected respondents were intervened through outreach activities i.e. through door-to-door visits during the month of August, 2012. The interveners have visited each household 4 times. The main intention of the intervention was to make the couple aware about the available modern reversible contraceptive methods and to inform them about the baskets of contraceptive choices. They were also advised the use of contraceptive methods if the couple do not want any children in future and also benefits of keeping a small family etc. Involvement of male in the family

welfare activities (i.e. Planned Parenthood) was also emphasized during the intervention campaign. However, no evaluation of intervention was carried out since it was neither the goal of the project nor possible in the limited activities and timeframe.

CHAPTER 9

Conclusion

Chapter 9

Conclusion

This chapter summarizes the major findings of the study and highlights the key points on contraceptive awareness, attitude and practices in rural areas of Birbhum district in West Bengal. The Family Welfare Programme in this region has been successful in spreading the message of small family norm, improving contraceptive acceptance and reducing fertility rates. However, its achievements have been modest. Although the Family Welfare Programme in India is heavily skewed towards female sterilization, new policies such as National Population Policy (NPP) 2000, National Health Policy 2002 and National Rural Health Mission 2005 envisaged the necessity to expand the basket of contraceptive choices – 'by *providing access to safe, effective and reversible methods*'. These policy documents also envisaged the greater involvement of males in the family planning programme. It may be argued that contextual and structural factors such as high levels of illiteracy, poor access to source of knowledge, poverty, religious restrictions and gender and non-gender disparities etc. are also responsible for the lack of allround success Family Welfare Programme in India. Moreover, there are barrier on the way to promote contraceptive choice and meeting contraceptive needs in the country till date.

The small family norm is widely accepted (the mean number of family members is 4 persons) and the general awareness of contraception is universal (100% of the women in the study population were aware of at least one contraceptive method). Also, the knowledge of modern reversible methods was almost universal (99% of the respondents were aware of at least one modern spacing method). However, what is disturbing is that the awareness of specific reversible methods, which are more suitable for young women is low (42% women were found to be aware of female condoms, 62% were aware of injectables and 67% were aware of IUDs). Although 88% of the respondents are reported to have used contraceptive method currently and 82% of the women adopt a modern method, what is surprising from the data is that only 18% follow modern reversible methods and overwhelming majority of 64% adopt modern permanent methods. This highlights the fact that although more emphasis is given on providing greater knowledge about modern spacing methods, still the adoption of permanent methods (mostly tubectomy) is the highest.

Such a low adoption of modern reversible birth control measures can be attributed to the fact that the lack of knowledge regarding the source of these methods (in our study medical shops were the most prominent sources of spacing methods), the fear of side-effects (26% of women were informed about the side-effects) and ignorance as to the use of the selected methods correctly act as impediments (Bongaarts and Bruce 1995). Evidence from a number of small-scale studies in various parts of the country indicates that inadequate knowledge of contraceptive methods is a reason for not accepting family planning (Levine et al. 1992; Roy et al. 1991). Incomplete or erroneous information regarding where to obtain methods and how to use them is strongly associated with unmet needs (Viswanathan, Godfrey and Yinger 1998). Moreover, several studies reported that misconceptions are common among women and men, particularly related to the side-effects of contraceptive methods (Balaiah et al. 1999: IIPS 2001a: Parveen et al. 1995: Population Council 2002: Sharma et al. 1997).

Qualitative studies conducted among healthcare providers in the selected area also reported the fact that couples lack the knowledge needed to use spacing methods. It follows if they do not properly use such methods, women can conceive. For this reason, the respondents asked couples to undergo sterilization after having two living children. They suggested door to door campaign to highlight awareness and to organize awareness camps periodically, which can increase their knowledge and serve as catalyst to enhance the practice of modern spacing methods. Thus, information, education and communication (IEC) efforts need to be strengthened, and integrated as a part of the training of all health providers. Although the Reproductive and Child Health Programme (RCH) recognises the programme, lack of collaboration between the health sector and IEC units resulted in a recorded a fall back (Population Council 2002).

Within the patriarchal set-up in India, women have relatively little power. The role of the husband has been noted in several studies of decision-making related to the use of contraception, especially during the early years of marriage (Acharya and Sureender 1996: Barua and Kurz 2001: Dharamalingam 1995: Ghosh 2001: Haberland, McGrory and Santhya 2001: Jeejeebhoy and Kulkarni 1996: Ravindran 1993). Although in our study most of the husbands approved the contraceptive use of their wives, yet, according to the contraceptive providers it is difficult to suggest to a man to adopt contraceptive methods. Given that men's domination in reproductive health is a fact that matters, promoting shared responsibility and the active involvement of men in safe and responsible sexual relationships, family planning,

safe motherhood and parenthood is of critical importance. Many studies report that reproductive decision-making is often beyond the control of young women and their husbands (Barua and Kurz 2001: Piet-Pelon, Rob and Khan 1999: Ravindran 1993: Santhya, McGrory and Haberland 2001). Indeed, it is the extended family's decision on what is permissible that influences the husband/couples's decision. Access to appropriate contraception is frequently thwarted by family members and peer pressure.

Efforts to broaden the basket of choices have been underway (Puri 1998). The government has introduced emergency contraceptive pills in the Reproductive and Child Health Programme (MOHFW 2002). However, most men and women relying on public sector do not have access to a wide range of contraceptives. Not only is access to a wider choice of methods limited, but also providers often do not assist women and men to exercise their right to contraceptive choice by not offering them complete and accurate information about the variety of methods available. In our study, 31% users of modern reversible methods were motivated by the providers or health workers and were informed about at least one alternative birth control method. Providers are reported to have a bias towards sterilization (Visaria 2000) due to the fact that they receive *targets* from the district or block level health administrators. Perhaps, the district or block level authority believes that tubectomy is the best way to control population growth. Reports going back to the early 1990s state that most women were informed about female sterilization and only a minority were told about reversible methods (Barge and Ramachandar 1999: ICMR 1991: Khan, Patel and Chandrasekhar 1993: Khan, Gupta and Patel 1999: Khan, Patel and Gupta 1999: Murthy 1999: Ravindran 1999: Roy and Verma 1999: Verma and Roy 1999: Visaria 1999). Our study which was conducted in 2012, found more or less a similar trend.

Evidence from a growing number of studies suggests that pre-acceptance counselling of clients on how the method works, what the expected side-effects are and how to manage the side-effects are typically lacking or limited in the Family Welfare Programme across the country (Foo and Koenig 2000). Small scale studies on reasons for contraceptive discontinuation also reiterate these findings (Bhat and Hasalkar 1996: Bhatnagar et al. 1988a, 1988b: Gandotra and Das 1996; Kanitakar et al 1988; Kanojia et al 1996; Khan, Patel and Chandrasekhar 1990; Prabhavati and Sheshadri 1988; Rao 1990; Schaap 1993).

According to the current qualitative study conducted among health or family planning workers, it was felt that they are required to regularly visit each household in their assigned areas to provide information related to health and family planning, counsel and motivate women to adopt appropriate health and family planning practices, and also deliver other related services.

The way forward

Though the Family Welfare Programme has experienced significant growth and modification over the past half century, pregnancies continue to be unplanned and the unmet need for contraception remains substantially high. Moreover, certain socio-religious communities and sub-groups were neglected or under-served. A vast majority of contraceptive users is using tubectomy as contraceptive method while contraceptive choice is conspicuous by its absence and the quality of care is limited within the programme. Several efforts were made to promote, expand and inform contraceptive choice, but considerable efforts have to be made by various stakeholders. Some recommendations are highlighted below:

- To address men both in terms of their shared responsibility as partners, husbands as well as fathers, and this should not be limited to promoting the use of male contraceptive methods.

- Provider's bias continues to restrict the rights of women and men in exercising contraceptive choice. Providers need to be oriented about the client's right to exercise choice.

- Given that woman, especially young women are powerless and voiceless in sexual and reproductive matters, multi-sectoral activities to enhance women's status are urgently needed.

- The involvement of the community in planning and monitoring remains minimal, and concerted efforts to promote community participation are needed.

The report reveals significant gaps in the understanding of dynamics of contraceptive use and there are several issues that need research attention. Some of these are highlighted below:

- Research on the attitude and practice of men regarding fertility regulation and the factors inhibiting their role and participation in reproductive health could help improve and modify the delivery system.

- Research is also required to determine men's needs for services and information in specific communities.

- Operation researches are required to assess how educational campaigns could effectively promote shared responsibilities.

- As methods of fertility regulation available to men are limited, priority should be given to developing male methods of family planning.

- Gaining a better understanding of how women and men choose and negotiate trade-offs among methods could provide useful insights for policymakers, programme managers as well as the clients themselves.

- Future research should explore the context in which women and men exercise choice, including the power dynamics within relationships, and the interface between clients and the service system.

- Additional research is required to understand why women discontinue the use of contraception and whether efforts to provide detailed information under the new programmes have improved contraceptive continuation rates.

- Similarly, explorations into whether the new rhetoric on quality of care has been translated into reality and impacted dynamics of contraceptive use are critically needed.

- Qualitative studies are needed to assess the perspectives of primary and secondary stakeholders regarding the changes in the programme.

- In addition to the above points, one important aspect of reproductive health problems that should also be emphasized by the policy makers is contraceptive morbidity in addition to RTI/STI.

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Appendix

List of persons who were engaged in the project

Persons involved in data collection in the surveys as investigators

1. Pampa Mondal
2. Banani Mondal
3. Sulekha Pal Ghosh
4. Mehebuba Khatun
5. Banashree Ghosh
6. Chanda Goppe
7. Meherunnessa Khatun
8. Rehena Khatun
9. Baishakhi Mondol
10. Shubhra Mondol
11. Najma Khatun
12. Bandana Gorain
13. Barnali Mondol
14. Tanuja Begam
15. Bandana Pal

Persons supervising the data collection in the surveys

1. Md. Firoz Ali
2. Rabindranath Ghosh
3. Subhendu Pal

Data entry operators who entered data

1. Anirban Hazra
2. Pallabi Ghosh

Research Associate at the IDSK during the project period

1. Manashi Saha