

Customary Obstructions in achieving the Goals of Family Welfare Programmes in Rural India: A Case Study

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Introduction

Population is an asset for a country, but when its size becomes too large in relation to available resources, naturally it becomes an acute problem (Wahab, 1989: 5). People concerned with the economic and social development of the nation are equally concerned with population growth. Population problems are not small in number, content or size and so to find out solution to these problems is not an easy task. Concerted efforts have to be made by resorting to if necessary, unpleasant action plans giving due consideration and thought to side-tract counter-productive elements within the family planning scheme of things (Arun, 2000: 1).

Family planning connotes the endeavor on the part of a couple to interrupt their natural family building process by the use of some birth control methods with a view to have a pre-determined scheme regarding how many children they should have and at what intervals they should have them (Viswanathan, et al., 1998). The family welfare programme signifies a set of activities to propagate family planning. 'These activities include the provision of necessary information about the utility of family planning, health care, motivating married couple to become family-planners and offering them contraceptive services (Roy, et al., 1985: 2). The Indian government in its effort to fertility promotes family planning by offering free contraceptives through local health services and monetary incentives for sterilization (cf. Puri, 1998). Although the use of modern contraceptive is reportedly on the rise in rural India, but the facts available for contraceptive use are still relatively low. As nearly 68.84 per cent of Indian population still lives in villages (Census of India, 2011), there is a strong push is required to increase the acceptance of birth control measures in non-urban settings. Both men and women have been vigorously targeted for birth control, but especially in the last two decades, women have been the primary targets. There is increasing recognition that for family planning to be implemented and effective, both men and women must be encouraged (Oppenheim Mason and Smith 2000; Sternberg and Hubley 2004). Besides being less effective, interventions that only target and engage women- and thereby fail to address underlying gender inequities-may actually do more harm than good (Bawahet al.1999). Thus, there is a need to convince men for the purpose (cf. Murthy, 1999). Notwithstanding these achievements, several issues continue to daunt the programme and many goals remain under-achieved: a significant proportion of pregnancies continue to be unplanned; the contraceptive needs of millions of women

remain unmet; several sub-population groups including adolescents and men continue to be neglected and under-served; and contraceptive choice remains conspicuous by its absence, as is quality of care within the programme (Santhya, 2003).

Health is affected by the economy and income levels. There are two major perspectives on how inequality in economic well-being can affect the health of the population. One is the absolute deprivation hypothesis, which suggests that very low living standard is bad for health. The other is the relative position hypothesis, which emphasizes individuals' position on the socio-economic hierarchy, independent of standard of living, as the key to understanding the link between economic well-being and health (Xi et al., 2005).

Problems caused by rapid population growth in the study area may be understood by keeping in view the relationship between population growth and available resources. The goal of family welfare programme, therefore, is not merely to reduce, increase or well-balance the number of people, but to offer a possible standard quality of life incorporating increasing proportion of the population in Chakia block. Hence, attempt has been made here to identify the problems first and to overcome them through some suitable measures for planning of family welfare. It is hoped that the study will be helpful in meeting some of the needs of policy makers and managers of family welfare programme in the country in general and Chakia community development block of Chandauli district of Uttar Pradesh in particular. Level of education increases the likelihood that women will look after their own well-being along with that of their family.

Objectives

The present study has been carried out with the following specific objectives:

- To identify the barriers in adoption of family welfare methods among rural family.
- To suggest some remedial measures for efficient use of family welfare programmes.

The Study Area

The Chakia community development block (*Vikashkhand*) is located in the north-western part of Chakia *tahsil* in Chandauli district of Uttar Pradesh. It extends from 24°58'14" to 25°9'46" north latitude and from 83°3'14" to 83°15'53" east longitude. Chakia block with a total geographical area of 226.81 sq. km and a population of 160494 persons is a medium densely populated block (773 persons per sq. km.). Sex ratio in study area is 908 in 2001, but it remains above the state average of 898. The population below six years of age in 2001 was 32037 persons constituting 19.96 per cent of the total population. The total literacy accounts for 43.42 per cent incorporating 54.23 per cent male literacy, and 32.35 per cent female literacy.

The study area is delimited by the district boundary of Mirzapur in the west, *tahsil* Chandauli in the north and development block Shahabganj and Naugarh (Chakia *tahsil*) in the east and south respectively. The Chakia development block consists of 288 villages (including 53 uninhabited Ones) along with the block headquarters town of Chakia. The villages are grouped into thirteen *Nyay Panchayats*. The economy of the area is primarily agriculture based, though some people also depend on services and business.

Data base and methodology

The primary data have been collected by interviewing 550 households, selected from five villages in Chakia development block. The villages have been selected in accordance to their distance from CHCs having at least 110 households. All castes and communities of the study area do belong to Hindu and Muslim religions. Females aged between 15-49 were interviewed in depth to obtain information about their reproductive health and behavior. More than ninety per cent households belong to Hindus while remaining belongs to Muslim religion. According to social-group 12 per cent belong to General castes while 64 and 24 per cent belong to other backward castes (OBC) Scheduled caste (SC and ST) respectively. Purposive sampling method was employed to select the samples. A focused group discussion was organized to gauge the information. Logistic regression analysis has been used to ascertain the association between various socio-economic determinants and acceptance of family welfare methods.

Results and discussion

The study collected information from women with varied socio-economic characteristics. Socio-economic profile of the respondents is presented in Table1. The study covered 550 women within 15-49 years age group. The computed mean age of the respondents is 32 years and their average monthly family income ranges from Rupees 1000 to 2000. Nuclear families account for 65 per cent of the surveyed population while remaining 35 per cent respondents belong to joint families. Most of the respondents are farmers (46 per cent) as they are engaged in agriculture and per cent respondents are engaged in secondary and tertiary sectors.

Table 1: Socio-economic profile of respondents

Socio-economic characteristics		Number	Per cent
Religion	Muslim	43	7.82
	Hindu	507	92.18
Caste-group	SC/ST	133	24.18
	OBC	352	64
	General	65	11.82
Age at Marriage	Below 18	452	82.2
	Above 18	98	17.8
Females with no motherhood	Below 18	8	1.45
	Above 18	10	1.82
Females with motherhood	Below 18	283	51.45
	Above 18	249	45.27
Female education	Illiterate	372	67.6
	Primary	36	6.5
	J.H. school	50	9.1
	High school	37	6.7
	Above high school	55	10
Level of Income	Below 1000	141	25.6
	1000-2000	305	55.5
	2000-5000	81	14.7
	Above 5000	23	4.2
Family type	Nuclear family	358	65.09
	Joint family	192	34.91
Female age-group	15-24	72	13.09
	25-34	241	43.82
	35-49	237	43.09
Occupation	Government services	19	3.45
	Private services & Business	42	7.64
	Agriculture & allied activities	254	46.18
	Labourers	235	42.73

Source: Based on personal survey, 2011-12.

Only 11 had done high schooling and above high schooling courses, while majority of the respondents are illiterate. There are a few respondents engaged in agriculture and allied activities, and 43 per cent respondents are labourers employed in primary sector.

Population and poverty are both linked with the wellbeing of the individual, the overall quality of life in a society and national development as well. As it is said that population increase invites the poverty and vice-versa. Table 1 show that monthly income below Rs. 1000 per month is found in 25.6 per cent families whereas only 4.2 per cent families have income above Rs. 5000 per month. Moderate monthly income between Rs. 1000-2000 is found in 55.5 per cent families and 14.7 per cent families possess monthly income between Rs. 2000-5000 Hence, the monthly income below Rs. 2000 per month of above 81 per cent families in the study area indicates the low level economic condition of majority of the respondents.

Age at marriage and motherhood

The right to marry or not to marry is a basic human right. It is legally defined by a series of conditions, namely the requirement of the spouses consent for the marriage to be valid; the existence of a minimum required age for marriage; and the obligation to officially register the marriage. The absence of these conditions amounts to a violation of the right to marry or not to marry (Turan, 2008: 7). According to a United Nations Children's Fund ("UNICEF") report, girls who marry during their childhood do not develop properly, neither physically or psychologically. They are frequently denied access to education and are subject to different types of diseases arising from abnormal births and isolation.

In Chakia block among the women aged between 15 to 49 years, 82.2 per cent share of them are married below the age of 18 years and only 17.8 per cent women are married above 18 years. Lower age at marriage and lower age at first childbirth are undesirable since this results in worse health of both the mother and children (Pandey et al. 2013). Girls who are forced to marry in their childhood are not physically prepared for pregnancies and childbirth. The child marriage has many adverse effects in their physical as well as overall personality development. It causes several problems in their education, nutrition level and health.

Table 2: Age at marriage and motherhood

Age-group (years)	Age at marriage		Attended motherhood			
			No		Yes	
	Number	Per cent	Number	Per cent	Number	Per cent
Below 18	452	82.20	8	1.45	283	51.45
Above 18	98	17.80	10	1.82	249	45.27
Total	550	100	18	3.27	532	96.73

Source: Based on personal survey, 2011-12.

It is evident that 96.73 per cent of women became mother. Out of this, 51.45 per cent women hold the responsibility of motherhood below 18 years and 45.27 per cent women above 18 years. In addition, these births show that very young mothers carry on the burden of common marital life, the responsibility of assisting their other children, both girls and boys. The child marriage is a major cause of high fertility rate and in turn high fertility rate is the major reason for rapid population growth. High growth of fertility rate has the adverse effect on the health of low age women. The female child is not aware of sex and reproductive health. The abortion among these women is the major cause of uterus cancer and of many other related diseases. In rural areas majority of the women face the problem of anemia.

Intra-spouse communication about family welfare programme

Husband-wife communication is an important factor in the field of family planning communication, because, spouses are the major persons to decide about their family size. Sufficient evidence exists from the studies conducted in abroad to substantiate the dominance relations and the segregation roles which may affect the decision of the husband and wife jointly to practice family planning (Raju, 1987: 22). In societies where the male is the decision-maker in the family, he makes important decisions such as those relating to having or not having a child, using or not using contraceptives. In such a setting, an understanding of the role of healthy husband–wife communication in reducing the country's total fertility rate or in enhancing the use of contraceptives becomes a necessity (Acharya et al., 1996). In the survey, it is found that 76.90 per cent women discussed with their husbands about the family welfare programme whereas 23.10 per cent women never discuss about the family welfare methods. It is seen that the 61.82 per cent women were involved in the discussion of use of the family welfare methods and 15.09 per cent women do not use any family welfare method. One can find that merely 6.55 per cent women under non-discussion group use family welfare methods and 16.55 per cent women are not aware of these methods. Thus intra-spouse communication and promotion of family welfare programme are positively related.

Table 3: Intra-spouse communication about family welfare programme

Response	Never discussed	Discussed	Never discussed		Discussed		Total
			Non-users	Users	Non-users	Users	
Number	127	423	91	36	83	340	550
Per cent	23.10	76.90	16.55	6.55	15.09	61.82	100

Source: Based on personal survey, 2011-12.

However, in the study area, the educational data show that the intra-spouse communication is very high among the educated people (89.66 per cent) in comparison to the illiterate people (71 per cent). Thus, it can be inferred that education and intra-spouse communication are directly connected to each other. In the conclusion, it is found that 21.28 per cent illiterate women under non-discussion group are the not users of family welfare programme and merely 7.71 per cent are the users of the family welfare. Among the illiterate women, the percentage of users and non-users of family welfare programme are 58.51 per cent and 12.50 per cent respectively. Among the literate women, there are 20.69 per cent non-users and 68.97 per cent users.

Table 4: Education wise intra-spouse communication about family welfare programme

Educational level		Never discussed	Discussed	Never discussed		Discussed		Total
				Non-users	Users	Non-users	Users	
Illiterate	Number	109	267	80	29	47	220	376
	Per cent	29.00	71.00	21.28	7.71	12.50	58.51	100
Literate	Number	18	156	11	7	36	120	174
	Per cent	10.34	89.66	6.32	4.02	20.69	68.97	100

Source: Based on personal survey, 2011-12.

Child spacing (interval between first and second birth)

Limitations of birth rate and proper birth spacing have been two main objectives of the family planning in India (Bhalla et al., 1974). Social scientists believe that differences in birth-interval lengths are explained by varying breastfeeding patterns, contraceptive use, frequency of intercourse, incidence of abortion, and fecundity (Trussell et al., 1985). Birth spacing is not a popular practice in Chakia block as most of the couples who use contraceptives are interested in sterilization, once they have the desired number of children. In the study area 74.90 per cent women kept two years gap between first and second birth of child and 14.40 per cent women kept one year gap. And only 7.50 per cent females adopted 3 years gap between first and second birth, which is a healthy sign in view of the family welfare programme.

Table 5: Child spacing (interval between first and second birth)

Response	Interval between first and second birth				Total
	No child	1 year spacing	2 years spacing	3 years spacing	
Number	18	79	412	41	550
Per cent	3.30	14.40	74.90	7.50	100

Source: Based on personal survey, 2011-12.

Male and female involvement in decision of adoption of family welfare programme

Decision-making processes that involve both partners promote shared responsibility for contraception, lessening the burden on women, and encourage inter-spousal communication (MacDonald et al. 2013:33). Almost universally, women are responsible for actually using the contraceptive methods and men generally take decisions about what contraceptive method is to be used by their wives. "Since women usually did not hold a paying job and inherited little or no land, they were considered weak and worthless. Men felt that since they earned a living, women should always be subservient to them" (Efroymsen et al. 2006, 6). The study found that gender factors such as men's dominance in decision-making and cultural norms that condone a man beating his wife if she uses contraceptives secretly are barriers to use modern contraceptives (Visaria, et al., 1999). Personal survey conducted by the researcher shows that only 23.10 per cent married couple took decision jointly about the family welfare programme in Chakia block. But normally in male dominating rural society, all the decisions related to any aspect of family welfare programme were taken by male counterpart only. Similar response can be seen in the area under study where about 67.50 per cent husbands alone took decision about the family welfare methods. Very less percentage (9.50 per cent) is found in regards to wives who took decision in this context. This fact appears as one of the reasons against operating the family welfare programme successfully in the study area. Illiteracy among the females may be another reason behind this failure.

Table 6: Male and female involvement in decision making regarding adoption of family welfare programme

Responses	Decisions makers		
	Husband	Wife	Both Husband & Wife
Number	371	52	127
Per cent	67.50	9.50	23.10

Source: Based on personal survey, 2011-12.

Educational infrastructure and level as constraint in adoption of family welfare programme

Generally, a positive relationship exists between educational level and adoption of contraceptive. As a result of education both the age at marriage of wife and husband will go up automatically, adoption of contraceptive methods will be attempted and small family size will be achieved (Raju, 1987: 18). Shastri (1977) found that the level of income had a positive effect on knowledge of family planning (but not on its practice); it was the educational level which influenced the adoption and use of family planning method. Rising levels of education improve women's productivity in the home which in turn can increase family health, child survival, and the investment in children's human capital (M. Anne Hill & Elizabeth King, 1995 :21).

There are 113 primary schools and 47 junior high schools in the Chakia block. As per government norm there should be a primary school for a population of 300 at a distance of one kilometer and a junior high school for a population of 800 at every two kilometers. In view of these two norms, there is shortfall of 422 primary schools and 153 junior high schools. These schools may be established at the suitable places. The literacy level is very low in the study area. According to 2001 census, the total literacy is 43.12 per cent, while the male and female literacy rate is 54.23 per cent and 32.35 per cent respectively, which is comparatively very low compared to the state and country's average rate.

Table 7: Poor educational infrastructure and level as constraints in adoption of family welfare programme

Respondents		Educational level				
		Illiterate	Primary	J.H. school	High school	Above high school
Husband	Number	217	38	74	84	137
	Per cent	39.50	6.90	13.50	15.30	24.90
Wife	Number	372	36	50	37	55
	Per cent	67.60	6.50	9.10	6.70	10.00

Source: Based on personal survey, 2011-12.

Numerous studies indicated that education of husband and wife is a major determinant of completed family size and the length of the interval between births. Table 7 clearly shows that 39.50 per cent husbands and 67.50 per cent wives are uneducated in the study area. Thus 60.50 per cent husband and 32.40 per cent wives are educated. Along with low level of education in the study area there is a high educational gap between the husband and wife. Share of husband and wife with education above high school is 24.90 per cent and 10 per cent respectively while percentage of husband and wife with primary education is 6.90 per cent and 6.50 per cent respectively. Percentage of junior high school education of wives is only 9.10 per cent and of high school is 6.7 per cent. With regards to husband's education for these two levels are 13.50 per cent and 15.30 per cent respectively.

This means in the study area maximum husbands and wives are uneducated or they are educated less than high school standard. The knowledge about the health education and family welfare is not adequately provided to rural population and as a result they face many problems. Therefore, integrated efforts are needed for the improvement in literacy in general and women literacy in particular.

Planning of pregnancy

In India more than half children are being given unplanned birth. On account of insensibility of contraception, ignorance of taking pills and the lack of vigilance among women, they become victim of unwanted delivery (Visaria and Ramachandran, 1999). In the study area 95.2 per cent females reported

to have unplanned pregnancy during the first birth and only 1.6 per cent females were conscious for planned pregnancy. Similarly, at the second birth, 83.8 per cent females have opined for unplanned pregnancy and only 12.9 per cent females planned for second pregnancy. Although this fact indicates towards increase in the level of awareness about the planned pregnancy yet the magnitude is much less, indicating the partial failure of family welfare programmes. The reason attributable to the lower proportion of planned pregnancy is the lack of awareness among women (cf. Khan and Patel, 1997).

Table 8: Response about planning of pregnancy

Response	First pregnancy		Second pregnancy	
	Number	Per cent	Number	Per cent
No child	18	3.30	18	3.30
Unplanned pregnancy	523	95.10	461	83.80
Planned pregnancy	9	1.60	71	12.90
Total	550	100	550	100

Source: Based on personal survey, 2011-12.

Institutional and safe delivery

India's maternal and child health programmes have not aggressively promoted institutional deliveries, except in high-risk cases. The reason is that provision of facilities for institutional delivery on a mass scale in rural areas is viewed as a long-term goal requiring massive health infrastructure investments. Institutional delivery is nevertheless desirable, in as much as it reduces the risk of both maternal and infant mortality (Sugathan, K. S., Mishra, V. and Retherford, Robert D., 2001).

Table 9: Place of delivery

Place of delivery		Number	Per cent
Hospital (25.8 per cent)	Government hospital	119	21.6
	Private hospital	23	4.2
Home (70.9 per cent)	Home by trained personnel	122	22.2
	Home by untrained personnel	268	48.7
Total		550	100

Source: Based on personal survey, 2011-12.

Table 9 clearly shows that only 25.8 per cent of the deliveries were conducted in institutions including government and private hospitals. Of these deliveries, 21.6 per cent were performed at the government hospitals and remaining 4.2 per cent deliveries took place at private hospitals. In the area under study 70.9 per cent of the deliveries were conducted at home. Of these deliveries only 22.2 per cent were conducted by the trained personnel (ANM or trained dais), rest of them (48.7 per cent) were conducted either by family members or the untrained traditional dais and untrained doctors. *Dais* (TBAs) provide help to pregnant women at the first stage. With their experience and training, they give them some

massage, etc., and refer serious cases to the ANM or the health centre. Mostly, they conduct deliveries by themselves; it is only in complicated cases that they ask for the help of ANMs and other better-qualified persons. If they realise during an advanced stage of pregnancy, that the delivery is going to be complicated, they advise the pregnant mother to go for institutional delivery. They would like to have support from the state in the form of training and supplies (Khan et al., 1990). Some of the TBAs have already been trained, and the others expressed a keen desire to undergo training.

Income status of respondents and use of family welfare methods

Population and poverty are both linked with the wellbeing of the individual, the overall quality of life in a society and national development as well (cf. Xi et al., 2005).. As it is said that population increase invites the poverty and vice - versa. Table 10 shows that monthly income below Rs. 1000 per month is found in 25.6 per cent families whereas only 4.2 per cent families have income above Rs. 5000 per month. Moderate monthly income between Rs. 1000-2000 is found in 55.5 per cent families and 14.7 per cent families possess monthly income between Rs. 2000-5000 Hence, the monthly income below Rs. 2000 per month of above 81 per cent families in the study area indicates the low level economic condition of majority of the respondents.

Table 10: Income status of respondents and use of family welfare methods

Income group (Rs. in per month)	Respondents income status		Current use of family welfare methods				Total
			Non-users		Users		
	Number	Per cent	Number	Per cent	Number	Per cent	
Below 1000	141	25.60	54	38.30	87	61.70	141
1000-2000	305	55.50	92	30.20	213	69.80	305
2000-5000	81	14.70	25	30.90	56	69.10	81
Above 5000	23	4.20	3	13.00	20	87.00	23
Total	550	100	174	31.60	376	68.40	550

Source: Based on personal survey, 2011-12.

In the study area the positive relationship has been found between current users of family welfare methods and per month family income (cf. Table 10). While, there is negative relationship between non-users of family welfare methods and per month family income. This means with increase in income level there would be consequent increase in the percentage of users of family welfare programme. The lowest income group (below Rs.1000 per month) the proportion of non-users is highest (38.7 per cent) and vice-versa in the highest income group (Rs. above 5000 per month) (cf. Table 10). Several studies established the fact that employment opportunities will increase contraceptive use among women (Dharmalingam and Morgan,1996.187) Hence to enhance the use of family welfare programme, serious

efforts are needed to improve the economic condition of the village people especially targeting the women segments through agro-based industries, agro-business, household industries, poultry farming, pig farming, fish farming etc. There is a need of promoting more women Self Help Groups in the area under study.

Status of protection from sexually transmitted diseases (STDs)

Study of Sexually transmitted diseases (STDs) is an important component of reproductive health. The health programmes of developing countries have not traditionally accorded a high priority to the prevention and control of diseases which are predominantly transmitted by sexual intercourse (Nalwa et al., 2006). STDs are the major causes of mortality and morbidity in India, yet control of STDs has not been satisfactory. If STDs can be controlled HIV infection too can be controlled. These diseases and their consequences can be prevented in most of the people by properly educating them about STDs, thus checking HIV transmission also. Some major classical sexual disease includes syphilis, gonorrhoea, genital chlamydial infection, chancroid. It is known fact now that STDs increase the chance rate of transmission of HIV infection. For example syphilitic infection can increase the possibility of HIV infection by nine times. Gonorrhoeal infection and chlamydial infection may increase the HIV infection by five times. Chancroid or soft sore also increases the risk by five times (Ghys et al., 1997). As the heterosexual transmission of HIV and other sexually transmitted infections is an increasing problem in India, particularly amongst youth, it was deemed crucial to address the stigma and misconceptions that exist around condom use (Roth et al. 2001; Kaljee et al. 2007). Condom is regarded as the most effective contraceptive method to keep or maintain the difference between the consecutive births. Using condom can not only control the pregnancy but also check the transmission of STDs. CHC of Chakia in the year 2007-08 got 87.6 per cent achievement in context of services related to condom use. But according to personal survey the result is astonishing, because according to present survey, only 3.82 per cent people are using condom as a contraceptive method of family planning. This directly point outs that about 96 per cent married couples are still vulnerable to the danger of STDs. To reduce the number of vulnerable couples from STD/RTI/AIDS the use of condom as a dual protection device should be popularized among the masses. In addition, male-centered contraceptive methods involve active male participation, thus promoting shared responsibility against pregnancy and the transmission of disease.

Table 11: Status of protection from sexually transmitted diseases (STDs)

Respondents	STDs protected method	Non STDs protected methods			Non-users
	Condom	IUD	Oral pills	Tubectomy	
Number	21	71	46	238	174
Per cent	3.82	12.91	8.36	43.27	31.64

Source: Based on personal survey, 2011-12.

Sex-wise discrimination in adoption of family welfare methods

The family planning programme will become the people programme only when both the males and females are involved in equal proportions without leading to any bias to one sex in its implementation (Reddy, 1998: 260). But table 7.11 shows biased family welfare programme towards females in the study area. Sterilization is a permanent method of family planning to limit the size of family. Population control programme in Chakia block is women centered because in spite of concerted effort for male sterilization (vasectomy), female sterilization (tubectomy) is more prevalent. There is huge difference between the adoption of vasectomy and tubectomy. In the study area the female sterilization is 43.27 per cent while male sterilization is nil. This fact is also clear from the government record that during the period 2007-08 and 2008-09 entire sterilization at Chakia CHC has been done only to females.

Table 12: Sex wise discrimination in adoption of family welfare methods

Respondents	Male users		Female users			Non-users
	Condom	Vasectomy	IUD	Oral pills	Tubectomy	
Number	21	-	71	46	238	174
Per cent	3.82	-	12.91	8.36	43.27	31.64

Source: Based on personal survey, 2011-12.

This trend of a significant variation between vasectomies and tubectomies in sterilization programme makes the entire programme a female family planning programme. This aspect of female segment of population became a cause for concern of alarm and needs proper timely action to bridge this gap. And interestingly and surprisingly this trend is not limited to sterilization alone. It is even noticed and observed in the case of the adoption of different spacing methods also. Almost all temporary methods are also centered on females. If this trend is not changed immediately, a situation will prevail where the entire burden of the adoption of family planning will fall upon the females only. It will lack the people's participation and support from the other male segment of the population whose contribution and co-operation is essential to make the family welfare programme a successful one in the country.

Multivariate analysis

Table 13 presents the results of logistic regression assessing the association between adoption of family welfare methods and the explanatory variables. The 95 per cent confidence intervals are presented in the Table. The result shows that respondent's Intra spouse communication, female education and income are significantly associated with adoption of family welfare methods. Contrary, marriage age, motherhood age, child spacing, decisions making and place of delivery have not appeared significantly

associated with adoption of family welfare methods. As it is expected, level of education has shown a positive relationship with the current use of contraceptive. With the increase in level of education of wife, the current use rate of contraception also increases. Analysis revealed that the contraceptive use rate is 2.2 times higher among the respondents who are educated. This is an important fact for programme implication. A significant association was found in terms of contraceptive use with high monthly income for family planning acceptance. The respondents who have per month family income above Rs. 5000, the current contraceptive use rate is 3.2 times likely to be higher than low income group (below Rs. 2000 per month family income).

Table 13: Logistic regression results, predicting the odds of adoption of family welfare methods according to selected major problems in adoption of family welfare programmes

Basic characteristics		Odds ratio	95% Confidence interval	
			Lower	Upper
Age at Marriage	Below 18(RC)			
	Above 18	1.378	1.109	9.101
Age at Motherhood	Below 18(RC)			
	Above 18	2.189	2.309	12.154
Intra-spouse communication	Never discussed (RC)			
	Discussed	2.521**	1.181	5.723
Child spacing	1 year spacing (RC)			
	2 year spacing	4.754	2.109	5.101
	3 year spacing	1.126	0.562	2.229
Female education	Illiterate (RC)			
	Literate	2.290**	0.767	2.171
Income level	Below 2000 (RC)			
	2000-5000	1.106	0.566	2.162
	Above 5000	3.270**	0.708	15.109
Decisions making	Husband (RC)			
	Wife	1.106	0.566	2.162
	Both husband & wife	2.270	0.708	15.109
Place of delivery	Home (RC)			
	Hospital	0.535	0.128	2.226

Note: ** $p < 0.05$, (RC) Reference category.

Comment: Intra spouse communication, female education and income are important predictor of adoption of family welfare methods.

From the results of logistic regression analysis, it appears that respondent's intra spouse communication is the most significant factor affecting the current use of contraceptives. Education, intra-spouse communication and family welfare are directly connected to each other. If the female education is increased in the study, it will automatically increase the intra-spouse communication and this communication in turn will support to the use of family welfare methods. Therefore, government should promote female education because it may be a good catalyst to control the rapidly increasing population in the study area.

Concluding remarks

The study demonstrates that socio-economic development and women's status significantly impact the use of contraceptive methods in study area. The results also suggest that families with better female educations, higher monthly family income are more likely to use contraception than those who have little or no formal education and who do not have better family income. The knowledge about the health education and family welfare is not adequately diffused in rural population; therefore, they face many problems. Hence, integrated efforts are needed for the improvement in literacy in general and women literacy in particular. In the study area a positive relationship has been found between current users of family welfare methods and monthly family income. It implies that with increase in income level there would be consequent increase in the percentage of users of family welfare programme. In this context, to enhance the use of family welfare programme, serious efforts are needed to improve the economic condition of the rural India through promotion of women empowerment and encouraging several agro-based industries, agri-business, household industries, poultry farming, pig farming, fish farming etc. Women Self Help Groups, NGOs can be instrumental in reducing the hurdles coming in the way of rural health, meeting the unmet needs and achieving the unachieved targets rural India in general and Chakiya Block in particular.

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