LISTENING TO WOMEN

"EVOLVING A WOMAN-SENSITIVE POPULATION POLICY THROUGH CONSULTATIONS WITH RURAL WOMEN IN INDIA"

Final Report of the First Phase
September 3rd, 1993 - January 31st, 1994

by

INSTITUTE OF SOCIAL STUDIES TRUST

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I The Process

The Institute of Social Studies Trust, a small research and advocacy organization, attempted to bring the voices of rural women from poor households into the ongoing debate on population and development. For this, a number of consultations were carried out with rural women with the help of seven rural-based voluntary agencies who offered their willingness to participate in this process. This is the first glimpse of their views. A fuller presentation will be developed for Cairo.

Partnering organizations discussed the issues of concern as well as the methodology for drawing women's views out at the first round table. The discussions centered around health needs, reproductive rights, contraception, and the issues that rural women would like to address in order to change the system into one that gives them a better quality of life. An open-ended checklist or prompter was designed by the groups on which to base their discussions in the villages. A series of consultations with rural women were held and summed up in a final workshop. Rural women were listened to as individuals and in groups. The organizations that could included men as well.

The seven grassroot organizations partners were selected to represent the four regions of India - North, South, East and West as well for their large mass base and intimacy with rural women (see Chart attached).

II What did they say?

What we learnt is that these women need not be taught: they need to be listened to.

"Does the government think we are stupid, appealing to us to reduce our family size, as a panacea for our problems of hunger, unemployment, water, and security? Those who fell for the trap in those appeals are fools. The message now has no value."

- Banwasi Sewa Ashram workshop

"Family Planning means women's sterilization... and the indifference of the services is leading to sickness.."

- Kasturba Gram workshop

"Men do not even use the condom their demand for sex is so impulsive that they have no time to put it on..."

- Kasturba Gram workshop

"Who will protect our girls when they walk to school?"

- Mahila Haat workshop

"Inform us about these technologies and state programmes and we will resist."

- RUWSEC workshop

III Messages

Clearly, the message is that salesmanship without good product investment is counterproductive. Attention to social amenities like water, electricity, employment, women's role and power, is critical and prior to reduction in family size and ensuring family happiness.

Attention to men in canvassing, education, contraceptive research and technologies is much more important than addressing women. i.e. Family Planning is about men.

The demand for information from Tamil Nadu women tells us that consumer education is critical in strengthening women to resist assault of their bodies.

IV Convergence

The most important finding of these consultations was the recognition that despite cultural, geographical, and socio-economic indicator-based diversity, the voices of our partners converge in their experience, analysis and findings. With one voice they see:

a) Elements of economic and social security as not only prior but a necessary condition of moving into size of family choices.

b) Injustice in access to and allocation of assets, resources, services as deterrent to their struggle for a sustainable livelihood and life strategy.

c) The State and its functionaries as perpetrators of injustice and violence on them.

d) The approach as perpetuating the hierarchies of gender : the onus being put on the woman, the whole system sees her as perpetrator of numbers adding to the further reduction of "value" of the female.

e) Problems of violence resulting from alcohol consumption, corruption within the health care system, male-dominated social and political structure run through their analysis.

f) The power to decide, to live and choose freely, through organized strength of women's groups, having access to information, and networking towards solidarity is their key to reproductive choice.

V Their views:

1. **Employment:** The main issue for women was economic security through employment, how to get a job that would enhance the family income.

2. **Water:** Several of the regions complained of a total lack of water facilities with women having to walk long distances everyday to collect water for family-use. In areas where agriculture is the main activity, a lack of water results in the inefficient use of land.

3. **Service delivery system:**

a) Blood and urine testing laboratories

b) Well equipped PHCs (adequate beds,medicines, trained doctors, especially lady doctors)

c) Counselling facilities and information: Health education workers to give them correct information about contraceptive methods, their advantages and disadvantages.

d) Facilities for child delivery

f) Facilities for those who cannot have children

g) More access to ANMs/MHWs.

h) Training to village women to handle deliveries

4. **Sanitation:**

a) Toilets: Women complained that it was extremely difficult for them as there were no adequate toilet facilities.

b) Training to children for cleanliness

c) Proper drainage system, particularly in areas where water clogging is a problem

d) Covering the well, pots etc which are used for drinking water

5. **Roads:** Many groups complained that a lack of roads further decreased their access to health care facilities.

6. **School:**

a) The desire is there for educating children but a lack of schools in many cases prevents them from sending their chil dren to school.

b) Sex education to be given from Std. 9 onwards.

7. **Research on contraceptives:**

Research should be oriented towards developing new methods that are applicable to men as well as developing less harmful indigenous methods. Methods should be developed that do not weaken the health of people and ensure that the failure rate is negligible.

This package is familiar to the mainstream debaters- The need to provide access to water and food, to respect women for their intelligence, to provide the cultural milieu for enhancing women's worth, to improve their information base, as well as the range and quality of services.

VI Questions

But what the consultations do is to draw our attention to pressing questions that we must reflect on for future action: **What are the institutional alternatives to the current health care delivery system?**

Given the fact that the State and its service delivery system has lost credibility in the eyes of the recipients, as has come out clearly through these consultations, who will take responsibility in bringing better health services to the people in the future? Most pro-poor lobbies and forums would want the State to be made responsible to provide for the social and economic security of its people; however how can it fulfill this obligation given the corruption within the health care system, the frustration of both its own health care functionaries as well as the people receiving these services?

If the State cannot fulfill its role as **provider,** should it restrict itself to being a **funder** and entrust the role of provider to NGOs and community-based organizations? How will the State then **monitor** these activities, and how do we build accountability into the system?

The role of the Panchayati Raj institutions -i.e.local self government - vis-a-vis health services needs to be examined as an institutional alternative. Suggestions have been made that the PHCs should be made accountable to the Panchayats, that Panchayats and NGOs should link up their activities, that Panchayats should assume the responsibility of ensuring better quality health services in their areas. But local self government institutions do not want to be "reduced" to being extension limbs of the administration. They want to be autonomous.

How do we introduce the element of a "right" to health into a decentralized structure without a 'central' policy? And how do we link such mandates to local autonomy? These questions still remain. It is these implementation details that will make the difference to poor women : not the statement of intention.

CHART I

Name of the Organization	Main Activities	No.of women consulted (approx.)	No.of villages covered (approx.)	No. of workshops conducted by ISST
1.Mahila Haat U.P. (Hills)	Income generation projects for women producers in Kumaon	200	10	1.Sept.3-4 '93 2.Oct.9-10 '93 3.Jan.8-9 '94
2.Banwasi Sewa Ashram U.P. (Plains)	Rural development combining health care and economic development for socioeconomically depressed communities.	150	5	
3.Indian Institute of Education (Maharashtra)	Training, teaching, action-research projects relating to education, health, and overall development of rural women.	220	10	
4.Trust for Reaching The Unreached (Gujarat)	Works for promotion of community health in tribal and slum areas.	350		
5.Rural Women's Social Education Center (Tamil Nadu)	Main focus is on women health-related activities -training and empowerment of rural poor women.	300	15	
6.Kasturba Gandhi Nat'l Memorial Trust (M.P.)	Basic education center with maternal health care for poor women.	200	5	
7.Bijapur District Women's Multipurpose Cooperative Society Ltd. (Karnataka)	Political and economic empowerment of women.	500	5	

INDIAN INSTITUTE OF EDUCATION

Pune, Maharashtra

EVOLVING A WOMAN SENSITIVE POPULATION POLICY

(A Study conducted in Pune District, Maharashtra)

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PUNE
January, 1994,

PREFACE

This study is a part of a larger study undertaken by Institute of ocial Studies Trust, New Delhi, funded by UNFPA. The hope of this roject was to bring together diverse opinions and view points through uch studies that reflect on poor women's concerns and ideas on opulation, besides ideas and issues in the field of health, especially eproductive health that preoccupies rural poor women.

In all, Eight organisations were co-ordinated on this project by SST of which Indian Institute of Education, Pune, was one. I would like o acknowledge the guidance given by Dr. Chitra Naik, Member, Planning Commission, New Delhi and Project Director for the study conducted in Maharashtra, assistance in the data collection to Smt. V. Kotwal, Smt. J. Gaikwad and Smt. J. Bokil,(all staff members)and Smt. M. Parkhi for assistance in statistical analysis - all staff members of the Indian Institute of Education, Pune.

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EVOLVING A WOMEN SENSITIVE POPULATION POLICY

INTRODUCTION :

'Women are at the centre of the development process. The improvement of their status and the extent to which they are free to make decisions affecting their lives and that of their families is crucial in determining future population growth rates.'[1]

Historically, population policies and programmes have been driven more by demographic goals than by quality of life goals. This needs to change so that the goal of population policies is not just to bring down the birth rate, but to empower women through improving their health status and quality of life and enable free, informed and socially desirable decisions on reproduction. Review of the factors influencing fertility behaviour leads to the conclusion that an effective 'women-sensitive' population policy needs to go beyond a family planning programme, encompassing material and reproductive health and issues at various stages of women's lives. While assessing the usefulness of safety of FP methods in areas where resources are low and where women suffer from high levels of reproductive morbidity and malnutrition, where the health infra-structure is rendering poor quality of service, it is more important to address the non-reproductive health issues and the need to reduce morbidity and malnutrition in order to improve the quality of family planning methods.

Recent statistics show that 55% of F.P. acceptors are 30 years of age or over and already have three or more children. The death rate from all pregnancy-related causes is approximately 340 per 1,00,000 compared with 6 per 1,00,000 in Europe. Of the 57% married girls under

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1. Ahmed R., Population Headlines, No. 207, June 1992, p1.

19 years only 16% have adopted family planning methods. The undifferentiated pursuit of targets and the predominance of sterilisation have led to the above stated lopsided results.

The health system should be responsive to all health needs including occupational health, reproductive health, maternal health, mental health and nutrition. Along with this, a core programme of reproductive health needs to be strengthened. Demographic literature ranging from statistical accounts of fertility levels, target achievements and performance evaluation, including use of contraception to the survey of knowledge and attitudes towards family planning, brings out clearly that though fertility has been treated as an almost exclusively female attribute, the decision-making in terms of not only F.P. but also who would practise it lies beyond the female domain.

2. OBJECTIVES :

There needs to be a fundamental revision in the design, structure and implementation of population policies, so that the focus is on the empowerment and well-being of all women. Changes are therefore needed in the design of family planning and health services and information, the ways in which these are provided and the processes for involving women at all levels of decision-making and implementation. For this purpose, firstly, base-line information at grass-root level is needed. Information from selected areas needs to be collected with regard to birth-rate, family size, health services, income levels, literacy levels and other aspects relating to women's empowerment. Here, the objective of this study was to prepare a brief area profile.

The fundamental goals were -

i) to understand women's perspective on elements of quality of life reflecting on family size;

ii) to understand women's experiences about various contraceptive methods and information given to them about the same by F.P functionaries.

3. METHODOLOGY :

The entire study is a combination of surveys of the 'study population' and group meetings. An interview schedule was individually administered to the study-population which comprised 100 women selected by random sampling in 6 villages. The villages Wangani, Kodavadi, Kurungwadi, Alande, Manjaiasni and Kusgaon were randomly selected from the hilly and rain-fed areas of Pune district. All these villages lie more than 35 kms. away from Pune city approachable from the Pune-Bangalore highway. This was the first stage of the study and analysis of the information obtained through the interview schedule in keeping with the objectives was done.

In the second stage, group meetings were conducted for 120 women of the age-group 20-45 years of age in the villages of Kasurdi, Kapurhol, Wagazwadi and Kenjal, all approchable from the Pune-Bangalore highway. Informal discussions were conducted in these villages regarding family welfare and population issues.

4. FINDINGS :

A brief sociological, demographic and socio-economic status profile of the 100 selected respondents is given prior to the presentation of the findings.

4.1 Social Profile of Respondents :

Religion :

The sample had a mixed population of Hindus and Muslims. The dominant religious group was Hindus.

Table : 1

Sample size	100
Hindus	98
Muslim	2
Total :	100

Caste :

There were very few advanced caste respondents and it was a mixed group including backward and scheduled castes.

Age :

All the respondents interviewed in the sample were female. A majority of the respondents were in the peak reproductive age-group i.e. 15-39 years. Only 10 women were above 45 years of age.

Marital Status :

Only 3 respondents were unmarried while the others were all married.

Family Type :

By and large a majority of the respondents lived in joint families and some had nuclear families.

Table : 2

Sample size	100
Class	Frequency
Joint	62.00
Nuclear	38.00

Total :	100
	=====

Family Size :

The average family size was between 5.5 and 6.1 and the mean number of children ranged between 2.4 and 3.1

Table : 3 (a)

Total Numbers

Sample size	100
Total numbers C.I.	Frequency
1-4	14
5-6	41
7-10	37
11-20	8

Total :	100
	===

Table : 3 (b)

Sample size	100
Males in family C.V.	Frequency
0	11
1	56
2	24
3	98
4 and more than 4	11
Total :	100

Table : 3 (c)

Sample size	100
Females in family C.V.	Frequency
1	38
2	38
3	13
4 and more than 4	11
Total :	100

More often than not, it is the male members of the family who make decisions regarding all aspects of family life. In most joint families, the male or the senior-most female (usually the mother-in-

law) makes the decisions while nuclear families are generally male dominated, the women having little or no voice at all in decision making.

39 respondents had at least one son, 36 had two sons, 11 had three sons, 3 had 4 or more sons and 11 had no sons at all.

Table : 3 (d)

Sample size	100
Sons C.V.	Frequency
0	11
1	39
2	36
3	11
4 and more than 4	3
Total :	100

The 'boy fixation' is a dominant factor especially amongst the land owning communities. Some are regarded as an investment to plough the fields to generate income even if they migrate to cities, to look after old parents and continue the family line. On the other hand, daughters are regarded as belonging to the families they marry into. 39 responded as having one daughter, 25 had two daughters, only 9 had three daughters and 8 four or more daughters.

Table : 3 (e)

Sample size	100
Daughters C.V.	Frequency
0	19
1	39
2	25
3	9
4 or more than 4	8
Total :	100

Occupation :

Majority of the women (70) were engaged in agricultural activities, 20 in farming and 10 were housewives. As regards the occupation of their spouses the break-up is as given in Table:4 below.

Table : 4

Occupation of Spouses

Sample size	100
Occupation of Husband	Frequency
Agriculture	29
Business	12
Agriculture and Business	11
Service (as truck driver etc.)	32
Labourer	12
Agricultural Labourer	1

Milk cattle	1
No Job	2

Total :	100
	===

Most men are engaged in service outside their respective villages being employed largely as truck-drivers or in mills in Bombay and in other service sectors in and around Pune.

Among those whose occupation was agriculture, most worked in their own fields. 85 women responded as having their own agricultural land while 15 did not own any land. The average agricultural area owned was 64 Gunthas. (1 acre = 40 gunthas).

Annual Income :

The average annual income was found to be approximately Rs. 21,024/-. The income of the respondents was reflected in their housing conditions where a majority (41) had 2, room houses, 31 had 3 room houses, 18 had only 1 room houses while only 10 had 4 or more rooms in their houses. The last category comprises of mainly those who have larger pieces of agricultural land and also have business, mostly dairying.

Table : 5

Sample size	100
Rooms	Frequency
1	18
2	41
3	31

4 or more than 4	10

Total :	100
	===

Rooms average = 2

(Modal value for f = 41)

Educational Level :

The data on educational status revealed that 32 were illiterate, 14 had studied upto Class-II, 12 upto Class-IV and 42 upto Class-V and above.

Table : 6

Educational Level

Sample size	100
Level	Frequency
0	32
1-2	14
3-4	12
5 and more than 5	32

Total :	100
	===

Average Education = 2

(Arithmetic Average)

4.2 Drinking Water and Sanitation :

Drinking Water and Sanitation will have to be clubbed into health care and family welfare as both the quality of drinking water and state

of sanitation affect the health and family welfare of the people. The source of drinking water is more often than not the well (Table : 7) or even tap source where all other activities like washing and bathing are also carried out. For good health, provision of safe drinking water is essential. Moreover, the women have to be made aware of methods of purification of water and urged to use the methods which they do not use even if they have the information.

Table : 7 (a)

Source of Water

Source	Village
Well	4
Tank	1
Tap	1

Total villages :	6
	===

Table : 7 (b)

Water Purification

Sample size 100	Frequency
Boil	5
Do not boil	95

Total :	100
	===
Filter (with cloth)	58

Do not filter	42
Total :	100
Alum	7
Do not use alum	93
Total :	100

Cleansing of water storage utensils must be done in a hygienic way, since although most reported favourably, (84) they usually clean their utensils with ash which may not be hygienic.

Table : 7 (c)

Cleansing of water

Storage utensils	
Sample size 100	
Clean utensils properly	84
Do not clean utensils properly	16
Total :	100

Washing of hands especially after defecation is an important aspect in health and while 57 responded to using soap for the purpose, among the remaining 43, only a small number use 'ash' for washing of hands and while the others use mud.

Table : 7 (d)

Washing of hands

Sample size 100	
Use soap for cleaning hands	57
Do not use soap for cleaning hands	43
Total :	100

Sanitary conditions are poor. 79 reported not having toilets a their maternal home and 98 responded that there were no toilets a their mother-in-laws's place - their current home. Only 40 respondent had put forth before their husbands or in-laws their decision of havin a toilet at home while 58 were unable to put forth their views. A stated earlier, decision-making lies beyond the domain of women.

In order to improve sanitation, it is necessary to develop l cost sanitary arrangements including toilets with waste disposal syste which will be cheap, easy to maintain and acceptable to the people. A many diseases are transmitted by human faeces, extensive programme i enlightening the women and men on sanitary habits are necessary. I the rural areas, at least pit latrines which cost an insignifican amount should be initiated.

4.3 Environment and Pollution :

Indoor air pollution is a critical environmental problem, exposing the women (and other family members) to very harmful air pollutants than does pollution in outdoor air. Smoky houses have peak levels of total suspended particulates (10,000 or more micrograins per cubic

metre). Rural people are thus prone to much exposure to particulates. Women and young children suffer the greatest exposure.

Of the respondents, only 31 stated they faced problem due to smoke while 69 stated they had no trouble. This is because the women become used to working in an environment of smoke and the discomfort they face is not identified by them as a problem or trouble as it is a day-to-day affair for them.

Indoor air pollution contributes to acute respiratory infections in young children and chronic damage to the respiratory system among adults.

The most powerful forces for reducing domestic risks to health are better income and increased education for household members. Higher incomes make it possible for people to afford household improvements including water and sanitation services, as they desire. As people acquire more education, their hygiene improves and their responsiveness to public information programmes increases.

Diseases are also transmitted by insect vectors and 54 women reported using remedies (insecticides) for insect control while 46 did not use anything for insect control.

4.4 Nutrition :

As regards nutrition, the women responded that their daily intake includes 'bhakari', rice, pulses, vegetables and sometimes meat and eggs. They also have two meals a day and eat with the family. But data revealed that the diet intake of the women is very low. Moreover, they do not have awareness of a nutritious diet. They eat more poorly than their incomes allow because of ignorance.

Table : 8

% of Nutrition (N)	Frequency
25 (only 1 food item of V,D,P,S)	8
50 (2 food items of V,D,P,S)	32
75 (3 food items of V,D,P,S)	57
100 (4 food items of V,D,P,S)	3
Total :	100

93 out of 100 do not take salads.

(100% Nutritious food contains all 4 parts viz. V (vegetables), D (dals), P (Pulses, i.e. 'Usal') and S (Salads).

Regarding the opinion of the respondents as to the sufficiency of food, 90 stated their food intake was sufficient while 10 stated the did not get sufficient quality of food.

Though the women have started taking different food items, many find it difficult due to poverty to include nutrients regularly in their diet. More often than not, they make use of their farm/field produce in their day-to-day intake. Supplements in diet are made only during festivals or on certain occasions. As a result of this they (and children) suffer from diseases due to malnutrition which they generally tend to overlook.

Occasionally, women take meat (76) which supplements their diet to some extent.

Table : 9 (a)

Sample size : 100	Frequency
Taking meat and eggs	76
Only vegetables	24

Total :	100
	===

Intake of milk is very low. Usually women give the milk to children and even if they are having a home supply of milk they sell it rather than keep any part of it for themselves.

Table : 9 (b)

% intake of milk

Sample size 100	Frequency
0 (No. i.e. level 0)	71
25 (sometimes i.e. level 2)	9
50 (yes - taking with rice or) 'bhakari' i.e. level 2)	12
75 (sufficient i.e. level 3)	0
100 (ample i.e. level 4)	8

Total :	100
	===

Being close to Pune city, women do consume fruits (usually seasonal fruits) though there is no regularity in the intake. Many of them also fast, so their dietary intake at such time includes common fruits.

Table : 9 (c)

% intake of fruits

Sample size 100	Frequency
0 (No. i.e. level 0)	28
25 (Sometimes i.e. level 1)	14
50 (Yes i.e. level 2)	55
75 (Considerable i.e. level 3)	0
100 (Ample i.e. level 4)	3

Total :	100
	===

Table : 9 (d)

Meals information

Sample size 100

31 out of 100 women	take 3 meals
23 out of 100 women	take spicy food (which reduces their food intake)
82 out of 100 women	prepare sweet dishes.
39 out of 100 women	like to have variety in their meals.
58 out of 100 women would	like to use variety in meals.

Generally, the women are very much used to their regular food habits and they do not like to bring in variety. Given the information and know-how, they are, to a certain extent, interested in learning about new food.

Even during pregnancy, the women do not take any supplements in

ir diet. They either have their regular diet while those who have ckness' problem especially in the first trimester have a very poor tary intake. This leads to birth of low-weight babies which results infant mortality risks.

Table : 10

Nutrition during pregnancy

Sample size 100	Frequency
50 (very less)	25
75 (little less)	13
100 (as usual)	41
100+(more than normal)	21
Total :	100

Those women whose husbands work in cities around Pune, Bombay and operate as truck drivers or are in contact with the urban areas are aware of this and avert the risks through proper dietary care during pregnancy. High infant mortality indicates the prevalence of malnutrition leading to an increase in the number of children born. Even if this awareness is given to women, availability poses another problem. However, through educational programmes, women can be taught the use of local produce to have a nutritious diet.

The women are found to observe the ritual of fasting for various reasons. Many observe them for having sons though only 11% women declared to have used superstitious practices (like praying to a deity) regarding the birth of a son. Only 9% women have scientific knowledge

egarding the birth of a son, through their contact with urban areas. thers fast for the well-being of their husbands and children but very ew have been carrying on the tradition of fasting started by their mother-in-law or other elders in the house.

Table : 11 (a)

Fasting

Sample size 100	Frequency
% of fasting	
0 (No fasting)	10
25 (Once in a week)	30
50 (Once in a week)	40
75 (Thrice in a week)	16
100 (Twice in a week and many occasional fasts/thrice in a week and some occasional fasts).	4

Total :	100
	===

The diet during fasting is considered to be sufficient since it consists of some alternative foods and fruits.

Table : 11 (b)

Diet at fasting

Sample size 100	Frequency	
Sufficient (eating enough quantity)	78	87.00
Not sufficient (only taking tea or	12	13.00

fruits)

(10 do not fast)

Total :	90	100.00

4.4 Family Planning :

Most of the wome were married at a very early age and had children early as a consequence. Given below are the average ages of women at marriage and birth of children.

Table : 12

Sample size : 100	
Average age at marriage 15 years	100
Average age at 1st child 17 years	100
Average age at 2ns child 20 years	93
Average age at 3rd child 22 years	67
Average age at 4th child 25 years	28
Average age at 5th child 26 years	5
Average present age	28 yrs
Average number of deliveries	2.90
Average number of children	2.76
% Ratio of number of children to number of deliveries	95.17
The difference between deliveries and children.	290 - 276 = 14
Details :	
Children lost	11

Abortion	3
Child deaths among 100 families	14

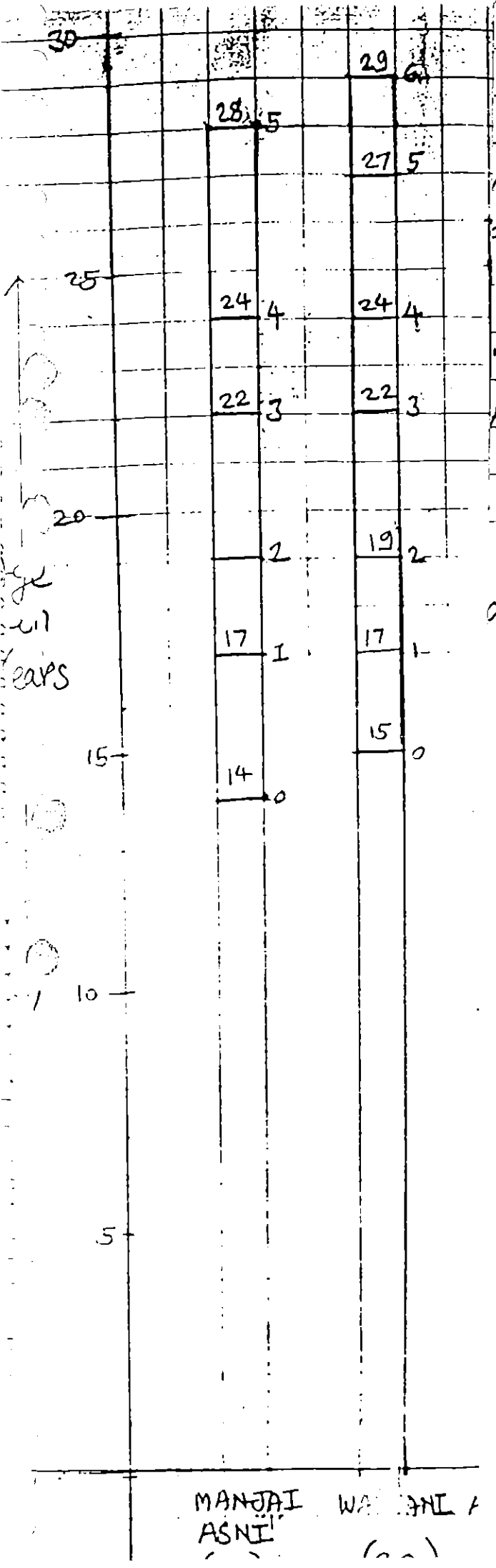
Most deliveries are carried out at home by a midwife, 'dai' or other, or mother-in-law. They are conducted by traditional methods and only a small number had their deliveries in the hospital or PHC.

Table : 13

Sample size 100 % delivery at home	Frequency
0	25
1-25	2
26-50	14
51-75	7
76-100	52
Total :	100

During menstruation, very few i.e. 37 women take rest while 63 continue with their daily routines. Even the 37 who take rest mainly do so due to the custom of 'sitting aside' during this period. While they do not do the cooking and other home-related work they are engaged in all outdoor activities. So one cannot say they are actually taking rest.

The data on spacing and small family size revealed that more than three-fourth of the respondents did not know about the advantage of



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eight of the BAR
o children i.e. the
dicating "Age at Marriage".

6 to the right of the BAR
"No. of children" corresponding
Age in years given to the
each of them.

in bracket below the
of villages and 'COMBINED'
Sample Size for the village

temporary methods of spacing in limiting the family size, the risks involved if enough spacing is not maintained and family size is large, and repurcussions in the case of quick succession of child-births on the child's as well as mother's health. There seemed to be a phenomenon of natural spacing of children due to prolonged on-demand breast feeding which leads to natural spacing though this is not a definite method.

Limiting the family to 2 children was generally not practised since family members - usually husband or mother-in-law wanted 2 sons or more. As regards the women, they gave an opinion regarding the desired number of children as follows :

Table : 14

Opinion about number of children

Sample size 100	Frequency
1 Son	24
2 Sons	29
3 Sons	0
1 Daughter	1
2 Children	18
3 Children	5
4 Children	2
As many as God gives	1
No response	20
Total :	100

Women have a preference for sons for it is their belief that the sons will look after them and shoulder their responsibility in their old age, as seen below :

Table : 15

Dependence on children (sons) score

Description and sons	Frequency
Don't depend i.e. 0	4
Are not sure i.e. 1	40
Expect to depend i.e. 3	44
Must depend i.e. 4	12
Total :	100

Regarding knowledge of contraceptive methods 28 were not aware of any contraceptive method to limit family size. The distribution regarding knowledge of family planning devices is as given in Table : 16.

Table : 16

Sample size 100

Type of FPD	Frequency
Tablet	1
Copper T	3
Condom	1
Tablet and Copper T	4
Tablet and Condom	1
Copper T and Condom	4

Tablet, Copper T and Condom	8
Copper T, Loop and Condom	2
F Ops (Tubectomy)	26
Tablet, Condom and F Ops	1
Copper T and F Ops	4
Tablet, Copper T and F Ops	8
Copper T, Make D, Condom and F Ops	1
Tablet, Copper T, Condom and F Ops	6
Copper T, Condom and F Ops	1
Tablet, Copper T, Condom	1
Loop, Jelly, F Ops.	
No FPD known	28

Total :	100
	===
Knowledge of Condom	26
No knowledge of condom	74

Total :	100
	===

Comment : 48% were F Ops (tubectomy cases).

Among the permanent methods of limiting family size i.e. sterilisation, 48% had got themselves operated. Though 4% knew about vasectomy they were not ready to have the men operated due to certain misconceptions about the operation. Besides, women preferred to be operated as it gave them a period of rest and marked attention from

their husbands and other family members.

From the data on use and non-use of contraceptive methods, 51 women did not use any contraceptive method, while 3 used IUD and 46 were sterilised. It can be seen that women opt for terminal method rather than temporary methods. The difficulties faced in use of contraceptives were given as lack of proper place to keep them, adverse side effects and opposition of in-laws to use of contraceptives. Only reported they used IUD with the consent of their husbands. 14% women have misconceptions regarding use of FPDs which must be removed. Data on reasons for not using contraceptive methods among those who did not use any FPDs, 15% did not use them as it is bad for health, 26% felt no need to use them as their husbands were away and they already had 1 or 2 children, 46% reported having no access to/no means, 20% did not like to use them while 15% were afraid to use them.

A positive attitude needs to be developed to put it into practice/action. For this, more systematic planning and strengthening of educational contact is needed to bring about an attitudinal change and thereby improve the quality of life of individuals.

4.5 Health

Vaccines to prevent tuberculosis, measles, diphtheria, tetanus whooping cough and polio have revolutionalized preventive medicine over the past two decades. These vaccines together with BCG immunisation against tuberculosis and leprosy and immunization of pregnant women against tetanus form the expanded programme of immunization. 98% women have immunised their children while 2% have not. Out of 98, one woman did not immunise her second child. 91% consult the doctor's mainly for

their children while 9% did not go to the doctor. 21% tried home cures before consulting a doctor while 79% did not use any home cures. More and more women are becoming aware of utilising health services available in nearby PHC but they also reported that very often it was difficult for them to reach the PHC usually located at a central village.

Regarding the illness of children generally found in these villages, the distribution is as in Table : 17.

Table : 17

Diseases in children	Frequency
Measles	62
Chicken - pox	51
Diphtheria	00
Conjunctivitis	35
Ear trouble	23
Dysentery	52
Diarrhoea	12
Mumps	07
Scabies	15
Eczema	03
Cannot walk even when 3 years old	01
Fits	03
Fever	01
Boils and Abscesses	01
Giddiness	01
Pneumonia	01

Weakness	02

Total :	100
	===

Levels of Illness :

Total disease :	Frequency
0	11
1	20
2	23
3	16
4 and more than 4	30

Total :	100
	===

As regards illness among the women, the distribution is as follows :

Table : 18

Self-illness	Frequency
Pain in limbs	17
Menstrual problems/Leucorrehoea	08
Stomach-ache	07
Back-ache	22
Weakness/Anaemia	09
Fever	05
Headache	13

Asthma	01
Ulcers	01
Conjunctivitis	01
Arthritis	01
Jaundice	01
Dysentery	01
Typhoid	01
Nose, Throat trouble	01
Cramps	01
Abscess	01
Chicken-pox	02
Weakness/pain in eyes	02
Giddiness	03
Measles	03

Backache and pain in limbs may be related to lack of care dur pregnancy and lack of post-natal care. Women tend to ignore thei health problems and avoid going to doctors for consultation.

Both food consumption and communicable diseases affect nutritic status by way of a 'malnutrition-infection' complex. Food consumpti depends both on the woman's capacity to acquire food and on th knowledge of how to choose a nutritious diet.

Chronic malnutrition is mostly a consequence of poverty. Hig income allows people to buy a more balanced diet as well as bet hygiene and medical care. Nutrition is also affected by who in household controls the money; women's income is more likely than me to be spent on better nutrition. Besides, chronic food insecurity

poor people is often made worse by seasonal fluctuations ir availability and prices. The control of communicable disease is alsc as crucial as the provision of food or money to buy food.

The Economic Index, Nutrition Index, Health Index, Sanitatio Index, Development Index and Composite Index were determined for th respective villages (6) individually. These have been determined a minimum levels required for existence. Comparison can be done village wise and also the position of an individual village to the combine index.

4.6 Observations of the Group Meetings :

Observations and discussions at the four camps held at Kasurdi Kapurhol, Wagazwadi and Kenjal revealed that not only do women hav special health needs because they bear and nurture children but they c most of the caring for their families. Good health is founded in th family. So if women are ignorant, malnourished, overworked as they a and if they have large numbers of children starting at an early ac then the health of their families as well as their own health continu to suffer. It is their health and their level of education that wi to a large extent determine the health and productivity of futu generation of both sexes.

VILLAGE:- WANGANI

SER. NO.	ECONOMIC STATUS INDEX	NUTRITION STATUS INDEX	HEALTH STATUS INDEX	SANITATION INDEX	DEVELOPMENT INDEX	TOTAL	COMPOSITE INDEX
	+VE SCORE OUT OF 2	+VE SCORE OUT OF 10	+VE SCORE OUT OF 2	+VE SCORE OUT OF 8	+VE SCORE OUT OF 5	+VE SCORE OF 27	PROPORTION OF +VE SCO.
001	1	4	1	5	1	12	0.44
002	0	4	0	1	3	8	0.30
003	2	8	1	4	2	15	0.56
004	1	8	1	2	1	11	0.41
005	1	6	2	4	3	16	0.59
006	2	8	0	1	1	10	0.37
007	1	7	1	2	2	13	0.48
008	1	7	2	1	3	14	0.52
009	1	6	1	1	1	10	0.37
010	1	5	0	1	1	8	0.30
011	1	7	0	2	2	12	0.44
012	0	5	1	3	1	10	0.37
013	2	8	1	4	0	15	0.56
014	1	7	0	4	1	13	0.48
015	1	7	1	5	3	17	0.63
016	1	7	2	2	1	13	0.48
17	1	3	1	1	1	7	0.26
018	2	7	2	3	4	18	0.67
019	1	4	1	2	1	9	0.33
020	2	5	1	2	0	10	0.37
TOTAL	23	117	19	50	32	241	
VIL.	1.15	5.85	0.95	2.5	1.6	12.05	0.45
COMB.	1.14	6.26	1.08	3.19	1.74	13.41	0.50

SER. NO.	ECONOMIC STATUS INDEX	NUTRITION STATUS INDEX	HEALTH STATUS INDEX	SANITATION INDEX	DEVELOPMENT INDEX	TOTAL	COMPOSITE INDEX
	+VE SCORE OUT OF 2	+VE SCORE OUT OF 10	+VE SCORE OUT OF 2	+VE SCORE OUT OF 8	+VE SCORE OUT OF 5	+VE SCORE OUT OF 27	PROPORTION OF +VE SCO.
021	1	8	0	5	0	14	0.52
022	0	5	0	4	1	10	0.37
023	1	8	1	4	2	14	0.52
024	1	5	0	4	0	10	0.37
025	2	8	2	0	1	11	0.41
026	1	8	1	1	0	11	0.41
027	2	9	2	5	4	22	0.81
028	2	7	1	7	3	20	0.74
029	1	8	1	3	1	12	0.44
030	1	8	2	1	1	11	0.41
031	2	8	1	2	1	12	0.44
032	1	5	2	3	1	12	0.44
TOTAL	16	77	13	39	16	169	
VIL.	1.25	8.42	1.08	3.25	1.25	13.25	0.49
COMB.	1.14	8.28	1.08	3.19	1.74	13.41	0.50

VILLAGE:- MANJAI ASNI

SER. NO.	ECONOMIC STATUS INDEX	NUTRITION STATUS INDEX	HEALTH STATUS INDEX	SANITATION INDEX	DEVELOPMENT INDEX	TOTAL	COMPOSITE INDEX
	+VE SCORE OUT OF 2	+VE SCORE OUT OF 10	+VE SCORE OUT OF 2	+VE SCORE OUT OF 8	+VE SCORE OUT OF 5	+VE SCORE OUT OF 27	PROPORTION OF +VE SCO.
033	1	5	1	8	3	18	0.59
034	2	7	2	2	3	16	0.59
035	1	4	1	3	1	10	0.37
036	1	4	0	4	1	10	0.37
037	2	8	0	5	4	19	0.70
038	1	4	0	3	0	8	0.30
039	1	4	1	4	1	11	0.41
040	1	2	2	3	1	9	0.33
041	2	8	1	3	2	16	0.59
042	1	9	1	4	2	17	0.63
043	1	7	1	4	0	13	0.48
044	0	5	1	3	0	9	0.33
045	1	6	2	3	2	14	0.52
TOTAL	15	73	13	47	20	168	
VIL.	1.16	5.62	1.00	3.62	1.54	12.92	0.48
COMB.	1.14	6.26	1.08	3.19	1.74	13.41	0.50

VILLAGE - KUSGAON

SER. NO.	ECONOMIC STATUS INDEX	NUTRITION STATUS INDEX	HEALTH STATUS INDEX	SANITATION INDEX	DEVELOPMENT INDEX	TOTAL	COMPOSITE INDEX
	+VE SCORE OUT OF 2	+VE SCORE OUT OF 10	+VE SCORE OUT OF 2	+VE SCORE OUT OF 8	+VE SCORE OUT OF 5	+VE SCORE OUT OF 27	PROPORTION OF +VE SCO.
046	0	7	1	5	2	15	0.56
047	1	8	1	3	0	13	0.48
048	1	9	2	6	3	20	0.74
049	0	6	1	2	1	10	0.37
050	0	8	2	2	1	13	0.48
051	1	8	1	3	1	12	0.44
052	2	7	0	4	1	14	0.52
053	0	3	0	4	1	8	0.30
054	0	4	2	1	1	8	0.30
055	2	7	2	3	2	16	0.59
056	1	8	0	2	2	13	0.48
057	1	7	1	3	0	12	0.44
058	1	5	1	5	2	14	0.52
059	2	4	1	3	2	12	0.44
060	1	8	1	4	1	15	0.56
061	2	8	1	3	1	15	0.56
TOTAL	15	105	17	52	21	210	
VIL.	0.94	6.56	1.06	3.25	1.31	13.13	0.49
COMB.	1.14	6.26	1.06	3.19	1.74	13.41	0.50

VILLAGE - KURUNGWADI

SER. NO.	ECONOMIC STATUS INDEX	NUTRITION STATUS INDEX	HEALTH STATUS INDEX	SANITATION INDEX	DEVELOPMENT INDEX	TOTAL	COMPOSITE INDEX
	+VE SCORE OUT OF 2	+VE SCORE OUT OF 10	+VE SCORE OUT OF 2	+VE SCORE OUT OF 8	+VE SCORE OUT OF 5	+VE SCORE OUT OF 27	PROPORTION OF +VE SCO.
002	2	8	0	3	1	12	0.44
003	2	9	2	4	2	19	0.70
004	1	6	0	2	2	11	0.41
005	1	4	1	4	1	11	0.41
006	1	5	2	4	2	14	0.52
007	1	9	1	1	1	13	0.48
008	1	7	2	1	3	14	0.52
009	0	7	1	2	3	13	0.48
010	1	10	1	2	3	17	0.63
011	1	5	2	3	1	12	0.44
012	1	4	1	4	1	11	0.41
013	1	3	2	2	2	10	0.37
014	2	8	2	3	3	18	0.59
015	2	8	2	3	4	19	0.70
016	1	5	0	2	2	10	0.37
017	2	7	1	5	3	18	0.67
018	2	8	1	3	3	17	0.63
019	2	6	1	2	1	12	0.44
020	1	7	2	3	1	14	0.52
TOTAL	25	122	24	63	39	283	
VIL.	1.32	6.42	1.26	2.79	2.05	13.84	0.51
COMB.	1.14	6.28	1.08	3.19	1.74	13.41	0.50

VILLAGE:- ALANDE

SER. NO.	ECONOMIC STATUS INDEX	NUTRITION STATUS INDEX	HEALTH STATUS INDEX	SANITATION INDEX	DEVELOPMENT INDEX	TOTAL	COMPOSITE INDEX
	+VE SCORE OUT OF 2	+VE SCORE OUT OF 10	+VE SCORE OUT OF 2	+VE SCORE OUT OF 8	+VE SCORE OUT OF 5	+VE SCORE OUT OF 27	PROPORTION OF +VE SCO.
001	0	5	0	1	2	8	0.30
002	1	7	0	5	3	16	0.59
003	2	7	2	4	3	18	0.67
004	2	8	1	5	3	19	0.70
005	0	3	1	2	1	7	0.26
006	1	4	1	4	3	13	0.48
007	1	10	2	3	2	18	0.67
008	1	8	2	3	2	16	0.59
009	1	5	1	4	2	13	0.48
010	2	6	2	4	3	17	0.63
011	0	5	0	4	2	11	0.41
012	2	7	1	5	3	18	0.67
013	1	6	1	6	2	16	0.59
014	2	5	1	4	2	14	0.52
015	0	7	2	4	2	15	0.56
016	1	7	2	3	3	16	0.59
017	2	8	0	5	2	17	0.63
018	0	8	1	3	3	15	0.56
019	1	9	1	4	2	17	0.63
100	1	7	1	5	2	16	0.59
TOTAL	21	132	22	78	47	300	
VIL.	1.05	6.6	1.1	3.9	2.35	15	0.56
COMB.	1.14	6.28	1.08	3.19	1.74	13.41	0.50

I...

Economic Index is defined as the sum of +ve scores if the following conditions are satisfied.

1) Annual Income>Avg. A.I. for the combined sample.
2) No. of Rooms>=2

II...

Nutrition Index is defined as the sum of +ve scores if the following conditions are satisfied.

1) F.I.Content>=75
2) Whether Food is Sufficient--'Yes' Response is there.
3) Whether eats Non-Veg.--'Yes' Response.
4) Whatever percentage of fasting is there, if the food at fasting is O.K.
5) Frequency of taking tea in a day>=2
6) Level of taking Milk>=2
7) Level of taking Fruits>=2
8) Whether takes 3 Meals in a day--'Yes' Response.
9) Whether takes Sweets--'Yes' Response.
10) Whether prepares Variety of Food--'Yes' Response.

III...

Health Index is defined as the sum of +ve scores if the following conditions are satisfied.

1) Total No. of Diseases for children<=2
2) Total No. of Diseases for the Respondent herself=0

IV...

Sanitation Index is defined as the sum of +ve scores if the following conditions are satisfied.

1) Boiling of water--'Yes' Response.
2) Filtering of water--'Yes' Response.
3) Use of Alum--'Yes' Response.
4) Using Utensils properly--'Yes' Response.
5) Using Soap for cleaning the hands.
6) Whether Insects Remedy is done.
7) If they have a separate Latrine in their house.
8) If she has told her opinion about a separate Latrin to some of the members in her family.
   This will be 'Not Applicable' if there is already Latrin facility in her house. In such case, one +ve score will still be given as it is assumed that some time or the other, she/somebody must have thought about this facility.

V...

Development Index is defined as the sum of +ve scores if the following conditions are satisfied.

1) No. of children of the Respondent<=2
2) Percentage of Deliveries at home for the Respondent=0
3) If the Respondent takes Proper Rest at M.C.
4) Level of Dependence on Son/Daughter=0
5) Level of Literacy>=1

COMPOSITE INDEX:--
****

The Sum Total of all these 5 Indexes is calculated and the Proportion of this total +ve score to the maximum total score of 27 is calculated is Denoted as 'Composite Index' for the Respondent.

-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0

In the changing society, woman is no more playing her age-old, traditional role of being confined at home. She plays multiple roles ranging from child bearing, child rearing, doing domestic work, managing the household and becoming breadwinner to maintain the family. In majority of cases she is ill-prepared to perform all such expected roles.

The net effect of the cultural, social and economic biases that women suffer from are reflected is their poor health, inadequate access to health care and medical services and increasing gap between men and women in literacy, education and training for employment, and employment status. This difference has widened from urban to rural society. In the rural areas, traditional practices regarding marriages and the status of the daughter-in-law in the household alongwith the practices associated with pregnancy, child-birth, lactation, fertility-control and health care utilization further aggravate the health impairment of women. In the rural societies parents wish to marry off their daughters as soon as they attai puberty. This custom precludes girls from achieving an educationa status comparable to that of boys. This lack of education the prevents women seeking an alternative role in life.

Yet non-salaried housewives or women peasants for example, car huge responsibilities which may prevent them from spending time health promotion and family care. This heavy workload is nev counted as 'employment' and therefore they are not covered protective legislation. Legislatures have enacted various laws enforcing the economic right of women but the women themselves are

aware of such legislations.

Health Status and Mothers :

In rural areas especially, as it came out, sex discrimination begins at birth and pervades throughout a woman's life, from childhood through adulthood to old age. Women receive lowest priority when it comes to health.

In any community, women of child-bearing age from 15 to 45 years constitute approximately 20%. In addition, there is no other period in human life-span when beliefs, customs and values affect health care as much as they do at the time of pregnancy and child-birth.

Repeated pregnancies, short birth intervals and pregnancies occurring at the extremes of reproductive age and lack of family planning practices are responsible for unfavourable outcomes for mothers and children. The women in rural areas, as stated, do not practise family planning mainly because of high infant mortality, the social custom to have sons to foster the family tree, and fear of desertion by husband and family members.

The role of illegally inducted abortions in case of maternal death is well recognised in this group but difficult to estimate because of the secrecy surrounding abortion as a cause of death and lack of available data.

On the basis of the information obtained from the camps, 70-75% women suffer from anaemia, 60-70% complain about general weakness, 50-60% suffer from chronic malnutrition and B complex deficiency' 25-30% suffer from repeated attacks of gastroenteritis, helminthic infestations and pain in the abdomen, 10% complain of upper

respiratory tract infections and 13% suffer from skin infections like scabies, pediculosis and pyoderma. Apart from these common ailments, the women also suffer from pulmonary tuberculosis, urinary tract infections, typhoid, malaria and infective hepatitis. Tobacco chewing also affects their health.

Nutrition :

Malnutrition in the mother is mainly due to poor food intake because of the social custom of eating food after feeding the male members and the children of the family and also wrong food beliefs. In addition, the repeated attacks of gastrointestinal infections and helminthic infections due to poor personal hygiene and environmental sanitation make her prone to malnutrition which further leads to G.I. tract infections. Thus, the vicious cycle sets in. Nearly 50% of all women and 2/3 of the pregnant women suffer from ananemia.

The incidence of deficiencies in riboflavin, pyridoxin (Vit B), vitamins E and A is also of much higher order during pregnancy in women from the low socio-economic groups in the rural areas.

Women do not receive additional nutrition requirement so essential during pregnancy and lactation. Nutritional requirements of women as laid down in the past have been based on the theory that her needs are less than those of men since she requires less calories. But this is a fallacy since activities like household duties, fetching water and wood and carrying food to the fields - all high calorie - spending activities have never been actually measured or considered.

Diet during pregnancy is strongly influenced by beliefs, customs and taboos. The avoidance of some foods (like papaya, jackfruit and

banana) is common in these societies. Beliefs about 'hot' and 'cold' foods are widely prevalent and various food items are excluded from the diet. Traditional birth attendants, mother-in-law and other elderly women have an important say in the diet. These dietary restrictions very adversely affect the mothers and more so in the case of those who are chronically malnourished. Maternal malnutrition also influence reproductive performance affecting the pelvic size, birth weight of child, lactation and breast feeding.

Education :

Illiteracy and lack of total education by impeding access to information is the greatest barrier to any improvement in the position of women in employment, health, nutrition, the exercise of legal and constitutional rights, equal opportunities in education, and generally in attaining equality of status. The level of education and attainment of good health have a very positive correlation.

Fertility Control :

Though vasectomy is a major and simpler F.P. device, tubectomies accounted for a major portion of the total sterilisations. In addition to other FP devices, women formed the larger proportion of the acceptors in sterilisation cases. Most of the couples are protected by female sterilisation alone. Since sterilisation based F.P. is essentially adopted by families who have already achieved their desired family size, greater use of birth spacing through intervening methods needs to be propagated. These methods include pills, IUDs, condoms, depending on selectivity of the individual. Given the nature of options available, the users aiming at family

planning would still be largely women. Thus, not only the technology itself is not gender neutral, it reduces women from productive persons to reproductive machines constantly undergoing experimentation.

5. IMPLICATIONS :

Women want to have reproductive freedom and the power to make reproductive choice. They want the well-being of their families and themselves, freedom from the drudgery of child-bearing and would like to limit their family size.

There is need to address men and enable them to understand and accommodate their role in fertility management. It is increasingly being recognised now that decisions on reproduction whether taken by the male or female have implications for self-image and status according to the cultural and economic context. Extension work in health must address itself to those implications.

There is need to address the programme to the whole life-cycle of the woman especially at the stage of childhood and adolescents and not only at the reproductive stage.

Women face hardships through malnutrition, early marriage, unsafe child-birth and inadequate health services to follow up morbidity. Population policy must therefore look into the well-being of women including their entitlement to good health and capacity to choose th reproductive path.

Nutrition, food for pregnant and nursing mothers as well a children, to build the base of a healthy body must be recognised a basic.

5.1 Environmental Influences on Health :

The environment in which people live has a strong influence on their health. For poor people and poor regions it is the household environment that carries the greater risks to health. By providing information, reducing poverty and facilitating and stimulating private sector action, governments can deploy potent mechanisms to improve this environment.

Poor households generally live in a domestic environment with high health risks caused by poor sanitation and inadequate water supply (often compounded by poor hygiene), inadequate garbage disposal and drainage, heavy indoor air pollution and crowding. Water quantity is as important as water quality. Washing hands after defecation and before preparing food is of particular importance in reducing disease transmission but without abundant water in or near the home, hygiene becomes difficult or impossible.

5.2 Diet and Nutrition :

Eating well is necessary for good health. Either directly or in association with infectious diseases, inadequate diets account for large share of rural disease burden including as much as a quarter of that among children. Much of this suffering stems from poverty-related under-consumption of protein and energy foods but equally important are deficiencies of key micronutrients - iodine, vitamin A, and iron - from which children and women suffer disproportionately. Increasing the incomes of the poor is the most effective means of reducing protein-energy malnutrition, but governments can play an effective direct role through nutrition education, measures to

increase consumption of micronutrients and reduction in diarrhoeal and parasitic infections among children. Public action is also essential for preventing crop failures from leading to famines.

5.3 Fertility :

All pregnancies and births carry some health risks to the mother and the child. But the risks are higher when women have health problems (such as high blood pressure, heart disease, malaria or diabetes) which go unnoticed due to lack of prenatal health care and identification of problems that could be aggravated by pregnancy, when pregnancies come too early or too late in a woman's reproductive life, when they are too closely spaced or are unwanted and when they occur to high parity women (e.g. those who have already had four or more babies).

The use of family planning services by couples is an effective means of avoiding many of these fertility related health risks and it enables families to achieve their fertility goals.

Births to very young women elevate the health risks to both mother and child. Births that are too closely spaced increase the risk of child mortality, births at older ages and high parities ar risks to mothers as are unwanted pregnancies that lead to unsaf abortion or to neglect of prenatal care.

Short birth intervals pose substantial risks to child healt throughout the first five years. Babies born to teenage children a also at greater risk of dying. Generally (61% of the sample surve births occur within 24 months of the previous birth and many wom wish to avoid such births. If the closely spaced births were delay

until mothers wanted them, overall child mortality might be reduced.

Family planning services can help women reduce the health risks from mistimed and unwanted pregnancies. In low-income populations and in rural areas there is a strong case on equity grounds for the government to subsidize and organise the provision of family planning services using public as well as non-governmental and private channels as appropriate. Transmitting family planning information is also important especially taking women's health in focus. Special efforts are also appropriate for addressing the needs of adolescents both because they tend to be particularly uninformed about reproductive health risks and because they often misjudge the consequences of early child bearing.

Fear of side-effects (as quoted by many at the camps) that may come as a result of adopting family planning measures by a temporary or permanent method keeps many people especially women away from approaching the agencies for help. Often the fears are based on rumours that may be spread by illiterate or undesirable elements or people who have a strong conviction that it is not right to limit the family. This needs to be taken up seriously an efforts be made to educate the people. A satisfied user is the best propagator (as seen in the Kapurhol camp). An association of satisfied acceptors of family planning may be formed in each panchayat to discuss and solve their own problems and popularise family planning (This has been tried out effectively in Rajasthan).

6. CONCLUSIONS :

The main barriers to use of family planning methods were found to

be -

i) Decision-making,

a) lack of information,

b) lack of power to make decisions,

c) infant mortality,

d) infertility,

ii) Access

a) physical,

b) economic,

c) social,

d) cultural.

iii) Lack of good quality appropriate services like -

a) drinking water,

b) sanitation.

Women's status comprising of rather difficult to define number o elements which include employment, education and 'rights' have positive effect on fertility reduction. Population policies need t have at their centre the well-being of all people and should take int account a wide range of phenomena including access to and distributic of resources, health status, gender relations and sexuality, migratic and urbanisation and societal factors that directly affect women's ar men's ability to have access to reproductive health. To assure huma well-being, in particular women's well-being population policies a programmes must be framed within and implemented as a part of broad development strategies that will redress the unequal distribution resources and power between social groups and men and women. T

focus should be on the empowerment and well-being of all women. This implies that changes are needed in the design of family planning and health services and information; the ways in which these are provided; the technologies they promote, the biomedical and social research that is done and the processes of involving women in all levels of decision-making and implementation.

Women's groups as in Mahila Mandals and in Panchayats or in non-governmental organisations joined together for economic or social purposes are the most effective and sensitive vehicles for safeguarding women's interest in developing and implementing reproductive health and fertility management programme.

Women's access to decision-making and capacity to exercise her interest in the social group has strong links to social well-being especially reproductive health and choice.

Nutrition, food not only for pregnant and nursing mothers but for children, to build the base of a healthy body has to be recognised as basic - whether as a human right and need or more narrowly for introducing contraception (the IUD and pill work better on a well-nourished body). Thus, population policy is closely linked to food security.

Education is another critical element which has an impact in a number of ways. Less educated, poor and physically exhausted mothers are likely to pass on poverty to their children, while better educated mothers is a key factor for improving the situation. Education raises the age of marriage of girls which has a very strong impact on birth rate. It also levels out power between men and women in and outside

the household. Besides, education gives knowledge on health and an opportunity and thus has an impact on fertility control. For this purpose to enable girls to go to schools, creches/balwadis should form a support system for the siblings apart from better household income for the adults and relief from time consuming chores like fetching water and fuel for the household.

The delivery systems need diversification as a means of increasing access. A comprehensive reproductive health, programme will need delivery systems in both public and private sectors. Clinic based services could include mobile services run by government, NGOs, paramedics etc. Community based services should include traditional health practitioners in the informal sector and field workers in community health programme.

The large number of female functionaries including female doctors in the health and family welfare sector is an asset that needs to be recognised as such : appropriate techniques of communication will change from a strict family welfare to a women's reproductive health and empowerment approach. Greater community involvement and counselling skills among female functionaries needs to be explored and further developed alongwith training in technical skills.

The present FP approach has emphasis on target setting. While targetting and monitoring need to be retained in some form, the system needs to be reformulated emphasising changes within the FP system. Targets could vary at different levels like (a) at district level, birth order, birth intervals, service coverage and quality of service could be monitored and targetted, (b) at state level birth and

death rates, age at marriage and female literacy could be monitored and (c) at national level it could be birth and death rates.

However, above all this it has to be a participatory approach. Without the involvement of the people themselves, especially women, population programmes will not achieve their goals. If people are to be involved, then programmes must be need-based and address their foremost concerns and priorities of the poor at the local level.

People must be involved in the entire process of planning, developing and implementing programmes through their own organisations at grass-roots level. The programme planners and implementators should be answerable to the local people, which is possible if programmes are decentralised resulting in local planning and implementation. Thus, decentralisation and a participatory approach go hand-in-hand.

There is a tendency to focus only on women, holding them solely responsible for using contraceptives and terminal methods in family planning programmes. While actively involving women, the responsibility and role of men in population programmes must not be overlooked or set aside. Decentralisation of population programmes and a participatory approach should be envisaged in such a manner that it may encourage men to accept responsibility and participation as well. This participation of men must even be extended to development activities like child care programmes, normally considered to be only women's concern.

The women's groups have observed that there is need for a sensitive approach and one that pays close attention to the quality of

services and follow-up after acceptance of contraception and terminal methods. Women must feel safe and assured that their well-being is taken care of and not that they are approached only to fulfil targets and priorities set somewhere by someone else.

APPENDIX : I

MAHARASHTRA (1991 : CENSUS)

1) Total Area in Sq. Kms.	T	307713.00	
	R	301485.00	
	U	6227.91	
2) No. of Households	T	15344435	
	R	9259441	
	U	6084994	

3) Total Population :

T	78937487	M	49825618	F	38111569
R	48395601	M	24536280	F	23859321
U	30541586	M	16289338	F	14252248

4) Literates :

T	42447139	M	25943455	F	16503684
R	21986542	M	13970829	F	8015713
U	20460597	M	11972626	F	8487971

APPENDIX : II

PUNE DISTRICT **(1991 : CENSUS)**

1) Total Area in Sq.Kms.	T	15643.00
	R	15066.32
	U	576.68
2) No. of Households	T	1079140
	R	504404
	U	574736

3) Total Population :

T	5532532	M	2861460	F	2671072
T	2725503	M	1387461	F	1338042
U	2807029	M	1473999	F	1333030

4) Literates :

T	3295228	M	1958169	F	1337059
R	1367991	M	855174	F	512817
U	1927237	M	1102995	F	824242

APPENDIX : III

MARITAL STATUS

	No. of females in 1981 age-group 15-44 (000S)		Percentage of married females to total females in age-group				
			15-44		15-19		20-24
	Total	Married	1971	1981	1971	1981	1971
INDIA	138234	112172	89.90	80.51	55.41	43.44	88.83
MAHARASHTRA	13247	10554	83.80	79.67	53.13	38.16	88.12

LIFE EXPECTANCY AT BIRTH BY SEX (1976-80)

	Males	Females	Persons
INDIA	52.5	52.1	52.3
MAHARASHTRA	55.6	57.1	56.3

CRUDE BIRTH AND DEATH RATES (1984-86)

	Crude Birth Rate	Crude Death Rate
INDIA	33.1	11.8

BIRTH RATES, DEATH RATES AND INFANT MORTALITY RATES (1986

	Birth Rate			Death Rate			Infant Mortality Rate		
	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban	Total
INDIA	34.1	27.0	32.4	12.1	7.6	11.1	105	62	9
MAHARASHTRA	31.6	27.0	30.0	9.7	6.0	8.85	13	44	63

COUPLES PER 1000 POPULATION (1981

	1971	1981
INDIA	170	169
MAHARASHTRA	171	168

APPENDIX - IV

1) For calculation of Annual Income other than Agriculture, the following assumptions were made :

i) Service minimum Rs. 12,000/- p.a.

ii) Business minimum Rs. 6,000/- p.a.

iii) Labour minimum Rs. 3,000/- p.a.

Thus, the Annual Income (A.I.) is estimated to be equal to the minimum level. For those showing income less than Rs.3,600/-, an amount of Rs. 3,600/- is added.

2) For estimation of A.I. in the form of crop produced the following assumptions were made :

i) 18 bags i.e. 1800 kg. of rice in /acre (40 gunthas) of land.

ii) 25 bags i.e. 2500 kg. of wheet in /acre (40 gunthas) of land.

iii) 30 bags i.e. 3000 kg. of jawar/bajra in /acre (40 gunthas) of land.

iv) 10 bags i.e. 1000 kg. of gram etc. in /acre (40 gunthas) of land.

3) Where area of agricultural land owned was not given but agricultural produce was given, then the area of land was estimated on the basis of (2) above.

4) Where both area and produce were not given but simply the names of the crop/vegetables was mentioned then the minimum agricultural land of ¼ acre or 20 gunthas was assumed.

5) Where area, produce and names were not mentioned then it was assumed that the family possessed minimum agricultural land of ¼ acre (20 gunthas) and produced 900 kg. of rice.

6) The total income from agricultural produce was based on the

rates of crops and vegetables given below :

Masuri rice	Rs. 7.00	Moong Dal	Rs. 14.00
Wheat	Rs. 6.00	Masur	Rs. 11.00
Jowar (Local)	Rs. 5.00	Matki	Rs. 10.00
Bajra (Local)	Rs. 4.00	Urad	Rs. 11.00
Chillies	Rs. 30.00	Chowli	Rs. 12.00 (white beans)
Satu	Rs. 16.00	Peas	Rs. 11.00
Tur Dal (Arhar)	Rs. 12.00	Hulga	Rs. 4.00 (Horse grain)
Gram	Rs. 17.00	Groundnut	Rs. 17.00
Nachani (Ragi)	Rs. 10.00	All vegetables	Rs. 10.00 (Average rate)

7) If simply names of vegetables was mentioned, the income from vegetables was taken at a minimum of Rs. 3,000/-

8) The total Annual Income = A.I. in the form of salary, profit/ wages etc. + A.I. from agricultural crops and vegetables converted in Rupees.

Appendix V.

DEMOGRAPHIC PROFILE OF THE VILLAGES SELECTED FOR INTERVIEWS
Source : District Census Handbook, Pune - 1981

S.No.	Name of Village and Taluka	Area	No. of House-holds	Population S.C. Male	S.C. Female	S.T. Male	S.T. Female	Total Population Male	Total Population Female	Total	Literacy Male	Literacy Female	Educational Facilities Balwadis	Primary Schools	Health Facility	Staple Food.	Geographical, Social, Educational and Economic Factors
1	Wangani Tal.Velhe	966 Hectares	163	-	-	1	-	407	504	911	284	183	1	1 upto 7th class + 1 middle school 1983-84	PHC	Rice Jawar Pulses.	Poverty, Labourers, Youth working all year round, Hilly, rain-fed area, in Sahyadris. Main occupation Agriculture, Secondary Dairying. Backward in education. Marathe caste predominates. Mahars are converted into Nava Boudhas. Superstitions prevail. River stream flows through boundary of village.
	Village + 2 Wadis + Dhangar Wadi	-	172	22	29	-	-	302	469	661	155	53	1	2	PHC		
2	Kodavdi Tal.Velhe	364 Hectares	64	7	4	-	-	171	185	356	81	32	1	1 upto 7th class. Middle school. 3 kms. away.	-	Rice Jowar Pulses. (Nachani Warai-Sometimes)	Poverty, Youth work in Pune, Bombay as labourers. Hilly, rain-fed. Nearby is Rajgad fort. Primary occupation Agriculture, also do dairying. Educationally backward. Hindu-Maratha families, Awareness started among women, 2-3 Brahman families. Gunjwani River flows to north of village. To south flow backwaters of Bhatghar dam. Educational development has begun village has started a Middle School.
3	Manjalasni Tal.Velhe Village + 1 Wadi	283 Hectares	52	12	8	-	-	156	152	308	73	58	1	2 upto 7th class. 1 middle school. since last 5 yrs.	-	Rice Jowar Pulses. (Nachani Warai-Sometimes)	In Sahyadris, 4 Kms. away is Rajgad fort. Hilly, lot of grass, & forest around, Kodavdi lies to east of village. To south beyond hills lie backwaters of Bhatghar Dam. East-West lies Gunjwani River. Deshmukh, Marathas predominant caste. Men work as labourers in Pune & Bombay. Agriculture and Dairying are main occupations. Traditions prevail, poverty.
4	Kusgaon Tal.Bhor	712 Hectares	228	3 Navboudhas	2	28	26	577	598	1175	274	111	2	1	-	Rice Jowar Pulses Vegetables	In Sahyadris, to west 3 Kms. away lies sinhagad fort, medium rainfall, agriculture dependent on rainfall. Primary occupation agriculture, secondary dairying and labour. Plastic pipe factory in village, poverty. Maratha caste predominates, Patils and Deshmuks are less, Mahars converted to Navoboudhas, Deshmuks are traditional. Vegetables are grown. Gram panchayat exists in village, hence obtained 10,000 Rs. for establishing taps for water.
	Village + 1 Wadi + 2 Dhangar Wadi																

S.No.	Name of Village and Taluka	Area	No. of House-holds	Population S.C. Male	S.C. Female	S.T. Male	S.T. Female	Total Population Male	Total Population Female	Total	Literacy Male	Literacy Female	Educational Facilities Balwadis	Primary Schools	Health Facility	Staple Food.	Geographical, Social, Educational and Economic Factors
5	Kurangwadi Tal.Bhor Village + 1 Wadi + 2 Dhangar Wadi	934 Hectares	145	35	34	-	-	614	678	1292	282	172	1	2 upto 7th class. Middle school at KhedShivapur 3 Kms. away	-	Rice Jowar Pulses. Vegetables	In sahyadris, to south flows Gunjwani river, but village not facilitated, Hilly and rain-fed region. Marathas pre-dominate, Patil Deshmukh Wadis and Dhangar Wadi separate. Primary occupation agriculture, secondary dairying. Youth work in Pune, Bombay. Poverty, Traditional. Since last 70 years there exists a flour mill in village. Sarpanch of the village was a woman earlier hence women groups formed.
6	Alande Tal.Bhor	671 Hectares	222	27	26	10	8	544	628	1172	389	218	2	2 upto 7th class. 1 middle school	PHC	Jowar Pulses. Vegetables	In hilly area of Sahyadris. To east lies the Gunjwani river - Neera river Sangam. Medium rainfall. Agriculture dependent on rainfall. Lift irrigation project on-going. Marathas Deshmukh and Patil castes predominate. Harijans also there. Primary occupation is agriculture, secondary dairying.

Appendix VI

DEMOGRAPHIC PROFILE OF THE VILLAGES SELECTED FOR GROUP MEETINGS
Source : District Census Handbook, Pune - 1981

S.No.	Name of Village and Taluka	Area	No. of House-holds	Population S.C. Male	S.C. Female	S.T. Male	S.T. Female	Total Population Male	Total Population Female	Total Population Total	Literacy Male	Literacy Female	Educational Facilities Balwadis	Educational Facilities Primary Schools	Health Facilities	Staple Food.	Geographical, Social, Educational and Economic Factors
1	Kapurhol Tal. Bhor Village + 2 Wadis	382.99 Hectares	137	4	4	-	-	388	396	784	251	160	1	1 Middle School 1	-	Jowar Bajra	Village approachable from Pune-Bangalore highway. To west lies Bhor. Poverty, Medium rainfall Agriculture dependent on rainfall. Youth work in Pune, Bombay Village importance due to past history of shivaji situated off the Pune-Bangalore highway the village has access to small hotels, shops, PHC and Middle School.
2	Kasurdi Tal.Bhor	258.6 Hectares	99	16	14	-	-	263	279	542	147	68	1	1	PHC	Rice Jowar	In Sahyadri hills. To east lies Gunjwani River. Medium rainfall. Agriculture dependent on rainfall. Backwaters of Veer Dam reach the village outskirts. Marathas predominate. Harijans present primary occupation agriculture - Pajher pond supplies water for irrigation. 1 lift irrigation pump exists. Youth seek employment at Pune, Bombay due to poverty prevails.
3	Kenjal Tal.Bhor	618.85 Hectares	239	11	18	-	-	545	644	1289	381	256	1	1 Middle School 1 Km. away	-	Jowar Wheat	Situated off the Pune-Bangalore Highway but lies 3 Km. in interior. Medium rainfall. Sangam of Gunjwani and Neera Rivers lies at outskirts of village. Backwaters of Veer Dam touches the village. Youth have started Poultry keeping and also go to Pune, Bombay for employment. Village is traditional in thought. Poverty prevails.
4	Wagazwadi (Kikwibeat)		153	58	44	11	15	432	395	827	-	-	1	1 Middle school 1 Km. away	-	Jowar	Lies 1 Km. off the Pune-Bangalore highway. Village lies in Hills. Less rainfall. Backward classes more in village compared to other villages. Agriculture is dependent on rainfall. Poverty prevails. Warkaris predominate.

General Information — Vil. Wangani (Sr.No.001 to 020)

Sample Size: 20

Religion: 90% Hindu, 10% Muslim

Family Type	Class	Freq.	%
	Joint	14	70.00
	Nuclear	6	30.00
		20	100.00

Total Members	C.I.	Freq.	%
	1-4	3	15.00
	5-6	6	30.00
	7-10	8	40.00
	11-20	3	15.00
		20	100.00

Males in the family	C.V.	Freq.	%
	0	1	5.00
	1	11	55.00
	2	3	15.00
	3	3	15.00
	4	1	5.00
	5	1	5.00
		20	100.00

Females in the family	C.V.	Freq.	%
	0	0	0.00
	1	7	35.00
	2	5	25.00
	3	3	15.00
	4	4	20.00
	5	1	5.00
		20	100.00

Sons in the family	C.V.	Freq.	%
	0	3	15.00
	1	6	30.00
	2	7	35.00
	3	3	15.00
	4 & > 4	1	5.00
		20	100.00

Daughters in the family	C.V.	Freq.	%
	Ø	2	10.ØØ
	1	8	4Ø.ØØ
	2	7	35.ØØ
	3	2	1Ø.ØØ
	4 & > 4	1	5.ØØ
		2Ø	1ØØ.ØØ

Hus. occupation	Freq.	%
Agriculture	7	35.ØØ
Business	5	25.ØØ
A & B	Ø	Ø.ØØ
Service	4	2Ø.ØØ
Labourer	3	15.ØØ
no job *	1	5
	2Ø	1ØØ.ØØ

* This family has only 1 male member who has no job.

	Freq.	%
Agri. Owned	17	85.ØØ
" not	3	15.ØØ
	2Ø	1ØØ.ØØ

Avg.Annual Income Rs. 15133/-

Avg.Agri.Area owned Ø45 Gunthe

Edn.	Code	Freq.	%
	Ø	8	4Ø.ØØ
	1-2	2	1Ø.ØØ
	3-4	5	25.ØØ
	5 & >5	5	25.ØØ
		2Ø	1ØØ

Avg. Edn. = 3
(Arithmetic Avg.)

Rooms	Freq.	%
1	2	1Ø.ØØ
2	12	6Ø.ØØ
3	5	25.ØØ
4	1	5.ØØ
	2Ø	1ØØ

Rooms Avg= 2
(Modal Value with the highest freq. = 12)

Wangani
Ser. No. ØØ1 to Ø2Ø

Type of FPD	Freq.	%
Tab	Ø	Ø.ØØ
Cop.T	Ø	Ø.ØØ
Condom	1	5.ØØ
Tab & Cop.T	1	5.ØØ
Tab,Cop T & Condom	2	1Ø.ØØ
F Ops	1Ø	5Ø.ØØ
Tab, Cop T & F Ops	Ø	Ø.ØØ
Tab, Cop T, Condom & F Ops	2	1Ø.ØØ
No. FPD known	4	2Ø.ØØ
	2Ø	1ØØ

Knowledge of condom	5	25.ØØ
NO - do -	15	75.ØØ
	2Ø	1ØØ

Comments :
1) 6Ø% of the women hav eundergone F Ops.(12 out of 2Ø).
2) Out of 2Ø, only one woman used FPD after 1 child, but 4 women used FPD after 2 or more children.
3) Out of 2Ø,15 women did not use FPD at all. Out of 15, 12 women - operation.

Dist.bet
two children opinion

Years	Freq.	%
2	2	10
3	12	60
4	2	10
Not mentioned	4	20
	20	100

Doctor's opinion about distance

	Freq.	%
Known	5	25
Not known	15	75
	20	100

Opinion regarding the birth of
the first child after marriage -
How many years?

Years	Freq.	%
1	5	25
2	6	30
3	0	0
4	2	10
5	2	10
Not mentioned	5	25
	20	100

Whether felt to stop delivery after 2 children:

	Freq.	%
Felt	14	70
Not Felt	6	30
	20	100

Doctor consulted

	Freq.	%
For FPD other than operations	1	5
For F Ops.	12	60
Not consulted	7	35
	20	100

Nutrition:

% of Nutrition (N)	Freq.	%
25(Only 1 Food Item of V,D,C,S)	1	5.00
50(2 Food Items of V,D,C,S)	4	20.00
75(3 Food Items of V,D,C,S)	14	70.00
100(4 Food Items of V,D,C,S)	1	5.00
	20	100

Comments:-
1) One woman with 25% N does not take D,C,S.
2) All the 4 women with 50% N do not take C & S.
3) All the 14 women with 75% N do not take S i.e. Salad.
4) 19 out of 20 women do not take Salad.

[100 % Nutritious Food contains all the 4 parts viz. V(Vegetables),D(dal),C(cereals i.e.'Usal') & S(Salad)]

Food(Opinion of the Respondent)	Freq.	%
Sufficient	18	90.00
Not sufficient	2	10.00
	20	100.00

Taking non-veg	13	65.00
Veg	7	35.00
	20	100.00

Fasting

% of fasting	Freq.	%
0(No Fasting)	2	10.00
25(Once in a week)	4	20.00
50(Twice in a week)	7	35.00
75(Thrice in a week)	5	25.00
100(Twice in a week & Many Occasional Fasts/ Thrice in a week & Some Occasional Fasts.	2	10.00
	20	100.00

Diet at fasting

Sufficient(i.e. eating enough quantity)	16	89
Not sufficient(i.e.only taking tea or fruits)	2	11
	18	100

Taking Tea

No. of time in a day	Freq.	%
1	1	5.ØØ
2	17	85.ØØ
3	2	1Ø.ØØ
	2Ø	1ØØ.ØØ

% Intake of Milk

	Freq.	%
Ø (No-i.e. Level Ø)	14	7Ø.ØØ
25(Sometimes-i.e. Level 1)	5	25.ØØ
5Ø (Yes/Taking with Rice etc.-i.e. Level 2)	Ø	Ø.ØØ
1ØØ(Ample-i.e. Level 4)	1	5
	2Ø	1ØØ

% Intake of Fruits

	Freq.	%
Ø (No-i.e. Level Ø)	8	4Ø.ØØ
25(Sometimes-i.e. Level 1)	3	15.ØØ
5Ø (Yes-i.e. Level 2)	9	45.ØØ
1ØØ(Ample-i.e. Level 4)	Ø	Ø.ØØ
	2Ø	1ØØ.ØØ

Meals - Information

Only 2 women take 3 meals (1Ø%)
9 out of 2Ø women take spicy (45%)
15 out of 2Ø prepare sweets (75%)
7 out of 2Ø like variety. (35%)
13 out of 2Ø would like to learn variety (65%)

Nutrition at carrying

5Ø(very less)	5	25.ØØ
75(little less)	1	5.ØØ
1ØØ (As usual)	11	55.ØØ
1ØØ + (more than normal)	3	15.ØØ
	2Ø	1ØØ.ØØ

Wangani
Sr.No. ØØ1 to Ø2Ø

	Size of Sample
Avg. Age at marriage 15 years	2Ø
Avg. Age at 1st chi 17 years	2Ø
Avg. Age at 2nd chi 19 years	2Ø
Avg. Age at 3rd chi 22 years	15
Avg. Age at 4th chi 24 years	8
Avg. Age at 5th chi 27 years	2
Avg. Age at 6th chi 29 years	1

Avg. present age = 31 years

Avg. no. of deliveries - 62/2Ø = 3.1Ø

Avg.No. of children 6Ø/2Ø = 3

% Ratio of No.of children to No. of deliveries =96.77

% of Delivery at Home	Freq.	%
Not at Home	2	1Ø
33% at home	2	1Ø
5Ø% at home	4	2Ø
67% at home	1	5
1ØØ% at home	11	55
	2Ø	1ØØ

Rest at M.C.

Taking Rest	1Ø	5Ø.ØØ
No Rest	1Ø	5Ø.ØØ
	2Ø	1ØØ.ØØ

5 out of 2Ø i.e. 25% women have wrong ideas about FPDs. 3- creates problems, 2-about copper T.

Opinion about no. of children	Freq	%
1 son	4	2Ø.ØØ
2 sons	6	3Ø.ØØ
4 children	2	1Ø.ØØ
Not told	8	4Ø.ØØ
	2Ø	1ØØ.ØØ

Only 3 out of 20 women ... superstition for getting a son. (15%)

Only 2 out of 20 have science knowledge about child birth (10%)

Dependence on children score

Description & Score	Freq.	%
Don't depend i.e. 0	1	5.00
Are not sure i.e.1	7	35.00
Expect to depend on child	6	30.00
Must depend i.e. 4	6	30.00
	20	100.00

Wangani
Sr.No. Ø01 to Ø20

Diseases	Freq.	%
Measles	13	65.ØØ
Chicken Fox	12	6Ø.ØØ
Dyptheria	Ø	Ø.ØØ
Conjunctivitis	7	35.ØØ
Ear problem	6	3Ø.ØØ
Dysentery	1Ø	5Ø.ØØ
Diarrohea	3	15.ØØ
Mumps	1	5.ØØ
Scabbies	5	25.ØØ
Ecxema	Ø	Ø.ØØ
Fits	1	

Total Diseases	Freq.	%
Ø	2	1Ø.ØØ
1	3	15.ØØ
2	6	3Ø.ØØ
3	2	1Ø.ØØ
4	2	1Ø.ØØ
5	3	15
6	1	5
7	1	5
	2Ø	1ØØ

Self Diseases	Freq.	%
Pain in limbs	5	25.ØØ
Regarding periods (irregular/ more bleeding)	Ø	Ø.ØØ
Stomach ache	1	5.ØØ
back ache	6	3Ø.ØØ
Weakness in neck and waist	3	15.ØØ
Head ache	3	15.ØØ
Asthma	Ø	Ø.ØØ
Giddiness	1	5
Cramps	1	5
Temperature	3	15
Leucorrohea	1	5
Measles	1	5.ØØ
Typhoid	1	5.ØØ
Abcess ('Naru')	1	5
No complaints	7	35.ØØ

At Home Cure 6 out of 2Ø i.e.3Ø% do at home cure

Goint to Dr	19	95.ØØ
No need of Dr.	1	5.ØØ
	2Ø	1ØØ.ØØ

Inoculation : all 1ØØ%

Wangani
Sr.No.001 to 020

Source of Water:- Well

Water	Freq.	%	
Boil	0	0	
Do not boil	20	100	
Filter	14	70	
Do not filter	6	30	
Alum	0	0	
No alum	20	100	
Utensils cleaning O.K.	14	70	* Major Factor for Sanitation
Not O.K.	6	30	
Use soap	4	20	* Major Factor for Sanitation
Do not use soap	16	80	
Insects remedy	10	50	* Major Factor for Sanitation
No Insects Remedy	10	50	
Smoke trouble	4	20	# There may be smoke, but
No smoke trouble	16	80 #	they do not feel the trouble.
	20	100	

75% i.e. 15 out 20 no latrin at mother's place
100% no latrin at m-in-law's place

Opinion about separate latrin

Told	9	45
Not told	11	55
	20	100

General Information — Vil. Kodawadi (Sr.No.021 to 032)

Sample Size: 12

Religion: 100% Hindu

Family Type	Class	Freq.	%
	Joint	8	67.00
	Nuclear	4	33.00

Total Members	C.I.	Freq.	%
	1-4	1	8.00
	5-6	2	17.00
	7-10	8	67.00
	11-20	1	8.00
		12	100.00

Males	C.V.	Freq.	%
	1	5	42.00
	2	4	33.00
	3	1	8.00
	4 & > 4	2	17.00
		12	100.00

Females	C.V.	Freq.	%
	1	3	25.00
	2	5	41.00
	3	2	17.00
	4 & > 4	2	17.00
		12	100.00

Sons	C.V.	Freq.	%
	0	1	8.00
	1	5	42.00
	2	4	33.00
	3	2	17.00
	4 & > 4	0	0.00
		12	100.00

Daughters	C.V.	Freq.	%
	0	2	17.00
	1	3	25.00
	2	3	25.00
	3	1	8.00
	4 & > 4	3	25.00
		12	100.00

Agriculture	3	25.00
Business	3	25.00
A & B	1	8.00
Service	4	34.00
Agri. & Labourer	1	8.00
	12	100.00

	Freq.	%
Agri. Owned	11	92
" not Owned	1	8

Avg.Annual Income Rs. 25650/-

Avg.Agri.Area owned 056 Gunthe

Rooms	Freq.	%
1	1	8.00
2	5	42.00
3	4	33.00
4 & >4	2	17.00
	12	100

Rooms avg = 2
(Modal Value for f=5)

Ednal Levels

Level	Freq.	%
0	6	50.00
1-2	2	17.00
3-4	1	8.00
5&>6	3	25.00
	12	100

Avg. Edn. 3
(Arithmetic Avg.)

Kodawadi
Ser. No. Ø21 to Ø32

Type of FPD	Freq.	%
Tab	Ø	Ø.ØØ
Cop.T	Ø	Ø.ØØ
Condom	Ø	Ø.ØØ
Tab & Condom	1	8.ØØ
Cop T & Condom	1	8
F Ops	6	5Ø.ØØ
Tab, Condom & F Ops	1	9.ØØ
No. FPD known	3	25.ØØ
	12	1ØØ.ØØ
Knowledge of condom	3	25.ØØ
NO - do -	9	75.ØØ
	12	1ØØ

Comments :
1) 7 out of 12 women i.e. 58 % F Ops.
2) Out of 12, only one woman used FPD after 3 children Others only know, but do not use FPDs

Kodawdi
Ser. Ø21 to Ø32

Dist.bet
two children opinion

Years	Freq.	%
1	Ø	Ø
2	Ø	Ø
3	8	67
4	1	8
Not mentioned	3	25
	12	1ØØ

Doctors opinion about distance

	Freq.	%
Known	4	33
Not known	8	67
	12	1ØØ

Opinion regarding the birth of
the first child after marriage -
How many years?

Years	Freq.	%
1	4	33
2	3	25
3	Ø	Ø
Not mentioned	5	42
	12	1ØØ

Whether felt to stop delivery after 2 children:

	Freq.	%
Felt	9	75
Not Felt	3	25
	12	1ØØ

Doctor consulted

	Freq.	%
For FPD other than operations	1	8
For F Ops.	7	58
Not consulted	4	34
	12	1ØØ

Kodawdi
Sr.No. 021 to 032

Nutrition:

% of Nutrition (N)	Freq.	%
25(Only 1 Food Item of V,D,C,S)	1	8.00
50(2 Food Items of V,D,C,S)	5	42.00
75(3 Food Items of V,D,C,S)	6	50.00
100(4 Food Items of V,D,C,S)	0	0.00
	12	100

Comments = 92% i.e. 11 out of 12 women do not take salad

[100 % Nutritious Food contains all the 4 parts viz. V(Vegetables),D(dal),C(cereals i.e.'Usal') & S(Salad)]

Food(Opinion of the Respondent)	Freq.	%
Sufficient	9	75.00
Not sufficient	3	25.00
	12	100.00

Taking non-veg	10	83.00
Veg	2	17.00
	12	100.00

Fasting

% of fasting	Freq.	%
0(No Fasting)	1	9.00
25(Once in a week)	1	8.00
50(Twice in a week)	8	67.00
75(Thrice in a week)	1	8.00
100(Twice in a week & Many Occasional Fasts/ Thrice in a week & Some Occasional Fasts).	1	8.00
	12	100.00

Diet at fasting

sufficient(i.e. eating enough qyantity)	11	100.00
Not sufficient(i.e. only taking tea or fruits)	0	0.00
	11	100.00

Taking Tea

No. of time in a day	Freq.	%
1	2	17.ØØ
2	6	5Ø.ØØ
3	2	17.ØØ
4 & >4	2	16.ØØ
	12	1ØØ.ØØ

% Intake of Milk

	Freq.	%
Ø (No-i.e. Level Ø)	8	67.ØØ
25(Sometimes-i.e. Level 1)	1	8.ØØ
5Ø (Yes/Taking with Rice etc.-i.e. Level 2)	1	8.ØØ
1ØØ(Ample-i.e. Level 4)	2	17.ØØ
	12	1ØØ.ØØ

% Intake of Fruits

	Freq.	%
Ø (No-i.e. Level Ø)	5	42.ØØ
25(Sometimes-i.e. Level 1)	1	8.ØØ
5Ø (Yes-i.e. Level 2)	6	5Ø.ØØ
1ØØ(Ample-i.e. Level 4)	Ø	Ø.ØØ
	12	1ØØ.ØØ

Meals - Information

6 out of 12 women take 3 meals (5Ø%)
3 out of 12 - spicy foods (25%)
11 out of 12 women prepare sweets (92%)
5 out of 12 like variety (42%)
7 out of 12 would like to learn variety (58%)

Nutrition at carrying

5Ø(very less)	4	33.ØØ
75(little less)	1	9.ØØ
1ØØ (As usual)	4	33.ØØ
1ØØ + (more than normal)	3	25.ØØ
	12	1ØØ.ØØ

Kodawdi
Sr.No. Ø21 to Ø32

	Size of Sample
Avg. Age at marriage 16 years	12
Avg. Age at 1st chi 18 years	12
Avg. Age at 2nd chi 2Ø years	1Ø
Avg. Age at 3rd chi 22 years	8
Avg. Age at 4th chi 25 years	8
Avg. Age at 5th chi years	-
Avg. Age at 6th chi years	-

Avg. present age = 28 years

Avg. no. of deliveries - 35/12 = 2.92

Avg.No. of children 34/12 = 2.83

% Ratio of No.of children to No.of deliveries =97.14

% of Delivery at Home	Freq.	%
Not at Home	2	17
5Ø	2	17
67	2	17
75	1	8
8Ø	1	8
1ØØ	4	33
	12	1ØØ

Rest at M.C.		
Taking Rest	3	25.ØØ
No Rest	9	75.ØØ
	12	1ØØ.ØØ

Wrong Ideas - Only 1 out of 12 has wrong ideas about FPD that it creates problem

Opinion about no. of children	Freq	%
	Ø	Ø.ØØ
1 son	3	25.ØØ
2 sons	2	17.ØØ
2 children	1	8
3 children	1	8
As many as god gives	5	42.ØØ
not told	12	1ØØ.ØØ

Only 1 out of 12 women declared to have superstition for getting a son.

All 100% do not have science knowledge about child birth.

Dependence on children score

Description & Score	Freq.	%
Don't depend i.e. 0	0	0.00
Are not sure i.e. 1	6	50.00
Expect to depend on child i.e. 3	6	50.00
Must depend i.e. 4	0	0.00
	12	100.00

Diseases	Freq.	%
Measles	8	67.00
Chicken Fox	9	75.00
Dyptheria	0	0.00
Conjunctivitis	5	42.00
Ear Problem	2	17.00
Dysentery	6	50.00
Diarrohea	0	0.00
Humps	1	8.00
Scabbies	3	25.00
Ecxema	1	8.00
Pneumonia	1	8.00

Total Diseases	Freq.	%
0	0	0.00
1	1	8.00
2	4	34.00
3	3	25.00
4	2	17.00
6	1	8.00
7	1	8.00
	12	100.00

Self Diseases	Freq.	%
Pain in limbs	3	25.00
Regarding periods irregular/ more bleeding	0	0.00
Stomach ache	1	8.00
back ache	3	25.00
Head ache	3	25.00
Arthritis	1	8.00
Conjunctivitis	1	8.00
Leucorrohea	1	8.00

At Home Cure 3 out of 12 i.e. 25% do at home cure

Going to Dr.	11	92.00
No need of Dr.	1	8.00
	12	100.00

Inoculation : all 100%

Sr.No.021 to 032

Source of water:- Tank.

Water	Freq.	%
Boil	2	17
Do not boil	10	83
	12	100
Filter	9	75
Do not filter	3	25
	12	100
Alum	4	33
No alum	8	67
	12	100

Utensils 1 out of 12 i.e. 8% women do not clean utensils properly.

Use soap	3	25
Do not use soap	9	75
Insects remedy	6	50
no	6	50
Smoke trouble	5	42
No smoke trouble	7	58
	12	100

6 out of 12 have no latrin at mother's place i.e 67%
12 out of 12 have no latrin at m-in-law's place i.e. 100%

Opinion about separate latrin told

Told	4	33
Not told	8	67
	12	100

General Information — Vil. Manjai Asni (Sr.No.Ø33 to Ø45)

Sample Size: 13

Religion: 1ØØ% Hindu

Family Type

Class	Freq.	%
Joint	1Ø	76.92
Nuclear	3	23.Ø8

Total Members

C.I.	Freq.	%
1-4	1	7.69
5-6	5	38.46
7-1Ø	5	38.46
11-2Ø	2	15.39
	13	1ØØ.ØØ

Males

C.V.	Freq.	%
1	3	23.Ø8
2	6	46.15
3	1	7.69
4 & > 4	3	23.Ø8
	13	1ØØ.ØØ

Females

C.V.	Freq.	%
1	3	23.Ø8
2	6	46.15
3	3	23.Ø8
4 & > 4	1	7.69
	13	1ØØ.ØØ

Sons

C.V.	Freq.	%
Ø	1	7.69
1	7	53.85
2	2	15.38
3	1	7.69
4 & > 4	2	15.38
	13	1ØØ.ØØ

Daughters

C.V.	Freq.	%
Ø	3	23.Ø8
1	5	38.46
2	4	3Ø.77
3	1	7.69
4 & > 4	Ø	Ø.ØØ
	13	1ØØ.ØØ

Hus. Occupation	Freq.	%
Agriculture	5	38.46
Business	1	7.69
A & B	5	38.47
Service	1	7.69
Labourer	1	7.69
	13	100.00

	Freq.	%
Agri. Owned	10	76.92
" not	3	23.08

Avg.Annual Income Rs. 13440/-

Avg.Agri.Area owned 028 Gunthe

Rooms	Freq.	%
1	1	7.69
2	4	30.77
3	7	53.85
4	1	7.69
	13	100

Rooms Avg.=3
(Modal Value with f=7)

Ednal Levels

Level	Freq.	%
0	6	46.16
1-2	1	7.69
3-4	1	7.69
5&>5	5	38.46
	13	100

Avg. Edn. 3
(Arithmetic Avg.)

Manjai Asni
Ser. No. Ø33 to Ø45

Type of FPD	Freq.	%
Tab	Ø	Ø.ØØ
Cop.T	2	15.38
Condom	Ø	Ø.ØØ
Tab & Cop.T	Ø	Ø.ØØ
Tab,Cop T & Condom	2	15.38
F Ops	1	7.7Ø
Tab, Cop T & F Ops.	2	15.38
Tab, Cop T, Condom & F Ops.	Ø	Ø.ØØ
No. FPD known	6	46.16
	13	1ØØ.ØØ

Knowledge of condom	2	15.38
NO - do -	11	84.62
	13	1ØØ

Comments : 1) 3 out of 13 women i.e. 23.Ø8 % F Ops.
2) Out of 13, only one woman used FPD after 2 childre
Others only know, but do not use FPDs.

Manjai Asni
Ser. Ø33 to Ø45

Dist.bet
two children opinion

Years	Freq.	%
2	2	15.38
3	5	38.46
Not mentioned	6	46.18
	13	1ØØ

Doctor's opinion about distance

	Freq.	%
Known	2	15.38
Not known	11	84.62
	13	1ØØ

Opinion regarding the birth of
the first child after marriage -
How many years?

Years	Freq.	%
1	3	23.Ø8
2	2	15.38
3	1	7.69
Not mentioned	7	53.85
	13	1ØØ

Whether felt to stop delivery after 2 children

	Freq.	%
Felt	4	3Ø.77
Not Felt	9	69.23
	13	1ØØ

2) Reasons for "Not Felt" to stop.

Reason	Freq.
A son is wanted	1
2nd son is wanted	1
Reason not mentioned	6
	8

Expression after the 1st daughter

Happy : 1st daughter But in one case, In-laws punished when got the 2nd daughter

Expression after son

Happy

Doctor consulted	Freq.	%
For FPD other than operations	Ø	
For F OPs	3	23.Ø8
Not consulted	1Ø	76.92
	13	1ØØ

Manjai Asni
Sr.No. Ø33 to Ø45

Nutrition:

% of Nutrition (N)	Freq.	%
25(Only 1 Food Item of V,D,C,S)	1	7.69
5Ø(2 Food Items of V,D,C,S)	4	3.77
75(3 Food Items of V,D,C,S)	8	61.54
1ØØ(4 Food Items of V,D,C,S)	Ø	Ø.ØØ
	13	1ØØ.ØØ

[1ØØ % Nutritious Food contains all the 4 parts viz. V(Vegetables),D(dal),C(cereals i.e.'Usal') & S(Salad)]

1) Out of 8 with 75% nutrition, 7 do not take Salad & 1 does not take Cereals.

2) All of 4 with 5Ø% nutrition do not take Cereals & Salad.

3) One woman with 25% nutrition does not take Dal, Cereals & Salad.

Food(Opinion of the Respondent)	Freq.	%
Sufficient	1Ø	76.92
Not sufficient	3	23.Ø8
	13	1ØØ.ØØ

Taking non-veg	11	84.62
Veg	2	15.38
	13	1ØØ.ØØ

Fasting

% of fasting	Freq.	%
Ø(No Fasting)	Ø	Ø.ØØ
25(Once in a week)	5	38.46
5Ø(Twice in a week)	6	46.16
75(Thrice in a week)	1	7.69
1ØØ(Twice in a week & Many Occasional Fasts/ Thrice in a week & Some Occasional Fasts).	1	7.69
	13	1ØØ.ØØ

Diet at fasting

sufficient(i.e. eating enough qyantity)	8	61.54
Not sufficient(i.e. only taking tea or fruits)	5	38.46
	13	100.00

Taking Tea

No. of time in a day	Freq.	%
1	5	38.46
2	7	53.85
3	1	7.69
	13	100.00

% Intake of Milk

	Freq.	%
0 (No-i.e. Level 0)	10	76.92
25(Sometimes-i.e. Level 1)	1	7.69
50 (Yes/Taking with Rice etc.-i.e. Level 2)	2	15.39
100(Ample-i.e. Level 4)		
	13	100.00

% Intake of Fruits

0 (No-i.e. Level 0)	1	7.69
25(Sometimes-i.e. Level 1)	0	0.00
50 (Yes-i.e. Level 2)	12	92.31
100(Ample-i.e. Level 4)	0	0.00
	13	100.00

Meals - Information

Only 1 woman takes 3 meals(7.69%)
Only 1 woman takes spicy(7.69)
8 women - sweet(61.54%)
5 womens - like variety(38.46%)
5 women - would like to learn variety(38.46%)

Nutrition at carrying

50(very less)	2	15.38
75(little less)	1	7.69
100 (As usual)	6	46.16
100 + (more than normal)	4	30.77
	13	100.00

Manjai Asni
Sr.No. Ø33 to Ø45

	Size of Sample
Avg. Age at marriage 14 years	13
Avg. Age at 1st chi 17 years	13
Avg. Age at 2nd chi 19 years	11
Avg. Age at 3rd chi 22 years	7
Avg. Age at 4th chi 24 years	2
Avg. Age at 5th chi 28 years	1
Avg. Age at 6th chi years	

Avg. present age = 24 years.

Avg. no. of deliveries - 34/13 = 2.62

Avg.No. of children 3Ø/13 = 2.31

% Ratio of No.of children to No.of deliveries =88.24

Remark:-
3 Lost, 1 Abortion.

% of Delivery at Home	Freq.	%
Ø	4	3Ø.77
1ØØ	9	69.23
	13	1ØØ.ØØ

Rest at M.C.

Taking Rest	2	15.38
No Rest	11	84.62
	13	1ØØ.ØØ

Wrong Ideas -Ø% have wrong ideas about FPDs.

Opinion about no. of children	Freq	%
1 son	1	7.69
2 sons	7	53.85
2 children	1	7.69
Not told	4	30.77
	13	100.00

Only 1 out of 13 women declared to have superstition for getting a son. (7.69%)

Only 2 out of 13 have science knowledge about child birth (15.38%)

Dependence on son score Description & Score	Freq.	%
Don't depend i.e. 0	0	0.00
Are not sure i.e. 1	6	46.15
Expect to depend on child i.e. 3	6	46.15
Must depend i.e. 4	1	7.70
	13	100.00

Diseases	Freq.	%
Measles	8	61.54
Chicken Fox	7	53.85
Dyptheria	0	0.00
Conjunctivitis	2	15.38
Ear Problem	2	15.38
Dysentery	7	53.85
Diarrohea	0	0.00
Mumps	1	7.69
Scabbies	2	15.38
Ecxema	1	7.69
Cannot walk when 3 years old	1	7.69

Total Diseases	Freq.	%
0	2	15.38
1	1	7.69
2	3	23.08
3	4	30.77
4	3	23.08
	13	100.00

Self Diseases	Freq.	%
Pain in limbs	3	23.08
Regarding periods irregular/ more bleeding	3	23.08
Stomach ache	1	7.69
back ache	3	23.08
Weakness in neck and waist	1	7.69
Head ache	1	7.69
Asthma	1	7.69
No complaints	7	53.85

Note : This total will not be 13, since a woman may have more than one complaint.

At Home Cure %

Goint to Dr.	11	84.62
No need of Dr.	2	15.38
	13	100.00

Inoculation : all 100%

Manjai Asni
Sr.No.Ø33 to Ø45

Source of water:-Well

Water

	Freq.	%
Boil	Ø	Ø
Do not boil	13	1ØØ
Filter	11	84.62
Do not filter	2	15.38
Alum	3	23.Ø8
No alum	1Ø	76.92
Utensils-clean properly		1ØØ
Use soap	7	53.85
Do not use soap	6	46.15
Insects remedy	1Ø	76.92
No Insects Remedy	3	23.Ø8
Smoke trouble	5	38.46
No smoke trouble	8	61.54
	13	1ØØ

1ØØ% no latrin at mother's place
1ØØ% no latrin at m-in-law's place

Opinion about separate latrin

Told	3	23.Ø8
Not told	1Ø	76.92
	13	1ØØ

One of these women has her brother-in-law and sister-in-law as Doctors, still,
1) Water not boiled
2) No Latrin
3) Self-leucorrohea disease is there.

General Information — Vil. Kusgaon (Sr.No.048 to 081)

Sample Size: 16

Religion: 100% Hindu

Family Type	Class	Freq.	%
	Joint	5	31.00
	Nuclear	11	69.00
		16	100

Total Members	C.I.	Freq.	%
	1-4	5	31.00
	5-8	10	63.00
	7-10	1	6.00
	11-20	0	0.00
		16	100.00

Males	C.V.	Freq.	%
	1	14	88.00
	2	2	12.00
	3	0	0.00
	4 & > 4	0	0.00
		16	100.00

Females	C.V.	Freq.	%
	1	11	69.00
	2	4	25.00
	3	1	6.00
	4 & > 4	0	0.00
		16	100.00

Sons	C.V.	Freq.	%
	0	2	12.00
	1	8	50.00
	2	6	38.00
	3	0	0.00
	4 & > 4	0	0.00
		16	100.00

Daughters	C.V.	Freq.	%
	0	4	25.00
	1	7	44.00
	2	4	25.00
	3	1	6.00
	4 & > 4	0	0.00
		16	100.00

Hus. occupation	Freq.	%
Agriculture	Ø	Ø.ØØ
Business	Ø	Ø.ØØ
A & B	Ø	Ø.ØØ
Service	9	56.ØØ
Labourer	6	38.ØØ *
Milk animals	1	6
	16.ØØ	1ØØ.ØØ

* one labourer is the wife

	Freq.	%
Agri. Owned	11	69
" not Owned	5	31.ØØ

Avg. Annual Income — Rs. 23119/-

Avg. Agri. Area owned — Ø25 Gunthe

Rooms	Freq.	%
1	6	37.ØØ
2	6	38.ØØ
3	4	25.ØØ
4 & >4	Ø	Ø.ØØ
	16	1ØØ

Avg. rooms = 2
(Modal Values for f=6 are 1 & 2, out of which 2 is preferred, since usually 2 rooms are frequent in other villages).

Ednal Levels

Level	Freq.	%
Ø	7	44.ØØ
1-2	4	25.ØØ
3-4	Ø	Ø.ØØ
5&>5	5	31.ØØ
	16	1ØØ

Avg. Edn. 2
(Arithmetic Avg.)

Kusgaon
Ser. No. Ø46 to Ø61

Type of FPD	Freq.	%
Tab	Ø	Ø.ØØ
Tab & Cop.T	1	6.ØØ
Cop T & Condom	1	6.ØØ
Tab,Cop T & Condom	2	13.ØØ
Loop, Cop T, Condom	1	6.ØØ
F Ops	2	13.ØØ
Cop T & F Ops	1	6.ØØ
Tab, Cop T & F Ops	2	13.ØØ
No FPD known	6	37.ØØ
	16	1ØØ.ØØ
Knowledge of condom	4	25.ØØ
NO - do -	12	75.ØØ
	16	1ØØ

Comments : 1) 5 out of 16 women i.e. 31.25 % F Ops.
2) Out of 16, nobody used FPD at all,
1Ø out of 16 know, but do not use FPDs.

Kusgaon
Ser. Ø46 to Ø61

Dist.bet
two children opinion

Years	Freq.	%
2	1	6
3	13	81
4	2	13
	16	1ØØ

Doctor's opinion about distance

	Freq.	%
Known	3	19
Not known	13	81
	16	1ØØ

Opinion regarding the birth of
the first child after marriage -
How many years?

Years	Freq.	%
1	7	44
2	5	31
3	2	13
4	1	6
Not mentioned	1	6
	16	1ØØ

Whether felt to stop delivery after 2 children

	Freq.	%
Felt	11	69
Not Felt	5	31
	16	1ØØ

Doctor consulted

	Freq.	%
For FPD other than operations	1	6
For F Ops.	5	31
Not consulted	1Ø	63
	16	1ØØ

Sr.No. Ø46 to Ø61

Nutrition:

% of Nutrition (N)	Freq.	%
25(Only 1 Food Item of V,D,C,S)	2	12.ØØ
5Ø(2 Food Items of V,D,C,S)	6	38.ØØ
75(3 Food Items of V,D,C,S)	7	44.ØØ
1ØØ(4 Food Items of V,D,C,S)	1	6.ØØ
	16	1ØØ

Comment: 94% i.e. 15 out of 16 women do not take salad.

Food(Opinion of the Respondent)	Freq.	%
Sufficient	16	1ØØ.ØØ
Not sufficient	Ø	Ø.ØØ
	16	1ØØ.ØØ

Taking non-veg	1Ø	63.ØØ
Veg	6	37.ØØ
	16	1ØØ.ØØ

Fasting

% of fasting	Freq.	%
Ø(No Fasting)	3	19.ØØ
25(Once in a week)	8	5Ø.ØØ
5Ø(Twice in a week)	3	19.ØØ
75(Thrice in a week)	2	12.ØØ
1ØØ(Twice in a week & Many Occasional Fasts/ Thrice in a week & Some Occasional Fasts).	Ø	Ø.ØØ
	16	1ØØ.ØØ

Diet at fasting

sufficient(i.e. eating enough qyantity)	12	92.ØØ
Not sufficient(i.e. only taking tea or fruits)	1	8.ØØ
	13	1ØØ.ØØ

Taking Tea

No. of times in a day	Freq.	%
Ø	1	6.ØØ
1	Ø	Ø
2	12	75.ØØ
3	1	6.ØØ
4 & >4	2	13
	16.ØØ	1ØØ.ØØ

% Intake of Milk

	Freq.	%
Ø (No-i.e. Level Ø)	9	56.ØØ
25(Sometimes-i.e. Level 1)	2	13.ØØ
5Ø (Yes/Taking with Rice etc.-i.e. Level 2)	2	13.ØØ
1ØØ(Ample-i.e. Level 4)	3	18.ØØ
	16	1ØØ.ØØ

% Intake of Fruits

Ø (No-i.e. Level Ø)	6	38.ØØ
25(Sometimes-i.e. Level 1)	1	6.ØØ
5Ø (Yes-i.e. Level 2)	9	56.ØØ
1ØØ(Ample-i.e. Level 4)	Ø	Ø.ØØ
	16	1ØØ.ØØ

Meals - Information

8 out of 16 - 3 meals (5Ø%)
4 out of 16 - spicy (25%)
13 out of 16 prepare sweets (81%)
7 out of 16 like variety (44%)
12 out of 16 would like to learn variety (75%)

Nutrition at carrying

5Ø(very less)	6	37.ØØ
75(little less)	3	19.ØØ
1ØØ (As usual)	5	31.ØØ
1ØØ + (more than normal)	2	13.ØØ
	16	1ØØ.ØØ

Kusgaon
Sr.No. Ø46 to Ø61

	Size of Sample
Avg. Age at marriage 15 years	16
Avg. Age at 1st chi 18 years	16
Avg. Age at 2nd chi 2Ø years	15
Avg. Age at 3rd chi 22 years	1Ø
Avg. Age at 4th chi 24 years	2
Avg. Age at 5th chi - years	Ø
Avg. Age at 6th chi - years	Ø

Avg. present age = 3Ø years.

Avg. no. of deliveries = 43/16 = 2.69

Avg.No. of children =39/16 = 2.44

% Ratio of No. of children to No.of deliveries = 9Ø.7

Remark:- 4 lost

% of Delivery at Home	Freq.	%
Not at Home	3	18.ØØ
33% at home	2	13
5Ø% at home	2	13
67% at home	1	6
1ØØ% at home	8	5Ø
	16	1ØØ.ØØ

Rest at M.C.

Taking Rest	1	6.ØØ
No Rest	15	94.ØØ
	16	1ØØ.ØØ

1 out of 16 i.e. 6% women have wrong ideas about FPDs.
She thinks that it is not proper to use FPDs

Opinion about no. of children

	Freq	%
1 son	7	44.ØØ
2 sons	3	19.ØØ
2 children	2	12.ØØ
3 children	1	6
Not told	3	19.ØØ
	16	1ØØ.ØØ

Expectation for getting a son. (6%)

Only 1 out of 16 have science knowledge about child birth (6%)

Dependence on son score

Description & Score	Freq.	%
Don't depend i.e. Ø	Ø	Ø.ØØ
Are not sure i.e. 1	5	31.ØØ
Expect to depend on child i.e. 3	1Ø	63.ØØ
Must depend i.e. 4	1	6.ØØ
	16	1ØØ.ØØ

Kusgaon
Sr.No. Ø46 to Ø61

Diseases	Freq.	%
Measles	11	69.ØØ
Chicken Pox	6	38.ØØ
Dyptheria	Ø	Ø.ØØ
Conjunctivitis	9	56.ØØ
Ear Problem	4	25.ØØ
Dysentery	12	75.ØØ
Diarrohea	4	25.ØØ
Mumps	2	13.ØØ
Scabbies	3	19.ØØ
Ecxema	Ø	Ø.ØØ
Giddiness	1	6.ØØ

Total Diseases	Freq.	%
Ø	1	6.ØØ
1	3	19.ØØ
2	3	19.ØØ
3	3	19.ØØ
4	6	37.ØØ
	16	1ØØ

Self Diseases	Freq.	%
Pain in limbs	2	13.ØØ
back ache	3	19.ØØ
Stomach ache	1	6.ØØ
Head ache	2	13.ØØ
Giddiness	1	6.ØØ
Ulcer	1	6.ØØ
Leucorrohea	1	6.ØØ

At home cure :

4 out of 16 i.e. 25% women do at home cure.

At Home Cure %

Going to Dr.	16	1ØØ.ØØ
No need of Dr.	Ø	Ø.ØØ
	16	1ØØ.ØØ

Inoculation : all 1ØØ%

Comment: In one case, a child died due to Dysentery.

Source of water:- Well

Water

	Freq.	%
Boil	2	13
Do not boil	14	87
Filter	6	37
Do not filter	1Ø	63
Alum	Ø	Ø
No alum	16	1ØØ

Utensils - 4 out of 16 i.e. 25% women do not clean utensils properly.

Use soap	9	56
Do not use soap	7	44
Insects remedy	14	87
no	2	13
Smoke trouble	9	56
No smoke trouble	7	44
	16	1ØØ

81% no latrin at mother's place--i.e. 13 out of 16
94% no latrin at m-in-law's place--i.e. 15 out of 16

Opinion about separate latrin

Told	7	47
Not told	8	53
	15	1ØØ

General Information — Vil. Kurungwadi (Sr.No.062 to 080)

Sample Size: 19

Religion: 100% Hindu

Family Type	Class	Freq.	%
	Joint	15	78.95
	Nuclear	4	21.05
		19	100

Total Members	C.V.	Freq.	%
	1-4	3	15.79
	5-6	5	26.32
	7-10	10	52.63
	11-20	1	5.26
		19	100.00

Males	C.V.	Freq.	%
	1	9	47.37
	2	6	31.58
	3	1	5.26
	4 & > 4	3	15.79
		19	100.00

Females	C.V.	Freq.	%
	1	4	21.05
	2	10	52.63
	3	3	15.79
	4 & > 4	2	10.53
		19	100.00

Sons	C.V.	Freq.	%
	0	2	10.53
	1	6	31.58
	2	8	42.10
	3	3	15.79
	4 & > 4	0	0.00
		19	100.00

Daughters	C.V.	Freq.	%
	0	4	21.05
	1	12	63.16
	2	0	0.00
	3	2	10.53
	5	1	5.26
		19	100.00

Hus. occupation	Freq.	%
Agriculture	4	21.05
Business	0	0.00
A & B	5	26.32
Service	8	42.11
Labourer	1	5.26
No job	1	5.26
	19	100.00

	Freq.	%
Agri. Owned	19	100
" not Owned	0	0.00

Avg.Annual Income Rs. 25068/-

Avg.Agri.Area owned 101 Gunthe

Rooms	Freq.	%
1	1	5.00
2	9	48.00
3	5	26.00
4	4	21.00
	19	100.00

Rooms avg = 2
(Modal Value with f=9)

Ednal Levels

Level	Freq.	%
0	4	21.00
1-2	2	11.00
3-4	4	21.00
5&>5	9	47.00
	19	100.00

Avg. Edn. 5
(Arithmetic Avg.)

Kurungwadi
Ser. No. Ø62 to Ø8Ø

Type of FPD	Freq.	%
Tab	1	6.ØØ
Cop.T	1	6.ØØ
Tab & Cop.T	1	5.ØØ
Tab,Cop T & Condom	1	5.ØØ
Cop T, F OPS	1	5.ØØ
Tab, Cop T & F Ops	1	5.ØØ
Cop T, Mala-D, Condom & FOps.	1	5.ØØ
Tab,Cop T,Condom,F Ops.	1	5.ØØ
F Ops.	6	32.ØØ
No FPD	5	26
	19.ØØ	1ØØ.ØØ

Knowledge of condom	3	16.ØØ
NO - do -	16	84.ØØ
	19	1ØØ

Comments:-

1) 1Ø out of 19 women i.e. 53% women F Ops.
2) Out of 19, only 1 woman used FPD after 1st child (woman's age 16 years)
3) Others only know, but do not use FPD.

Dist.bet
two children opinion

Years	Freq.	%
2	1	5
3	15	79
Not mentioned	3	16
	19	1ØØ

Doctor's opinion about distance

	Freq.	%
Known	4	21
Not known	15	79
	19	1ØØ

Opinion regarding the birth of
the first child after marriage -
How many years?

Years	Freq.	%
1	4	21
2	9	47
3	3	16
4	Ø	Ø
5	1	5
Not mentioned	2	11
	19	1ØØ

Whether felt to stop delivery after 2 children

	Freq.	%
Felt	18	95
Not Felt	1	5
	19	1ØØ

Doctor consulted

	Freq.	%
For FPD other than operations	1	5
For F Ops.	1Ø	53
Not consulted	8	42
	19	1ØØ

Kurungwadi
Sr.No. Ø62 to Ø8Ø

Nutrition:

% of Nutrition (N)	Freq.	%
25(Only 1 Food Item of V,D,C,S)	1	5.ØØ
5Ø(2 Food Items of V,D,C,S)	4	21.ØØ
75(3 Food Items of V,D,C,S)	14	74.ØØ
1ØØ(4 Food Items of V,D,C,S)	Ø	Ø.ØØ
	19	1ØØ

Comment: 95% i.e. 18 out of 19 women do not take salad.

Food(Opinion of the Respondent)	Freq.	%
Sufficient	18	95.ØØ
Not sufficient	1	5.ØØ
	19	1ØØ.ØØ

Taking non-veg	13	68.ØØ
Veg	6	32.ØØ
	19	1ØØ.ØØ

Fasting

% of fasting	Freq.	%
Ø(No Fasting)	1	5.ØØ
25(Once in a week)	7	37.ØØ
5Ø(Twice in a week)	7	37.ØØ
75(Thrice in a week)	4	21.ØØ
1ØØ(Twice in a week & Many Occasional Fasts/ Thrice in a week & Some Occasional Fasts).	Ø	Ø.ØØ
	19	1ØØ.ØØ

Diet at fasting

Sufficient(i.e. eating enough quantity)	14	78.ØØ
Not sufficient(i.e. only taking tea or fruits)	4	22.ØØ
	18	1ØØ.ØØ

Taking Tea

No. of times in a day	Freq.	%
1	1	5.00
2	12	63.00
3	4	21.00
4 & >4	2	11
	19.00	100.00

% Intake of Milk

	Freq.	%
0 (No-i.e. Level 0)	14	74.00
25(Sometimes-i.e. Level 1)	0	0.00
50 (Yes/Taking with Rice etc.-i.e. Level 2)	3	16.00
100(Ample-i.e. Level 4)	2	10
	19.00	100.00

% Intake of Fruits

	Freq.	%
0 (No-i.e. Level 0)	4	21.00
25(Sometimes-i.e. Level 1)	5	26.00
50 (Yes-i.e. Level 2)	8	42.00
100(Ample-i.e. Level 4)	2	11.00
	19	100.00

Meals - Information

4 out of 19 women take 3 meals (21%)
5 out of 19 - spicy (26%)
17 out of 19 women prepare sweets (89%)
8 out of 19 like variety (42%)
15 out of 19 would like to learn variety (79%)

Nutrition at carrying

50(very less)	5	26.00
75(little less)	2	11.00
100 (As usual)	7	37.00
100 + (more than normal)	5	26.00
	19	100.00

	Size of Sample
Avg. Age at marriage 15 years	19
Avg. Age at 1st chi 17 years	19
Avg. Age at 2nd chi 2Ø years	17
Avg. Age at 3rd chi 22 years	12
Avg. Age at 4th chi 27 years	3
Avg. Age at 5th chi - years	Ø
Avg. Age at 6th chi - years	Ø

Avg. present age = 26 years

Avg. no. of deliveries = 52/19 = 2.74

Avg.No. of children 5Ø/19 = 2.63

% 'Ratio of No.of children to No.of deliveries =96.15

Remark:- 2 lost.

% of Delivery at Home	Freq.	%
Not at Home	5	27.ØØ
25% not at home	1	5.ØØ
33% not at home	1	5
5Ø% not at home	1	5
1ØØ% not at home	11	58
	19	1ØØ

Rest at M.C.

Taking Rest	9	47.ØØ
No Rest	1Ø	53.ØØ
	19	1ØØ.ØØ

Wrong Ideas - 4 out of 19 i.e.21% women have wrong ideas about FPDs.
2 creates problems
1 about Cop T
1 says that FPDs should not be used

Opinion about no. of children

	Freq	%
1 son	5	26.ØØ
2 sons	4	21.ØØ
1 daughter	1	5
2 children	6	32.ØØ
3 children	3	16.ØØ
	19	1ØØ.ØØ

Only 1 out of 19 women declared to have superstition for getting a son. (5%)

Only 2 out of 19 have science knowledge about child birth (11%)

Dependence on son score

Description & Score	Freq.	%
Don't depend i.e. Ø	1	5.ØØ
Are not sure i.e. 1	12	63.ØØ
Expect to depend on child i.e. 3	4	21.ØØ
Must depend i.e. 4	2	11.ØØ
	19	1ØØ.ØØ

Kurungwadi
Sr.No. Ø62 to Ø8Ø

Diseases	Freq.	%
Measles	1Ø	53.ØØ
Chicken Fox	5	26.ØØ
Dyptheria	Ø	Ø.ØØ
Conjunctivitis	3	16.ØØ
Ear Problem	3	16.ØØ
Dysentery	8	42.ØØ
Diarrohea	3	16.ØØ
Mumps	Ø	Ø.ØØ
Scabbies	2	11.ØØ
Ecxema	1	5.ØØ
Fits	2	11.ØØ
Temp.	1	5.ØØ
Boils	1	5.ØØ

Total Diseases	Freq.	%
Ø	3	16.ØØ
1	7	37.ØØ
2	5	26.ØØ
3	1	5.ØØ
4 & >4	3	16.ØØ
	19	1ØØ.ØØ

Self Diseases	Freq.	%
Pain in limbs	2	11.ØØ
back ache	4	21.ØØ
Head ache	1	5.ØØ
Stomach ache	3	16.ØØ
Weakness	1	5.ØØ
Measles	1	5.ØØ
Chicken pox	1	5.ØØ
Temp.	2	11.ØØ
Dysentery	1	5.ØØ
Jaundice	1	5.ØØ
Anaemia	1	5.ØØ
pain in eyes	1	5.ØØ

6 out of 19 (32%) women do at home cure.

At Home Cure %		
Goint to Dr.	16	84.ØØ
No need of Dr.	3	16.ØØ
	19	1ØØ.ØØ

Inoculation : all 1ØØ%

Kurungwadi
Sr.No.062 to 080

Source of water:-Well

Water

	Freq.	%
Boil	0	0
Do not boil	19	100
Filter	2	11
Do not filter	17	89
Alum	0	0
No alum	19	100

Utensils

3 out of 19 (i.e.16%) do not clean utensils properly.

Use soap	15	79
Do not use soap	4	21
Insects remedy	10	53
no	9	47
Smoke trouble	4	21
no smoke isonable	15	79
	19	100

15 out of 19 i.e. 79%-- no latrin at mothers place.
* 18 out of 19 i.e. 95%-- no latrin at mother-in-law's place

Opinion about separate latrin

Told	9	50
Not told	9	50
	18	100

* One house has the facility of a separate latrin.

General Information — Vil. Alande (Sr.No.081 to 100)

Sample Size 20

Religion 100% Hindu

Family Type	Class	Freq.	%
	Joint	10	50.00
	Nuclear	10	50.00
		20	100

Total Members	C.I.	Freq.	%
	1-4	1	5.00
	5-6	13	65.00
	7-10	5	25.00
	11-20	1	5.00
		20	100.00

Males	C.V.	Freq.	%
	1	14	70.00
	2	3	15.00
	3	2	10.00
	4 & > 4	1	5.00
		20	100.00

Females	C.V.	Freq.	%
	1	10	50.00
	2	8	40.00
	3	1	5.00
	4 & > 4	1	5.00
		20	100.00

Sons	C.V.	Freq.	%
	0	2	10.00
	1	7	35.00
	2	9	45.00
	3	2	10.00
	4 & > 4	0	0.00
		20	100.00

Daughters C.V.	Freq.	%
Ø	4	2Ø.ØØ
1	4	2Ø.ØØ
2	7	35.ØØ
3	2	1Ø.ØØ
4 & > 4	3	15.ØØ
	2Ø	1ØØ.ØØ

Hus. occupation	Freq.	%
Agriculture	1Ø	5Ø.ØØ
Business	3	15.ØØ
A & B	Ø	Ø.ØØ
Service	6	3Ø.ØØ
Labourer	1	5.ØØ
	2Ø	1ØØ.ØØ

	Freq.	%
Agri. Owned	17	85
" not Owned	3	15
	2Ø	1ØØ

Avg.Annual Income Rs. 2361Ø/-

Avg.Agri.Area owned Ø92 Gunthe

Rooms	Freq.	%
1	7	35.ØØ
2	5	25.ØØ
3	6	3Ø.ØØ
4&>4	2	1Ø.ØØ
	2Ø	1ØØ

Rooms Avg = 1
(Modal Value for f=7)

Ednal Level

Level	Freq	%
ØØ	11	55
1-2	3	15.ØØ
3-4	1	5.ØØ
5&>5	15	75.ØØ
	2Ø	1ØØ

Avg Edn. 6
~~Avg Edn. 6~~
(Arithmetic Avg.)

Alande
Ser. No. Ø81 to 1ØØ

Type of FPD	Freq.	%
Tab	Ø	Ø.ØØ
Cop.T	Ø	Ø.ØØ
Condom	Ø	Ø.ØØ
Tab & Cop.T	1	5.ØØ
Cop T & Condom	2	1Ø.ØØ
Tab,Cop T & Condom	1	5.ØØ
Cop T, Condom & Loop	1	5.ØØ
F Ops	1	5.ØØ
Cop T & F OPs	2	1Ø.ØØ
Tab, Cop T & F Ops	3	15.ØØ
Cop T, Condom & F OPS	1	5.ØØ
Tab, Cop T, Condom & F Ops	3	15.ØØ
Tab, Cop T, Condom, Loop, Jelly & F Ops	1	5.ØØ
No. FPD known	4	2Ø.ØØ
	2Ø	1ØØ.ØØ

Knowledge of condom	9	45.ØØ
NO - do -	11	55.ØØ
	2Ø	1ØØ

Comments :
1) 11 out of 2Ø women i.e. 55% F Ops.
2) Out of 2Ø, only one woman used FPD after 1st chil
3) Out of 2Ø, only one woman used FPD after 2nd ch
4) Out of 2Ø, only one woman used FPD after 4th ch
5) Others only know, but do not use FPDs.

Dist.bet
two children opinion

Years	Freq.	%
2	5	25
3	13	65
4	2	1Ø
	2Ø	1ØØ

Doctor's opinion about distance

	Freq.	%
Known	4	2Ø
Not known	16	8Ø
	2Ø	1ØØ

Opinion regarding the birth of
~~the first child after marriage~~ -
How many years?

Years	Freq.	%
1	6	3Ø
2	11	55
3	1	5
4	Ø	Ø
5	Ø	Ø
not mentioned	2	1Ø
	2Ø	1ØØ

Whether felt to stop delivery after 2 children

	Freq.	%
Felt	14	7Ø
Not Felt	6	3Ø
	2Ø	1ØØ

Doctor consulted

	Freq.	%
For FPD other than operations	1	5
For F Ops.	11	55
Not consulted	8	4Ø
	2Ø	1ØØ

Alande
Sr.No. Ø81 to 1ØØ

Nutrition:

% of Nutrition (N)	Freq.	%
25(Only 1 Food Item of V,D,C,S)	2	1Ø.ØØ
5Ø(2 Food Items of V,D,C,S)	9	45.ØØ
75(3 Food Items of V,D,C,S)	8	4Ø.ØØ
1ØØ(4 Food Items of V,D,C,S)	1	5.ØØ
	2Ø	1ØØ

[1ØØ % Nutritious Food contains all the 4 parts viz. V(Vegetables),D(dal),C(cereals i.e.'Usal') & S(Salad)]

Comments = 95% i.e. 19 out of 2Ø women do not take salad.

Food(Opinion of the Respondent)	Freq.	%
Sufficient	19	95.ØØ
Not sufficient	1	5.ØØ
	2Ø	1ØØ.ØØ

Taking non-veg	19	95.ØØ
Veg	1	5.ØØ
	2Ø	1ØØ.ØØ

Fasting

% of fasting	Freq.	%
Ø(No Fasting)	3	15.ØØ
25(Once in a week)	5	25.ØØ
5Ø(Twice in a week)	9	45.ØØ
75(Thrice in a week)	3	15.ØØ
1ØØ(Twice in a week & Many Occasional Fasts/ Thrice in a week & Some Occasional Fasts).	Ø	Ø.ØØ
	2Ø	1ØØ.ØØ

Diet at fasting

sufficient(i.e. eating enough qyantity)	15	88.24
Not sufficient(i.e. only taking tea or fruits)	2	11.76
	17	100.00

Taking Tea

No. of times in a day	Freq.	%
1	2	10.00
2	7	35.00
3	11	55.00
	20	100.00

% Intake of Milk

	Freq.	%
0 (No-i.e. Level 0)	16	80.00
25(Sometimes-i.e. Level 1)	0	0.00
50 (Yes/Taking with Rice etc.-i.e. Level 2)	4	20.00
100(Ample-i.e. Level 4)	0	0
	20	100.00

% Intake of Fruits

0 (No-i.e. Level 0)	4	20.00
25(Sometimes-i.e. Level 1)	4	20.00
50 (Yes-i.e. Level 2)	11	55.00
100(Ample-i.e. Level 4)	1	5.00
	20	100.00

Meals - Information

10 out of 20 women take 3 meals (50%)
Only 1 woman takes spicy food (5%)
18 out of 20 women prepare sweets (90%)
7 out of 20 like variety (35%)
16 out of 20 would like to learn variety (80%)

Nutrition at carrying

50(very less)	3	15.00
75(little less)	5	25.00
100 (As usual)	8	40.00
100 + (more than normal)	4	20.00
	20	100.00

Sr.No. 081 to 100

	Size of Sample
Avg. Age at marriage 15 years	20
Avg. Age at 1st chi 18 years	20
Avg. Age at 2nd chi 20 years	20
Avg. Age at 3rd chi 22 years	15
Avg. Age at 4th chi 25 years	7
Avg. Age at 5th chi 25 years	2

Avg. present age = 29 years.

Avg. no. of deliveries = 64/20 = 3.20

Avg. No. of children = 63/20 = 3.15

Remark: 1 Abortion.

% Ratio of No.of children to No.of deliveries =98.44

% of Delivery at Home	Freq.	%
Not at Home	9	45.00
25	1	5
60	1	5
67	1	5
100	8	40
	20	100.00

Rest at M.C.

Taking Rest	12	60.00
No Rest	8	40.00
	20	100.00

Wrong Ideas(W.I.)-- 3 out of 20 (i.e.15%) have wrong ideas about FPDs.

(2 have W.I. about Cop T.
1 has W.I. in general i.e. she says FPDs should not be used)

	Freq	%
1 son	7	35.ØØ
2 sons	6	3Ø.ØØ
2 children	7	35.ØØ
Not told	Ø	Ø.ØØ
	2Ø	1ØØ.ØØ

Only 4 out of 2Ø women declared to have superstition for getting a son. (2Ø%)

Only 2 out of 2Ø have science knowledge about child birth (1Ø%)

Dependence on son score

Description & Score	Freq.	%
Don't depend i.e. Ø	2	1Ø.ØØ
Are not sure i.e. 1	4	2Ø.ØØ
Expect to depend on child i.e. 3	12	6Ø.ØØ
Must depend i.e. 4	2	1Ø.ØØ
	2Ø	1ØØ.ØØ

Diseases	Freq.	%
Measles	12	60.00
Chicken Fox	12	60.00
Dyptheria	0	0.00
Conjunctivitis	9	45.00
Ear Problem	6	30.00
Dysentery	9	45.00
Diarrohea	2	10.00
Mumps	2	10.00
Scabbies	0	0.00
Ecxema	0	0.00
Weakness	2	10.00

Total Diseases	Freq.	%
0	3	15.00
1	5	25.00
2	2	10.00
3	3	15.00
4	3	15.00
5	0	0
6	4	20
	20.00	100.00

Self Diseases	Freq.	%
Pain in limbs	2	10.00
Regarding periods- irregular/ more bleeding	0	0.00
Stomach ache	0	0.00
back ache	3	15.00
Anaemia	3	15.00
Head ache	3	15.00
Eyes weak	1	5.00
Nose, Throat Swollen	1	5.00
Giddiness	1	5.00
Measles	1	5.00
Chicken Pox	1	5.00

	Freq.	%
At Home Cure %	2	10.00
No Home cure	18	90
	20	100

Going to Dr	18	90.00
No need of Dr.	2	10.00
	20	100.00

Inoculation	18	90.00 *
No inoculation	2	10.00
	20	100.00

* Out of 18, one woman did not do inoculation to her 2nd child.

Alande
Sr.No.081 to 100

Source of water:-Tap.

Water

	Freq.	%
Boil	1	5
Do not boil	19	95
	20	100
Filter	16	80
Do not filter	4	20
	20	100
Alum	0	0
No alum	100	100

Utensils--2 out of 20 i.e. 10% women clean utensils properly.

Hands

Use soap	19	95
Do not use soap	1	5
	20	100
Insects remedy	4	20
No Insects Remedy	16	80
	20	100
Smoke trouble	4	20
No smoke trouble	16	80
	20	100

15 out of 20 i.e.75% no latrin at mother's place.
100% no latrin at m-in-law's place.

Opinion about separate latrin told

Told	8	40
Not told	12	60
	20	100

TRUST FOR REACHING THE UNREACHED

Baroda, Gujarat

S M A L L F A M I L Y N O R M
P E O P L E 'S V I E W S A N D P R A C T I C E S

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We are thankful to various individual friends and groups to have contributed their thinking to this work. The people who have talked freely regarding their beliefs and experiences require to be thanked specially. We are thankful to ISST to have enabled us to take up this study in reality. We thank our own research staff to have conducted the survey and also the Focus meetings very meticulously. We thank also Nilesh Joshi to have painstakingly completed the presentation in the form before you.

-TRU Team.

SMALL FAMILY NORM : PEOPLE'S VIEWS AND PRACTICES.

This study is undertaken by TRU in response to wider level discussions on "Rethinking about Family Planning Programme....". In several meetings and seminars attended by a crosssection of people, GOs and NGOs, Health and Development groups,Women's Organisations and Feminist groups, a debate has been going on in favour or against the Population Control activities in our country. Some progressive groups have questioned some of the basic premises of the National Population Policy. We feel there is a lot of truth in the stands of these groups. Through this study we have tried to bring the grassroots dimension into these discussions.

We hope we have been able to bring in some of the basic concerns of the people. We do hope that the study will give some stimulii to the policy makers, who supposedly "make ploicies to bring welfare"(Sufferings ?) for the people.

This study has been undertaken to influence the opinion of those who will be particpating /or sending their written presentations to the Cairo Conference, 1994. To what extent we have been able to achieve the objective, time will only prove. But our only plea to the readers is that we must learn to develop an understanding about people's realities and their wisdom to have lived through difficult situations.

The TRU works for promotion of health of poor and marginated strata of people in Rural and Urban areas. A short description of the project area is included here because it is also the study population.

Goals :

1. To understand people's perspective on family size / number of children including factors deciding the family size.
2. To understand women's experience about various contraceptive methods and the approach by the family planning functionaries.

Specific Objectives :

This is a descriptive study rather than an analytical one (Cause effect relation-ship). At the end of the study we envisaged to obtain following information (outcome).

1. Present family size ?

2. How many children they like to have ? Male / Female ? Why ?

3. Factors deciding family size.
3.1. Child as an asset / liability ?
3.2. Social security in old age ?
3.3. Number of male children ?
3.4. Reasons for male preference ?
3.5. Experience regarding child mortality ?
3.6. Religious beliefs regarding composition and size of family.
3.7. Who makes decision for limiting family size ?

4. Experience about contraceptives.
4.1. Whether birth can be prevented / planned ?
4.2. Present and past use of contraceptive methods.
4.3. Problems / no problems regarding above methods.
4.4. Reasons for choosing / changing particular methods.
4.5. Anxiety or fears about the methods.
4.6. Knowledge regarding other methods.

5. Approach by family planning functionaries :
5.1. Response to visit by family planning functionary.
5.2. Nature / Number of contraceptive methods offered by them.
5.3. Content of information given by them regarding various methods.
5.4. Follow up services.
5.5. Suggestions for improving the quality of family planning services.

6. Kind of reproductive health problems they have suffered. Response of health and family planning services to it.

METHODOLOGY:

The Study methodology included a combination of individual interviews through a questionnaire followed by focus group discussions, with the same groups. The sample was selected in a careful manner by random sampling method. Four groups were selected. They are -

Rural General Population :
Totally 200 families from various project villages were chosen by random sampling method. Out of the above families, interviews of the women were undertaken in 100 families by lady interviewers. Men were interviewered in other 100 families by male interviewers.

Rural Teachers :
Among the primary school teachers 20 were selected by random sampling to answer the survey questionnaire.

Urban Slums :
A sample of 100 households was selected based on a previous enumeration of Bastis. Out of these we could interview 89. The eleven households which could not be interviewed were either closed for some time due to recent migration to other places, demolished, or women were not available for interviews.

Urban Middle-Class :
We selected 25 families out of which 22 were interviewed. Three houses could not be interviewed for similar reasons as mentioned above.

THE SURVEY

Questionnaire
An open-ended survey questionnaire was prepared and field-tested. Field-testing was conducted with village level community health workers. The questionnaire had inbuilt scope for cross- checking of information.

The questionnaire (Appendix-1) was designed to take care of the points such as people's perspectives on (a) Family size-existing and desired. (b) Information, experience and practice of contraceptive devices (c) 'Operation' (Sterilisation) (d) Experience with the Government FP Machinery (Workers & Officials) and (e)Reproductive problems of women, if any.

Study Team & Their Training :

The study team comprised of

1. Three post graduate field workers, Already having a good rapport with the community in Urban Areas.

2. Three social workers and three senior field workers, living in same villages as the study population in Rural Areas.

A thorough training of all the team members was conducted by the senior researchers in four full-day sessions. They were taught how to create an informal environment with the interviewees, including reassurance about confidentiality of information wherever required. How to ask questions, how to record answers, how to recheck the answers without creating boredum and how to avoid interviewers' biases in the whole process was also emphasised upon. Ongoing training support to the rural workers was also carefully managed.

Schedule of The Survey :

The survey was conducted in all areas simultaneously during Oct.'93 - Nov.'93.The Focus group meetings took place in December '93.

Village meetings = 08 Regional meeting = 01
Urban meetings = 02

NOTE : Enough care was taken to see that women were interviewed by women and men were interviewed by men. The interviewees knew that we do not belong to FP machinery. Also they were reassured that all the information would remain confidential and no individual would be questioned by any Govt. officials on any of the statements. Moreover the project has a rapport with the people. So the information given by the people is unlikely to be under any pressure or fear.

Socio-economic background of Rural Project area

TRU works in this most backward district with basic objective of reaching health to the deprived and marginalised people. So before we started working four years ago, we had carried out a Socio-economic and Demographic survey of this area. We found that,

(a) The Sex ratio in this area is nearly 780, indicating adverse social climate for women and girls in general.

(b) Literacy rate (those who have gone to school) among men is 66.7% and among women is 19.7%. Literacy among older age group of females i.e. 15-45 years is less than 1% .

(c) Income levels are difficult to compute. According to a special index of 26 indicators, 85% of the families scored less than 10 indicators, and 2.5% families scored zero, while only 1% scored more than 16 indicators. This shows that most population lives on subsistence level only.

(d) Caste system is common. Although all people belong to either Backward class or scheduled tribes, the Barias consider themselves like high caste-Rajputs and follow predominantly Hindu ethoes. The Rathwa and Naik fall under schedule tribes and form the poorer sections of the villages.

(e) Temporary migration is very common. Many families have sons working outside the village i.e. mainly in urban centres such as Baroda, Halol, Ahmedabad, Modasa, etc.

(f) All common health problems are problems of these villages also, especially scabies and malaria come in sweeping incidence during seasons. Women suffer from leucorrhoea, anemia, post Tubectomy backaches, infertility etc. Exact quantam has not been worked out for any of these. TB is common. The project spends considerable energies to meet the TB related needs. Maternal child care,of course, is the mainstay of our project. PEM and undernutrition among children seek a lions share of our attention.

(g) The Govt. F.P. programme is very active in this area. Permanant sterilisation of women appear to be their main strategy for population control. According to Govt. officials they have already achieved the targets 10 years in advance of the year 2000. Our project is yet not involved in any FP activity so far.

(h) Age at marriage for girls is usually between 13-16 years despite the legal requirement of 18 years.

(i) Younger age children have learnt to go to school. We find many more boys and girls enrolled in the schools but the standard of education remains very very low. Girls usually drop out before Std. VII.

Socio-economic Background of Slums Project

TRU works in this area since Dec.'91 . These slums are situated on one end of Baroda. Small and big pockets of Bastis are in vicinity of the modern middle class societies. Following are findings from a survey carried out two years ago.

(a) The sex ratio in general is 879/1000 males. More significant is the sex ratio in the children under five years of age. We find it to be 699/1000 particularly indicating the rising incidence of amniocentesis followed by abortion of female foetus and adverse social environment for girls in general.

(b) Literacy rate is 58% & that among women is 46.2% . There is a negligible proportion who have studied beyond 10th Std.

(c) Caste system is common and more complicated sometimes, because there are different castes from different states of India living together. We find people from Rajasthan, Uttar Pradesh, Bihar, Maharashtra, Andhra Pradesh etc. in our Bastis.

(d) Economically most people are temporarily employed in one or the other industry, or they go for casual labour. Some are artisans and some involved in petty jobs such as vegetable vending, selling petty things, etc.

(e) These Bastis have been here for last 8-10 years. They still keep changing very often. Three Bastis have been already rehabilitated by local Municipality. While two have received notice for displacement.

(f) People have learnt to go to Govt, municipal and private clinics for seeking Family Planning operations. We do find a few families having more than 3 children. But Average family size is 4.03 in these Bastis.

(g) Age of marriage is usually 15-17 years despite the law.

OBSERVATIONS AND DISCUSSIONS

We report here the various data tabulated under different headings. usually each table has four groups drawn from four different populations (1) Rural General Population, (2) Urban Slums, (3) Rural Teachers, (4) Urban Middle Class. Educationally and economically these populations fall in the same order; i.e. the Rural General Population being the lowest and Urban Middle Class being the highest.

PROFILE OF THE INTERVIEWEES

AGE DISTRIBUTION

The sample population comprises of the following.

Table-I Age Distribution Of Sample Population

	20-30	31-40	>41
Rural Couples	39%	41%	20%
Rural Teachers	70%	15%	15%
Urban Slums	55%	42%	03%
Urban Society	38%	16%	46%

The sample of Rural Teachers comprises of younger age persons i.e. 70% of them are between 20-30 years of age. This may have resulted into some differences in the survey, such as,there is a greater number of persons who have not accepted sterilisation.

LITERACY

Minimum level of literacy is expressed in terms of having gone to the schools or not. On the later part of this report we would see that some of the findings are similar among the Rural Teachers and Urban Middle Class (see table II). It remains to be seen if it is connected to literacy levels or not.

Table-II Literacy Level of Sample Population

	Illetrate	1-5	6-9	10-12	Graduate
Rural Couples	73%	14%	10%	03%	-
Rural Teachers	-	-	10%	-	90%
Urban Slums	58%	15%	22%	05%	-
Urban Society	-	-	00%	41%	59%

FAMILY SIZE

The following table depicts the average no. of children in various samples,

Table-III Average children in whole group

Group	Children	Male Children	Female Children
Rural Couples	3.12	1.62	1.50
Rural Teachers	2.16	1.26	0.90
Urban Slums	2.44	1.30	1.14
Urban Middle Class	1.86	0.91	0.95

The average family size decreases in exactly the same way the literacy level increases. i.e. Rural General Population having more number of illiterate persons, scores highest (3.12 children/family)and decreases down the Urban Slums, Rural Teachers and Urban Middle Class. It can be said roughly that as income level increases, so decreases the family size.

Table-IV Average number of children in sterilised population

Population	Av.children
Rural Couples	3.35
Rural Teachers	3.00
Urban Slums	2.90
Urban Middle Class	2.10

Table-IV Shows that the avereage number of children per family who has opted sterilsation is little more than that in the unsterilised couples.

It is further interesting to know that although a strong male preference is expressed by all focus groups meetings (as reported in later parts of this writeup) the average number of male and female children remain almost equal among all the survey samples (0.09 to 1.5 female children per family)

FAMILIES HAVING MORE THAN THREE CHILDREN

Having seen the average to be roughly 3 children per family, we tried to find out proportion of families having more than 3 children. Here again The Urban Middle Class has no family with more than 3 children.

Table-V Percentage Families having more than 3 children

Rural Couples	Rural Teachers	Urban Slums	Urban Society
36.00%	15.78%	18.00%	-

NOTE : Percentage calculations are based on total no of families in each survey group

This shows that with increasing level of information, education & income leading to greater security in life, people tend to have less number of children. Behaviour of the Rural Teachers is different in this context and is nearer to that of Urban Slum Population. Although the Teachers have higher income and higher education,they being placed in remote, rural Society somehow seems to be affecting this deviation. Some of the other tables show why and how about the factors influencing family size. Before that let us see how many of them have accepted terminal methods of contraception.

F.P. "OPERATION" (STERILISATION)

It has been our general impression that the Govt. F.P. programme has concentrated much more on the terminal methods of contraception, such as Tubectomy. The actual data on acceptance of the "Operation" is quite revealing. Following table gives the break up in various survey samples.

Table-VI Families Having Sterilisations

	Female	Male	Unsterilised	Total
Rural Couples	92(46.0%)	6(3%)	102(51.0%)	200
Rural Teachers	05(25.0%)	1(5%)	014(70.0%)	020
Urban Slums	49(55.0%)	-	040(45.0%)	089
Urban Society	10(45.4%)	-	012(54.6%)	022
				331

It is also clear from the data that nearly all the "Operations" mean female sterilisations.It comes out more sharply in the Urban Slums and Urban Middle Class. It may be important to know that in the cities, barring a few F.P. camps in the municipal and Govt. clinics, most of the "Operations" were sought by people voluntarily, i.e. They have gone by themselves to the Govt. centres or private clinics and opted to be sterilised.

Most of the male sterilisations in the Rural area (Rural General Population) were done in the years '81-'85. Out of the 6 male operations 5 are in one group of villages geographically close to each other. In case of the single male operation in other cluster of villages, the wife was operated long ago and the husband was more than 45 years of age. The Govt. officials had to fulfill their target and pressurised him to go for operation, otherwise the second loan instalment (for the well in his farm) would not be released.....!

WHY STERILISED ?

Table-VII Reasons for Sterilisation

Reasons	Rural Couples	Urban Slums	Rural Teachers	Urban Society
Infuence of FP propoganda.	47(48%)*	43(69%)*	6(100%)	8(80%)
Pressure from Govt. officials	32(33%)*	-	-	-
Economic Hardship	07(07%)	18(29%)*	-	-
Health problem	07(07%)	01(02%)	-	2(20%)
Incentive & Disincentive	03(03%)	-	-	-
Child Mortality	01(01%)	-	-	-
More & More Girls	01(01%)	-	-	-
	98	62	12	18

(* Multiple answers)

One single reason that dominates among all responses in various populations is "Influence of FP propoganda." Under this category are tabulated the expressions in term of sloganeering such as "Two are enough", "Small family - happy family ",etc. such responses are in increasing proportion from rural to urban and 100% in case of Rural Teachers. Economic hardships is another important reason for people to limit their family. Even on this, the pinch is maximum among the urban populations. It is surprising because of obviously higher income level in the urban populations and the teachers.Some of the detailed answers reflect the costlier aspirations of urban living such as more education, more clothes, costlier food, etc. Also it appears that, on an average the urban child is a liability to parents for a longer period than the average rural child. Urban parents think more in terms of heavier investments for education of their children to pay off in future.

In Rural General Population the pinch of economic hardship is felt less because they live on subsistence level where there is hardly any scope of more expensive and modern lifestyle. At young age the rural children have to start productive wage-earning activity such as grazing the cattle, doing casual labour, looking after younger siblings, helping the household work, agricultural work etc, leaving very little scope for alternative about future aspirations from life.

Among the rural population some responses have expressed a sharp boredum due to the continuous coaxing and chasing by the Govt. officials for "Operations". Many answers have said that especially the lower cadres of FP workers such as Anganwadi Workers, TBA, Mid-day meal workers, CHVs, etc. may be among their relatives. They said,"It is difficult to stand the relative whose salary is threatened to be stopped because he/she could not bring a case for "Operations" ! Many cases were reported in which they said that the FP worker used to pay a fat contribution from her/his own pocket as incentive for the operation. In some cases the incentives such as giving loan for wells, benefits under various welfare schemes, giving utensils, ornaments (Kada), etc. were also reported to be coupled with sterilisation. Some have reported that sterilisation was opted due to any health

problems.In one case repeated deaths of children motivated for operation and in one case birth of only girls resulted into a sense of hopelessness and they went for termination of reproductive capability.

Why not sterilised ?

Reasons for not opting the "Operation" are listed below.

Table-VIII Reasons For Non-Sterilisation

Reasons	Rural Couples	Urban Slums	Rural Teachers	Urban Society
Want more children	51(50.0%)	15(36.7%)	4(21.1%)	3(25%)
Wants son/s	07(06.8%)	04(09.7%)	6(31.6%)	3(25%)
Wants daughter	02(20.0%)	-	-	-
Health problems	03(02.9%)	03(07.3%)	-	-
Fear of child mortality	03(02.9%)	06(14.6%)	7(36.8%)	2(17%)
Personal/Family opinion	11(10.8%)	-	-	-
Naturally can't have more children	08(07.8%)	01(02.4%)	-	-
Using other methods	03(02.9%)	-	-	-
No reasons	03(02.9%)	12(29.3%)	2(10.5%)	4(33%)
Fear of TL	04(04.0%)	-	-	-
Can't afford to take rest after TL	07(06.8%)	-	-	-
	102	40	19	12

It is expected of course that those who have not been sterilised are waiting to have more children. A distinct wish to have sons has also been expressed by number of interviewees. Proportion of these persons has been maximum among Rural Teachers. The preference is minimum among Rural General Population. Generally it is observed that people in rural areas accept the sex of the child as god's gift and do not like to express dissatisfaction, although their desire (see table V) may be different. Secondly, it is significant that there were at least two families who have clearly wanted a female child. Somehow the bias expressed for sons or daughters gets more clear explanation, when we look at the table IX,X and XI.

Table-IX Desired Number of Children

Children	Rural Couples	Rural Teachers	Urban Slums	Urban Middle Class
00	-	-	01(01.12%)	03(13.06%)
01	-	01(05%)	-	01(46.00%)
02	30(15%)	11(55%)	49(55.00%)	18(81.00%)
03	66(33%)	03(15%)	35(34.08%)	-
3+	98(49%)	05(25%)	02(02.25%)	-
No opinion	06-(3%)	-	02(02.25%)	-

Desired Number of Male Children

Male Children	Rural Couples	Rural Teachers	Urban Slums	Urban Middle Class
00	-	-	01(01.12%)	08(36.4%)
01	10(05.0%)	08(40%)	34(38.30%)	13(59.1%)
02	58(29.0%)	11(55%)	46(51.70%)	01(04.5%)
03	95(47.5%)	01(05%)	02(22.00%)	-
3+	31(15.5%)	-	01(01.10%)	-
No opinion (God's wish)	06(03.0%)	-	05(05.60%)	-

Desired Number of Female Children

Female Children	Rural Couples	Rural Teachers	Urban Slums	Urban Middle Class
00	-	-	01(01.12%)	05(22.7%)
01	116(58.0%)	13(65%)	67(75.30%)	16(72.7%)
02	041(20.5%)	04(20%)	18(20.30%)	01(04.6%)
03	024(12.0%)	01(05%)	-	-
3+	013(06.5%)	02(10%)	-	-
No opinion (God's wish)	006(03.0%)	-	03(03.30%)	-

NOTE : Most of the responses in favour of more than 3 or more daughters have opined that, "What we have is what we desire".

It can be seen from the above tables that the majority population in Urban area as well as the teachers desires for at least two children, whereas the Rural General Population desire 3 or more children.It also follows from data on desire for female children that all the survey populations have a desire to have more sons.But most of them desire to have daughters also.At least one daughter seems to be the majority-wish.

Generally the survey samples have explicitly desired son/s. The following table V-A gives reasons to have male children. Although it is easy to conclude that there is a son preference, we feel it may be unfair to interprete all opinions of the parents as "Son preference". It is important also to know that most of the families have opted for at least one daughter. Also we have received statements from our Urban Population that "In modern times son and daughter are almost equal in

terms of economic liability/ security. "Girls are not burdensome nowadays.", etc.This definitely points at positive feelings & thinking about girls in the modern society.

Table-X Reasons For Desiring Male Child

	Rural Couples	Rural Teachers	Urban Slums	Urban Society*
Economic benefits	138(43.60%)	14(70%)	61(54.9%)	-
Help in agriculture	082(25.89%)	-	-	-
Old age security	060(18.90%)	01(05%)	45(40.5%)	01(07.1%)
Dowry to girls	028(08.80%)	-	-	-
Daughter to be sent away	007(02.20%)	-	-	-
Continues family name	002(07.00%)	05(25%)	05(04.5%)	11(78.7%)
Psycho-social need	-	-	07(06.3%)	02(14.2%)

NOTE : Some Interviewees have given multiple reasons.
* 8 (35%) Families do not want any male child.

Sons are unequivocally considered as a possible source of economic benefit by nearly 70% of the interviewees. Old age security is another reason in favour of son/s. Rural population also considers it fairly important. The son/s mean more hands to help agriculture. Only two persons of the Rural General Population have replied in terms of son being a religions necessity to continue the family-name. This bias is more among Urban Middle Class.

Following table explains the people's desire/no desire for girls.

Table-XI Reasons For Desiring Female Child

	Rural Couples	Rural Teachers	Urban Slums	Urban Society*
Psycho-Social need	-	6(30%)	33(37%)	01(05%)
Help in House hold Work	121(61%)	6(30%)	-	02(10%)
Personal care & emotional support in old age	036(18%)	1(05%)	57(64%)	14(63%)
Get bride price	006(03%)	1(05%)	-	-
Girls are not burdensome	045(23%)	6(30%)	19(21%)	-

NOTE : Some Interviewees have given multiple reasons
* 5 families do not want any female child.

It can be seen that for the Rural General Population, extra hand for work at home is an equally important reason for having girls (just as sons for agricultural work). A large proportion of the reponses were in terms of girls' expected role to give emotional support and personal care (may be for a short while only) in old age and during debilitating conditions like illness or disability. Some responses also gave expression to the fear of not getting along well with the daughters in law.

In both the above tables we get a clue of the changing values in Urban Middle Class society by 8 families not wanting sons and 5 families not wanting girls. Also there have been responses clearly voting for having girls. This may be because of the basic inhibition to challenge God's wish to give girls or bad experience with son/s or a genuine desire in favour of the girl child.

On the other hand, in one case among the slums,the family wants sons only because in their caste (Rajput) after marriage, the girl is totally with her in-laws. She is made to bring a lot of gifts from her parents and if she fails to do so, then she has to meet with any amount of insults & cruelty. The parents are helpless and cannot say anything to her in-laws. This family said, "We do not want our child to suffer so much. We will not produce a girl to meet such a fortune....!"

DEATH OF PROGENY

To understand the quantum of the problem, regarding death of any child/children in the family, we had detailed interrogation. The answers are tabulated as follows :

Table-XII Death of children in The Survey groups

	No. of Families Reporting Death	% of such Families in sample	No. of Deaths	Death per Family
Rural Couples	106	53%	140	1.32
Rural Teachers	004	20%	005	1.25
Urban Slums	025	28%	032	1.28
Urban Society	003	14%	003	1.00

Table-XIII Reasons For Death of Children

	Illness*	Neonatal	Accident	Reasons not known
Rural Couples	67(48%)	57(41%)	-	16(11%)
Rural Teachers	02(40%)	03(60%)	-	-
Urban Slums	26(81%)	02(06%)	03(09%)	01(04%)
Urban Middle Class	01(33%)	01(33%)	01(34%)	-

* Illnesses include pneumonia, diarrhoea, measles, malnutrition, TB, septicemia, Tetanus, etc.
+ Neonatal problems include - Twins, lactation failure, premature birth, etc.

NOTE : All reasons are classified as reported by interviewees.

The table shows that cosiderably large proportion of the sample families have experienced the death of more than one child per family. The figure being highest (53%) in Rural Population, probably because of inaccessibility of health services, lack of competence of the health persons and lack of sensitivity towards people's health problems. This also explains to quite an extent a reason for rural population to have more children. Analysing the reasons of these deaths, (table XIII) we found that, in all the samples infectious diseases prevailed as a major reason for death. Neonatal problems are another major contributor to this. A large number of these deaths could have been prevented if there was a competent health service infrastucture readily accessible. In the slums, accident is another reason for deaths. In rural area many sudden deaths are attributed to effect of evil powers. We have tabulated them under "Reasons Unknown".

CONTRACEPTIVE METHODS

A set of questions were designed to assess people's knowledge of contraceptive methods, especilly the ones propagated under Govt. F.P. programme. The following table depicts a level of knowledge regarding these methods.

Table-XIV Knowledge About Contraceptives
(Can pregnancy be postponed or prevented ?)

Group	Do not know	Knows and used	Knows but not used
Rural Couples	91%	006%	03%
Rural Teachers	15%	050%	35%
Urban Slums	32%	021%	47%
Urban Middle Class	-	100%	-

NOTE : This table excludes knowledge regarding "Operations"-Tubectomy & Vasectomy. Nearly total lack of knowledge about contraceptive methods among rural population points at the fact that the FP propaganda mainly focusses on the "Operation" and has no emphasis on any of the other methods.

Regarding acceptance of the methods, the figures confirm the same impression. We can see this from the following table.

Table-XV Contraceptive Methods

	Rural Couples	Rural Teachers	Urban Slums	Urban Middle Class
Non users	80	04	21	-
Sterilisation	98	06	49	10
Users of cont. method	12(06%)	10(50%)	19(21%)	* 22(100%)
Cu.T	01	-	07	07
Nirodh	04	03	03	02
Tablets	03	03	04	02
Abortion	-	01	-	06
Others	04	03	05	05

* In some cases women have used one method and then opted for sterilisation.

The above table indicates the level of awareness and experience regarding various methods. Naturally Urban Middle Class is highest in the ladder. The six families have undergone abortion as a method mainly to ensure the desired sex of the second or third child. There have been instances who stopped its use because they wanted a child or underwent "Operation". The Rural Teachers remain inbetween the two extremes. The tables are self explanatory.

Following tables depict the size of complaints or side effects of the various methods as expressed by the interviewees. The data has been small regarding other methods. So detailed analysis is not done. The supposedly underreporting of side effects may be due to people not able to attribute complaint to the device.

Table-XVI After-Effects Of Tubectomy

Effect	Rural Couples	Rural Teachers	Urban Slums	Urban Society
Physical Debility	22	-	-	-
Leucorrhoea	14	-	-	-
Backache	27	01	-	-
Pain in abdomen	24	03	-	-
Menstrual irregularity	05	01	-	-
Mental Tension	06	-	-	-
Infection on stitches	01	-	-	-

Table-XVII Side Effects of Contraceptive Methods

Method	Side effect	Frequency
Cu.T	Excessive Bleeding & Pain	06
Tablets	Headache/Nausea	03

The after-effects of Tubectomy were invariably part of all conversations on the methods. Many problems are posed by Rural Population on this, such as feeling of weakness, backaches, pain in abdomen, leucorrhoea, etc. It is not possible to draw inference on cause-effect relationship. But we have reported the people's perception regarding Tubectomy and the complaint. There may be substance in their perception. This needs further exploration. However Post-Tubectomy Syndrome is reported widely in scientific literature. Classical descriptions on how they started feeling weak, having backaches, etc. have been narrated. Above all Some have said, they suffer form tension due to the "Operation". One lady said, "I live in continuous fear regarding my son's illness."

One male respondent who has had the Vasectomy said,"He feels depressed and suffers from loss of libido and premature ejaculation. Side effects of Cu-T mainly included excessive bleeding & Pain in lower parts of abdomen. Headache, nausea were reported by pillusers.

EXPERIENCE WITH FP WORKERS

As reported earlier the Urban Population have gone on their own to seek the "Operation", while the Rural people have been persuaded by others to go for "Operation". The table-XVIII gives a listing of the various functionaries. Major source of information of FP workers regarding the eligible couples is the local dai(birthattendant -trained or untrained). There were some cases of involvement of higher officials such as TDO, M.O. etc. We can see that people do not receive any information regarding the operation, except for the incentive/disincentive part.

Table-XVIII List of FP Workers Who Motivated For Sterilisation

FP Workers	Rural Couples	Rural Teachers
Malaria Worker	28(23.70)	-
Nurse	25	3
Teacher/Talati and other officials	29	-
CHV/AW	14	-
TBA	02	-
Police	01	-
Others	19	-

Generally more than one person is involved in motivating most people in Rural area.

Table-XIX Information Given By FP Workers.

Monetory benefits	26
No difficulty in TL	04
Male-female child are equal	03
You cannot afford more children	09
Operation is good for you	58

During our focus groups meetings many participants said, that in general FP workers are worried only about fulfilling their targets. There is no care taken after the operations. Sometimes the Govt. vehicle comes to their house to fetch them but on the return, they are

left somewhere near the village. They have to walk back the hard way. The nurse would visit once for removing the stitches. After that nobody comes to meet them. In case of any complaint regarding the operation, they try to meet the FP worker for only a distant and oral advice to go to the PHC. The malaria worker or nurse would say they have no medicines for their complaint except for a few painkiller tablets.

The community in general also expressed a word of sympathy for the village level workers by saying, "The higher officials give them the target and stop their salary. So they will do this work. Otherwise in their heart they do not like this type of work...".

The Urban Middle Class does not get exposed to these FP workers. The slums also have comparatively less contact. However it is invariably reported that whenever they have to go for help in the Govt. or Municipal centres, they are questioned on how many children they have and why no "Operation" is yet carried out, etc.

OTHER HEALTH (REPRODUCTIVE) PROBLEMS

Among the Rural General Population we were quite surprised to see that the men generally reported their ignorance on wife's reproductive problems. The women only talked about their own problems.

Table-XX Reproductive Problems

Problem	Rural Couples	Urban Society	Urban Slums	Rural Teachers
Leucorrhoea	03	03	18	NO
Menorrhagea	10	01	11	REPORT-
Infertility	05	-	-	ING
Backache	09	-	02	AT
Pelvic Pain	15	-	04	ALL
Weakness	03	-	02	
Tumour in Uterus	-	02	-	
	45(22.5%)	06(27%)	37(42%)	

NOTE : Most reporting in Rural Couples is in women's interviews. Men are gernerally found to be not knowing about the women's problems. All Rural Teachers interviewed were male teachers.They also did not report about reproductive problem of the wife.

The Table-XX shows the quantam of complaints as expressed by the women. The slums have reported higher proportion of leucorrhea, etc. No conclusion can be drawn about the quantam or on nature of the problem. But we can do say that the women suffer from various problems. Surely they do not talk about it to the FP workers because they do not feel confident about the response.

FOCUS GROUP MEETING

A series of focus group meeting with the survey population was planned keeping mainly two things in mind. i.e.

1. To fulfill further gaps in information as obtained by individual interviews.

2. To share the information obtained and possible conclusions with the people who had participated to give information.

F G MEETING IN URBAN AREA

Meeting Slum Women at Devnagar

In all 22 women participated despite the heavy housework for deepavali festivals. They were very enthusiastic about sharing various information. Happily talking about their personal lives they underline the folowing things.

Question 1 Almost all of you have prefered a small family having 2 or 3 children only, why ?

Ans. 1 It is difficult to cope up with demands of more children because everything has become very costly. e.g. cloths, footwear, schooling, food, etc. The children's aspiration from life have changed drastically. In older times we started earning at a very young age. These days the children have to go up to graduation at least to prove their worth. Even the girls have to study quite a lot to get a good husband. Now the income in the households is not sufficient to take care of everything. Thus economic helplessness is the major reason for the people to have only two children.

Question 2 If you want only few children why don't you get operated (Tubectomy) as soon as you have the desired number of children i.e. two or three.

Ans 2 There is no guarantee that our children will survive. Recanalisation is next to impossible and succeeds only in a very very few cases. There are some women whose children died after Tubectomy. There is more problem if the son/sons die. Geetaben's son has died. She and her husband now repent for the operation.

Question 3 Most of you have expressed a desire to have one daughter; not less not more. Why ?

Ans 3 We can not give enough to their in-laws if we have more daughters. One daughter should be there because in old age we may be sick, incapacited or either spouse only surviving. At that time the daughter will come to our house and give personal help.She will feel more intensely for us and so will give some support in old age. We do not know if the son's wife will be that much kind to us or not. The son takes care of the food and stay for us but daughter helps on emotional needs.

We do not want more daughters because our society is very unkind to the women. We do not know what problems she may have to face. In Narmadaben's community women are even burnt to death for trivial problems and nothing can be done to her in-laws. Thus more daughters means more problems.

Question 4 Whether the doctor who conducted your Tubectomy or her assistants told you about what they will do to your body ? Whether they gave any other information ?

Ans 4 Gernerally we only go and tell them that,'we want operation'. So they will ask which one - Lightwala or Stitchwala? And they operate upon us. We do not know what they do to us.

Question 5 Why have you not used any contraceptives ? But some of you have opted to advice your friends/nearones for using the devices ?

Ans 5 We were not knowing about it. We still do not know about that, but we do like to suggest to others for any effective and safe device. Is there any such device ?

Meeting ended with a lot of enthusiasm to know about women's and men's reproductive life cycle and also regarding Birth control measures, etc. We of course promised many such sessions in future and parted.

Meeting at Dudheshwar (Urban Middle Class)

This is a group of Middle Class educated women. They were very vocal about their situation. But the social norm about son preference seems to have decided their way of reproductive life.

Question 1 Why do you want a small family ?

Ans. 1 It is not our pesonal wish. The whole society wants, us to bear only two children. Life has become very costly and we have only one working member in the house. Thus the income is limited. So we cannot have more children.

Question 2 Why do you want one son and one daughter ?

Ans. 2 Personally some of us feel there is no problem if we have only one child either a daughter or a son. But the family wants a son. So we have to undergo repeated amniocentesis even, to ensure a son to the family. Otherwise our life will be miserable. Noone will consider us socially important if we do not have a son.

Actually these days cost of bringing up a son or daughter is the same. Both have to be educated enough. While theer is expense in daughter's marriage, the parents have to even help the son financially for setling into any economic activity, e.g. We may have to provide capital for his business or donation/bribe for his "Naukery" (employment). That is why we feel that most probably the younger generation will not want more than one child.

Question 3 What about contraceptive devices ?

Ans 3 These days we learn about many such devices. But we know that they are harmful. It will be very good if there is a harmless device. The tension of getting pregnant every month is too much for us. In fact we feel more free and happier after we have finished with sterilisation. Perhaps that is why some women become very fat after operation.

Question 4 Why the men do not go for operation ?

Ans 4 The men have to work very hard. Outside the home they are answerable to their bosses. Thus if they become weak after operation they cannot perform their duties as well and it will have impact on the economic situation of the family. On the other hand we are always at home. If we have trouble, we may take rest in between the work. Again this will not have bad effects on income of the family.Secondly, if the husbands' operation fails then the wife who becomes pregnant will have to face lot of trouble.

Thirdly, the man would feel shy and embarrassed in exposing himself before the doctors. We will not feel so shy because all our life we are exposed several times to the doctors.

Question 5 What do you feel about aborting a female foetus ?

Ans 5 That is very bad. It is insulting to ourselves only. But we have to give sons to our family. Only now we learn from you that we are not responsible for the sex of the foetus. But the Society's craze for sons will never go.

The meeting concluded with a hope expressed for better life situations regarding society's craze for son/s, discrimination of girls, etc. These women felt quite concerned about the situations of the women in rural areas. They were surprised to hear how the F.P. propaganda and there activities bring miseries for rural folk. They also said such information is never given to them and that only through such meetings we may be able to know about it. They requested us to conduct such meetings more often.

FOCUS GROUPS MEETINGS IN RURAL AREA

There were meetings of men at Chhantalavadi, Nana Sandhia and Moti Umarwan, and those of women at Jimiapura and Moti Umarwan.

Meetings with Men

All the three meetings were well attended (average attendence - 20) by the interviewees. The response in terms of discussions was quite different than what be had initially thought of. There were many stories of excesses by FP workers narated. In fact this was almost the first meeting of this kind when there was an exchange of experiences within the group. Some points which got highlighted are :

Question 1 How many children do you desire ? why ?

Ans 1 We have a lot of work at home and in the farm. So we would like to have as many children as we could. Secondly,in our villages there are a lot of diseases and other problems like evil spirits. So we are not sure how many of them would survive. So generally by our

own desire we do not like to put restriction on family size. These days we hear a lot about operation. We do not believe in sterilization.

Question 2 What about accepting the 'Operation' ?

Ans 2 That is artificial way and so all the people suffer very much after the operation. Moreover, we are able to have only fewer children these days. Look at our forefathers. They had many children. But now we hardly have 3 or 4 children. Our sons and daughters will have still fewer children. That is God's wish. Over the last decade, Govt is pressurising individuals to have the operation. They tell us that we will become poorer and our children cannot progress well.It is all lie. We see in the villages that when there are more children especially sons,then the family is happier because one son may do the agriculture, one may get good 'nauckery' in cities ! Look at their homes. They have the brick houses with manglori roof tiles,or even terrace,etc. Even if there are more girls, the family does not get poorer. The girls usually earn for themselves by working in the mines, etc. Also after they are married they go away. So how can we become poorer? In fact they are a big help at home till 15 years of age.

The FP workers perform their duty. But it is unfair for the Govt. to give them targets. Govt. does not feed our children, nor give employment or prevent deaths of our children. We want to tell them that they have no right to do so.

The FP worker only worries about 'case'. Govt. only teaches them to give us bribes. What to do, some of our own prople do not understand all this and fall prey to them.

Everyday they come and tell us that we should not have more children, we will not be able to bring them up well,it is the Govt. rule that we should have less children, etc. We feel that they are better educated peole than we are. So we get convinced and send our women for operation.Only from you we learnt that we have a right to say 'no' and that we are not breaking any rule if we have more children. Now we will think twice before sending our women for operation.

Question 3 Why do you send women for operation ?

Ans 3 Because we have heard that man's operation often fails. In case the wife gets pregnant after man's operation there will be some social problem. Secondly we have to do hard work in the fields. We might get weak after the operation.

Question 4 Do you know other methods of preventing pregnancy ?

Ans 4 There is a herbal medicine. If the juice is taken for 3 days then for the whole life there will be no children. But it is not good. We should not meet the wife on certain days so that we can avoid the pregnancy.

Question 5 Do you know about Cu.T, Nirodh, etc ?

Ans 5 No. Please tell us what it is. We saw some posters on the bus.....

Question 6 Do you think the Govt. should give more incentives to those who go for operation ?

Ans 6 Actually this method is not good. Only because of these bribes our thinking capacity gets destroyed and we keep asking for more money. If Govt. really wants us to be operated, why do not they give us any assurance about education, employment, housing, health etc. for our existing children ? What about our own life in old age ? Who will take care of us at that time ?

There used to be long conversations on the issues involved in population control. We as a group of study team felt that our insights into people's ability to think has increased tremendously after these meetings.

Meetings with Rural Women

There were two meetings fairly well attended (average 20). The discussions on FP programme always got side tracked during the discussions on the social issues in relation to family size and men - women relationships. However following emerged.

Question 1 Most of the women go for operations. Why ?

Ans 1 By daily persuasion of the FP workers and our husbands' wish we have to go. There is no question of our saying 'no', if husband says 'yes'. But only we know how do we suffer.

Question 2 How ? What is the suffering ?

Ans 2 Often the son may die after the operation. Then the husband will send us to join the tubes or bring another woman in the house. There is daily tension related to this. If the children are sick we feel more insecure and take them to the private doctor for better medicine. We spend more in turn. Above all we feel very weak and lethargic. We can not do as much work as we used to do before, what happens ? There are quarrels everyday in the house and we again feel bad.There is so much in the air to have only few children for our own good ! Why don't they also do something about giving children to those who have none ? This is also necessary because such women have no good life. Why don't you do something about it ?

Question 2 Have you heard about various methods of contraception ?

Ans 2 Nobody has told us about it. In our villages, if the pregnanacy is not wanted, we go to the dai who gives medicine. After 2-3 days we will have fever and it falls off. Generally nobody likes this because the woman may sometime die also. But you say there are methods which even the married women may use, then please tell us all about them. You have studied in the city so you would know about all that.....

Rest of the discussions was too repetetious of what has been already said above. Hence detailed reporting is not taken up here. However, women were in general concerned about after-effects of Tubectomy and negligence on the part of health services.

SUMMARY AND RECOMMENDATIONS

1. Family size

It is seen from elaborate discussions and the survey data that the people's choices regarding the number of children are mainly guided by their own individual needs. e.g. family which thrives on agriculture requires more working hands and can not afford to pay wages to labourers. So they prefer to have more children. However family which thrives on service cannot afford to have more children because of limited income and stressful life. So they prefer to have less children.

Secondly, the kind of social and ecomomic aspirations also need to be attended to. Educated parents want to educate their children more and their expectations from life are different and more demanding than the village based farmers. Hence the small family norm seems to be a rule of the day for Urban Middle Class. Due to the changing trend of Urban areas and increasing competition due to market forces in Rural areas coupled with the propoganda and policy for "Operations" the Rural scenario has been changing also in favour of smaller family norm.

Almost the whole study population has voted for at least 2-3 children (a mix of 2 boys and a girl). In various conversations they have said that to have or not to have children is a personal matter. The Govt. should not dictate the terms and conditions. This necessarily implies that the people have a rational mind to select what is best for themselves.

Our Recommendation

Blanket/uniform policies and norms for the whole nation are not only unrealistic but appear antidemocratic. Especially the "One Child Norm" cannot be uniformly enforced. Such norms should be decided on the data based upon socio cultural and economic conditions of the various groups of people. Of course ! We believe that the Govt. may spread the message in an educative way leaving the choices to the people rather than to the demographic interpreters.

2. Lack Of Health Services

One important aspect of any society's decision about the family size, etc. is the anxiety about survival of its children. We find that the parents are not confident about the health and survival of children. This problem is more serious in Rural areas, where the health services are not in vicinity and also they are inadequate, e.g. there is no competence to deal with gynec, pediatric and other complaints. Half of the times drugs are not available and at other times the doctor is not there. In our data, we find that majority deaths are due to diarrhoea, pneumonia, measles, septicemia, etc. Many of these could have been prevented, if the services were available and the parents could have reached the health centres. The later necesarily means there should be good roads and good transport system in the remotest area ! We wonder if the Govt. would attempt to achieve any of the above in near future..

Our Recommendations

There is a lack of good health services leading to insecurity about efficient and effective medical care and therefore survival. So it is unjust to thrust upon the norms which limit family size. There should be a competent Primary Health Care infrastructure available nearer to the homes of the people which implies good transport, roads, safe water supply and sanitation, housing facilities, etc. Unless we achieve this, pressurising people to opt for any measures which limit their family size is not justified.

3. Victims of Target Approach

A lot has been said about evils of target approach in the F.P. programme. We also come across problems such as exploitation of the FP workers, unhealthy promises to the community, system of incentives and disincentives, personal persuasion of the people especially the women, derogatory behaviour towards persons with large families, etc. We found enough evidence of the fact that even the FP workers themselves do not like to continue to talk about "Operation" ! One of the workers was also heard talking that "whatever mistakes we make we are always pardoned if we have completed the FP target. So we have learnt to do only FP work and no other....".

Our Recommendations

An important reform in the population control programme would be to free the people and the workers both from being victims of the target based approach.

4. Training Of The FP Workers

People have invariably complained about the insensitive behaviour of the FP workers. Most of the times they are seen "hunting" for cases. They reduce the community into numbers and money. From top to the village level workers they are found to fail in responding to the socio-cultural needs of the individual couples. Naturally they are unable to impart information on contraceptive methods, etc to enable free informed choices. Let apart informed choice, they have always pressurised people about the "Operation" and no other method of contraception, because it is more suitable for themselves.

Our Recommendation

F.P. Programme should have enough scope for rigorous training of all cadres of officials to deal in a more humanitarian way with the people. There should be specially designed training modules to train them to impart free informed choice to the people. This necessarily involves a change in attitudes of the policy makers, and higher and lower FP workers, etc. amounting to total overhauling of the whole machinery.

5. Opting for Sterilisations

We came across many who said they have opted for "Operations" by their own will but slight interrogation into the reasons for this revealed a very gloomy picture. Most have adopted it for the fear of becoming poorer or going to be labelled as antinational and guilty of

breaking Govt. rule of two children-norm. A lot of them have replied in terms of Govt. FP propaganda and sloganeering such as small family-happy family two are enough, etc. We feel this to be a very unhealthy way of picking on any programme aimed at people's welfare.

Our Recommendation

The brainwashing FP propaganda induces fears and gives illusiv slogans. They do not sound realistic enough to appeal for welfare or the people as originally laid down. Thus unifocal FP propaganda has t stop immediately. A new and fresh approach respecting people's rationality to make decisions needs to be adopted for 'famil education' rather than 'population control' or 'family planning propaganda.

6. Incentives, Disincentives and Women

Women have been made easy target of all population control activities The schemes for incentives and disincentives have been aimed at women. It is not only derogatory but insulting to be offered utensils an ornaments for having the tubes cut. "women are easy to be convinced for operation". This is the popular belief among FP workers. In fac the women also fall prey to their husbands who do not want to be operated for themselves and force the women to go for sterilisation If for any god given reasons male child dies after her Operation, She is the one who suffers most. The vicious circle continues with more suffering for women. People have said that, in place of monetary incentive, the Govt. should give more comprehensive development oriented programme which may enable social benefit as well as individual enhencement of income leading to greater social security and helath of individuals.

Our Recommendation

Really speaking, the incentives should be oriented towards over development in terms of social security, educational opportunities, employment, improved health services, etc. Peoples' participation in making decisions on such programme would definitely lead their choice in favour of small family norm.

7. Spacing Methods

It was a very depressing experience to know that more or less there is a lack of knowledge about spacing methods among all survey populations. The real situation is that most FP propoganda is directed towards terminal methods i.e. sterilisations only. The over-emphasis on "Operations" and method of giving targets to each level of workers has resulted into total negligence of education for spacing methods. Even among stray cases where a Cu.T or tablets is used as a method of contraception, knowledge about other methods is lacking.

Even these incidences of women using the spacing methods would not have occured if the women had not sought medical care for specific health problem. Thus the official argument that people cannot understand nor effectively use the present (Pill, Cu.T, Nirodh and other barrier methods) spacing methods is uncalled for and not supported by sound studies.

The Govt. is desparate to introduce newer technologies (like Depo Provera, Norplant, Vaccines, etc) Which ensure greater control over fertility and deprive the people of free choice and control over their bodies. This is not justified because the irrelevance of the present spacing methods is not proved in our context. Whatever the present apparent failure of the existing spacing methods is seen, is because of lack of proper infrastrucure to introduce, supply and support these methods consistently and continuosly in Urban Slums and Rural area.

Our Recommendations

The problems inhibiting the use and propagation of the user friendly spacing methods should be thorughly researched. Depending on the results of this research it is possible to rectify the various problems.

Govt. should create the extensive infrastructure to provide health services in remote areas and Urban Slums. The FP education on spacing methods should be conducted consistently by this infrastructure. It should be equipped enough to monitor and deal with the complications and side effects of these methods.

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RURAL WOMEN'S SOCIAL EDUCATION CENTRE

Chengalpattu, Tamil Nadu

Rural Women's Social Education Centre

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RUWSEC

Date 18.1.94

Population Policy - Voice of Rural Women

Report submitted to ISST, Delhi January 1994.

Meetings with village women's groups were conducted in 15 villages where RUWSEC is working, during the month of November, 1993.

Meetings began with an explanation of the objectives. A National Population Policy is about to be evolved in our country. Several policy changes are already underway to make population control more stringent.

Moreover, the International Conference on Population & Development is about to take place in Egypt later this year. Decisions taken in this meeting are likely to affect policies for the next decade. As women who will be most directly affected by these policies, we should not sit back and be mute while policy decisions are made without taking into account our views and needs. We should give voice to our problems, needs and demands and ensure that these are taken into account. It was therefore very important that all the women present articulated their thoughts on these issues.

We began with discussions on population as a problem. The opinion on this was divided. There were those who saw it as the cause for price rise, unemployment, landlessness, low wages due to excess labour supply and inability to afford dowries for daughters.

There were others who felt that population was not a problem and not a cause of their poverty. Landlessness, price rise and low wages were the main reason. The more the number of members in a family, the more the hands to work and greater the wage income. Even ration shops gave more cereals for large families.

Three or four children were considered as appropriate. This will ensure companionship for children. Also, if one or two die atleast two will survive. A few women disagreed with this and said that given the adverse economic conditions, even raising two children was difficult.

Sons were very important. They stayed with you till the end and lit your funeral pyre; support us economically. Girls are a constant source of expenses. No matter how badly a son treated you, he was the one you could rely on. A daughter's loyalty lies elsewhere. But daughters do play an important role when mothers are old and bed-ridden. They look after their mothers - bathe and clothe and feed them and are a source of emotional support.

They had some basic information on all the modern methods of contraception available, provided by RUWSEC through pamphlets and workshops.

The method of preference for the majority of women was tubectomy. This ensured that there would be no further births. However, there were a lot of associated health problems. One became too thin or too fat; developed back ache, hyperacidity and loss of appetite.

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Date 18.1.94

Then why did they accept tubectomy? Because they thought it better than suffering the consequences of having too many children why not adopt methods such as the diaphragm, which do not have side-effects? Because women had very little privacy; they did not feel it would be easy to maintain the diaphragm in a hygienic condition. Also, given their workload, they would prefer nor to have to bother with thinking constantly about birth control.

Natural methods could be adopted, but had too major limitations - the men had to co-operate; and keeping track of the safe period was not easy.

Copper 'T' has been associated with several negative health effects. Back ache and pain in the legs, frequent and heavy bleeding, white discharge and discomfort to men during sexual intercourse. Most of those who had been inserted with IUD had discontinued use.

There were two women on whom IUDs had been inserted without their knowledge.

Women said that men were unwilling to undergo vasectomy. Also, women saw them as breadwinners and felt that if they were adversely affected, there would be no one to economically support the family. Post-partum sterilization of women also had the advantage that no additional days of work were lost, because women combined the rest period following delivery with that following sterilization.

Women complained of not being told of all the contraindications and side effects of methods; the ANM gave them pregnancy care only if they were potential tubectomy acceptors. They were not given any follow-up care following surgery.

In the hospitals, there was rampant corruption. Every person had to be bribed for the least service rendered - including fetching the bed-pan. The compensation amount they give is all spent before women return home.

Women were verbally abused if they had three or more children and literally bullied into accepting sterilization. After the surgery, there is no care given; only the sutures are removed and women sent home. In Government hospitals, we have to take even the cotton and gauze and worse still water. Not even beds are available, one has to take it from home.

Those going for MTPs are directed to see doctors in their private clinics, where they are charged a highly amount.

Suggestions for change

1. All villages should have roads and lights and water.
2. All sub-centres should be functional, the ANM should stay there. It should function as a health centre and not be restricted to MCH. Essential drugs should be available here.

Rural Women's Social Education Centre

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Date 18.1.94

3. PHC should have basic facilities; water supply, toilet, electricity, adequate beds and labour room. An ambulance should be a must.

4. Sterilization should not be performed in 'Camps' but in PHCs.

5. PHCs should offer Medical Termination of Pregnancy.

6. Medical Officers employed in PHCs should not be permitted to carry on private practice.

7. We do not need incentive money for sterilization. Please invest this on providing good quality services.

8. Sex education and FP education for youth should be part of the FP programme agenda.

9. Women should have access to objective information on all contraceptive methods and devices and have the option of choosing any of these.

10. Adequate antenatal care/postpartum and trained attendance in delivery should become available to all women.

11. Treatment of reproductive health problems should be part of the health services package available to women.

There were discussions on some proposals made by the draft population policy document, such as disqualifying those with more than two children from electoral offices. This was seen as grossly unjust and unwarranted.

The meetings concluded with an agreement to campaign against such legislative decisions, speak out on women's demands and remain vigilant to counter violations against women's reproductive rights.

BANWASI SEWA ASHRAM

Sonbhadra, Uttar Pradesh

THOUGHTS AND OPINION OF VILLAGERS AND DEVELOPMENT WORKERS OF BANWASI SEVA ASHRAM ON THE PROBLEM OF POPULATION AND PROGRAMME OF FAMILY PLANNING

A REPORT Dec. 1993

The Institute of Social Studies Trust had organised a workshop on the topic, 'Evolving a Woman-Sensitive Population Policy and Programme' in Delhi from 3rd to 5th of Sept.1993.At the workshop it was decided that Banwasi Seva Ashram will participate in developing an understanding about the grasp of the rural people, specially the women, about the problem of population growth, the programme of fertility control and their priorities for achieving family welfare. The dialogue on the topics was to be

The main method for gathering the information. The idea was discussed with the staff of the Ashram, specially those involved with and the medical and health care,the development of women and that of rural development.

Following was the action plan worked out:

1.The Dialogue Programme :

The topic of population growth and that of the fertility control is of significance to both women and men. Further, if any policy is to be successful both need to have an understanding of it and a common concern. Therefore, at Banwasi Seva Ashram we decided to involve men also.The dialogue programme worked out was as follows:

1.1) Dialogue with a group of health and medical care staff.
1.2) Dialogue with the village leader women the Gramsakhees.
1.3) Dialogue with village women groups.
1.4) Dialogue with families in villages.

2. The opinion collection through schedules.

3. A workshop with field workers men and women and representative of ISST.

The dialogue with health and medical care personnel was held on 12th of October. The dialogue with village leader women on the topic took place at the time of their 3 day meetings in the first week of October. Thereafter, there was a gap because of Dashahara festival. The women's development wing of Ashram had organized 3 day meetings for village women at village cluster levels primarily for informing them about the Panchayat Raj. The opportunity was used to have a dialogue with them on the subject of family size norm, fertility control and their priority for family welfare. The interviews with the individual families of neighbouring villages were conducted in the

month of November and the opinions of the individuals were obtained in the month of December. The workshop took place on 9th and 10th of December. The observations made during the dialogue programme and the findings of dialogue, the schedules and the interviews are presented here programme wise first followed by a brief concluding summary:

THE FINDINGS AND THE OBSERVATIONS REGARDING PEOPLE'S OPINION ON FAMILY SIZE NORM, FERTILITY CONTROL AND PRIORITY FOR FAMILY WELFARE :

1.1. The Dialogue with a group of health and Medical Care personnel.

The group consisted of Dr. Ragini, Director of the Agrindus Health Project of Banwasi Seva Ashram, two other doctors, Dr.Vibha and Dr. Bhola Singh and four trained assistants belonging to the area and having experience of field work.

The group had a feeling that blaming population growth for every problem faced in life is a wrong attitude. The control of population growth in itself cannot achieve family welfare. Yet, for wellbeing, it is necessary that family is planned and in the present context it has to be a small one. The people in general favour a small planned family but the success rate is low. The group was concerned about this gap in the thought and the action. It is a common observation that young couples are often not able to space the child birth. The question around which the dialogue centred was why is it so and what needs to be done to improve this situation. The points that emerged are:

a) Opinion regarding family planning:

1. The size of the family should be small, ie 2-3 children in a family.

2. Girls need to be given equal status to that of the boy and there should be no craving to have a second male child. In case all the three are female children, that should not be an excuse for enlarging the family size.

3. Adult marrige should be preferred. The maturity of thought and feelings facilitates planned parenthhood.

4. The child birth should be spaced.

5. As the fertile period is long one and there is the possibility of having number of children born, hence contraception is a necessity for limiting the number of children in the family.

6. Contraception methods promoted should not be harmful. Should not interfere with hormonal balance of the body and that there should be proper health checkup and follow-up care.

b) Causative factors for failure of spacing the child birth.

1) marriage in early adolescence when the mind is not mature enough to think of the responsibility, not wise enough to plan for the future and not strong enough to mould the behaviour.

2) impulsive nature of the personality having disregard for restraint in life in the interest of overall welfare of

the person and the family in the long perspective.

3) lack of understanding regarding menstrual cycle, the fertility and contraception.

4) Lack of concern on the part of men about the health of women.

5) disregard for spacing of child birth.

6) nuclear family status-which deprives young couples of guidance and encouragement in fertility control.

c) Opinion regarding planning for family welfare:

The family welfare depends on social organisation: the productivity, and availability and accessibility of the basic needs, of life the possibility of holding self esteem and the social security along with affectionate relationship. Therefore, the development plans should take equal care of all the aspects of life.

Having gone into what exists and what has to be achieved with regard to family planning, the question that came forth was how to go about it. It was decided to initiate a dialogue in the community and to work out the modality for promoting planned parenthood and fertility control in the community.

1.2 Dialogue with village leader women, the Gramsakhees:

Banwasi Seva Ashram is running a special programme for awareness and development of village women since last 4 years. It has reached to 200 villages in the last year. The women from the village community willing to work for the community are brought in repeated short training courses and are sent back to villages to do the general awareness building as well as some specific educational functions periodically. Eighty four women the Gram Sakhees were in the field from July to September advising the villagers on protection of drinkng water, prevention and preliminary treatment of seasonal illnesses, promoting kitchen gardening and plantation of tree and education of girls and women's literacy. They were also putting up fights against injustice (not only with women but also with families or community as well). These women were called for a meeting to report what was done and to gain some new information. These meetings were held in two groups and the dialogue on population policy and family planning was discussed during these meetings.

The dialogue was started with the question, of interpretation of the terms, 'family planning' and 'family welfare'. There after questions were posed as and when necessary to touch all aspects of the subject. It was made sure that every one participates in the discussion. The views that were expressed are as follows:

1) The terms family planning and family welfare were interpreted as meaning stoppage of child birth and small and happy family.

2) There was a consensus that family size should be small for increasing the happiness in the family.

3) The mejority of women leaders were of the opinion that there has to be at least one son in the family,preferably two.

4) There were about 30 women (out of the 84) who said that if by chance only grils are born in the family even then one should feel contented and limit the size of the family.

5) All were of the opinion that there should be no discrimination between a boy and a girl and that both should have equal status.

6) Their spontaneous response that followed the mention of Nasbandhi was that it makes men and women weak and ill.

7) About 30 women, said that they know about Nirodh, Copper T and Mala D. Many more know about safe period.

8) In general women were ignorant about the experience with copper T and Mala D. Only 6 women said that they knew women who had used them and that these women suffered from heavy menstrual bleeding.

9) As regards desirable age of marriage all were of the opinion that girl should be around 16-18 years of age and boy around 20-24 years. They felt that to make it a tradition special efforts are required.

10) With regard to the problem of promoting the spacing the child birth, women leaders were not very vocal. Their expression was that it depends on the person and his conviction. When suggested that elders should guide the young ones they all said, "if the young people do not listen to what can be done."

11) When the leader women were asked to comment on what are their priority needs for welfare of the family, the unanimous expression was that irrigation facility first, then education to children and then employment opportunity. They appeared oblivious of their needs of health and medical care.

Women leaders had no idea of the mechanism of action of Copper-T or Mala-D, neither had they heard of hormonal injections for birth control or Norplant. They had no such feeling that women are made the target for the practice of contraception. Their argument for preferring of tubectomy was that the man needs to be saved from weakness and illness,resulting from family planning operations as on his labour depends the bread of the family .Before concluding the discussion women were told about the Copper-T, Mala-D, Norplant, and their side effects and the need to be vigilant before and after accepting these methods of contraception. Their attention was drawn towards the fact that if protecting man's health is important for family earnings, then in that case women's health is equally important for the care of the family as whole even the man and, specially that of the children on whom depends the future family welfare.

1.3. Dialogue with village women groups:
As mentioned earlier, Women's development wing of Banwasi Seva Ashram had planned a number of 3 day awareness meetings at village cluster level in the month of November and December. This opportunity was used for gathering opinions of the village women on the topic of family planning and family welfare at 26 news centres. Four lady field workers conducted this dialogue. Two of them also talked to 22 village

women groups of other villages. In all 1881 women from 162 villages participated in the dialogue. The main points of t(e information gathered are as follows:

1) The term 'family planning'is interpreted by all of them as family planning operation.

2) The commonly known methods of birth control,specially for spacing was 'abstinence'

3) The common method of terminating unwanted pregnancy is massage and at times indigenous medicine is also used. Both lead to profuse bleeding.

4) Some women know about Nirodh and safe period and very few knew about Coper-T and Mala-D.

5) All the women said that Government workers do not explain the different methods of contraception, they are only often getting a case.

6) For catching hold of a case additional incentive is often offered and after care is guaranteed. But there is no surity of getting these benefits. Quite often nothing is available.

7) There are a number of cases where operations have failed and nothing was done for it.

8) It was a common feeling that operation makes the person weak and ill.

9) Women who knew about Copper-T and Mala-D said that these methods cause profuse bleeding. Regarding Nirodh, they said that it is not liked and is not freely available.

10) As regards desirable the number of children in the family, the opinion was in favour of having 3-4 children of which there should be one to two sons.

11) Some women said that elders of family have a say in deciding the number of children in the family especially the number of sons, specially whether or not to get operated.

12) The women were conscious about increase in population and the resultant increased demands on the natural resources, but could not relate it to their day to day problems of drinking water scarcity, lack of irrigation, sparce, irregular and inefficient education and health coverage etc. (Actually the village area is not overpopulated but there is an increasing invasion by the outsiders around townships).

13) The common feeling was that merely reducing the number of children in the family will not make it happy. For happiness, water should be available for drinking and also for irrigation, opportunities should be there for education and employment for every one.

14) With regard to of the health of the mother and child the women felt that the know have of contraception needs to be spread.

15) All were of the opinion that the methods of contraception should be such that they do not weaken the health and at the same time failure rate is negligible. It is this fear of ill health and the fear of the method failure that prompts them to the permanent method of contraception.

1.4 Dialogue with families in villages:

The experienced auxilliary nurse midwife working with Ashram's health project and women's development wing talked to 60 (90 women + 22 men) families of five villages in the nighbourhood of Ashram. On the subject to know about their opinion her findings of the family specefic dialogue are;

1) Out of the 60 families 40 had accepted the sterilization method for birth control.

2) After operation the persons had taken rest, tonics and necessary treatment. They had no complaint of weakness.

3) The feeling was that if other methods of contraception are adopted without proper knowledge, it may affect health adversely and hence, after getting the desired number of children they chose to attend the operation camps and get operated.

4) In some families young children had died of pneumonia and other illnesses for want of treatment as a result of poverty and hence they had postponed operations.

5) The families who had no complaint about operation stated that there is a lot of rush at the operation camps and some receive proper attention, medicine and money and others go without it. Those cases which belong to interior villages and lack access to health care follow-up face lot of difficulties and experience weakness.

6) Men avoided talking about spacing the child birth. The men were very perticular of having at least one son in the family.

7) Educated and other persons with maturity of thought said that people should not be forced to limit the family size. It was much more important that the water and electricity is made available to the people. When there is enough to eat and the children grow healthy the parents on their own will be willing to get operated.

8) The belief was that the child is an insurance for the future happiness of the family. The poverty and inflation reduces the chances of child survival and hence the hesitation to accept the permanent method of contraception.

2. The opinion collection through schedules:

It was felt that people may not like to talk about their personal experience regarding family planning but may be they will not mind writing them down. Hence, a schedule was worked out and the willing persons, men and women were asked to fill it up. Thirty eight persons

filled the proforma. The analyses of the data obtained is given in the table below.

Table 1
Sex, Age and Occupation of the Respondents

Sex	No.	Age			Occupation			
		25-35	36-55	56 & above	Self-employed	Service	Ashram Staff	Other Ordinary
Male	29	16	8	5	3	7	18	1
Female	9	5	4	-	2	-	5	2

It is seen that majority of respondents are of young and middle age. Out of 38, 23 respondents belong to Ashram 13 to village community and 2 are wives of the Ashram staff. 30 are in service and 5 are self employed. It can be said that respondents belong to aware community.

Table 2
Family Planning - Acceptance and Opinion

Respondents*	Acceptance				Opinion			
Total 38	Small family acceptors		Large Family acceptors		Desirable No.of children		Decision makers	
	Operation	Other methods	Operation	Other methods	2-3	4/above	couple	elders
Male Respondents	8	10	6	5	26	3	25	4
Female respondents	2	4	1	-	9	-	-	-
	10	14	7	5	35	3	25	4

* Two respondents had no children yet but showed their preference to small planned family.

All the respondents are acceptors of family planning. Two of the respondents who have not had children are in favour of small family. 24 have small families and 12 have 4 and above children in the family. Acceptors of permanent method of contraception are more among older age group and of temporary method in younger age group. But it is seen that in both the groups good number of people have adopted temporary methods.

The respondents were also asked to give their opinion on other

related matter. The opinion expressed are :

1. The term family planning is interpreted as population control by 11, as small family by 20 and as planned parenthood by 16.

2. The requirement for the happiness of the family was thought to be education and morals by 27, curtailing unwanted expenditure by 4 and having small family size by 15.

3. To resolve the difficulties in living government should care for increasing employment opportunity - 18 resp., economic development - 10 resp., bringing down inflation - 5 resp., health-education-infrastructure facility - 12 resp.

4. According to respondents for resolving problems in living individual should do work - 12 resp., should reduce expenditure - 4 and should keep family small - 17 resp.

5. All were of the opinion that government needs to improve its population policy. There should be no coercion, approach should be educative and informative and health care and follow-up should be proper.

6. The suggestion of respondents for Ashram was that Ashram organises group meetings and short courses and also provides guidance to individuals.

It is clear that limiting the size of the family is seen as one of the requisites for resolving the problems faces. There is no feeling that population control in itself can resolve the problems. People are expecting government to act, they has few thoughts about what they can do apart from reducing the size of the family, reducing the expenditure and doing work. Respondents are in favour of birth control but they think for popularizing its practice approach should be educative accompanied by appropriate health care facility.

WORKSHOP ON POPULATION POLICY

The workshop was organised on 9th and 10th of December in Ashram premises. There were total 31 participants; 6 health staff; 9 women village leaders; 5 other lady workers of Ashram and 10 male workers of Ashram working in the field. There were 3 coordinators - one from Ashram, Dr. Ragini Prem and two from ISST - Miss Seemi Quasim and Mr. Anarendra Singh.

On the 9th morning the proceedings started with mutual introduction followed by introduction of the topic of workshop and presentation of participants views on population policy. In the afternoon, discussions were held in two groups, one of men and other of women to facilitate the expressions on family planning. On the 10th morning both the groups had a joint session. The experience of the workshop was encouraging. All the participants expressed their views freely. The points that emerged cover most of the opinions expressed by the villagers and also through light on other important facets.

Following are the points that emerged in the discussions :

A. Points related to growth of the population -

1. Continuously growing population does become problem in terms of meeting the basic needs of life.

2. No doubt the population growth is a problem today but there are equally significant problems other than population growth which need more stress that if population control.

3. In old terms (40-50 year back) there was no need to limit the family but it is the need of the present.

4. The size of the population even though oriented to be avail ability of resources and opportunities for family welfare in a region, the balance achieved can get disturbed because of many other factors. The invasion of the area by displaced persons from big projects including other outsiders or inconsiderate outflow of the local resources and materials and the loss of employment opportunity as a result of centralized production can create rearcity conditions and give an impression of population over growth. This is what is happening in tribal area of Sonbhadra. It is necessary to consider to what extent population growth is really responsible for present problems of development.

5. Poor people feel that more the working hands, more is the income. This is so because low paid manual labour is their lot. The development efforts should be such that the poor will feel confident of earning sufficient even with less man power.

6. It is reasonable to think of small family norm in the context of population growth. It is also true that if family size is small in the present situation it will contribute to happiness. But that in itself does not make a family happy.

7. The way government is wanting to control the population growth, it is less likely to be successful.

8. For bringing happiness to family there was to be provision for employment, irrigation and other welfare facilities. In villages there are no employment opportunities.

B. Points related to promotion of Family Planning Acceptance :

1. Government programme of family planning needs improvement. The approach should be educational along with the development and health care activity.

2. Government family planning programme is less beneficial as it is inefficient, inaccessible and reaches only those who have already enlarges their family size.

3. It is necessary that the small family norm becomes a social value.

4. It is necessary that young generation is informed about the problem of population growth and motivated to adopt birth control

methods for having a small family.

5. The stress should be on adult marriage, spacing if child birth followed by permanent birth control.

6. It is necessary that family planning educators and A.N.M. belong to the community or reside in the community where they are supposed to work.

7. The attitude of the family planning motivators towards the villagers needs to be respectful. Villagers should not be ridiculed. Ridicule hampers the achievement.

8. There should be no direct talk of family planning rather, it should become part of the general dialogue in normal course on various important aspects of life and living.

9. At present the government programme is operated in the style of seasonal campaigning. There should rather be a steady, continuity in educational programme and contraception services.

10. The people should receive right information and arrangements for birth control operations etc. should be improved so that fear in the minds if the people is removed and

11. It is important that people take initiative in spreading the message of planned parenthood. The peoples initiatives will be more influenced. Ashram should initiative action.

12. The points that need consideration in educating people in family planning are :

a) These are people who cannot think beyond their own personal welfare - such people can be motivated by arguing in favour of theirs own individual interest.

b) There are people who are curious about society - such peoples can be motivated to act in the interest of the community.

c) Young people always are fascinated with something great and glorifying. They should be explained the national significance of population control and motivated to put up with inconveniences in personal life or make sacrifices for the sake of welfare of the nation.

13. For educating the people in family planning:

- group discussions, short courses and consultations;
- need to be organized.

14. Elder in the family should take initiative in guiding the young couples.

15. Family planning programmes should incorporate treatment of infertility as well.

c. Family Planning campaign and the issue of womens' equality :

i) The village women were of the opinion that women want to safeguard the strength of the man on whose hard manual work the family earnings depend and so they willingly suffer the side effects of tubectomy.

2) Men dislike the condoms and that makes women suffer.

3) It is necessary that men learn to restrain and put up with some inconvenience.

4) Research should be oriented the developments of new methods applicable to men

5) Research should be there for less harmful indigenous methods of birth control.

By the time of concluding the workshop, all the participants felt enthused and were thinking of promoting the idea of planned parenthood and small family norm in the community for the sake of family welfare. There was a suggestion from the participant's that Ashram organizes short courses for the staff and village people on family planning and holds depots for distribution.

After the concluding the workshop Dr. Ragini and Ms. Seeme went to lady health workers and PHC doctor a long with two of the Ashram staff. The PHC doctor said that they face difficulty in obtaining supplies and other things that there is an overlap in reporting and follow-up which complicates the matter. The lady health workers said that ANMs do not reach to the villages they are supposed to as it needs walking through fields and farest. The eligible couple surveys are done in summer season when villagers are either harvesting forest produces or have migrated to townships and so figures are more a guess work. She herself does not visit more than a few hours near the ANMs centre.

It was quite obvious that there were lacunac in planning and lack of honestly on the part of workers.

As regards use of Copper-T and Mala-D the doctor said that people was township prefer them. The health worker confessed about the side effects of the method and said that drop out rate is high.

CONCLUSION

Opening a dialogue in a planned manner on the subject helped in gathering opinion of the people, the staff and the village leader women on the topic of population control and family planning. It became evident that the willing acceptance of family planning increases with access to education., employment and health care. Though idea of birth control is not new failures are due to lack of concern for mother and child health, lack of willingness to put up with inconveniences for the sake of family well-being. Among the new methods of birth control operation is acceptable is general inspite of side effects as it offers a permanent solution. All wanted government family planning programme to change its operative modalities, combine

it with appropriate education programmes and efficient health care.

The women in general (and even men) are not aware of the real meaning of the terms 'Family Planning' or 'family welfare'. They knew the functional meaning of them and thus they identify both the terms as meaning family planning operation. There is ignorance about the physiology of menstruation and contraception.

All the people, the staff, the other in employment and the little more aware, and little better people and the common people are clear about one thing that welfare depends on other situations, mainly the accessibility of welfare facilities, employment opportunities and development agricultures potential. A few of them were conscious that government was promoting family planning for the sake of control of population growth.

The people in general were not vocal about population growth. The villagers do realize that farm size is getting reduced year after year but their main botheration is to find assurance for irrigation which they think can give employment and also the food. The area is drought prove and has not received appropriate rains over last more than a decade. Actually the rapid changes in the environment and social situations are beyond their immediate and full grasp. What they urgently need is irrigation and employment. They have no leisure to reflect upon and analyse and responsible for difficulties.

The need of health and medical care facility on a continuing basis, was overlooked, almost neglected by the women in general.

This must be due to their long dependence on nature, the indigenous knowhow and the fate. They are yet to experience the benefits of health care.

The people of the area are much engrossed in their personal affair and are less conscious about the social problems in general. Further, they are not in the habit of giving an expression to their thoughts or arguing. It will need longer contact to make them vocal. The men and women involved in the dialogue and workshop are now conscious that women's health care is an important as that of men and that the it is better to accept the safe contraceptive method's rather than use the hazardous methods just for the sake of convenience.

The family planning or the use of contraception is not linked with either the problem of population growth on the welfare of the family by the people. To an extent common man's acceptance of family planning operation is in the context of obtaining monetary and other benefits.

This whole enterprized if opinion gathering has provided feed back and also motivated Ashram staff to get involved into the education process for mobilization of the people in favour of planned parenthood.

KASTURBA GANDHI NATIONAL MEMORIAL TRUST

Indore, Madhya Pradesh

KASTURBA GANDHI NATIONAL MEMORIAL TRUST
KASTURBAGRAM - INDORE M.P.

REPORT OF EVOLVING A WOMEN SENSITIVE POPULATION POLICY

Present population policy is on developmental basis. It should be more concerned with the health specialy reproductive health of women. The women especially poor women of the developing world should have authority to control their reproduction, The poor women should get this freedom this power, this option and this right over their own reproduction.

Family Welfare Programme is still remaining as "Population Control" programme only. The reproductive choice, reproductive right and the reproductive health is not yet included in the family welfare programme. It is only on demographic basis.

The poor women are concerned and interested to control over their reproduction. But the lack of knowledge, resources, education, poverty, pressure from in-laws, traditional customs, the existing health care system prevents them to carry out their concern properly.

When we are thinking about the development of women we should think of their health also. A total health is that the person is physically, mentaly and socialy healthy. Re-productive health is not separable from the total health.

Women have no freedom to make decision about the matters which affect their life and it automatically affects the reproductive health also.

The population environmental and development problems. The problem of poverty disease and poor environmental sanitation are bindrases against keeping a good health.

The technologies of contraceptives promises risk free contraception to the poor women and a lot of money is spent on new technologies and defence. If this money is utilized for the health of women material morbidity and mortality can be reduced to such extend.

When policies and programmes are made for the well being of women, women should plan the programme for them self not by the planners and implementers. Government and other action groups must improve personal and family life by expanding income oppertunities and providing basic services like education, health, sanitation etc. Policy makers should concentrate on rural women's health.

The design, structure and implementation of population policies should be changed. So that the focus is on the enpowerment and well being of all women.

We are grateful to ISST for including us to have a discussion with the village community on planning family the problem of population growth and human welfare. We could start the programme very late as we were not having a formal group.

Formal group have started to work at the middle of November 1993 only.

The formal group include a qualified female health worker and 5 grassroot workers.

According to the information collected we could find the following problems and drawbacks which prevents the women to keep a good reproductive health. We conducted the study by interviews and group meetings in four villages and at the clinic.

A survey on population was done randomly selecting 200 women of age group 20-40 from the 4 villages and the women comming to the clinic. Then group meetings and personal interviews were conducted in four of the villages at Joshiguradia, Kelod, Machala and Limbodi. These areas are covered mostly of Hindus - including Scheduled Caste and Tribes. Most of them are married and the age group of 15-35 Years. Half of them are with joint family and the rest with neuclear family.

Most of them were uneducated not knowing even to write their names. The younger age groups from 10-15 were studied up to 4 or 5th standard.

Child marriages is still existing Many of the girls who are up to the age of 10-12 are married and were staying with parents but in few days ready to go to inlaws. Previously also these was child marriage. But after marriage they stay with the parents and when reaching the age of 15-16 only they go to inlaws. Now in-laws and husband complell to take them after marriage, Giving reasons that they need them for work, or some body is sick. At home Due to this education is discontinued. The mothers says that the child will not get a good life partner if we keep our children late for marriage. The traditonal customs also force them to marry early. If the girls are kept at home after the age of 10-12 the community will remark on them.

Water supply is sufficient at present due to the provision of tubewells with hand pump. But the Sourroundings of the wells and housesare not kept clean. Due to the lack of knowledge the quality of drinking water and state of sanitation affect the health and family welfare of people. The women should be motivated to keep water clean. Even if they are knowing the methods of purification it is not carried out Many of the backward classes and poor family were not having Latrines. In order to improve sanitation it is necessary to develop low cost sanitary tailets and also animal sheds. The proper disposal of waste also is needed many of the diseases are caused by improper water supply and improper disposal of waste.

The diet includes mainly of Juwar, Makka, Wheat, Pulses, Vegetables occasionaly and on festivals egg and mutton. They used to have 2 meals in a day. Many of them were working in the field as majdoor. They take food with them for lunch which includes mainly Rotti, Dhal, some times - Rotti and Chilly which shows the defficiency of vitamins, minerals and other nutrients. Due to poverty many of them find it difficult to have a nutritious diet. Lack of knowledge of a nutritious diet also exists. Due to poverty and lack of knowledge many of them use the product of farm for earning money. Even they are producing Soyabean and Thuwar etc. in the field but they are sold out to earn money.

During pregnancy the women do not eat a proper diet The parents and elder people are in an openion that if they eat more they will have a big baby. Which causes difficult

labour. Even when they are pregnant they work in the field. With an improper diet. The insufficiency of nutrients causes the birth of under weighted and under nourished baby. The women should be aware that nourishment is needed for her health and for the health of the child.

The information about family planning and the use of contraceptives shows that most of them have less knowledge about the contraceptive methods. Those who are adopted permanant methods have already 3-5 children male fixation is there. Most of them says that at least one boy should be there, Preferance is for two male child. If no male child lot of trouble is taken to get a male child. One of the lady who is having already 2 female child is tring for a male child and doing all the investigations and treatment to get a male child as her mother in-law is forcing to have a male child.

Absents of free and easier source of contraceptives also prevents to use contraceptives. A women could not afford 12 rupees per month to purchase Mala'D'. So she stopped it after taking for 2-3 months. Most of the women used breast feeding as one of the method of spacing. Due to lack of spacing children were born 2-3 years intervals and it causes ill health of mother and child. Among permanent methods of limiting family size very seldonam Prefer Vasectomy women are operated at the age of 25-26 years. By that time they will have 3-5 children. The tubectomy is decided by the women because if the male have operation and suppose they have some complications there is nobody to look after the wife and the children.

With proper sexual education and counselling a positive attitude must be developed for the use of contraceptives and natural methods. For this proper functioning of the family planning functionary is needed. They should provide free supply of contraceptives at the door step with proper instructions and follow up programme.

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The use of localy made liquir is existing among men and women. Even though women do not want to take it men are forcing them to use it. During pregnancy also they use it which automaticaly cause ill health of ~~mmth~~ mother and child.

When we think of the fertility management ment also should include in the programme to make aware of them about the important role they play for sex determination.

Those who have no children or not having male child they marry for second time to get a male child. The wife have to face mental tension and ill health. One of the family who have no children were under gone investigations and treatment. The male was important still the wife is forced to under go treatment.

Rajput and Patidar people are involved in polygamy; child marriage is one of the rason for divorce and remarriage More life partners are one of the cause for sexually transmitted diseases.

MEENA//16-12-93

Joseph

BIJAPUR DISTRICT MULTIPURPOSE WOMEN'S COOPERATIVE SOCIETY LIMITED

Bijapur, Karnataka

16-10-1993

Group discussions conducted at Bijapur Agriculture Office Hall

We conducted group discussions on general health of women and family planning. Thirty women from five different villages of Bijapur Taluk attended the workshop. The discussions went on for two hours. We got very good responses from rural women.

Women want to have their first baby without planning. It gives a great pleasure to become a mother for the first time. When a woman becomes pregnant, everybody in the family cares for her including her in-laws. Everybody feels happy if the first born is a son. Most women are not against family planning if they have two sons or one daughter and one son. She does not want to undergo operation before having atleast one son. In most of the villages they do not find trained dais who can handle deliveries with care. They have to travel for approaching the nearest PHC is there is any complication. PHC people charge for giving tablets and injections. Family planning operations are conducted only when there is a camp and not as and when women want them. People are scared to go to these camps because of lack of care and facilities. There are no follow-up programmes.

Particulars of the Survey conducted in 15 villages of Mudhal, Taluk and Bijapur

Sno.	NAME OF VILLAGE	NAME OF PERSON, AGE & OCCUP.	NEAREST PHC & DISTANCE	FAMILY PARTI-CULARS	KNOWLEDGE ABOUT THE USE OF CONTRACEPTIVES	OPTIONS
1	Hanumavva Bandiger	Malapur 30 yrs.	Mudhal, 3 kms from Malapur	Two sons	Aware of family planning nurse supplies oral contraceptives regularly.	No trained dai, private dai attends emergency cases. Two laparoscopy cases have failed. People prefer to undergo tubectomy.
2	Budni P.D	Smt.Masabi Khan Mohd. 29 yrs.	Mahalingpur 2 km from Budni.	No Children	People know use of contraceptives. Nurse regularly visits to take care of post operative cases.	Blame goes to ladies if they deliver baby girls. No special care in govt.hospitals. Family Planning operation are conducted in camps and not when a lady wants.
3	Vajnamatti	Bheemavva Tippavvagel 40 yrs.	-	3 girls & a son.	Govt.operated according to her will, 3 yrs age gap between two children.	PHC is there. It is better to have a small family. At least one son is necessary.
4	Timmapur	Fakeeravva Madur 23 yrs.	Lokapur 5 kms from Timmapur.	-	Nurse visits once in a month. Pvt. trained Dai attends emergency cases.	People want well equipped PHC at Timmapur.
5	Nagaral	Lakkavva Hosamani 58 yrs.	Mahalingpur 10 kms from Nagartal.	6 sons & 5 daughters	She had no idea of family planning. Now aware of the facilities available.	Her first daughter wanted to have a small family. She got a son after having 5 daughters. She had to extend her family against her will. She wants to restrict her son's family. People want to have PHC at their village.
6	Chichakhandi	Lurugavva Madar 38 yrs.	Lokapur 10 kms from	2 sons & 1 daughter	Already operated on her father's advice.	Her husband is grateful to her father for advising to undergo family planning operations. Weakness is the side effect. She is under the impressions that she is started getting Asthma after undergoing operation.
7	Jaliber	Sonavva Metri 50 yrs.	Mudhol, 10 kms from Jaliber.	7 children	Not used contraceptives Got operated after having 7 children.	She herself went to F.P. workers & got operated. No side effects. Pvt. untrained Dai attends delivery cases. People want PHC at Jaliber, if not a trained Dai should attend cases.
8	Sanganatti	Gouravva Natikar 33 yrs.	Mahalingpur	-	People know about contraceptives.	People are scared to go to govt. hospitals. They consult pvt. doctors if they have some serious problems.
9	Kulaji	Balavva Hacchalappagol 30 yrs.	Mudhol	3 children	Not used contraceptives not undergone operation. People in her village know about family planning.	Her daughter is married and has no issues. Her daughter and son-in-law have consulted doctor.
10	Belagali	Lakkavva Kyatappagol 28 yrs	-	-	People are scared to go to doctors. They prefer oral contraceptives.	Decision making is left to her. People in her family agree to what she says or does. There is PHC.

Sno.	NAME OF VILLAGE	NAME OF PERSON AGE & OCCUP.	NEAREST PHC & DISTANCE	FAMILY PARTI-CULARS	KNOWLEDGE ABOUT THE USE OF CONTRACEPTIVES	OPTIONS
11	Budni B K	Tangavva Madar 30 yrs.	-	-	Family Planning workers visit regularly.	No bus facility to nearest PHC. She has undergone D&C twice and still has not conceived. Nobody blames her for that.
12	Machakanur	Tangavva Kenchappagol 56 yrs	Mudhol 20 kms from Machakanur	1 son	She has one son. Not used contraceptives, not undergone operation.	No health centre at Machakanur. Her son has got 6 children and got operated. She preferred a big family for her son.
13	Nandagaon	Rukamavva Gasti 29 yrs.	Mahalingpur	2 sons & 1 daughter	She uses Copper-T for maintaining gap between two children. Nurse visits once in a week & charges for the medicines.	She wants to undergo family planning operation. Her husband is against it, as he wants a big family. Decision making is with her husband.
14	Gulaga Jambagi	Yallavva Talagade 32 yrs.	Mudhol	No children	Family planning workers visit regularly. People know about contraceptives.	She has no child. She has not consulted any doctor. She is not bothered about infertility. Nobody thinks it is her fault only.
15	Yadahalli	Doddavva Metri 32 yrs.	Mudhol 12 kms from Yadahalli	-	Undergone family planning operation.	She is suffering from nerve pain after operation. No post operative care taken at health centre. She has consulted a pvt. doctor. There should be a systematic follow-up programme of F.P.

General Opinions : Most of the ladies said that family planning workers encourage people to undergo family planning operation. They never take care of the patients once operation is over. They do blood tests but never give report. Workers expect money from patients at the time of discharge. PHC workers charge for medicines and injections. Doctors attending family planning camps do not take much care at the time of conducting operations. Usually ladies undergo FP operations and not gents. Most of the rural women asked us to conduct an eye camp as they want to check their eyes.

Particulars of the survey conducted in 5 villages of Bijapur Taluk on 16-10-93

Sno.	NAME OF VILLAGE	NAME OF PERSON AGE & OCCUP.	NEAREST PHC & DISTANCE	FAMILY PARTI-CULARS	KNOWLEDGE ABOUT THE USE OF CONTRACEPTIVES	OPTIONS
1	Hittinhalli	Smt. Gouribai Shankargouda Birader, 48 yrs Housewife	Bijapur 9 kms	1 son & 1 daughter 5 grand children	Not used any type of contraceptives & not undergone F.P operations.	It is good to restrict family now-a-days She has encouraged her daughter & son to plan their respective families.
2	Jumanal	Smt. Savitri Basappa Dhandaragi, 45 yrs, Dai	Bijapur 10 kms	-	Nurse & family planning workers regularly visit and give idea about F.P. She does prefer any method.	Children are God's gift. No one should go against nature. It was the previous opinion of some rural women. Now because of continuous efforts made by L.H.V. & H.V. and her guidance. People are in favour of family planning. F.P. is followed by follow-up activities.
3	Savanalli	Smt. Shanta Basavraj Mamadapur, 28 yrs Motivator for Backward class women	Bijapur 12 kms	-	People know about Copper-T and oral contraceptives.	Women prefer oral contraceptives to Copper-T. It is better to undergo F.P. operation after having two or three children.
4	Sarawad	Smt. Annapurna Balaraj Badiger, 30 yrs Housewife	Babaleshwar 3 kms	2 sons & a daughter	Used Copper-T for maintaining 3 yrs gap between the children & undergone laproscopy after having 3 children.	It is better to maintain at least three years gap between two children as it is good for both mother & child.
5	Jumanal	Smt. Danamma Rachappa Arakeri.	Bijapur 19 kms	1 son & 1 daughter	Oral contraceptives preferred to maintain the gap between two children. Undergone family planning operation.	Whether male or female, only two children are preferred. People prefer F.P operation to use of temporary methods. Women prefer oral contraceptives as they are free from side effects.

MAHILA HAAT

Almora, Uttar Pradesh

1. Mahila Haat, Uttar Pradesh

Mahila Haat was set up in 1989 with a view to providing support to poor women producers from Kumaon. It has its regional centre located in Almora and helps women to market their products and to develop their collective strength and solidarity. Mahila Haat plays a catalytic role in helping these women producers organize themselves for their economic and social betterment, by providing support and assistance in developing local-based projects.

Mahila Haat carried out its survey in Almora District of Uttar Pradesh. Almora is the most centrally located of the three districts that comprise the Kumaon region i.e. Nainital, Pithoragarh, and Almora. Stretching over an area of 5385 square kilometers, Almora district consists of 4 tehsils : Ranikhet, Bageshwar, Almora, and Bhikiyasen. The total population of Almora district numbers 8,24,134. The major rivers running through the region include the Pindar, Saryu, Ramganga, Gomti, Kosi and Sewal. The average annual rainfall in the region is 1189mms. The main languages spoken include Kumoani, Nepali, Garhwali, and Hindi. The main occupations practised in these regions include agriculture, cattle rearing for purposes of providing milk, meat, and fertilizer for the fields, as well as knitting of wool which is mainly done by women. It is very common for men of the region to migrate since employment opportunities in the region itself are scarce e.g. many men serve in the armed forces.

Health facilities are provided by voluntary organizations working in the area including the Bharat Scouts, Lakshmi Ashram which provides homeopathic and ayurvedic medicines, the Sahyog Sehbhagi Gramin Vikas Sansthan that works on health and literacy issues, Gramin Uthan Samiti that provides homeopathic medication. Governmental health infrastructure includes 40- 50 subcenters for each block, a PHC/MCH for each block, and 1 district hospital. As part of the ICDS Scheme, anganwadis are run in which people are educated about nutrition.

Medical facilities in the region are still far from adequate, however, and access to facilities depends upon the distance at which the village is located from the district headquarters. Villages like Kimu and Jayanti which are located in the interior and are unreachable by road have access to no medical facilities at all with villagers having to travel a great distance to the nearest town that has a hospital in case of an emergency. These people have to rely on the clean, fresh air and water of the mountains as their source of natural medicine. Most of these children are not even immunized- those who cannot survive are left to die.

Similarly, education facilities for those living in the interior are virtually inaccessible, with children having to walk many hours everyday in mountainous terrain in order to get to school. For example, children belonging to the village of Jayanti who want to persue an education higher than 8th class have to walk about 15 - 20 kms (one way). Once they get to school, there is no guarantee that the teacher will show up.

It is ironical that despite the abundance of water in the region, water shortage is still the most pressing problem faced by the villagers, with the situation getting especially hard during summer. Women living in the interior must walk an average of 6- 7 kms. a day in order to collect water which is required both for cattle as well as fulfilling family needs.

Research methodology:

The survey team carried out discussions (group-wise as well as individual) with both males and females in 11 villages in the district. Dai (local midwife) and doctors were included in the survey as well. Villages were selected in which Mahila Haat has already worked:

Village	Block	Caste/Community	Distance from dist. HQ
1. Khatyari	Havalbagh	Shawka, Bhotiya	0 kms
2. Chitai	Havalbagh	Pravasi,Kanjar	10 kms
3. Paliyon	Dholchina	Kshatriya	26 kms
4. Kalon	Dholchina	Brahmin	30 kms
5. Kausani	Takula	Shawka, Bhotiya	52 kms
6. Garur	Garur	Brahmin	70 kms
7. Tith Bazar	Garur	Muslim	75 kms
8. Baijnath	Garur	Harijan	75 kms
9. Gwaldam	Gopeshvar	Shawka	100 kms
10.Kimu	Kapkot	Harijan	158 kms
11.Jayanti	Kapkot	Kshatriya	165 kms

Findings:

The poverty in these regions has created a situation in which working hours are extremely long, with villagers working a minimum of 10 hours a day collecting grass for cattle, working on the farm etc. For women the day is even longer since she must work both outside the house as well as fulfill household responsibilities. Women living in the region have to walk great distances to collect the crucial products of grass (to feed the cattle), wood, and water. They risk their lives collecting grass from the slippery, steep mountain slopes.

Women spoke of how fulfilling all these responsibilities - working, having children, looking after the home- leaves them little time to take off to get operated. They cannot afford the time to get operated. This is one of the reasons that sterilization is not as widespread here as in other regions. Contraception is also not widely practised due to its inaccessibility and lack of information about the various methods.

Amongst the methods of contraception that are practised in the region, sterilization is the most common, with women being the majority of those being operated upon. Women spoke of how 'cases' were

chased for this purpose. Operations were done quickly in camps without any pre or post operation care/information being given. Bed rest after the operation is uncommon. No medicine or diet was recommended after the operation, and often the woman was left to walk back home, often through rough terrain. Quite frequently, the operation failed.

Due to operation failure, as well as complications that have occured - e.g. stomach pain, back pain - women do not have a favourable impression of the tubectomy operation. Further, they said that given their tough lives which involved climbing steep slopes to collect grass, carrying heavy loads on their heads, walking a lot, the operation was not good for their general health. Yet, they had to undergo it since they were "majboor" (forced) under the circumstances and did desire small families after all.

Copper-T is known to those women living closer to urban areas but is not used much because it often causes bleeding and pelvic inflammatory disease. In both the interiors as well as regions close to urban areas very little information exists about temporary methods of contraception. Villagers are often told that they are illiterate and incapable of understanding by doctors who only seem to stress sterilization. Most of the information girls do get about family planning is through heresay - from friends etc since their mothers/mother-in-laws never discuss such issues with them. Schools also serve to give exposure to students.

Women's disillusionment with the medical facilities and doctors was clearly evident as women complained of how difficult it was to pay doctors when they demanded a fee from them. PHCs only distributed medicines after cash was produced with doctors frequently selling stocks to chemists. "Though it is their (doctors) duty to give it to give us free medicines, they refrain from giving it in the hospital and ask us to collect it from their homes for a fee" (Final workshop, Almora). Dais, sweepers, nurses working in hospitals also had to be informally paid after a child was born for things like a bucket of warm water to bathe etc. "for otherwise our clothes are thrown away."

For those living in the interior, deliveries are typically done at home by older women of the village since there are no nurses or dais. Typically it was observed that a woman is transported to a place having medical facilities only in a crisis situation i.e. only when it becomes a serious case for not only is it extremely difficult to carry someone through rocky paths but for many villagers paying for the resulting medical costs is simply out of their reach. Doctors complained that this is typical of the villagers - bringing in the patient at the last minute- and very often nothing can be done because the situation has reached such a state.

Many women were saddened by their frequent miscarriages. A high infant mortality rate exists in the region. Not only do they live in fear of losing their children (most children living in the interior are not even immunized) but women who cannot have children live in constant fear of losing their husbands to another woman.

The desired family composition almost universally seems to be two sons and one daughter. Reasons for preferring a son include the fact that the daughter eventually leaves her own family to live with that of her husband, so a son is necesary to look after the parents when they grow old. The burden of dowry did not come out as being a major reason for preferring boys to girls since the people in the region are much to poor to pay dowry in the first place. However, it seems that social evils such as dowry and bride-burning are slowyly creeping into interior Kumaon culture as mobility and contact with urban areas increases.

In many parts of Almora it was observed that pregnant women are restricted from eating certain foods. "Garam" (hot) food is not allowed - this includes meat, eggs, and green vegetables. Some people believe that ghee, butter etc also should not be eaten as this would make the baby grow too big while it is in the womb and would create problems during delivery. Sometimes, the woman is not allowed to eat anything for 3 days after delivery.

Menopausal problems experienced by older women include a burning sensation in the eyes, hands, and feet, back ache, anxiety, headache, and general irritability.

Many women reported that they breast feed their children for as long as 2 - 2.5 years.

Local prioirities for action:

1. Employment:

   a) The women of Garur want a room to work in besides also using a part of it as a small health centre with school facilities under their exclusive control. This would also be a place for women to meet.

   b) Employment for men that is located in/close to the village so that they aren't compelled to migrate and live away from the family.

   c) Young girls in Gwaldum expressed a great desire to be informed about opportunities to start up a small employment project of their own that would enable them to earn some money.

   d) Basic Training Institutes for vocational training.

2. Water: Pipes to carry the water should be fitted at convenient locations. Water is there, but its inaccessibility is resulting in the inefficient use of land.

3. Roads and adequate transportation facilities.

4. Medical facilities to be upgraded and made more accessible:

   a) Facilities for those who cannot have children.

   b) One ANM should live in each village itself, with incentive and facilities being provided for her. Doctors should als be given similar incentives to live in and serve th villages.

   c) Women should be given basic training/information abou delivery methods with periodic check-ups being carried ou in their areas.

   d) Village women even suggested that the training center c converted into a health center.

   e) X-Ray and plaster for several cases of people who slip a injure themselves in the mountains.

   f) Immunization facilities

5. Toilets

6. Health education/information not only for the youth, but also f mothers and mother-in-laws so that they are able to explain/answe questions posed to them by younger women in the house.

7. Land: The Kanjar community, a group of nomads who earn their living begging, expressed the desire to be given a plot of land so that the children do not have to beg in future.