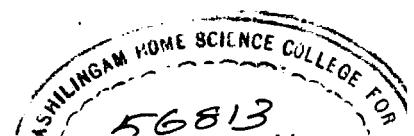


**ADOPTION OF FAMILY WELFARE MEASURES BY
SELECTED RURAL FAMILIES**

**BY
ANITA RODRIGO**

**A Thesis Submitted To The University Of Madras In Partial
Fulfilment Of The Requirement For The Degree Of
Master Of Science Through Sri Avinashilingam
Home Science College For Women, Coimbatore
May, 1983.**



A C K N O W L E A D G E M E N T

The investigator is highly grateful to Dr.Sitalakshmi, M.Sc., Ph.D.(Madras), Professor in Extension Education for her continuous guidance and encouragement given throughout the study. Her deep insight and sustained interest were of immense value for the successful accomplishment of the research.

The investigator records her very sincere thanks to Mrs. C. Velmayil, M.Sc., Dip.Ed.(Madras) Assistant Professor in Extension Education for the valuable suggestions and boundless assistance rendered in conducting the study.

The investigator records, her hearty gratitude to Dr.(Tmt.) Rajammal P. Devasas, M.A., M.Sc., Ph.D.(Ohio State), D.Sc. (Madras), Dean of Post graduate studies, for providing an opportunity to conduct the study and to Dr.(Tmt.) Godavari Kamalanathan, M.S.(Cornell), Ph.D. (Madras), Principal of Sri Avinashilingam Home Science Autonomous College for Women, Coimbatore for facilitating its successful completion.

The investigator also expresses her thanks to the selected rural families who co-operated with her in giving the details required for the research work.

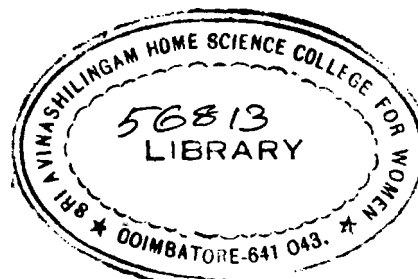


TABLE OF CONTENTS

CHAPTER	PAGE NO.
LIST OF TABLES	
LIST OF FIGURES	
LIST OF APPENDICES	
I. INTRODUCTION	1
II. REVIEW OF LITERATURE	7
A. Population trend in the world	7
B. Population trend in India	9
C. The need for population control	11
D. Why family welfare?	17
and E. Highlights of research on population	23
III. METHODOLOGY	33
A. Baseline survey on the extent of adoption of Family Welfare Measures in the rural areas	
1. Selection of the area	33
2. Selection of the sample	35
3. Selection of the method	35
4. Preparation of the interview schedule	35
5. Collection of data	36
and B. Conduct of the Family Welfare camps in selected villages	36

CHAPTER	PAGE No.
IV. RESULTS AND DISCUSSIONS	39
A. Results of the survey on the extent of adoption of family welfare measures	
1. Socio-economic background of the families	39
2. Nutritional and dietary practices	43
3. Health and sanitation practices	47
4. Adoption of family planning practices	51
and B. Impact of Family Welfare Camps on the participants	64
V. SUMMARY AND CONCLUSION	66
REFERENCES	71
APPENDICES	80

LIST OF TABLES

TABLE	PAGE NO.
I. EDUCATIONAL BACKGROUND OF THE FAMILIES	40
II. OCCUPATIONAL PATTERN OF THE FAMILIES	40
III. TOTAL INCOME OF THE FAMILIES	41
IV. EXPENDITURE PATTERN OF THE FAMILIES	42
V. VIEWS OF THE SAMPLE ABOUT NUTRITIOUS DIET	44
VI. FREQUENCY OF USE OF FOOD ITEMS	45
VII. METHODS OF COOKING	46
VIII. MEDICAL FACILITIES AVAILABLE	47
IX. IMMUNISATION/VACCINATION DONE TO THE CHILDREN	48
X. SANITATION FACILITIES IN THE VILLAGES	49
XI. HELP RECEIVED FROM OFFICIALS	50
XII. YEARS OF MARRIED LIFE	51
XIII. AGE AT MARRIAGE	52
XIV. NUMBER OF FAMILY MEMBERS	54
XV. NUMBER OF CHILDREN IN THE FAMILIES	54
XVI. SOURCES OF INFORMATION	55
XVII. AWARENESS OF THE RESPONDENTS ABOUT THE METHODS OF FAMILY PLANNING	56

TABLE	PAGE NO.
XVIII. DETAILS OF THE ADOPTION OF FAMILY PLANNING	57
XIX. REASONS FOR ADOPTION AND NON-ADOPTION	58
XX. FACTORS INFLUENCING THE ADOPTION OF FAMILY PLANNING	59
XXI. SUGGESTIONS FOR IMPROVING THE PROGRAMME	62
XXII. PERSONS TO BE EDUCATED ON POPULATION CONTROL	63
XXIII. EXTENT OF KNOWLEDGE, ATTITUDE AND SKILL GAINED	64

LIST OF FIGURES

FIGURE		PAGE NO.
1.	MAP OF KARUNADAI PANCHAYAT UNION	34
2.	<i>DIFFERENT ASPECTS OF THE FAMILY WELFARE PROGRAMME.</i>	38
3.	FACTORS INFLUENCING THE ADOPTION OF FAMILY PLANNING	60

LIST OF APPENDICES

APPENDIX

PAGE NO.

- I. SCHEDULE TO ELICIT INFORMATION
REGARDING THE ADOPTION OF FAMILY
PLANNING MEASURES BY SELECTED
RURAL FAMILIES**

80

I. INTRODUCTION

All third world countries today face a common problem. That is population growth in excess of their capacity to feed, to clothe, to educate and to employ their growing population. Their most concern is population control (Murthy, 1979).

Population pressures, economic crises, aspirations for higher standards of living and the recognition of human rights, have all led to the need for population control. Population size and population growth have become problematic not only to some demographers, but to ecologists and environmentalists, economists, public health administrators, politicians and statesmen and informed citizens (Beulson, 1976). The realization of the consequences of a population explosion has led these people to coin slogans like "Zero Population growth" and to organise a World Population year in order to create a greater awareness and acceptance of the means of fertility control around the world and particularly in the developing countries (Wadia, 1976).

The recent census figures shows that the total population of India has come up to 683.8 million. As compared to the 1971 census, it showed an increase of 24.75 per cent.

The main cause of this increase in population is the fall in the death rate brought about by better health conditions, effective control of epidemics, efficient handling of famine conditions and general improvement and economic development (India, 1981).

As our Prime Minister, Smt. Indira Gandhi (1981) has exhorted, the family planning programme was estimated to have prevented 37 million births in the past decade, but even then our death curbing strategy has been far more successful than our birth control strategy. The population of India is huge indeed but the danger of its doubling again in another 30 years, if unchecked, is a challenge which we have to meet by a stupendous, well organised, systematic and continuous effort.

Family Planning in our country is an essential part of our whole strategy of enlarging welfare. Greater welfare is in fact the only reason for family planning. And we need it not because we are against more children but because we want every child to have the best opportunity possible in life. This is the aim of every father and mother and this is the objective of planned development (Indira Gandhi, 1976).

India attached immense importance to the small family norm. It was also being realised, specially in developing countries that rapid and tangible improvement in levels of living of men, women and children is possible only if the family size is small (Roerich, 1981). In developing countries, there is an active government policy and programme in complete support of birth control. In addition to a national policy to provide information, education and services to regulate the number and spacing of births, most governments need supportive social legislations for raising the legal age for marriage, giving rewards for small families, buying taxes for larger families, and changing the role of women by providing better education and job opportunities (Rao, 1974).

Family Welfare Programme is being implemented as a wholly voluntary programme and as an integral part of overall national strategy of growth covering health, maternity and child care, family welfare, women's rights and nutrition. In keeping with this approach which treats the family as the primary basic unit of development and regards family welfare as an essential input in it, the programme aims at improving the quality of life of the people through adoption of small family norm as a way of life (Juneja, 1981).

The need therefore is to modify the assumptions of the family planning model so as to incorporate the social and cultural aspects of the population, specially the rural one (Chaurasia, 1982).

The approach during the Fifth Plan was to increasingly integrate family welfare services with those for health, maternal and child care and nutrition. The family welfare workers would thus be converted into multipurpose workers who would be able to pay special attention to purveying family welfare motivation and services (India, 1981).

Sustained nutritional uplift of a people can be brought about only as a part of an all round socio-economic improvement, not as an isolated operation. Thus family welfare planning and nutrition programme must be closely integral. Unless nutritional status is improved, with a view to achieve the desired family size with the minimum number of pregnancies, family welfare programmes will not be accepted. Unless family welfare is accepted and practised, nutritional improvement of both mother and child will be difficult (Parvathi, 1977).

The promotion of community mental health, the prevention of specific mental health, the prevention of specific

health problem and the identification, management and effective follow-up of patients are among the key areas of health care where a primary health care approach can have a direct impact on the health status of any population (Wankiri, 1982).

Family Planning Programme has been integrated with maternity and child health programme as part of a broad spectrum of overall national development programme, including health and nutrition, education, employment, recreation and social dynamism (Srinivasan, 1976).

Simultaneously clinical and other facilities should be rapidly improved, made more accessible and developed as an integrated part of our comprehensive health system. Family Planning should be made consistent with the needs of the people and be related especially to the health and care of women and children and the economic well being of the family as a whole. We must also be careful that any programme should relate to the local culture and tradition of the people (Parthasarathy, 1981).

The much needed social change in perception and behaviour of people in the sensitive area of family planning can gather and sustain momentum, only if all of us consciously

work along with the missionary zeal for contacting, communicating and converting the people to think on right lines (Saaz, 1982).

While on one hand efforts should be made to motivate the population to adopt family welfare measures, time to time evaluation is essential on the otherhand, to serve as pointers for future strategies. The present investigation is an attempt to study the extent of adoption of family welfare measures by selected rural women and explore the possibilities of educating them for adoption of desirable practices.

II. REVIEW OF LITERATURE

The review of literature pertaining to the study "Adoption of Family Welfare Measures by selected rural families in Coimbatore District" consists of the following phases:

- A. Population trend in the world
- B. Population trend in India
- C. The need for population control
- D. Why family welfare?
- and E. Highlights of research on population

A. Population trend in the world

World population increased more than eight fold between 1600 and 1975, from under 500 million to just under four billion. It took all of human history before 1650 to reach a world population of one half billion. But the second half billion was achieved in less than 200 years, the third in 50 years, the fourth in 30 years, the fifth in just over 20 years, the sixth in a little more than a decade and the seventh in only eight or nine years. The growth rate of the world's population has increased from about 0.3 per cent per annum in the period from 1600 to 1750 to two per cent per annum by 1971. It seems that the population growth has not taken place uniformly in different

parts of the world. Between 1750 and 1850, for example, the population of the area of European settlement—including Europe, Asiatic Russia, North and South America and Oceania - virtually doubled. But at the same time, the population of Asia excluding Russia increased by only about 60 per cent and the population of Africa hardly increased at all. The growth pattern looks much different, later on. Between 1920 and 1975, Europe's population increased by only 69 per cent. But Africa's grew by 202 per cent, Asia's by 144 per cent, North America's by 139 per cent and Latin America's by 338 per cent (Matras, 1977).

During the period 1900-1930 rate of population growth varied greatly between different countries and people. In Japan the population grew from 43.8 million in 1900 to 63.9 million in 1930 or by approximately 46 per cent in 30 years or a little less than 13 per 1000 per year. This is considerably faster than in the area of European settlement (excluding Latin America). The Philippines population grew by almost 12 per cent (20 per 1000) a year after the first census, under United States auspices, increasing from about 7.6 million in 1903 to about 13 million in 1930 (Thompson & Lewis, 1972).

The dynamics of world population reached 1000 million about 1820, 2000 million 109 years later in 1929 and 3000 million 31 years later in 1960. The world population reached 4000 million in 1976, i.e. 16 years later. That is it has doubled since 1929 (taking 47 years). At the beginning of the twentieth century the total population of the planet slightly exceeded 1600 million and had doubled by 1964. Thus 64 years were needed to double the population. At present rates of increase, doubling will require only 35 years (Urlanis, 1978).

B. Population trend in India

It would appear that economic and political conditions in India during the century and a half (1650-1800) were much less favourable for population growth than in China. Civil strife, with the consequent insecurity of life and property, the stagnation of agriculture, arbitrary taxation and personal government, have always had an unfavourable effect on the death rate. Birth rates probably were in the range 40-45 and death rates about the same. Further more there was probably less new land readily available for settlement in India in 1650, than in China, hence it appears likely that India's population grew slowly, if at all, during much of this period (Thompson and Lewis, 1972).

The population of India reached the 550 million mark in 1971 and is currently growing at the rate of nearly 1.2 million persons per month. About 22 million babies are born each year and about 8 million persons die, bringing about a net annual increase in population of 14 million, numerically equivalent to the population of Australia. India is the second most populous country in the world after main land China. In fact, till the 1921 census, India's population grew very little. During the thirty year period between 1891 and 1921, India's population increased by only 15.4 million or at an average rate of 0.5 million per year. But after 1921, which is called the year of the big divide, India's population increased significant by roughly 28, 33, 44 and 78 million during the 1921-31, 1941-51, 1951-61 and 1961-1971 decades respectively (Agarwala, 1972).

India's population exceeds 15 per cent of the world's total but this 15 per cent lives on less than 2.5 per cent of globe's total land area. Average levels of income place the country among the poorest. Due to improvements in health conditions during the half century preceeding the 1971 census, mortality has been declining and the rate of population growth has been accelerating. Government programmes aimed at controlling fertility were given strong emphasis during the better

part of the 1970's reaching a peak during the 1975-77 emergency. For example, in the second half of 1976 alone, some 6 million sterilizations were reported (Churchill, 1981).

The population of India as of March 1981 was 683, 810, 051 persons. This implies an increase of 24.75 per cent in the ten year period, since the 1971 census. Thus proportionate growth between 1971 and 1981 was virtually the same as the 24.80 per cent growth registered between 1961 and 1971. In terms of annual averages, these figures imply a rate of population growth of 2.21 per cent between 1971 and 1981 and 2.22 per cent between 1961 and 1971 (Census, 1981).

C. The need for Population Control

The enormous additions to our population of the order of 13 million every year are setting at naught all our herculean efforts to raise the living standard of the average citizen. It is indeed a matter of serious concern that while the net national product has increased by 91 per cent during the period from 1948-49 to 1967-68, the corresponding increase in the per capita net national product is only 30 per cent (Balakrishna, 1971). But the national urgency to bring down the birth rate from the present rate of 39 per 1000 to 25 per 1000 as early as possible, cannot be appreciated very much by the 100 million

couples in the reproductive age group, particularly the large majority who are in the countryside, unless its relevance to their everyday life is explained in a language meaningful to them. For another, it is idle to expect spectacular results in a short time in the matter of breaking the shackles of tradition, superstition and ignorance in our society and building about a change in the social mores of the people to persuade them to take to the small family norm.

India like other developing countries, has been facing the acute problem of rapid population growth. Population explosion is not a metaphoric expression in the Indian context. Population statistics are indeed horrifying. The run away rates of population growth have nullified the results of developmental efforts, living standards of the populace could not be improved despite our honest intentions (Rao, 1974). Population constitutes a problem not only in terms of the size and rate of growth but also in terms of its composition, sex ratio and age distribution. The latter determines the burden of non-productive persons on productive ones showing the dependency load. The policy must also relate to urbanisation and the availability of food, housing, employment, standard of living, health, services, education, recreation and other essentials of human existence. Balanced socio-economic

development requires investments in social services, employment, industries, regional development etc. (Chatterjee, 1982).

It is being increasingly realised by our people that our energies and economic growth of the country are being eroded and virtually set at nought by the relentless high growth rate of our population. Unregulated and unrestricted child bearing and child rearing on the one hand reduce and sometime deny the love and affection and care that children are entitled to in their formative years from their parents and on the other, adversely affect the health and economic status of the family as a whole. Acceptance and adoption of the small family norm call for delaying the marriages and arrival of the first child, spacing of the next and limiting the number of offspring to two. These are in the interest of each couple and the nation. A small family with proper health care for mothers and children can be the most central catalyst for our economic growth (Saaz, 1982).

We have laid down the objective of attaining a reduction in the national birth rate from about 36 to 21 per thousand, the death rate from about 19 to 15 per 1000 and the infant mortality rate from 125 to 60 per 1000 live birth by the turn of the century. To achieve this, 60 per cent couples in the

eligible age group would need to be protected by one or the other family planning method, as against the present 22.6 per cent. All of us, both government and non-government organisations together have to shoulder the responsibility for speedy control of population growth (Anand, 1981).

The path to family planning in every country lies through the eradication of poverty, which in fact, has historically been the main cause of over population. The need is to adopt an integrated approach encompassing the entire eco system and covering the man-environment relationship in such a way that every human being born on this planet is assured of the material, intellectual and spiritual inputs necessary for the full flowering of the human personality (Shabbir, 1976).

The Family Planning Programme has been integrated with maternity and child health programmes as part of broad spectrum of over all national development programmes, including health and nutrition, education, employment, recreation and social dynamism. The net result of these efforts has been that an estimated 23 million births have been accepted upto date (Srinivasan, 1976).

A programme relying for its success entirely on the voluntary acceptance of small family norm by the couples has to ensure optimal use of existing social institutions, traditions,

values and culturally approved goals. Since they influence the acceptance of family planning as a way of life, a proper understanding of these assumes crucial importance (Siddh, 1974).

Population control will take firm root as a voluntary and personal decision when it is fortified by the achievement of a certain threshold in the interrelated texture of improvement in the quality of life, social transformation and technological progress. The greater part of this demographic, sociological transformation will depend upon the speed with which changes occur in the economy of the Indian household and the new demographic and economic value that is ascribed to each of its members. We proceeded on the hypothesis that the quality of the population should improve simultaneously with intensified population control. There is enough justification for the assumption that while the family planning programme must be quickened in pace, other national wide synergistic, social and economic programme must be intensified simultaneously to obtain greater mileage out of the programmes of population control.

The population policy if not checked vigorously and in time the accelerated thrust of human spill over will bring to nought all our concentrated efforts to provide better medical facilities, better control of diseases, more job opportunities,

an increased per capita income, stepped up agricultural and industrial output and efficient and stream lined transport network and a leap forward in providing a qualitative educational pattern, not to speak of clothing and shelter to the 'have-nots' particularly in the backward areas. The strategy is an integrated package covering health, family planning and nutrition. For neglect of one at the cost of the other would simply mean ignoring the psychological dimensions of tomorrow. The crux of the policy is to strike at the underlying causes of poverty and diseases (Murthy, 1976). The population policy is thus one of the several vital instruments for securing comprehensive social development and it cannot be effective unless certain concomitant economic policies and social programmes succeed in changing the basic determinants of high fertility. It has truly been said that the best contraceptive is development (Karen, 1976).

The most difficult problem before low-income and technologically backward countries like India is the choice of a contraceptive that is acceptable under poor living conditions, particularly in the depressed rural areas where privacy, running water, electricity, any knowledge of reproductive physiology and most important, motivation, are more or less absent. Besides, in India's vast heterogeneous population

no single method, however, good, can be suitable to all. Hence the 'cafeteria approach' has been adopted in India. That is, theoretically all the scientifically approved contraceptives are available to the people in the Government Family Planning clinics, but for mass consumption only four methods are now advocated and made available (Chandrasekhar, 1972).

To reduce the birth rate in our country, the government has taken much care to create a separate department called Family Planning Development with enough supporting staff. The publicity given to this programme was unique in the history of our country. Mass media have been rightly involved in propagating and popularising the idea of Family Planning (Kaveori, 1981).

D. Why Family Welfare?

India started the Family Planning Programme in 1951. The population education programme aims at creating an awareness of the impact of demographic factors on development and vice-versa at the macro and micro levels and promoting the formation and adopting of such attitudes, values and practices, which support responsible parent-hood and reproductive roles which are consistent with the achievement of the overall improvement in the quality of life. The family

Planning education on the other hand has fertility control as the main goal. The population education has a wider concept and scope and deals with those aspects of population that can influence the quality of life at both community and family levels (Nautiyal 1976).

The key idea which we are implementing is that family planning must be integrated with the general package of health and nutrition services. The idea that family planning is an independent programme involving some kind of a vast give away is no longer valid. Family Planning services have got to become part of the health structures in this country, of which the apex may be the All India Institute of Medical Sciences but the roots are the primary health centres and the sub centres in the vast out reach of rural India. For achieving this we have decided to use all the media that are available to us, the radio, television with the new satellite technology, hearings, the press, person to person visits and so on. So far we have motivated people in the cities, but we have not really been able to get to the people in the villages. This basic motivation will come only when the vast masses in this country realise that Family Planning is in their own immediate interest (Shabbir, 1976).

India has made significant progress in the field of health during the 33 years after Independence. Small pox the dreaded scourge, was eradicated in 1975, other communicable diseases have been controlled to a great extent. Malaria, which was nearly eradicated, showed its head again in 1966 a modified plan of operation was launched in 1977, the execution of which has reduced the incidence of the disease. One of the prime approaches to reach the target of health for all is to help people to achieve health by their own activities and efforts (Ghosal, 1981). Health also depends on a number of supportive services, nutrition, improvement in environment and health education. During the next two decades, therefore the three programmes of integrated over all development including Family Planning, Improvement in nutrition, environment and health education, and the provision of adequate health care services for all and especially for the poor and under privileged will have to be purchased side by side.

Health is one of the important indices of development. Morbidity and infant mortality rates are a good yard stick of the health of community. On the other hand, poverty syndrome is characterised by low incomes, low educational level, poor sanitary conditions, diminished food intake, repeated episodes of infectious diseases, too many children, births too closely spaced, family instability, low social status etc. (Ranalingeswamy, 1981).

Every minute, some 10 children under five die and 10 more are handicapped as a result of six childhood diseases. The diseases are measles, polio, tuberculosis, diphtheria, whooping cough (pertussis) and tetanus. All are preventable through vaccines that already exist. Thanks to immunisations, the diseases are a rarity in the developed world (Bland, 1981).

Nutrition will have to be improved through adequate production of food, reduction in post harvest losses, proper organisation of storage and distribution and increasing the purchasing power of the poor through generation of employment and organisation of food ^{for} work programmes. Great emphasis should be placed on improving the status of women and children and special programmes should be developed for specific nutritional disorders like iron deficiency, anaemia or vitamin A and iodine deficiencies.

Good nutrition plays an essential role in the total well-being of a person. It can never be considered apart from the individual's feelings, economic status, culture and status of health. Good nutrition is also a key element in recovery from illness and in the maintenance of well-being when chronic health conditions call for a modified diet (Fikry, 1981).

Adequate nutrition is an important component of proper mother and child care. The average intake of children below three years is 500 to 700 calories per head per day, although the protein intake is only marginally below the recommended level. The intake shortage for pregnant and lactating mothers is nearly a third of the recommended requirements. In Madras City alone, out of total 30,938 deaths, 44 per cent of all deaths (13, 647) occurred in children below six years. Most of these are due to malnutrition and preventable infections (Devadas, 1978).

Devadas (1974) states that malnutrition and population growth are interrelated. Family size affects inversely the nutritional status. Studies on nutritional status and mental activities of children of pre-school age by Devadas et al (1972, 1973) have reported higher number of malnourished children among larger families than in smaller families. Devadas (1974) studied the family size, calorie and protein intake and nutritional status of 125 children with reference to their heights and weights and clinical picture. The study revealed that children from small size families the total members being (below five) had a better nutritional status than children from larger families (total members being above five).

In the Family Health Programme the main emphasis continues to be on extension of coverage to under-served populations, particularly those groups at greater risk. In line with this support has been given to several countries for studies on the risk approach in the delivery of maternal and child health care (Bland, 1982). The major objective of the National Health Policy is to provide health for all by 2000 A.D. implies the provision of a good and adequate health care system for all citizens especially for women and children as well as the poor and under privileged groups. It also implies a drastic reduction in the total morbidity and mortality.

The integration of nutrition work into primary health care and the development of a coordinated approach with other disciplines in planning, programming and research are the main elements of the comprehensive nutrition programme. Health behaviour studies, health education programmes and appropriate educational methods and materials are being developed while at the same time mass communication is being utilized as an integral component of health education.

For at least a decade the provision of safe drinking water and the sanitary disposal of excreta will remain the main field of work in environmental health. All governments

recognize that the adhoc project approach by a single agency must give way to inter planning as part of over all socio economic development and that the coordinations of external cooperation is vital if assistance is to be channeled to the poorer population as yet unserved. The National programme of protected water supply and sanitation has benefited many areas rural and urban. Killers like malaria, cholera and tuberculosis have been controlled and small pox has been totally eradicated while vigorous campaigns are on to eradicate the rest of the span of communicable diseases (Srinivasan, 1976).

2. High Lights of Research on Population

Srinivasan (1977) carried out a field investigation recently in one village namely Mannangidinne of Kavali Taluk in Nellore District of Andhra Pradesh. The study covered 90 respondents 45 persons drawn from each of the two generations. The people of two generations have common source of income and close blood relationship. The random sample method was adopted for selecting the respondents from among the 233 households. It has been found that 97.8 per cent of the respondents belonged to the Hindu religion and the rest 2.2 per cent were Christians. All the respondents of the first generation have knowledge about safe period, vasectomy and tubectomy. They have little knowledge of Nirodh, IUCD, etc.

About 42 per cent respondents in second generation have knowledge of safe period, vasectomy, tubectomy, nirodh and safety pills. No respondent had knowledge of IUCD, Jelly application etc. Fifty eight per cent of the respondents expressed that they know about vasectomy and tubectomy.

Saha (1975) conducted a study in the village Noapara in Hooghly district of West Bengal to find out the attitude of the people regarding the idea of using Nirodh, and their attitude in using the family planning practice in question. A random sample of 75 families was selected from 287 families for the purpose of the present study. The findings show that there were 31 (41.3%) men in favour of the idea of using the Nirodh and 44(58.7%) against it. A further study of those favouring use of Nirodh reveals the following: 45.16 per cent were in the age group of 40 and above and 54.84% were below 40 years; 25 (80.64%) had education above secondary level and 6 (19.36%) had lower education 18 (53.68%) belonged to families having 6 or more members and 13 (41.94%) to families having 5 or less members; 29 (93.55%) had a land holding of 3 acres and more and 2 (6.45%) had 2 acres or less. This study shows that respondents with more education and large size of holding have a more favourable attitude towards the idea of using Nirodh.

According to Sathapathy et al (1974) the progress of family planning is conditioned by the attitude of people towards it. A study was conducted in Ehubaneswar and Jatani blocks of Orissa to find out the general feelings of the people towards family planning. The Panchayats and villages were selected at random. The total population of these two blocks selected was 2,628 covering 357 farm families. Eighty six respondents covering 24 per cent of the total farm families were selected for study. The respondents were interviewed personally by means of structural schedule. The results of the investigation revealed that all respondents were aware of family planning measures while only 15.1% of the total sample were adopting one or the other type of family planning techniques.

Mouli (1981) conducted a study taking sample of 3200 rural and 2000 urban population in Karnataka and asked if they approved of Medical Termination of pregnancy under six specified circumstances. The answers indicate positive attitude to MTP in both rural and urban areas. Data shows that a greater proportion also approved Medical Termination of pregnancy when the pregnancy is found fatal to the child. It also reveals that 69.7% of males and 64.5% of females approved MTP under such a circumstance.

Gopalakrishnan (1981) states that the population which was covered by the study consisted of 11,000 potential clients who underwent vasectomy operation during the Mass Family Planning Camp at Cannanore. A systematic sample of 140 cases was selected, by including every 80th of the universe, the sampling unit being the acceptor. The average age of the acceptor was 39 years, their marital duration being over 13 years. The majority of acceptors were in the age group of 35 to 39 in all the communities (76.4% Hindus, 13.1% Christians and 10% Muslims). The characteristics of sterilized persons are of great relevance for the progress of the Family Planning Programme, the most important variable in this regard being the age at sterilization.

Jolly and Grover (1971) the sample consisted of 1602 out of 1680 households. Nearly half of the households were nuclear. The average age of the head of household was 22.3 years. The average number of pregnancies was 4.9 and live births 4.5. The total fertility rate was 6.0 live births. The fertility rate was higher for illiterate women, those in joint family, labourers and original residents of the village. About 68% women knew of some birth control method and over 50 per cent women knew of condom and loop. Two thirds of women knew the family planning centre from which to seek advice. Radio was found to be the most

popular media of communication followed by books and magazines and newspapers. Of 27 per cent ever users of birth control methods 20 per cent were current users. Of women with knowledge who had never used family planning method, nearly 84% approved of family planning while 50 per cent expressed the desire to use birth control soon. Of those women who had no knowledge, nearly 85 per cent approved of family planning and 50 per cent expressed the desire to practice a method.

Fifty males were randomly selected in a village of Ludhiana district, Punjab. More than half of the respondents had specific knowledge about methods of family planning and of these more than half were practising birth control. The socio economic status of the respondents was found to be positively and significantly related to the knowledge, attitude and practice of family planning. The knowledge and use of family planning was concentrated in the age group 25-44 (Bhatia, 1970).

A study was conducted taking a random sample of 307 males aged 21-60 with wives in age group 14-45 and with at least one living child, were selected from 8 villages. Sixty four per cent of the sample knew family planning operationally and the rest know it by its actual name. 54% knew about

vasectomy and tubectomy, 35% knew vasectomy only and 9 per cent mentioned vasectomy, tubectomy and loop, 54% respondents in the age group 26-30 and 46.8 per cent in the age group 31-35 had medium knowledge of Family Planning. 47% of illiterates and 77% of those with primary education had medium knowledge of Family Planning while 49% of those with middle school education had high knowledge of family planning (Aaidu, 1971).

A study was conducted taking 396 out of 400 eligible couples by 10% systematic sample from 17 villages. The mean age of the husband and wife worked out to be 35.75 and 30.85 years respectively. Over 40 per cent couples belonged to middle class. Mean living children was 3.41, 21% were owner cultivators, 19.7% in services and 18.69% in business - only 22% of 396 couples had not heard of Family Planning. Of 310 who were aware of family planning, 64% reported that the Family Planning staff as the source of information reasons in favour of birth control were easy rearing of children (mentioned by 31.23%) and economic reasons (25.21%). Major reasons for opposing Family Planning mentioned by 106 persons were, religious objection (25.47%) and objection by husband (18.87) per cent and elders (18.87%), 50% couples wanted to get sterilized after attaining the desired family size (Vora and Khatri, 1971).

Narayan (1972) conducted a study taking randomstratified, proportionate sample of 2,520 households in the city and 1251 in rural Baroda. Sex wise break down of sample worked out to 1,219 males and 1,422 females in urban Baroda. Nearly 77 per cent of urban males and 64 per cent of urban females had heard of family planning methods as compared to 72 per cent rural males and 69% rural females; 58% urban males and 60% urban females, favoured 2 to 3 children with at least a son as compared to 25% rural males and 48% rural females; 44% urban males and 31% rural males had ever practised family planning while 48% urban females and 51% rural females reported practice of natural methods. Higher proportion of knowledge in rural males was found in the age group 15-24 and, 25-34(78.9% each).

David and Bhas (1973) conducted a study interviewing 482 (of the 3000 households selected for the larger survey of the rural population) at Allahabad Agricultural Institute 40% of the respondents had knowledge of contraceptive method 36% males and 4% females were literate. Knowledge of contraceptive methods was significantly and positively related to the level of education. About 32% had knowledge of vasectomy and 28% about IUCD. Knowledge of condoms and oral pills was practically non existent. There was no

significant difference between males and females regarding knowledge of specific methods. Of the 482 respondents, only 3.3 per cent (16) had ever used contraceptives (Vasectomy 8, tubectomy 3, condom 1, IUCD 3, Orals 1).

Marwah et al (1972) conducted a study of a sample consisting of 1,880 females with at least one pregnancy and living with husbands, drawn from a random sample of 10 villages. Ninety seven per cent were Hindus, Literacy was 27.7 per cent and females literacy 8 per cent. For 100 mothers 9.63 abortions were reported. The number of abortions per effective year of marriage was 0.0057, for 1000 life time pregnancies 22.0 and per 1000 live birth 22.6 reported abortions declined after 40 years of age due to memory lapses in reporting and to higher mortality rates 1771 out of 1880 women had no abortion of the 109 who had, 68 had abortion, 21 had 2 abortions, 13 had 3 abortions, 4 had 4 abortions, 3 had 5 and above abortions.

Nagaraj and Shirwadhar (1973) conducted a study of a sample consisting of 1,073 sterilizations, 477 tubectomies and 596 vasectomies. Two thirds of females were 30-39 years old compared to 5 per cent males in the same age group. Thirty per cent females and 42% males acceptors had 1 to 3 children and 60% of the tubectomised women were illiterate and 32.3% of vasectomised men had completed primary school education.

Prasad et al (1970) conducted a study on 124 out of 255 sterilized cases, 84% of the sample wives were very poor (Rs.15 or less monthly income) and 51% were educated up to primary school. Mean age was 30.4 years. Mean number of living children was 4.84. About 71% had not used contraceptives before and of those who had used 15% used condom. (Major source of information about tubectomy 88% cases was operational cases). After effects reported were deterioration in general health reported by 62% better health 8.87% no change 29%, menstrual disorder 39% and marital disharmony (13.71%). Over 89% were fully satisfied with the operation. Only 4% women regretted the operation.

Ratnaraj et al (1970) conducted a study on 100 tubectomy cases admitted to C.S.I Campbell hospital in July and August 1970. The number of tubectomies performed increased from 5 in 1956 to 1,194 in 1969 (each year) 75% cases came from villages more than 10 miles away from the hospital. The sample women had on an average 5.28 deliver and 4.34 living children - Relatives (54%) and husband (25%) were the major sources of information about the operation. Of those knowing operated cases 83% were encouraged to under go the operation, 63% of the cases did not know of

any other birth control method and 20% preferred it for its reliability. Three fourths of the respondents underwent tubectomy as they had enough children and 2% took it for maintaining mother's health.

A survey with 500 rural and 500 urban home makers undertaken by Devadas and Rajalakshmi (1977) revealed that in communities with effective family planning drives majority of urban (94.4%) and rural 93% home makers preferred to have a small family norm for reasons to safeguard the health of the mother and children and to have a better standard of living.

India (1981) states that the primary health centre forms the base of the integrated structure of medical services in the rural areas. At the end of December 1980, 5,499 centres were functioning in the country. The primary health centres and 49,323 sub-centres provide basic medical care to the community through multi-purpose health workers.

III. METHODOLOGY

The steps followed to collect data for the study on the adoption of Family Welfare Measures by selected rural families in Coimbatore District were:

- A. Baseline survey on the extent of adoption of Family Welfare Measures in the rural areas.
- and B. Conduct of the Family Welfare camps in selected villages

A. Baseline survey on the extent of adoption of Family Welfare Measures in the rural areas

1. Selection of the area
2. Selection of the sample
3. Selection of the method
4. Preparation of the schedule
5. Collection of data

1. Selection of the area

Ten villages from the Karamadai Panchayat Union in Coimbatore district were randomly selected for the purpose of the survey (Figure 1). These were selected in consultation with the Family Welfare Bureau, Coimbatore and these were associated with the other research and extension activities of the village.

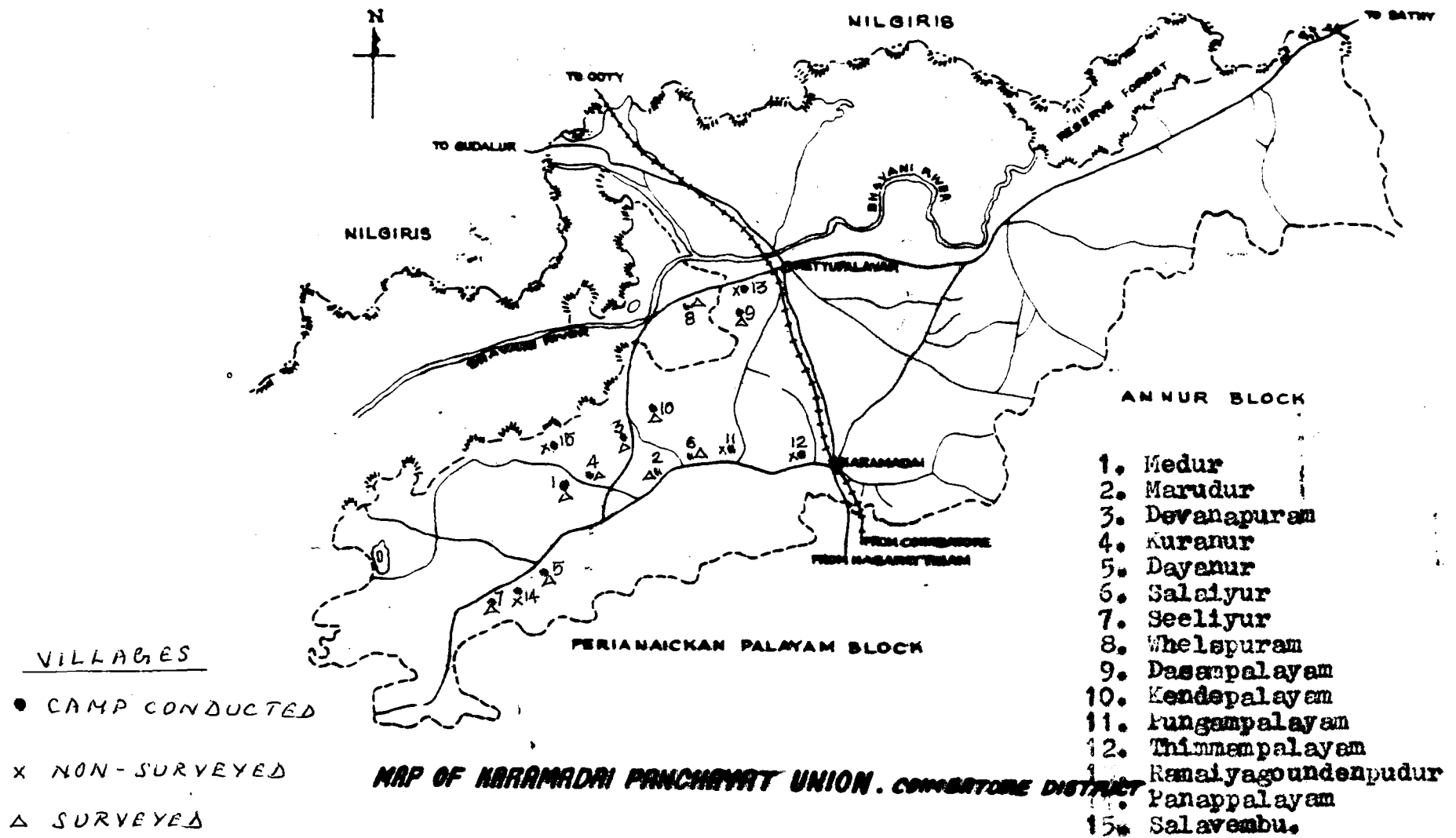


FIGURE 1

2. Selection of the sample

Fifteen married women from each of the 10 villages (total 150) were selected randomly. According to Gupta (1978) in random selection, each and every item of the population has an equal chance of being selected in the sample. A sample selected in this manner would be representative of the population.

3. Selection of the method

The interview is a systematic method by which the person enters more or less imaginatively into the inner life of a comparative stranger (Rangaswamy, 1976). It is a verbal interaction between interviewer and interviewee. The interview method was chosen to collect the data from the selected samples, since many of them were illiterates and no other method could be used effectively, to collect data on delicate matters related to family welfare.

4. Preparation of the interview schedule

An interview schedule including all the details on Family Welfare was prepared so as to call for information on the family background, educational background, occupational pattern, sources of income, expenditure pattern, nutrition and dietary practices, health and sanitary conditions medical

facilities available, extent of help received from officials for family welfare, family planning and general opinion about the programmes. In order to test the suitability of the schedule to elicit the required information it was pretested by administering it on ten samples from two villages, not included in the study. Modifications and improvements were made in the schedule based on the results of pretest. Appendix I, gives the modified schedule used in this study.

5. Collection of data

Good rapport was established with the village leaders and the respondents before conducting the survey through home visits. Then the schedule was administered on the sample after informal talks explaining the purpose of the study.

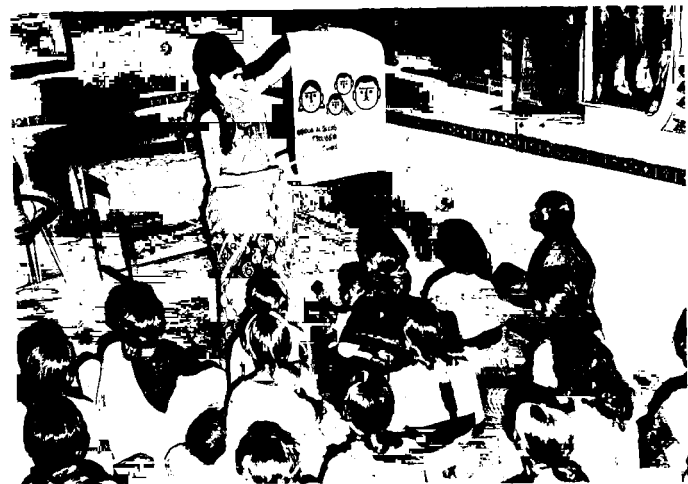
B. Conduct of the Family Welfare camps in selected villages

One day campaigns (16th-30th March, 1983) on Family Welfare were conducted in all the surveyed 10 villages and five other villages (totally 15), with the financial help of the Bharatiya Gramin Mahila Sangh, a national organisation for rural women. Forty (women) between the age group of 20-40 years were the participants from each village who attended these camps. These camps were conducted in the

block Karamadai of Coimbatore District. The family welfare aspects like health, nutrition, sanitation, mother and child care and family planning were the subjects covered in these camps. Informal discussions, exhibitions, film-shows and demonstrations were the method used in these camps (Figure 2). The technical help from the Family Planning Bureau, Coimbatore, Mass Education Office, Primary Health Centre, Block and from the nutrition experts of Sri Avinashilingam Home Science College were received to conduct these camps.

These are discussed in details in the following chapters:

The impact of these camps were assessed in terms of awareness created. Owing to time factor, the extent of adoption of the practices taught could not be assessed.



DIFFERENT ASPECTS OF THE FAMILY WELFARE CAMP

Figure.2

IV. RESULTS AND DISCUSSION

The results of the study are discussed in detail under the heads listed below:

- A. Results of the survey on the extent of adoption of family welfare measures.
- and B. Impact of Family Welfare Camps on the participants

A. Results of the survey on the extent of adoption of family welfare measures

This aspect included the following:

- 1. Socio-economic background of the families
- 2. Nutritional and dietary practices
- 3. Health and sanitation practices
- and 4. Adoption of family planning practices

1. Socio-economic background of the families

Of the 150 families interviewed, 45.3 per cent of the families were found to be Gowders, 23.3 per cent Harijans, 12.6 Boyers and 10 per cent other castes. Kannada was the main language spoken by the majority.

A large majority of 87 per cent were Hindus. Nuclear families were more common, with 85 per cent being in this system.

The educational background of the families is shown in Table I.

TABLE I

EDUCATIONAL BACKGROUND OF THE FAMILIES			
S.No.	Educational level	Percentage	
		Male	Female
1.	Illiterates	33.6	33.8
2.	Primary	31.9	33.5
3.	Secondary	15.8	16.5
4.	Higher Secondary/PUC	8.2	5.9
5.	College	15.5	10.3

One third of the respondents were illiterate requiring programmes of adult education for improving literacy status among the elder generation. On the other hand the fact that 10.3 per cent females were graduates was interesting.

The occupational pattern of the families is given in Table II.

TABLE II

OCCUPATIONAL PATTERN OF THE FAMILIES		
S.No.	Occupation	Percentage
1.	Agricultural coolies	47.5
2.	Agriculturists	19.2
3.	Non-agricultural coolies	16.4
4.	Professionals	11.5
5.	Self-employed	5.4

Agricultural and non agricultural labour was the major occupation for a majority of respondents, followed by agriculture. The other categories of the sample were professionals and self employed.

Table III gives the income pattern of the households.

TABLE III

TOTAL INCOME OF THE FAMILIES		
S.No.	Per capita Income in Rs./Month	Percentage
1.	Up to 100	68.5
2.	101 - 200	15.4
3.	201 - 300	10.1
4.	301 - 400	4.6
5.	401 and above	1.4

The per capita income range of the families shows that about 72 per cent of them had a very poor income and they were found to be below the poverty line.

The expenditure pattern of the families is given in Table IV.



TABLE IV

EXPENDITURE PATTERN OF THE FAMILIES

S.No.	Percentage expenditure	Percentage
1.	Food	Up to 25
		26 - 50
		51 - 75
		76 - 99
2.	Clothing	Nil
		Upto 5
		6 - 10
3.	Shelter	Nil
		Upto 5
		6 - 10
		11 - 15
4.	Education	Nil
		Upto 5
		6 - 10
5.	Health	Nil
		Up to 5
		6 - 10
6.	Transport	Nil
		Upto 5
		6 - 10
7.	Recreation	Nil
		Upto 5
		6 - 10
8.	Savings	Nil
		Upto 5
		6 - 10
		Above 10
9.	Others	Nil
		Upto 5
		6 - 10

Food was the major item in the expenditure pattern as 93 per cent of the families spend over 75 per cent their income on it. Next being transport and health about 95 per cent of the families spend upto five per cent of their income on it. 64 per cent of families does not allot any money for savings.

2. Nutritional and Dietary Practices

A majority of 65 per cent had three meals per day, while the rest 35 per cent had only two meals per day. For 45 per cent of the families rice was the staple cereal and the remaining 55 per cent consumed millets such as ragi, jowar, bajra and maize as the staple foods.

This shows that even the villagers are slowly shifting to rice which is not a good sign in terms of nutrition. Only a combination of cereals would help in attaining good nutrition.

The views of the sample regarding what is a nutritious diet are listed in Table V.

TABLE V

VIEWS OF THE SAMPLE ABOUT NUTRITIOUS DIET

S.NO.	View	Percentage
1.	Use of pulses and cereals	32.0
2.	Use of cereals, pulses, vegetables and fruits	24.0
3.	Use of cereals alone	16.00
4.	Use of pulses, vegetables, fruits and greens	11.4
5.	Use of cereals, pulses and greens	10.0
6.	A combination of all cereals, pulses, vegetables, fruits and greens	6.6

Only a negligible 6.6 per cent could state that a combination of all the food items contributes to a nutritious diet. The others were ignorant about the major components of a balanced diet, pointing out the need for nutrition education.

The frequency of the use of food items by the families is shown in Table VI.

TABLE VI

FREQUENCY OF USE OF FOOD ITEMS

S.No.	Foods	Frequency of use & percentage of families				
		Daily	On alter- nate days	Weekly	Monthly	Rarely
1.	Cereals	100	-	-	-	-
2.	Pulses	71.1	28.9	-	-	-
3.	Vegetables and greens	45.4	48.6	6.0	-	-
4.	Fruits	8.6	31.4	42.6	16.6	8.0
5.	Oil	70.0	28.2	1.8	-	-
6.	Milk	58.6	21.4	5.6	9.9	4.5
7.	Meat, Fish and Poultry	9.9	4.6	6.2	35.6	43.7

All the families used cereals daily, following pulses (77.7%) and oil (70%). Milk (58.6%) vegetables and greens (45.4%) ranked next. Consumption of fruits, meat, fish and poultry was rare.

The methods of cooking adopted by the sample are illustrated in Table VII.

TABLE VII

		METHODS OF COOKING				
S.No.	Food	Methods of cooking				
		Boiling	Steaming	Frying	Stewing	Roasting
1.	Cereals	92	57.3	0.01	-	-
2.	Pulses	90	37.3	-	4	0.01
3.	Vegetables	71.3	52.6	54.6	46	2.6
4.	Greens	54	55.3	37.3	33.3	2.6
5.	Meat	7.3	25.3	76.6	64.6	40.6
6.	Fish	5.3	25.3	70.	74	40

Boiling and steaming were the methods followed by a majority of families for cooking cereals, pulses, vegetables and greens. Cooking water was stated to be strained by a large majority of 99 per cent, which habit needs to be changed.

Regarding the nutrition programme in operation at present, only 79.3 per cent of the interviewees were found to be aware of the Honourable Chief Minister's Nutritious Noon Meal Programme. However only 34.6 per cent of the sample were the beneficiaries of the programme. The beneficiaries stated the reasons for participation as to reduce the food expenditure of the family and to give better food for their children. Sixty eight per cent welcomed the programme while the rest were not satisfied with the programme.

3. Health and sanitation practices

The health and sanitation practices of the families are analysed under the following headings.

- a) Medical facilities available in the villages
and b) Existing sanitation practices in the villages

a) Medical facilities available in the villages

Only 50 per cent were aware of the presence of the Primary Health Centre and its role in giving health care to the people.

The people in the villages were found to resort to different places for medical treatment as revealed in Table VIII.

TABLE VIII

MEDICAL FACILITIES AVAILABLE				
S.No. Facility	No. utilising this facility	Purposes for which utilised and percentage utilising		
		Immunisation/ vaccination	Health check up	Referral services
1. Primary Health Centre (Karanadai)	95	53.6	30.6	15.8
2. Private hospital	73	35.6	52	12.4
3. Government hospital (Mettupalayam)	132	24.3	55.3	20.4

The majority utilised the services of the Government Hospital for health care. The distance between the village and the hospital was two to 12 km. The medical facilities were resorted to, more for curative purposes rather than for preventive measures. Only 77.3 per cent of the families were found to be utilising the facilities for immunisation and vaccination.

Table IX gives the details of immunisation and vaccination done to the children in the selected families.

TABLE IX

IMMUNISATION/VACCINATION DONE TO THE CHILDREN					
Sl. No.	Immunisation/vaccination	No. of respondents	Percentage of families utilising		
			Primary Health Centre	Private Hospital	Government Hospital
1.	B.C.G.	102	47	23.5	29.5
2.	DPT	97	47.4	18.6	34
3.	Small Pox	69	60.7	17.4	21.9
4.	Measles	58	53.5	24.1	22.4

No doubt the steps taken by the government were found to be reaching the rural mass who live in remote areas. The above table shows that majority of them had been immunised against BCG(87.9%) and DPT(83.6%) utilising mainly the primary health centre for this purpose.

b) Existing Sanitation facilities in the villages

Table X points out the existing sanitation facilities in the villages.

TABLE X

SANITATION FACILITIES IN THE VILLAGES

S.No.	Sanitary facilities available	Percentage stating
A. <u>In the houses</u>		
1.	Lavatory facilities	10.6
2.	Facilities for disposal of waste	80.0
3.	Garbage	80.0
4.	Drainage	65.3
	Sewage	10.0
	Sullage	3.3
B. <u>In the villages</u>		
1.	Drainage	64.0
2.	Sweepers to clean the streets	40.0

As for sanitation in the households, only 10.6 per cent respondents stated that lavatory facilities were available in their houses. For 80 per cent garbage disposal facilities were available and for 65 per cent drainage facilities.

With regard to sanitation facilities in the villages 64 per cent respondents mentioned about drainage facilities and 40 per cent, the availability of sweepers for street cleaning. This points out that the villages have to go a long way in the direction of provision of sanitation facilities.

Table XI indicates the extent of help received from the officials with regard to health.

TABLE XI

HELP RECEIVED FROM OFFICIALS						
Sl. No.	Help received	Officials giving help and percentage of families standing them				
		PHC Doctor	Health visitor/AMM	Rural welfare officer (Women)	Extension Officer for social welfare	Rural Welfare Officer (men)
1.	Attention during sickness	4.6	-	-	-	17.3
2.	Giving immunisation/vaccination	-	23.3	-	-	-
3.	Motivating the women to adopt family planning	-	-	9.3	16.6	23.3
4.	Training balas-vikas in health care	-	-	9.3	14.6	-
5.	Implementing health programmes	-	-	4.8	2.2	-

The health visitor and the block personnel officer for Social Welfare and Rural Welfare Officer (Women) were the major officials involved in health care delivery. The services were offered in the village itself. Only 12 per cent of the sample stated that they visited these officers.

4. Adoption of Family Planning Practices

This aspect is discussed under the following headings:

- a) Years of married life
 - b) Age at marriage
 - c) Size of the families
 - d) Sources of information about family planning
 - e) Adoption/non adoption of family planning
 - f) Reasons for adoption/non adoption
 - g) Knowledge of the selected sample about population
 - h) Suggestions for the future improvement of the programme
- a) Years of married life

Table XII gives the years of the married life for the sample.

TABLE XII

YEARS OF MARRIED LIFE		
S.No.	Years of married life	Percentage
1.	Up to 5	30
2.	6 - 10	27
3.	11 - 15	17
4.	16 - 20	16
5.	20 and above	10

About 57 per cent of the sample had got married within the past ten years.

b) Age at marriage

The age of the selected couples at the time of their marriage is as given in Table XIII.

TABLE XIII

AGE AT MARRIAGE

S.No.	Age at marriage (in years)	Percentage
1. <u>Wife's age at marriage</u>		
	10 - 15 years	4.6
	16 - 20 years	74.6
	21 - 25 years	19.4
	26 - 30 years	1.4
2. <u>Husband's age at marriage</u>		
	16 - 20 years	13.3
	21 - 25 years	51.3
	26 - 30 years	30.0
	31 - 35 years	5.4

Seventy five per cent of the women respondents got married between 16 - 20 years, while 51 per cent of the men got married between 21 - 25 years and 30 per cent between 26 and 30 years.

c) Size of the families

The number of members in the families is mentioned in Table XIV.

TABLE XIV

NUMBER OF FAMILY MEMBERS		
S.no.	Number of family members	Percentage
1.	Two	4.6
2.	Three	17.3
3.	Four	23.3
4.	Five	39.3
5.	Six	9.5
6.	Six and above	6.0

Nearly 80 per cent of the families had three to five in number, which is moderate. The average size of the households ranged from 4.6 to 6.8 in the different villages.

Table XV shows the number of children in the selected families.

TABLE XV

NUMBER OF CHILDREN IN THE FAMILIES		
S.No.	Number of children	Percentage
1.	One	19
2.	Two	41
3.	Three	19
4.	Four	6
5.	Five	3
6.	Six	1

A large majority of 79 per cent had one to three children pointing out the impact of family planning programmes in the rural areas.

d) Sources of Information about family planning

All the members interviewed were aware of family planning programmes but only 68 per cent of them were found to be favouring the idea.

Table XVI gives the sources of information about family planning.

TABLE XVI

SOURCES OF INFORMATION

S.No.	Sources of information	Percentage Stating N: 40	
1.	Filmshows	30	75
2.	Radio	26	65
3.	Extension workers	26	65
4.	Newspaper	18	45
5.	Neighbours and friends	17	42.5
6.	Posters	15	37.5
7.	Primary Health Centre	7	17.5
8.	School Teachers	2	5

Mass media such as filmshows, radio, newspapers and posters had a very good effect on the rural people, as revealed by 75, 65, 45 and 37.5 per cent of the respondents respectively.

Only 35 out of the 150 respondents (23.3 per cent) stated the officials as the sources of information, while 42.5 per cent were influenced by personal localite sources such as neighbours and friends.

Table XVII reveals the awareness of the sample about the methods of family planning.

TABLE XVII

AWARENESS OF THE RESPONDENTS ABOUT THE METHODS OF FAMILY PLANNING

S.No.	Awareness of the methods	Percentage(N:150)
1.	<u>Sterilization</u>	
	a) Vasectomy	66
	b) Tubectomy	66
2.	Laproscopy	12
3.	Condoms	9
4.	Contraceptive pills	7

The majority (66 per cent) of the samples were aware of the permanent method namely sterilization, both vasectomy and tubectomy. Only 12 per cent were aware of the recently introduced laproscopy.

e) Adoption/Non Adoption of Family Planning

Only 40 (26.7 per cent) had adopted one or the other methods of family planning and the rest 73.3 per cent were the non-adopters of family planning in this study. The details of the adoption of family planning are given below in Table XVIII.

TABLE XVIII

DETAILS OF THE ADOPTION OF FAMILY PLANNING

S.No.	Methods	No. of families	Person adopting (in percentage)	
			Wife	Husband
1.	Sterilization	36	77.7	22.3
2.	Laprosocopy	4	100	-

The latest method being laprosocopy had been adopted only by four women and sterlization had been adopted by 28 women and eight men. More publicity should be given to laprosocopy as it has many advantages, like ease in adoption, less expensive and more number can be covered at a short time.

f) Reasons for Aoption/Non-adoption

The reasons given by the sample for their adoption and non-adoption of family planning are mentioned in Table XIX.

TABLE XIX.

REASONS FOR ADOPTION AND NON-ADOPTION				
S.No.	Adoption	Percentage stating	Non-adoption	Percentage stating
1.	To have better living	87.5	Want of more children	42.7
2.	To give proper care to children	22.5	Want of male child	21.8
3.	To have improved health conditions for the mother	12.5	Fear about the after effects	6.3
4.	To have small families	5	Religious barrier	4.5

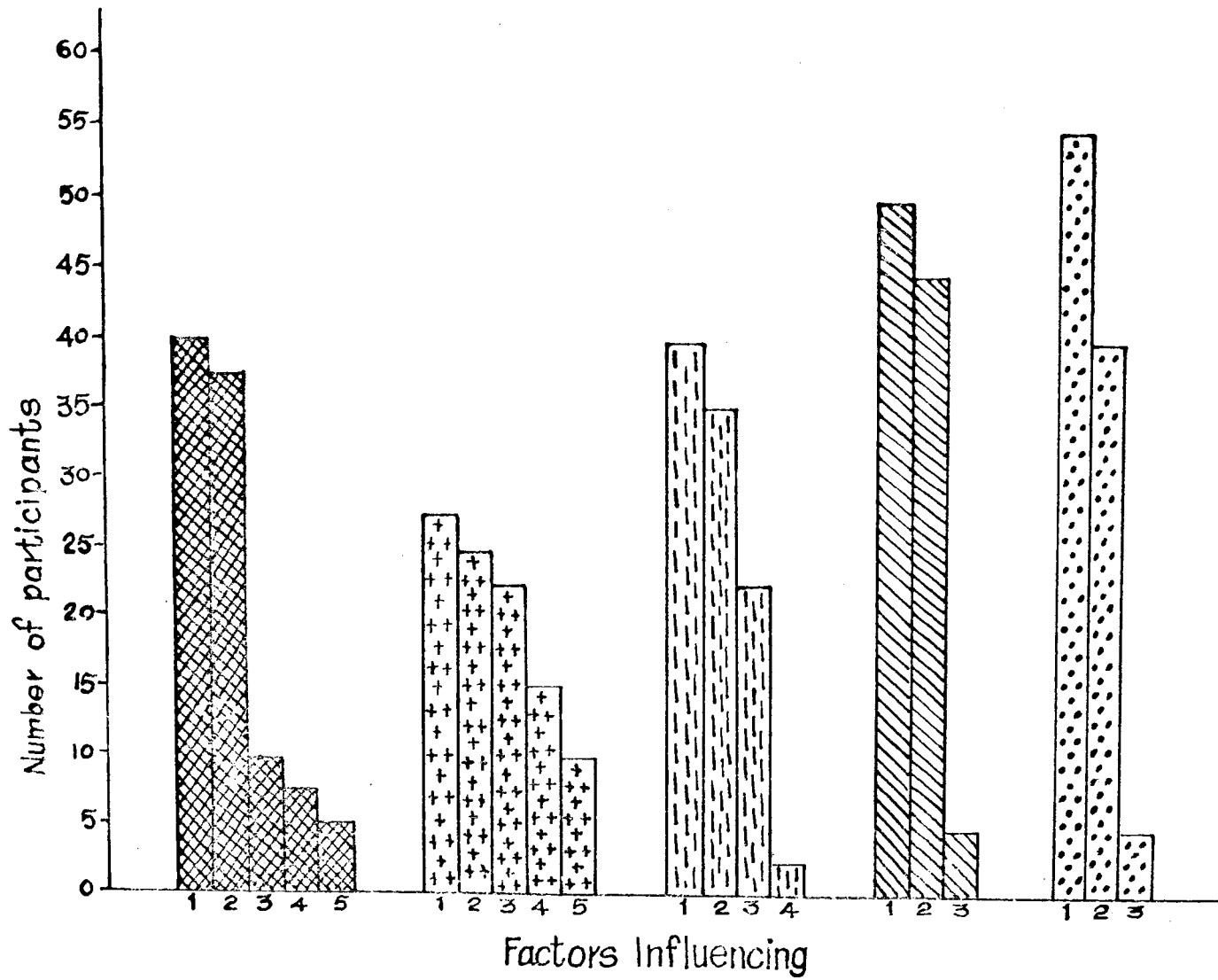
Those who had adopted family planning were in a position to justify their decision, such as, for better living, concern for the welfare of existing children and health of the mothers. The reasons given by non adopters were in tune with the social and cultural set up of the Indian rural society. To make people adopt family planning, the stigma attached to such non-adoption should be removed through population education, motivation, more propaganda to reach even the remote areas, and conduct of more campaigns on family planning to remove the psychological, social and religious barriers.

An attempt was made to correlate certain socio economic factors with the adoption of family planning (Table XX).

Table XX and Figure 3 tries to exhibit how the various factors such as education, occupation, income, age and number of children had influenced the adoption of family planning.

TABLE XX

FACTORS INFLUENCING THE ADOPTION OF FAMILY PLANNING			
S.No.	Family	Number of members	
		Adopters (N=40)	Percentage of Adopters
1. <u>Education</u>			
	Illiterate	15	37.5
	Primary	16	40
	Secondary	4	10
	Higher Secondary	2	5
	College	3	7.5
2. <u>Occupation</u>			
	Agricultural coolie	10	25
	Agriculturists	4	10
	Non Agricultural Coolie	11	27.5
	Professional	9	22.5
	Self employed workers	6	15
3. <u>Per capita income</u>			
	Up to 200	22	55
	201 - 400	16	40
	401 - 600	2	5
4. <u>Age</u>			
	21 - 30	20	50
	31 - 40	18	45
	41 - 50	2	5
5. <u>Number of children</u>			
	1 Child	--	--
	2 Children	9	22.5
	3 Children	14	35
	4 Children	16	40
	5 Children	1	2.5
	6 Children	-	-



FACTORS INFLUENCING THE ADOPTION OF FAMILY PLANNING

Education

- 1. Primary
- 2. Illiterate
- 3. Secondary
- 4. College
- 5. Higher secondary

Occupation

- 1. Non-agricultural coolie
- 2. Agricultural coolie
- 3. Professional
- 4. Self employed workers
- 5. Agriculturists

Number of children

- 1. 4. children
- 2. 3. children
- 3. 2. children
- 4. 5. children

Age

- 1. 20-30 - 50
- 2. 31-40 - 45
- 3. 41-50 - 5

Per capita Income

- 1. Upto 200-55
- 2. 201-400-40
- 3. 401-600-5

Figure. 3

The above table reveals that majority 62.5 per cent of the families being literates have adopted family planning. About 52.5 per cent of the coolies both from agriculture and non-agriculture have done family planning. A majority of 95 percent of the families adopted had percapita income below Rs.400. About 50 per cent of the adopters had done it between the age of 20-30 years. Seventy five per cent of the adopters were found to have children more than two. The factors influencing the adoption of family planning were found to be literacy level, low income, age and more children in the family. The incentives received were in terms of cash i.e. Rs.150 for laproscopy and Rs.100 for sterilization. According to 70 per cent of the adopters the incentives were not satisfactory. The problems as mentioned by the adopters were uterus trouble, excess of bleeding and less of capacity to do work.

g. Knowledge of the sample about population explosion

It is encouraging to learn that 83 per cent of the sample was aware of the fact that the population of our country is very high.

h. Suggestions given by the sample for the future improvement of the programme

The suggestions as given by 46 respondents, for the improvement of the programme are given in Table XXI.

TABLE XXI

SUGGESTIONS FOR IMPROVING THE PROGRAMME		
S.No.	Suggestions	Percentage of Families (N=46)
1.	More publicity on family welfare methods	36.9
2.	More number of officials should be involved	36.9
3.	Mass media such as radio and filmshow should be utilised properly	32.6
4.	New inventions (like laproscopy) which are easy to adopt should be introduced	21.7
5.	Incentive should be increased	19.6
6.	Provision of medical facilities to overcome after effects	17.3

For 104 persons no suggestion was available to give as it shows their ignorance about the population problem. The other suggestions were more publicity of family welfare methods, involvement of more number of officials publicity through mass media such as radio and filmshows, introduction of new inventions (like laproscopy) which are easy to adopt, increased amount of incentive and availability of medical facilities which are found to be note worthty and should be taken into consideration for future plans.

The fact that 104 respondents could not give any suggestion revealed the ignorance prevailing in the rural areas. However, the suggestions, though given only by a small proportion of the sample (46) were worthy of consideration by the officials concerned.

The persons to be educated on population control as suggested by the sample are listed in Table XXII.

TABLE XXII

PERSONS TO BE EDUCATED ON POPULATION CONTROL

S.No.	Persons	Number of sample stating	N=124 percentage
1.	Both parents	70	56.5
2.	Mothers	64	51.6
3.	Entire village	49	39.5
4.	Youth(13-25 years)	13	10.4
5.	Children	9	7.3

Whether they had adopted or not, the respondents could offer their frank views as to who should be educated on population control. The fact that a few mentioned that youth and children should also be educated on family planning indicates the positive trend in the rural areas.

B. Impact of the family welfare campaigns

Table XXIII points out the views of the women who attended the one day family welfare campaigns organised, in terms of acquisition of knowledge, attitude and practices.

TABLE XXIII

EXTENT OF KNOWLEDGE, ATTITUDE AND SKILL GAINED

S.No.	Impact	Percentage (N: 600)
<u>Knowledge</u>		
1.	Family planning methods	80.8
2.	Nutritious diet	61.6
3.	Health and sanitation	55.8
4.	Immunisation/vaccination	53.5
5.	Mother and child care	51.2
<u>Attitudes</u>		
1.	Towards adoption of health and sanitation practices	71.3
2.	Towards adoption of family planning	65.2
<u>Skill</u>		
1.	Preparing infant weaning foods out of low cost, indigenous food stuffs	36.8

The impact of the one day campaigns had made on the rural women was tremendous, considering the poor socio economic and educational background of the people and the short duration of the campaign.

The impact was mainly in terms of awareness building and development of desirable attitudes. However, skills in the preparation of low cost supplementary foods were started to be acquired.

If sustained efforts are made, no doubt the rural women could be motivated to adopt desirable family welfare measures.

V. SUMMARY AND CONCLUSION

A study on the Adoption of Family Welfare measures by the selected rural families in Coimbatore District was carried out with a randomly selected sample of 150 homemakers in 10 villages of Karamadai, Panchayat Union, Coimbatore District. Efforts were made to educate the rural women on family welfare through one day campaigns. The findings of the study are listed below:

1. Socio economic profile

- a) A large majority of 87 per cent were Hindus.
- b) Kannada speaking Gowders were the dominant caste among the sample.
- c) Eighty five per cent of the sample belonged to nuclear type of families.
- d) The educational background as usual was as similar as any of our rural area, the mass being illiterates. While 34 per cent were illiterates there was evidence for the youth going for higher education, denoting the changing trends.
- e) Majority belonged to the category of Agricultural and non-agricultural labourers.
- f) A large majority of 88 per cent families had percapita income below Rs.200/- per month.
- g) Food was the major item in the expenditure pattern as 93 per cent of the families spent over 75 per cent of their income on it.

2. Dietary practices

- a) Only 65 per cent had three meals per day, while the rest had a two meal pattern.
- b) For 45 per cent of the families, rice was the staple cereal while for the rest 55 per cent, millets such as regi, jowar, bajra and maize were the staple foods.
- c) Cereals were the only items used daily by all the families.
- d) The knowledge of the sample regarding nutrition was inadequate that only 6.6 per cent could state that a combination of all the food items constitutes a nutritious diet.
- e) The families were found to be adopting different methods of cooking for different types of foods, boiling and steaming being the major methods.

3. Health and sanitation

- a) The people in the villages were found to resort to different places for medical treatment. A large majority utilized the services of the government hospital at Mettupalayam and Primary Health Centre at Karamadai.
- b) The samples were found to be aware of the immunisation/vaccination given for the children. The services were utilized for vaccination and immunisation.
- c) The block officials (Extension Officer for Social Welfare) and Rural Welfare Officer (Women) were the sources of help in the area of health, in addition to health personnel.
- d) Only 10.6 per cent of the samples had lavatory facilities in their houses.
- e) As for disposal of waste 80 per cent could mention facilities for disposal of garbage while 65.3 per cent stated drainage facilities.

4. Family planning

- a) Seventy nine per cent of the women got married between the years 11 and 10 and 65 per cent of the men got married between the ages 16 and 25 years.
- b) The number of family members in the majority of the families were three to five. The number of children for 79 per cent respondents ranged from one to three.
- c) Mass media of communication such as filmshow, radio and newspaper were found to be the major sources of information on family planning. The extension workers also had some role to play in this regard.
- d) Of the 150 samples interviewed, only 40 (26.7 per cent) were found to be the adopters of family planning.
- e) Of the adopters 80 per cent of the women and 20 per cent of the men had undergone tubectomy and vasectomy operations respectively. Only 20 per cent of them had undergone laproscopy, the technique recently introduced.
- f) The reasons for acceptance of family planning were, desire for a better living and concern about the children already born, in addition to the health of the mothers.
- g) Want of more children and also want of male child were the reasons for non-adoption besides fear about after effects.
- h) For 70 per cent of the adopters, the incentives given were not satisfactory.
- i) Eighty three per cent *felt* that the population of our country was high and pointed out that serious action should be taken to control the same.

- j) Regarding the suggestions for future improvements, about 104 of them could not give any suggestions. The suggestions as given by only 46 respondents were more publicity to the programme, more officials to work for the programme, adequate use of mass media, introduction of innovations like laproscopy which easy to adopt, increased amount of incentives and sufficient provision for medical care for the adopters.
- k) The respondents opined that the fathers, mothers, youth and the entire population should be given education on population in order to have a purposeful check on the increase of population.

5. Impact of one day campaigns

The one day family welfare campaign were attended by the rural women. It had good impact in terms of awareness building and development of desirable attitudes and to a certain extent, acquisition of skills.

Recommendations

On the basis of the study conducted the following recommendations are offered, for consideration by the officials concerned.

1. The age of the marriage both for men and women should be raised, that the women should get married only after 20 years and the men after 25.
2. Population Education can be started even at the school level so that our future generation can have an exposure to these problems and plan their families at the proper time.

3. More publicity should be given to mass media so as to reach even the remote areas of the country. Free medical facilities and free education to children may be given as incentives to limit the family.

and

4. The family planning programme should be integrated with nutrition, health, child care, sanitation and other such programmes, in order to have a wholistic approach to reach the target population.

R E F E R E N C E S

BOOKS

Agarwala, S.M.
1972

India's Population Problems -
Tata McGraw Hill Publishing Co,
Ltd., New Delhi, Pp.1, 2, 40, 41.

Balakrishna, S.
1972

A sample survey in Andhra Pradesh
Family Planning - Knowledge,
Attitude and Practice - Published by
National Institute of Community
Development - Hyderabad P.32.

Chandrasekhar, S.
1972

Population Growth, Infant Mortality
and Family Planning - Infant Mortality
and Population Growth and Family
Planning in India - Printed in
Great Britain in 10 on 11 Pointcut
Times New Roman by Alden and Howbray
Ltd., at the Alden Press, Oxford, P.81.

Devadas, R.P.
1978

Relevance of Family Size and Child
spacing to Family Well Being popu-
lation Education in Rural Development
Government of India - Ministry of
Agriculture and Irrigation Department
of Rural Development, New Delhi P.51.

Gupta, S.P.
1978

Statistical Methods, New Delhi,
Sultan Chand and Sons, Pp.4, 7.

Gopal Rao, D.
1974

A unit lesson plan of population
Education, Population Education - A
guide to curriculum and Teacher
Education Sterling Publishers, Pvt.
Ltd., New Delhi - 100 016 P.19.

Jellyker and
Grover, S.R.
1971

Fertility and Family Planning in
Chandrawal "A village in the Delhi
Metropolis, Demographic Research
Centre Delhi, Pp.42.

Matras, J.
1977

Introduction to Population - A
Sociological approach - Published by
Prentice Hall, Inc., Englewood Cliffs,
New Jersey 07632. Pp.32.

Mattiyal, S.D.
1976

Population growth and Small Farmer
Population Education in Rural Develop-
ment - Tata McGraw Hill Publishing
Co., Ltd., New Delhi, P.47.

Rangaswamy, R.P.
1976

Tools for Collecting Data - Interview - A Hand book of Methodology of Research, Coimbatore, Ramakrishna Mission, Vidhyalaya Teachers College, Pp.94.

Siddh, K.K.
1974

Family Planning. The Religious Factor. Abhinav Publications. New Delhi, P.67.

Thompson and
Lewis
1972

"Population Growth in the Modern World" - 1650 - 1930" Population Problems - Published by Tata McGraw Hill Publishing Co., Limited Pp.411, 417, 418.

Urianis, B.T.
1978

"World Population Growth", The Theory of Population - Essays in Marxist Research - Progress Publishers-Moscow, Pp.7, 8.

Year Book
1975-76

Based on data in Family Welfare Programme in India, Government of India, Ministry of Health and Family Welfare, Department of Family Welfare, New Delhi, Pp.45.

REPORTS

Devadas, R.P.
1974

Social and Economic dimensions of nutrition, Proc. Nutr. Soc. India, No.17, 1974, Pp.66,72.

Devadas, R., and
Rajalakshmi, R.
1977

A study on the motivational factors in limiting the size of the family, 1977. A thesis submitted to the University of Madras for the Degree of Doctor of Philosophy, Pp,14, 15.

India - A Reference
Annual
1981

"Land and the People" Research and Research Division Ministry of Information and Broad casting government of India. Pp 6, 7.

Vora, V.D. and
Khatri, T.D.
1971

A Study on knowledge, attitude and practice of eligible couples of Banaskantha district towards Family Planning - Report series No.1, Family Planning (F.P. No.5) Pp.17. 18.

Anand, B.S.
1981

"Rapid Recovery" in the Family Planning Programme" - Centre Celling - Vol.XVI No.12, Dec. 1981 - Published by - Temple Lane, Kotla Road, New Delhi, p.16.

Beulson, B.
March 1976

"Population Control" - The Journal of Family Welfare, Vol.XXII No.3, Published by Family Planning Association of India, Nariman Point, Bombay, P.3.

Bhatia, J.C.
March 1970

Rural Health Research Centre, Meerangwal "Prevalent knowledge and attitude of males towards Family Planning in a Punjab village". The Journal of Family Welfare, 26, 3, March 1970, Ludhiana District (Punjab,) P.14.

Bland, J.
1982

"Promotion of Environmental Health" WHO Chronicle - 3 Vol.36, No.3, World Health Organisation, Geneva, Pp.85, 128.

Bland, J.
April 1981

World Health - The magazine of the World Health Organization, WHO Av.Appic. 1211, Geneva, 27, Switzerland, P.13.

Bland, J.
July 1981

World Health - The magazine of the World Health Organization, World Health, WHO, Av. Appic. 1211, Geneva 27, Switzerland, Pp.31.103.

Chatterjee
July 1982

"Health and Nutrition" - Yojana Vol.XXVI, No.24, Publications Division, Patiala House, New Delhi, Pp.30, 31.

Chaurasia, A.R.
Sept. 1982

Correlates of social and health status with family planning performance in India - The Journal of Family Welfare - personal, Marital and Sociological, Vol.XXIX, No.1, Published by Family Planning Association of India, Bajaj Bhavan, Nariman Point, Bombay 400021(India) P.21.

Churchill, B.P.
1981

India population growth in the 1970's population and Development Review, Vol.7, No.2, June 1981. Printed in USA, Library of Congress Catalog card, Number 75-27311. ISSN 0098 - 7921, Pp.326-327.

David, K.H. and
Bhas, M.
Dec. 1973

Knowledge of contraceptive methods in rural area", The Journal of Family Welfare 20, 2 (Dec. 1973) Pp. 379.

Fikry, M.O.
April 1981

Nutrition and the elderly -World Health - The magazine of the World Health Organization. World Health, Who, AV. Appie, 1211, Geneva 27, Switzerland, P.13.

Ghosal, B.C.
April 1981

Health Education in Primary Health Care" Swasth Hind -March Issued by the Central Health Education Bureau, Kotta Marg, New Delhi 11002. Pp. 37.

Gopalakrishnan, T.D
March 1981

The Journal of Family Welfare personal, Marital and sociological Vol XXVII No.3, Published by FPAI. Bajaj Bhawan, Nariman Point, Bombay 400021 (India) P, 24.

Indira Gandhi,
June 1976

"Family Welfare programme. SWASTH HIND. Vol IX, No,6, Published by - Central Health Education Bureau, Kotta Marg, New Delhi, 110 001. p.163.

Indira Gandhi,
Aug 1981

need for national consensus on family planning. Swasth Hind. Vol, XXV. No, 3, Issued by Central Health Education Bureau, Kotta Marg, New Delhi 110 002. Pp. 22.

Juneja, R.
Oct 1981

Family welfare programme in India,
Kurukshetra, Vol. XX No.2,
Published by the Director, Publications
Division, New Delhi. 110 001. P.21.

Karen, S.
July 1976

Population, poverty and the future,
of India-Yojana, Vol XX No. 11,
New Delhi, 10, Karmasthik
Asadha 1993, pp.33,34.

Kavoori, J.C.
May 1981

"Integrating population Education
with Adult Education", Indian Journal
of Adult Education, Vol 42, No.5, Pub-
lished by Dharm virfor Indian
Adult Education Association 17-B,
Indraprasth Marg, New Delhi 110 002.
pp. 11,12.

Marwah, M.S.M.
1972

Abortion prevalence in Rural
Community - Indian Journal of
preventive and social medicine,
3,2 (June 1972). Varanasi District,
pp.16.

Murthy, G.V.J
1976

"Family planning and the New
population Policy"- Yojana Vol XX.
No.16, New Delhi 15-30 sept 1976.
16 Bhadra, 1993, pp. 22.

Murthy, R.
July 1979

Population control in the third
World" Kurukshetra, Vol. XXVII,
No.19-P.25.

Nagraj, B.S. and
Shri walker. P.S
1973

"A study of sterilized cases in
South Kanara District, the journal
of Family welfare, 20 1 (Sept.1973).
pp.22-25.

Haidu, N.Y.
Sept.1971

"Knowledge and approval of Family
planning as correlated to some
characteristics of rural respon-
dents". The journal of Family
Welfare, 18.1, 74-80- pp.

NarayanDas,
Sept 1972

"Factors related to knowledge
Family size preference and pra-
ctice of Family Planning in India,
The Journal of Family Welfare,
19, 2, Pp.40, 45.

Parthasarathy,
April 1981

Health For All: An Alternative
strategy-Swasth Hind March
Vol XXI, No.2, Issued by the Central
Health Education Bureau,
Kotla Marg, New Delhi, 110 002. p.17,

Parvathi, R.
June 1977

"Family size and Growth of the
Child" SWASTH AHIND Vol XXI.
No.6 Published by -Central
Health Education, Bureau, Kotla
Marg, New Delhi, 110001, Pp. 175.

Prasada B.C.
Aug 1970

"Health for All: An Alternative
strategy" SWASTH HIND- Issued by
the central Health Education
Bureau, Kotla Marg, New Delhi,
110 002. Pp. 7.

Ramalingaswamy, V.
Jan -Feb 1981

Health for all: An alternative
strategy, swasth HIND, Issued
by the central Health Education
Bureau, Kotla Marg, New Delhi. 110 002.
P.7.

Ratnaraj et al.,
Nov. 1970

"A Tubectomy programme, Rural
Andhra Pradesh" Journal of
Christian Association of India,
45, 11 628-635 Rural Andhra
Pradesh, Pp.37,38.

Roorich, D.R.
Nov. 1981

"World population Growth" Centre
Calling -vol XVI No.11, published
by Temple Lane, Kotla Road,
New Delhi Pp.21.

Saas, J.L.,
Nov. 1981.

Centre calling - Vol XVI, No,11,
Nov. 1981-Publishing by-Temple Lane,
Kotla Road, New Delhi P.7.

- Saas, J.L.
Nov. 1981
- Centre calling - Vol XVI.No.11
Published by Temple Lane,
Kotla Road, New Delhi, P.7.
- Saas, J.L.
Jan 1982
- "Family Planning" Vol XVII No.1
Jan. 1982 Published by Temple Lane,
Kotla Road, New Delhi P.4.
- Shabbir, S,
Nov 1976
- "Family Welfare Programme",
Yojana vol.XX No, 20, New Delhi
15-30 Nov. 1976, 24 Kartika,
1998, Pp: 25, 26.
- Srinivasan, P.
March 1976
- "Decade of progress in Health
and Family Planning", Kurukshetra
Vol, 24, No,12, phatgans 26,
1867, P.6.
- Srinivasan, P.
March 1977
- 'Population problems'
Kurukshetra, Vol 25, No, 11,
Published by the Director
Publications Division, New Delhi
P. 11.
- Saha, G.and
Mirmal Kanti Saha.
Dec. 1975
- Attitude towards Family Planning
Kurukshetra, Vol XXIV No 5,
Published by the Director,
Publications Division, New Delhi
100 001. P.13.
- Wadia, A.B,
March 1976
- Values and their effects on attitudes
towards family planning-the journal
of Family welfare, Vol XXII, No3,
published by Family planning
Association Of India,
Marina Point, Bombay. P.16.
- Wadia, A.B.
March 1981
- "Knowledge and practices of Family
planning methods " The Journal of
family welfare personal, marital and
sociological, Vol, XXVII No.3,
Published by Family planning Asso-
ciation of India, Marina Point,
Bombay, Pp. 38.
- Wankuri, V.B.
Dec. 1982
- World Health, The Magazine of the
world Health organisation, WHO,
AV, Appia, 1211, Geneva 27,
Switzerland. Pp.10.

A P P E N D I C E S

**SCHEDULE TO ELICIT INFORMATION REGARDING THE ADOPTION OF
FAMILY WELFARE MEASURES BY SELECTED RURAL
FAMILIES**

Name of the Interviewer:

Date:

Name of the Interviewee:

Date:

Address:

Religion:

I. 1. Family Background

Sl. No.	Relation-ship to the head of the family	Age	Sex	Marital status	Ednl level	Occupation	Income/Month

2. Other sources of Income:

S.No.	Item	Income/Month in Rs.	Total family income / Month

3. Expenditure pattern

S.No.	Items of expenditure	Amount per month Rs. Ps.
1.	Food	
2.	Fuel	
3.	Clothing	
4.	Shelter Rent	
	Maintenance and repair (if own house)	
5.	Education	
6.	Health	
7.	Transport	
8.	Recreation	
9.	Festivals	
10.	Savings	
11.	Others (specify)	

II. Nutrition and Dietary practices:

1. Give the number of meals you have in a day.
2. What is the staple cereal?
3. Which are the foods which you take in a new state?

Reasons:

4. What according to you is a nutritious diet?

Use of Cereals

Use of greens

Use of pulses

Use of vegetables & fruits

a combination of the above

5. Frequency of use of food items

S.No.	Food Items	Days	Frequency of use			
			On alter- nate days	Weekly	Monthly	Rarely
1.	Cereals					
2.	Pulses					
3.	Vegetables					
4.	Fruits					
5.	Oil					
6.	Milk					
7.	Condiments					
8.	Meat, Fish, Poultry					
9.	Others (Specify)					

6. Methods of cooking

S.No.	Foods	Boiling	Steaming	Frying	Stewing	Baking	Roasting
1.	Cereals						
2.	Pulses						
3.	Vegetables						
4.	Greens						
5.	Meat						
6.	Fish						
7.	Others						

7. Do you strain cooking water?

Yes No

If yes,

From cereals

From vegetables

From others (Specify)

Reasons:

8. Is there any nutrition programme in operation in your village?

Yes No

9. If yes, give details

Where conducted	Name of the Programme	Sponsors	Beneficiaries	Remarks
-----------------	-----------------------	----------	---------------	---------

Balwadi

School

PHC

Others
(Specify)

10. Have you participated in any such nutrition programme?

Yes No

Reasons:

11. Training undergone in nutrition:

S.No.	Sponsors	Where conducted	When attended	Items taught	Follow up
-------	----------	-----------------	---------------	--------------	-----------

1. Sri Avinashilingam
Home Science College

2. K.V.K.

3. Extension Officer
for Social Welfare4. Rural Welfare
Officer(Women)

5. Others (specify)

III. Health and sanitary conditions:

1. Prevalence of communicable diseases:

Diseases affected your family during the past one year	Person affected	Consequence	How treated or protected
--	--------------------	-------------	-----------------------------

2. Have your children been protected from diseases?

Yes No

3. If yes, give details

Immunisation/ vaccination	Diseases/against which protected	Age at which given	Where done
------------------------------	-------------------------------------	-----------------------	------------

B C G

D P T

Smallpox

Vaccination

Measles vac-
cination

Others

4. Medical Facilities Available:

Facilities	whether available in the village	If not in the village, near by place available	Distance	How utilized
------------	----------------------------------	--	----------	--------------

Primary health Centre

Private Hospital

Govt. Hospital

Others(Specify)

5. Is there any doctor who is staying in the village itself?

Yes

No

6. If no, at times of emergency how do you overcome the situation?

7. Is there any lavatory facility in your house?

Yes

No

8. If yes,

Borehole latrine

Basket system

French latrine

Flush out

9. How do you dispose the waste?

Sewage

Garbage

Sullage

Drainage

10. Is there any sanitation/Drainage facility available in the village?

Yes NO

11. If no, How do you dispose the waste water?

12. Are there any sweepers who come to sweep the village?

Yes NO

If yes, specify the agency which sends them:

13. Have you received any prophylactic treatment?

Yes NO

14. If yes, give details:

<u>Prophylactic Treatment</u>	<u>Deficiencies against which protected</u>	<u>To whom given</u>	<u>Where done</u>
-------------------------------	---	----------------------	-------------------

Vitamin A.

Ferrous sulphate

Others

15. Extent of help received from officials for your family welfares

S.No.	Officials	Help rendered	Frequency of visit to your village	Whether you go to their office
1.	PHC doctor			
2.	Gram sevak (Rural Welfare Officer men)			
3.	Mukhya Sevika (Ext. Officer S.W.)			
4.	Gram Sevika (Rural Welfare Officer women)			
5.	Health visitor/ANM			
6.	Sanitarian			
7.	Others (Specify)			

IV. Family planning:

1. When did you get married?

Wife's age at marriage:-

2. How many children have you got?

No of children :

Boys:

Girls:

3. Mention the age differences of your children:

I Child

II Child

III Child

IV Child

Others, if any:

4. Have you heard of family planning?

Yes No

5. What is your opinion about family planning?

Acceptable Not Acceptable

6. Are you aware of the family planning methods?

Yes No

7. If yes, mention the methods:

1. Oral contraceptive pills
2. Loop
3. Condoms (Nirooh)
4. I U D
5. Sterilization
6. A. Vasectomy
b. Tubectomy
7. Laproscopy

9. Who took the initiative to adopt family planning in the family?

Husbands

Wife:

Others:

10. What is the source of information?

S.No.	Sources
1.	Radio
2.	Filmshows
3.	Newspapers
4.	Posters
5.	Primary Health Centre
6.	Neighbours and friends
7.	Extension workers
8.	School teachers
9.	Any other, specify

11. If you are practising family planning, give details on the method you follow.

S.No.	Method	Person practising		Reasons
		wife	Husband	

12. Why did you adopt that method?

Influenced by,

1. Doctors
2. Neighbours
3. Relatives
4. Friends
5. Husband/wife

- 6. Elders at home
- 7. Teachers
- 8. Extension workers
- 9. Easy to adopt
- 10. Availability of Incentives
- 11. Any others (Specify)

13. If it is operation, where did you/your husband get operated?

14. Opinion of adoptions

Is it satisfactory	If no, what are the difficulties	How do you overcome them	Follow up	Do you feel better after the treatment	Did you receive incentive	If yes, is it enough
Yes/No				Yes/No	Yes/No	Yes/No

15. How many of your family members have adopted family planning?

16. Is there any opinion difference between the husband and wife for adopting family planning?

Yes

NO

17. In Your opinion who should adopt?

Husband Wife

Reasons:

18. Did you/elders at home oppose the adoption of family planning?

Yes No

If yes, who?

Why?

19. Do you feel abhorred to say that you have adopted family planning?

Yes No

20. Do you motivate others to adopt family planning?

Friends:

Relatives:

Neighbours:

21. Is want for more children a reason for non-adoption?

Yes No

22. Is want for a male child a reason for non-adoption?

Yes No

23. Is there any religious barrier for your non-adoption of family planning?

Yes No

24. Does adoption of family planning affect your status in any way?

Yes No

25. Do your believes and values affect the acoption of family planning?

Yes No

26. Did you attend any training regarding family planning?

Yes No

27. Have the health personnel conducted any camp on family planning in your village?

Yes No

28. If yes, who conducted?

29. Who took the classes?

30. On what topic was the camp conducted?

31. What was the duration of the camp?

32. Were you benefited by the camp?

Yes No

If yes, in what way

V. General opinion:

1. Do you feel that present family welfare programme needs to be modified in its method of approaching the people?

Yes No

2. What is the present trend in population?

3. Do you feel that family planning is necessary?

4. In your view, who should be educated in this field?
Children (mention age) -
Youth at what (age) -
Mothers -
Parents -
Whole population -

5. What are your suggestions for improving the programme?