

“Knowledge, constraints & Adoption about population control measure among rural tribal and urban women of Bhiloda, Taluka; Dist. Sabarkatha of Gujrat” .

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LITERATURE CITED

Alag. V. And banerjee, A. 1995 Acceptance of spacing methods of contraception in municipal. Health and Population perspectives and Issues, 18:2-56.

Allport, G.W.1935 Attitude Inc. murchism (Ed.), A Handbook of social psychology, worastes Mass, clark University Press.

Ambani, R. 1993. Maternal and child health and family planning services of the India population project-IV in selected health posts. M.Sc. Dissertation, S.N.D.T. Women's University, Mumbai, India.

Bajpai, S.R. 1960. Methods of social survey and research. Kitab Ghar, Kanpur: 463.

Balaish, D ; Ghule, M.; Naik, D.D.; Parida, R.C. and Hazari, K.T.2001. Fertility attitudes and family planning practices of men in a rural community of Maharashtra. The journal of Family Welfare, 47 (1):56-57.

Basu, A.M.1984.ignorance of family planning methods in India : An important constraints on use. Studies in Family planning, 15(3):136-142.

Basu, S.; Kapoor, A.K. and Basu, S.K. 2004. Knowledge, attitude and practice of family planning among tribals. Journal of Family Welfare, 50:27-28.

Bhattacharya, P.C. 1998 Determinants of fertility in three North Indian States: Caste, female Autonomy And Economic Development. Canadian Journal of Development Studies, 19(1):37-53.

Chaudhary, R.H. 1984. The influence of female education, labour force participation and age at marriage on fertility behavior in Bangladesh. Journal of Social Biology,31(1-2):59-74.

Dubey, D.C. and Bardhan, A. 1969. Development status of women and fertility : case study of a tribal group. *Njournal of the Indian Association for the study oif population*, 7:88-96.

Freeman, F.S. 1965. *Theory and Practices of Psychological Testing*. Oxford and IBH Publishing co.:596.

Vayen, K. and Raeside, R. 2006. Communication and contraception in Rural Bangladesh, *World Health and Population, Health Care Quarterly*, 9(4):110-122.

Jaffery, R. and Basu, A.M. 1996. *Girls schooling women's autonomy and fertility change in South Asia*. Sage Publications, New Delhi.

Jaitley, V. 1988. *Attitude of slum women towards small family norm*. M.Sc. Thesis, S.N.D.T. Women's University, Mumbai.

Joshi, D.R. 1996. *Development and tribal fertility*, Shiva Publication, Udaipur, 87-90.

Joshi, J.v.; Gokral, J.S.; Rathod, D.; Adhav, A.; Gurjar, N.; Ghule, M.; Baji, M. and Samant, S. 1990. Contraceptive utilization in 842 rural women in PHC Kaman. *Journal of Obstetrics and Gynecology*, 40:8-96.

Khan, M.E, and Cernada, G. 1996. *Spacing as an alternative strategy: India's family welfare programme*, B.r. Publishing Corporation, New Delhi: 95-114.

Levine, R.E.; Cross, H.E. and Chhabra, S. 1992. Quality of Health and family planning services in rural Uttar Pradesh: the clients view. *Demography India*, 21(2):66-247.

Mari. Bhat, P.N. and Hasalkar, J.B. 1996. Factors influencing IUD retention in northern Karnataka. Cited in Khan, M.E. and Cernada, G. Eds., *spacing as an Alternative Strategy: India's Family Welfare programme*, B.R.Publishing corporation, New Delhi:63-94.

Mohanan, P.; Kmath, A. and Sajjan, B.S. 2003. Fertility pattern and family planning practices in a rural area in Dakshina Kannada. *India Journal of community Medicine*, 27:15-18.

Pal, S. and Makepeace, G. 2003. Current contraceptive use in India: Has the Role of women's Education been overemphasized? *The European journal of Development Research*, 15(1):149-169.

Phyllis, T. and Piotro. 1994. Strategies for family planning promotion. World Bank Technical Paper NO.223.

Rajaretnam, T. 1994. Popularizing spacing methods in India: The need and needed efforts. *The Journal of Family Welfare* , 40(1):41.

Raju, S.S. 1997. Regional Development and family planning. Daya publishing House, Delhi.

Rao, D.P. and Babu, S.M. 2005. Knowledge and use of contraception among Racha Koyas of Andhra Pradesh. *Journal of Anthropologist*,7(2):115-119.

Rosenzweig, M. and Seiver, D.A. 1982. Education and contraceptive choice: A conditional demand frame work. *International Economic Review*,23(1):98-171.

Rose, J.A.; Rich, M. and Molzan, J.P. 1989. Management strategies for family planning programmes. New York: Columbia University Centre for Population and Family Health.

Sarbajana, S. 1987. Intra uterine device as a means of contraception in our population. *Journal of Obstetrics and Gyanaecology of India*. Cited form www.cehat.org/publications/rhr2.html.

Sharma, A.K.; Grover, V.; Agarwal, O.P. and Dubey, K.K. 1997. Pattern of contraceptive use by residents of a village in South Delhi. *Indian Journal of Public Health*, 41(3):8-75.

Shobha, J. 1990. Fertility and child survival: A study of seleted slums of Hyderabad. *The Indian Journal of Social Work*, 1:40-134.

Sharma, V. and Sharma, A. 1991. Family planning practices among tribals of rajasthan, India. *Journal of Res. Edu. Indian Med.*, 10(4):5-9.

Singh, N.; Devi, T.I.; Devi, T. B.; Singh, Y.M.; Devi, T.N. and Singh, N.S. 2004. Acceptability of contraceptive methods among urban eligible couples of Imphal, Manipur. Indian Journal of Community Medicine, 29(1).

Sinha, R.K. and Kanitkar, R. 1994. Acceptance of family planning and linkages with development variables: Evidence from an 80 village study in Orissa. The Journal of Family Welfare, cited in [http://www. Cehat.org/publications/rhr4:htm/:31](http://www.Cehat.org/publications/rhr4:htm/:31).

Tiwari, V.K. and Kumar, A. 2004. Premarital sexuality and unmet need of contraception among youth: evidence from the cities of India. The Journal of Family Welfare. 50(2):67.

Verma, j. 1986. Some problems related to family planning: Observation from a Bihar village. Journal of Family Welfare, 33:1-4.

Webster, N. 1958. Webster's New Twentieth century Dictionary of English Language. The World Publishing Company, New York.

Chapter 1

Introduction

Research is an essential and powerful tool in leading men towards progress. Without systematic research there would have been very little progress. Scientific research leads to progress in some field of life. New products, new facts, new concepts and new ways of doing things are being found due to ever-increasing significant research in the physical, biological, social and psychological fields. Research today is no longer confined to the science laboratory. The manufactures, the agricultural experts and the archaeologists are carrying on research in their respective spheres, besides, the sociologists, anthropologist, economist and educationists.

To awaken people, it is the women who must be awakened, once she is on the move, the family moves, the villages moves, the nation moves.

Jawahar Lal Nehru

Overpopulation is defined as the condition of having more people than can live on the earth in comfort, happiness and health and still leave the world a fit place for future generation.

Indian Scenario of population

India's population as on 1st March 2001 stared at 1027 million (531.3 million males and 495.7 million females) in spite of the fact that India was the first country in the world to have a population policy. The rapid growth of population is one of the major problems the country is facing today. Considering the population of the country, the annual surplus of births over deaths stands at 15 million. There is no doubt that the "population Explosion" still continues. This large population is causing alarm, India is in the midst of a demographic transition with fertility rates definitely declining though not as fast as was expected. Population growth is the reason for every

environmental problem facing India with a current estimated population of one billion and a population growth rate of 2.15 per cent has specifically staggering population related problems as one third of the total population are subject to live below the poverty line. In addition, India's natural and environmental resources are shrinking, 53 per cent of India's total land area is prone to soil erosion, dense and closed forests have been declining considerably and widespread water scarcity and water pollution subsist. The rate of population growth in India comes to 2.2 per cent per annum which is fairly high as compared to many other countries of the world including the third world countries i.e. developing countries. This rapid increase in population has been termed by different scholars as "population explosion", "Bumper Crop for Human Pups" and "Baby in India",

Table 1. India's population growth

Year	Population(in million)	Annual exponential growth rate(%)
1991	843	2.14
2001	1027	1.93
2006*	1094	1.55
2011*	1179	1.49
2016*	1264	1.39

Projection by Committee on Population Projection appointed by planning Commission chaired by RGI 1996.

The necessity of controlling population growth was seriously recognized as early as 1965, when a large-scale National Family Planning Programmed was initiated. It was realized that any plan, programmed of development efforts would end in a fiasco, if the yearly addition of 2.3 million people to the total population could not be controlled.

Family planning services were considered to be a remedy in achieving the national objective of zero population growth. But despite of a concerted effort, the Family Planning Programme achieved very little success in promoting the practices of family planning. The major impact of the programme was the awareness that had been created in about 85 per cent of the target population (Where the wife was in the age of 15-44 years) despite the high rate of illiteracy and a high degree of conservatism amongst they people.

And yet the rural population was unaware of the basic requirements of family planning. The large gap existing between awareness and adoption of family planning points to the weaknesses of the programme.

Among the major states of the country, most rapid population growth has been registered in Rajasthan and Gujrat. In both these states, population increased at an average rate of more than 2.4 per cent per year between 1991 and 2001. As a result, the proportionate increase in the population of both the states during the ten years period has been more than 28 per cent. Other major states, where the average population growth rate during the nineties has been more than 2 per cent per year are Bihar, Uttar Pradesh, Madhya Pradesh, Maharashtra and Gujrat .In all these states, the population increased by more than 20 per cent during the ten years between 1991 and 2001.

Since today, the rural and tribal area of the country remained isolated from the modern developing civilization because of various reasons; lack of communication and transportation facilities like in the urban area may be the main reasons for their backwardness. Thus benefits of medical and education and better living were confined to urban people only. Even now, hospitals and specialized clinics are concentrated in big towns and cities. The villagers are not only deficient in primary health facilities and medical aid but also plagued by unsanitary conditions, illiteracy, lack of privacy and above all the poverty. These all factors add in the unhealthy and unchecked growth of rural population Because of ignorance, rural masses can not understand the direct impact of high population growth which press them to lead starved or semi-starvation

life. They put all these consequences to the God and luck. Thus, to give them the better standard of living and gose civilized life, birth control measures are essential to control fertility in tribals.

GUJRAT POPULATION

Gujrat is the state in the country with an area of 196027 sq.km. In terms of population, the Indian state of gujrat holds 10th position among the states and union territories republic of India. The population growth in Gujrat state is higher than the national average. Gujrat has registered a population growth of 22.48% as compared to the national average of 21.34%. This number is relevant during the decade starting from 1991 and 2001. The population is 5.05 crore expected the census has completed 2001. The tribal population in Gujrat state according to census 2001 was 74.81 lac i.e., 14.65 percent of the total population. Gujart is the fourth state in terms of the tribal population in India.

Since to the tribal and rural area of the country remained isolated from the modern developing area because of various reasons; lack of communication and transportation facilities like in the urban area may be the main reason for their back wardness. Thus benefits of medical and education and better living were confined to urban people only. Even now hospital and specialized clinics are concentrated in big towns and cities.

All communities, rural or urban require some services to support, improve and facilities their economic activities also to cater their civic needs such as health, education, public conveniences and safety. The level of various types of services are linked with population sizes to that higher order of services requires a proportionately larger population have to be located in a town or city or urban area.

Employment, agriculture productivity, income level and literacy rates are higher in areas closer to towns and cities inaccessible peripheries and the remote countryside are characterized by backward subsistence economic system so it has been universally accepted that rural fertility is higher than urban fertility. This fact has been proved by

many studies in India and abroad. Easier access to education, job opportunities and media, are factors taken together to result in preference for smaller family size.

The population of Gujrat in 2011 [Census of India](#) was 6,04,39,692 of this the tribal population in gujrat state according to the census report, 2011 was 89.17 lac in which rural Population 80.21 lac & urban population is 8.95 lac i.e.14.80 per cent of the total state population . The state has registered 21.4 per cent decadal growth in the Scheduled Tribe population between 1991-2001. Gujrat is the fourth largest state in terms of tribal population after Madhya Pradesh, Maharastra & orissa .The scheduled tribes concentration is in area of study is shyamalaji and modasa of North Gujrat districts, where their population comes to 72.30 and 65.10 Per cent respectively. The other districts having higher proportion of tribals are saberkatha (47.90%) syamalaji (21.50%),modasa (20.25%) .

Scheduled tribes are backward class Hindus. According to Webster Dictionary, historically or developmentally, a tribe consists of a social formation existing before the development of, or outside of states.

List of communities

There are twenty nine (29) notified Scheduled Tribes in the state, which are as follows:

1. Barda
2. Bavacha, Bamcha
3. Bharwad (in the Nesses of the forests of Alech, Barada and Gir)
4. Bhil, Bhil Garasia, Dholi Bhil, Dungri Bhil, Dungri Garasia, Mewasi Bhil, Rawal Bhil, Tadvil Bhil, Bhagalia, Bhilala, Pawra, Vasava, Vasave.
5. Charan (in the Nesses of the forests of Alech, Barada and Gir)
6. Chaudhari (in Surat and Valsad districts)
7. Chodhara

8. Dhanka, Tadvi, Tetaria, Valvi
9. Dhodia, Dhodi
10. Dubla Talavia, Halpati
11. Gamit, Gamta, Gavit Mavchi, Padvi
12. Gond, Rajgond
13. Kathodi, Katkari, Dhor Kathodi, Dhor Katkari, Son Kathodi, Son Katkari
14. Kokna, Kokni, Kukna
15. Omit
- 16 .Koli Dhor, Tokre Koli, Kolcha, Kongha
17. Kunbi (in the Dang Districts)
18. Naikda, Nayaka, Cholivala Nayaka, Kapadia Nayaka, Mota Nayaka, Nana Nayaka
19. Padhar
20. Omit
21. Pardhi, Advichincher, Phanse Pardhi (excluding Amreli, Bhavanagar, Jamnagar, Jungadh, Kutch, Rajkot and Surrendranagar district)
22. Pateliya
23. Pomla
24. Rabari (in the Nesses of the forest of Alech, Barada and Gir)
25. Rathwa
26. Siddi, Siddi-Badshan (in Amreli, Bhavnagar, Jamnagar, Junagadh, Rajkot and Surendranagar Districts)

27.Omit

28. Varli

29. Vitolia, Kotwalia, Barodia

According to the Scheduled castes and Scheduled Orders Act, 1976, eleven groups have been scheduled tribe in the state of gujrat. Out of these eleven scheduled tribal groups, Bhil, Bhil Garasia, Dholi Bhil, Dungri Bhil, Dungri Garasia, Mewasi Bhil, Rawal Bhil, Tadvil Bhil, Bhagalila, Bhilala, Pawra, Vasava, Vasave constitute the major tribal groups of the state. They are major, because they have a good strength and their concentration is in a definite pocket. As a matter of fact, racially and historically , there are two major stocks of tribals, namely the Aadiwasi and the Bhils. The Bhils forming probably the third largest tribal group in India. The concentration of Bhils in the country is found in four states namely Maharashtra, Gujrat, Madhya Pradesh and Rajasthan. Though, Bhils are spread broadly all over the state, their major concentration is in the districts of kheda, bhiloda and saberkatha where about 60 per cent of their population resides. The tribal population has increased by higher rate in comparison to the total population of the country as well as in gujrat also.

Demographic and population condition of tribes in Dist. Sabarkatha

Dist. Sabarkatha in gujrat state comprises 7 Talukas. It is spread across an area of 7390 km. It has a gender ratio of 947 females per 1000 men, and the literacy rate for the district is 67.31%. The administrative headquarters of the [district](#) is [Himatnagar](#), about 80 km from [Ahmedabad](#). Sabarkantha District is bounded by [Rajasthan](#) state to the northeast, [Banaskantha](#) and [Mehsana](#) districts to the west, [Gandhinagar](#) to the south and [Aravalli District](#) to the South - East.

Himmatnagar is a district headquarters, and talukas Prantij and Talod are major industrial locations in Sabarkantha.

Sabarkantha district has following 7 Talukas :

- [Himatnagar](#) - District Headquarters
- [Idar](#)

- [Prantij](#)
- [Talod](#)
- [Khedbrahma](#)
- [Vadali](#)
- Vijaynagar

New District named Aravalli has been carved out of Sabarkantha having following 6 Talukas

Modasa

- Dhansura
- Bayad
- Megharaj
- Bhiloda
- Malpur

It is not surprising therefore that a large number of villages follow a primitive way of life, age old social customs and antiquated contraceptive methods.

The situation is even worst among tribal communities, which constitute approximately 7.5 per cent of the total population of the country. In such societies, which still lead an isolated existence, far removed from the modern way of life. A wife is primarily regarded as an investment for production of labour and a child bearing house keeper. In such societies, male dominance is a rule and preference for a male child is a traditional compulsion. Women are considered too inferior in status to voice their views and concerns even in matters which have a direct bearing on their own health and well being. Family elders and caste leaders reign supreme in the decision making processes and prehistoric practices and primitive rituals and customs are still very prevalent. Consequently, such societies are typically characterized by uncontrolled fertility. One of the main reason for having many children in tribal areas is the feeling of insecurity rising from poor infant survival. Unless and until, each mother is given proper antenatal care along with nutrition and education and assured protection of her children by immunization and nutrition, the rural and tribal masses will not accept the small family norm. Poor infant survival has therefore lead not only to an increased growth rate and over population but has added to poverty and lowered the quality of life.

CAUSES OF RAPID POPULATION GROWTH

1. **Food Production Distribution** During the past ten years, the world's food production has increased by 24 per cent, outpacing the rate of population growth.
2. **Improvement in public health** People have concerns about surviving daily living such as meeting basic needs food, water and housing. First, access to safe drinking water was related to the incidence of epidemic diseases such as cholera and child survival. Less than 50% of the population has access to safe drinking water before 1990. By 1990, access to safe drinking water had increased by 75 per cent.
3. **Conquest of disease** Scientists have learned a great deal about the ways to prevent and cure many types of disease. Thus, today millions of people who would die because of disease a century ago are more likely to live to old age.

In Indian context, besides above reasons, following are others responsible reasons for over population viz., illiteracy, gender disparity, myths, religious beliefs, feeling of insecurity, non-serious attitude related to ill effects of over population, less knowledge regarding contraceptive methods, early marriage, high infant mortality rate etc.

Effects of over population

- 1) Poverty
- 2) Malnutrition and starvation
- 3) Poor Mother's health
- 4) Migration from rural to urban
- 5) Unemployment
- 6) Undesirable impact on urban settings/housing problem
- 7) Crime
- 8) Child labour
- 9) Environmental degradation etc.

STRATEGIES FOR SLOWING POPULATION GROWTH

1. Family planning devices.

Family planning v/s population growth was the motto of the national population policy in independent India. Family planning programme is perhaps the most effective policy intervention to control fertility and stabilize population size. For this purpose, our government is trying to encourage the people to prevent early marriages before legal age of 18 years, early pregnancy and encourage the couple to accept small family norm (two children), proper spacing between two births of children (3years) and use of contraceptives.

2. Contraceptive technology

The effectiveness of family planning services is in part dependent on the quality of contraceptive technology offered to millions of clients in all stages of their reproductive life in varying cultural and religious environments. Only 44 percent of India's 168 million couples in the reproductive age group use effective contraception. A large proportion of the remaining couples may want contraception but do not have access to it. Reproductive services often do not reach the villages. There is need to aware the couples about the use of contraceptive methods in every phase of reproductive life.

3. Population policy

Government has adopted a national Population policy in February 2000, which provides holistic approach for achieving population stabilization in the country.

The immediate objective of the national population policy is to address the unmet needs of contraception, health care infrastructure, health personnel and to provide integrated service delivery for basic reproductive and child health care. The medium term objective is to bring the total fertility rate to replacement level by 2010, through vigorous implementation of intersectional operational strategies. The long term objective is to achieve population stabilization by 2045, at a level consistent with the requirements of sustainable economic growth, social development and environmental.

4. Control of infant mortality

Infant mortality is higher in developing countries like India, China, Sri Lanka and Cuba. Many couples have large families as insurance against multiple infant and child health. To control this problem, there is urgent need to aware the women about per natal and post natal care during pregnancy, vaccination, nutrition and set up the health facilities like primary health center, sub center in the remote areas.

5. Women's education, income and status

High fertility is directly related to women illiteracy backwardness and their status in society, poverty, preference of son and age at marriage, In Rajasthan, high child mortality rate and women's low status in society are main constraints of accept small family norm.

A BRIEF NOTE ON THE METHODS FOR PREVENTING CONCEPTION

Several methods are in vogue to prevent conception and they have been suggested on the basis of preventing the living male sperm from coming into contact with the ripe female ovum. The extent of safety and certainly of the different methods like natural, unnatural, chemical, medical, operation etc. varies. Several methods have been referred in this report and a short note on few of them is given.

1. Safe period of rhythm method

The principle underlying this method is that conception can be avoided by restricting intercourse to the times in the wife's menstrual cycle when she is not likely to be fertile. In the female, the egg is expels from the ovary roughly 14 days prior to the occurrence of the menstrual period in a normal 28 days cycle. The safe period begins from the end of the menstrual flow until the 10th day and again from 18th until the period begins.

2. Condom of French leather

This method is known as Male Sheath, French Cap etc. It is hollow rubber tube open at one end and closed at the other. It is a cover for male organ designed for use by the husband before conjugal union. About half an inch is to be left free at the closed end of the sheath to provide room for the discharged semen. After the intercourse, the sheath should also be withdrawn carefully.

- 3. Oral tablets** Oral contraceptives were introduced in 1956. The pill has a combination of different types of hormones and prevents the development of fertile eggs by producing an effect on the pituitary gland for controlling fertility. 25 tablets are to be taken every month beginning on the 5th day of the menstrual cycle and the next course should be started on the 5th day the cycle.
- 4. Cooper-T**
It is made in T shape from copper material. This is an intra uterine contraceptive device, fitted on the mouth of uterus. This contraceptive method is efficient and had great promise for family planning and reducing, spacing the number of children. New copper-T can prevent pregnancy from 10 to 12 years. This intrauterine device has however some drawbacks and side effects in some cases minor.
- 5. Sterilization(Vasectomy and Tubectomy)**
This is carried out by means of a surgical operation. The operation is carried out by tying or removing a portion of the tube in which the seeds are carried away from the reproductive glands in both man and women. As a result of operation in man, the sperms cannot pass into the semen and in woman; the egg cannot pass into the uterus.

IMPORTANCE OF THE PROPOSED INVESTIGATION

Today, the world's population is six billion with witnessing of Indian population 1,027 million as per the latest figure available, which is expected to be 1 billion by 2020 A.D. The situation seems to be alarming and the future of human beings survival would be in terrible condition. It is hard to predict the future of mankind with the ever-increasing population.

Now there is earnest need for paradigm shift if we talk about the all-round development of the people. For the sake of all-round development of people, they are required to be developed socially, economically, and aesthetically and all other aspects of life like living better life with small family size, Before sometime, everybody might have heard the slogan "We two and our two" means the small family, but in today's context, the slogan has been changed and people are being educated for believing in new slogan that is "we two and our one" means still small family for better living.

The present project is quite deviated investigation from the past trends of projects, it is of its own kind because it is presumed that whatever the researcher would find out definitely, would be of great importance for future strategies in decreasing the population of tribal people so as to provide them better living standard.

The present project comprises overall five objectives. The results regarding socio-economic status in the study area would present the real picture of the area based on which the future programmes could effectively be executed.

Knowledge regarding compatible contraceptives is imparted to reduce population pressure on the land to a great extent that may lead in lessening the food shortage in the study area. The findings will be of use specifically for family planning departments and NGOs, working in the area for tribal upliftment.

Similarly, result about the adoption level of contraceptives by the tribals would help in finding out the real situation in use of control measures.

Mostly, the tribals are economically depressed, poor, backward, and illiterate, socially cut off from the people of other communities and exploited by other groups of the society. It has been realized that in spite of vast expansion of family welfare services in rural areas of the state, the work and utilization of services in rural areas of the state, the reach and utilization of services is poor and the state is lagging behind as compared to National average.

It has also been observed that difficult terrain, low accessibility, sparseness of population, low literacy, low accessibility of health personnel, low status of women and lack of community participation have adversely affected the services as well as their utilization in tribal and rural areas.

The fertility among tribes is also high in rural or undeveloped areas while low in urban or developed areas. However, a lot of cultural transformation is taking place in their community due to developmental activities. In our constitution, government has made special provision for their upliftment. An attempt has been made to reach the tribal community through various development plans. Especially in the last two decades, many developmental programmes are going on in the tribal sub plan area. These programmes have been introduced by a number of agencies, viz., NGOs, Semi Government and Government Department such as area development plan and tribal development etc. The family welfare programme is not much effective in remote tribal areas because their education, status of women, communication and mass media is very low as compared to urban areas.

It is one of the major issues for upliftment of the tribal people. Hence, the present study is very important and useful for planners, geographers, demographers, and administrators of family welfare programmes, policy makers and those who are engaged in tribal welfare.

Considering the significance of the above stated facts, the present study entitled “**Knowledge constraints & Adoption about population control measures among rural tribal women of Bhiloda, Taluka; Dist. Sabarkatha of Gujrat**”. A study was undertaken with the following specific objectives:

- 1) To study the socio-economic status of selected respondents in the study area.
- 2) To study the knowledge of the respondents regarding different to available contraceptives for population control...
- 3) To study the adoption level of the contraceptives by the respondents for population control in study area.
- 4) To identify the constraints in adoption of population control measures by the respondents in rural and urban areas.
- 5) To suggest suitable strategies for adoption of population control measures.

DEFINITION OF THE TERMS

Attitude Attitude is the degree of the positive or negative feelings associated with a psychological object. In present study, the psychological object is population control measures towards which tribal women have expressed positive or negative feeling.

Adoption It is a decision to make full use or a new idea as the best course of action available (Rogers.) . The term adoption in this study is used to denote the use of contraceptive methods by the tribal women.

Constraints Constraints implies forced restriction and confinements of actuions. In this study, constraints mean “an impediment” in adoption of contraceptive methods.

Contraceptive Methods of preventing pregnancy, devecor by blocking the process of reproduction.

Knowledge It has been defined as those behavior and test situations which emphasized the remembering either by recognition as recall of ideas, material or phenomena (Bloom, et al., 1956). In this study, knowledge is defined as the amount of understood information an individual possess regarding population control measures at the time of data collection.

Population control A broad concept that addresses the relationship between fertility, mortality and migration, but is most commonly used to refer to efforts to slow population growth through action to lower fertility.

Tribal Adivasis” or tribal people comprise a substantial minority of the population of India.

Chapter 2

REVIEW OF LITERATURE

Webster (1958) in his dictionary has given the meaning of the word review as “a look back on, a retrospective view or survey as of past events, experience etc.” The summaries of the writings of recognized authorities and of previous researches have been presented in this chapter, which provides testimony to the fact that what is already known and what is still unknown and untested.

The sin-qua-non supplementation of any scientific investigation with review of its relevant literature can be evident from the fact that it helps to eliminate the duplication of what has been done. The main function of the review of literature is to determine, what work both theoretical and empirical has been done previously so as to assist the researcher in delineation of the problem area. It provides a basis for the theoretical framework, provides an anticipatory, insight into method and procedures, suggests empirical definitions to major concepts, provides a basis for interpretation of findings and finally supports the findings.

The available relevant literature has been received under the following heads:

- 1) Socio-economic status and independent variables and knowledge/adoption of population control measures.
- 2) Knowledge regarding different available contraceptives for population control.
- 3) Adoption level of the contraceptives for population control.
- 4) Constraints in adoption of population control measures.

1. **KNOWLEDGE REGARDING DIFFERENT AVAILABLE CONTRACEPTIVES FOR POPULATION CONTROL**

Chung et al. (1972) found that women with higher developmental score had significantly less fertility and higher knowledge about birth control methods.

Singh et al. (1987) found that level of awareness regarding various aspects of contraceptive methods was very high and people were conversant with the various family planning methods both sterilization and temporary methods both sterilization and temporary methods including their merits and demerits.

Sunday (1990) reported that knowledge regarding contraceptives and their acquaintance was found to be more among educated women with the decreased demand of children and fertility.

Joshi et al. (1991) revealed that knowledge of different contraceptives particularly spacing methods was significantly lower among non-acceptors than among acceptors.

Lakshmana and Reddy (1991) assessed the knowledge and practices of women about family planning methods. The study revealed that almost all women in rural and urban areas were aware of both temporary and permanent methods of family planning and knew them by their popular names.

Sharma and Sharma (1991) in their study revealed that only 60.8 per cent tribal women had knowledge regarding contraceptive methods in tribal communities of Udaipur district in Southern Rajasthan.

Jamil (1991) studied the contraception knowledge and their use among slum women and findings suggested that knowledge of contraception was high among slum women where as the most widely used methods were identified as oral pills, periodic abstinence, IUD and condom.

Joshi (1996) in his study revealed that highest (98.41%) knowledge about birth control method was higher in urban tribal women, while lowest (61.02%) in rural women.

A survey across the nation (National family Health survey-11,1998-99) revealed that 99 per cent of women in the reproductive age group knew at least one method of contraception.

Basu et al. (2004) reported that majority of the Santhal (80.3%) and Lodha (87.3%) tribal communities were aware of sterilization but spacing methods were less known. Only 1.0 per cent of Santhals knew of oral pills and 1.7 percent about IUDs.

Rao and Babu (2005) reported that knowledge of contraceptive methods was fairly high (81%) among tribal and rural population. Female sterilization or tubectomy was more popular among the women who reported knowledge of the contraceptive methods.

Saini et al. (2006) concluded that difference of knowledge between the users and non-users was statistically significant. All the couples had knowledge regarding at least one spacing method. They also reported that maximum users (81.8%) were among those who knew all the three approved methods of contraception. Non users (94.1%) were more in the group, who were having knowledge of only one method.

1.2 ADOPTION LEVEL OF THE CONTRACEPTIVES FOR POPULATION CONTROL:

Dubey and Bardhan (1969) in their study "Adoption of intra uterine device (IUD) by middle class residents of New Delhi", found that a higher proportion of the acceptors of IUD were influenced by the level of living status.

Reddy (1984) reported that 50 per cent respondents preferred individual decision for adopting contraceptive method.

Ramchandran (1987) found in his study that sterilization was the dominant form of contraception comprising 68.5 per cent of the respondents and use of spacing methods was very low (31.5%).

Pendse (1988) found that 86.5 per cent of the respondents were married before the age of 16 year. Only 41 percent of married women were found currently using contraceptive methods and sterilization was the most commonly used method.

Joshi et al. (1990) indicated that condom use was significantly lower (1.5%) as compared to IUD(26.2%) and oral pills (7.5%). They also reported that vasectomy acceptance was less(0.4%) as compared to tubectomy (21.3%).

Mondal (1990) in his study revealed that out of 340 females, 164 did not use contraceptives and 54 were unsatisfactory users.

Singh et al. (1990) observed low incidence of adoption of spacing methods in young people.

Zachariah (1990) observed that 40 percent of eligible women were not adoption any contraceptive method.

Nag (1991) suggested that adoption and practice of contraceptive methods by the eligible couples depends to a very large extent on their awareness and knowledge regarding birth control methods, favorable attitude towards contraceptive practices.

Puri (1992) observed that breast feeding is a major factor which helps to lengthen the relatively infertile period among tribal communities and plays a major role in being an affective natural contraceptive for those women who shy away from most of the modern contraceptive technique available today.

Ramchandran and Chandrashekar (1992) repoted that the use of condoms in a rural setting was as low as 2.2 per cent and vbasectomy even lower, at less than one per cent .

Ambani (1993) studied the “awareness, sterilization and extent of effectiveness of maternal and child health and family planning

services.” He found that family planning services were found effective to a large extent by field workers and beneficiaries due to the free regular services and motivation given by the health workers and doctors. Temporary methods were found to be utilized more and oral pills were preferred than permanent methods.

Sharma and sharma (1993) indicated that the practice and use of modern contraceptives has been known to be non-existent among tribal people. Further, it was observed that irrespective of the training in family planning received by 46 per cent of the respondents, they themselves or their spouses were not using any method of contraception.

Tripathi et al. (1994) stated that there has been a progressive decline in vasectomy acceptance in India during last 20 years.

Gandotra (1996) showed higher non adoption level for oral contraceptive pills and condoms than IUDs.

Joshi (1996) found that there were only (7.63%) traditional respondents in rural areas who adopted birth control methods, while it increased the proportion in modern (46.15%) respondents in urban areas.

Khan and Cernada (1996) in their study revealed that from among temporary methods, adoption of condom and oral pills was about 16 per cent .

Sushmita and Bhasin (1998) concluded that only 10-19 per cent respondents among Bhotias (Tribal community) of Uttar Pradesh were adopting birth control methods.

Ingle et al. (1999) reported that only 25 per cent of the eligible couples are currently adopting any contraceptive method and amongst the current users, the common method was tubectomy (59%).

Baweja et al. (2000) found in their study that majority (80%) of the respondents adopted reversible methods and only a few (17%) respondents district of Andhra Pradesh.

Verma et al. (2002) reported that the use of birth spacing methods was found to be less (13%) among rural population of west Godavari district of Andhra Pradesh.

Pal and Makepeace (2003) revealed that rural and urban women aged 35 or more were significantly less likely to use any contraception and scheduled tribe households from rural areas had a significantly lower likelihood of using contraceptives.

Singh et al.(2004) found that more number of couples had adopted permanent methods of contraceptives (vasectomy and tubectomy) i.e.7.75 percent compared to temporary methods (5.89%). They also reported that as compared to vasectomy (1.19%), percentage of tubectomy was far greater (12.37%). Among the temporary methods, maximum number of couples had adopted IUCD as spacing method (15.20%). This might be due to technical advantage and personal comfort of IUCD over other methods.

Rao and Babu (2005) found that 73 percent women use sterilization (38 percent tubectomy and 35 percent basectomy) while the use of modern spacing methods was reported by 19 percent of women (oral pills by 13 percent and IUD/loop by 6 percent). The remaining 8 percent of women reported use of herbal medicine for contraception. The use of birth spacing methods was found to be less (13%) among tribal population.

Gayen and Raeside (2006) found in their study that 69.3% of the interviewed women practiced at least one contraceptive method. The most popular method was pill with 66 percent of the respondents using this method.

Susuman (2006) reported that majority of the women (54%) were non-users of contraceptives and the remaining (46%) were

users of one or other methods of contraception. He also found that among the users, 38 percent were using temporary methods namely IUD(2%), condom (1.5%) and oral pills and other methods(4.5%).

1.3 CONSTRAINTS IN ADOPTION OF POPULATION CONTROL MEASURES

Khan (1967) found that despite having knowledge, women and men did not use these methods because they needed more children.

Choudhary (1977) found that achievement of the desired number of sons was positively associated with the use of contraception.

Basu (1984) agreed that lack of knowledge about spacing methods especially among young couples was main constraint for low use of spacing methods.

Nag (1984) observed that misconception of weakness after sterilization was main constraint for not using permanent method of contraception.

Singh (1986) observed that despite the high level of awareness and knowledge, a great deal of hesitation in accepting contraceptives was expressed for various reasons. The side effects of both tubectomy and IUD were particularly mentioned by women. In unitary families, particularly there was a high problem of managing the household work. Even if the woman was willing to undergo sterilization, the problem of looking after the milch cattle and also the routine work of the household during the two weeks, when she underwent the operation and took adequate rest were major hindrances.

Verma (1986) revealed that many women do not know much about contraceptive method and also they had certain misconception too and women were some what afraid to adopt the methods like IUD and sterilization. She found the major problem of a psychosocial character. Women do not want their men to under go vasectomy. In the course discussions, she got a very strong feeling that the biggest danger to the family planning programme came from the non-serious attitude of men and women towards family planning. The problem of a son is common problem for the whole Indian community and to adopt a family wel fare programme.] Sharif (1989) agreed that many programme managers and workers believed that cultural factors, storage/dilposal problems, need for regular use, side effects are main constraint associated with the non adoption of contraceptive methods.

Shobha (1990) fond that main constraint was side effects of contraceptives originating from experience of friends and rum ours, which were told and retold through the communities have contributed to low contraceptive acceptance.

Levine et al. (1992) observed that inadequate knowledge of contraceptive methods and incomplete information about where to obtain methods and how to use them are main constraints for not accepting birth control methods.

Rajaretnam and Deshpande (1994) observed that were many constrints affecting the adoption of contraceptive methods but the major problem faced by the respondents regarding contraceptives were undesirable side effects or high failure rates, desire for more children and inconvenient to use.

Alag and Banerjee (1995) found that little perceived risk of pregnancy; desire of more children is a singnificant factor for non use of contraceptives.

Murthi et al. (1995) revealed that cultural and locational factors like urbanization may also affect the use of population control measures.

Jeffery and Basu (1996) concluded that strong son preference is complicate decisions regarding fertility and contraceptive use.

Arnold et al. (1998) found that adoption or non adoption of contraceptive method depends on achieved sex preference of children.

Vishwanathan et al. (1998) found that inadequate knowledge of contraceptive methods and incomplete information about where to obtain methods.

Kumar et al. (2005) revealed that women did not adopt contraceptives due to its side effects (50%) and other health problems (50%) which were main constraints.

Weakness was narrated as the commonest complaints from contraceptive methods. More than 70 per cent women told that irregular menstruation from oral contraceptive pills and ill health from tubectomy as the other side effects were main constraints.

Petro et al. (2005) found that main constraints for non-acceptance of contraceptive methods in a majority of women were either due to an expectation of a male child (44%) or fear of side effects(29%).

Susuman (2006) reported that highest proportion wanted to have as many as children (41%), second reason was that women did not get the desired sex (18%) and third reason which was lack of knowledge about contraceptive methods (18%).

RESEARCH METHODOLOGY

This chapter of the study describes the entire method and procedure followed in selection of location and sampling design for the investigation. The tools used for data collection and statistical analysis are also included in this chapter. The chapter has been classified into following sections.

- 1.1 Locale and sampling of the study
- 1.2 Construction of tools
- 1.3 Measurement of variables
- 1.4 Field procedure and method of data collection
- 1.5 Statistical analysis

3.1 LOCALE AND SAMPLING OF THE STUDY:

3.1.1 Selection of District:

1. This study was conducted in the purposively selected rural tribal women of Bhiloda, Shyamlaji, Kishangarh, Lusadiya, Khalwar Dist. Sabarkantha of Gujrat” of northern Gujrat which lies between 23.6N latitude and 72.95 E longitude. Administratively, the district is divided into thirteen talukas. According to the [2011 census](#) Sabarkantha district has a [population](#) of 2,427,346 roughly equal to the nation of [Kuwait](#) or the US state of [New Mexico](#). This gives it a ranking of 183rd in India (out of a total of [640](#)). The district has a population density of 328 inhabitants per square kilometre (850/sq mi). Its [population growth rate](#) over the decade 2001-2011 was 16.56%. Sabarkantha has a [sex ratio](#) of 950 [females](#) for every 1000 males, and a [literacy rate](#) of 76.6%.

2. 3.1.2 Selection of panchayat samiti:

There are total thirteen taluka in Sabarkatha district of Gujrat out of which 5 localities was selected for the Study on the basis of maximum number of tribal women living in urban & rural area respectively. For the purpose of rural study, kishangarh,lusadia,khalawar locality & for urban sabarkatha and shyamalaji was selected for the present investigation because there are higher concentration of tribal population and faculty is also familiar with area.

3.1.3 Selection of Respondents:

A list of all tribal married women below the age of 45 years were prepared. It was proposed to have 60 respondents together, 30 respondents from rural tribal population and 30 from uurban tribal from urban tribal population, 30 women from each village and ward were randomly selected for the study. Thus a sample of 60 women were selected, 30 tribal women from rural area and 30 tribal women from urban area finally.

3.2 CONSTRUCTION OF TOOLS:

Keeping in mind the purpose and objectives of the study along with the subject included in the study, an appropriate toll already developed by Dr. B. S. Bhimawat & Dr.venus vyas and most pertinent interview schedule was constructed by them was used. The schedule consists of major five parts viz.,in which we used three out of them.

1. Knowledge regarding different available contraceptives
2. Adoption of the defined contraceptives
3. Constraints in adoption of population control measures

(1) Section-1-knowledge test:

This section takes care of testing knowledge of rural and urban tribal women regarding contraceptive methods. According to opinion of SMS of Extension Education, Doctors, Family Planning Specialists, Sociologists, population programme Specialists, the test was divided into five aspects of contraceptive methods viz., family planning methods, condom, oral pills, copper-T, sterilization (tubectomy and vasectomy). The statements related to knowledge about different methods of contraception were listed under each aspect.

The selected items were in the objective form and the multiple choices. The responses were also recorded on dichotomous scale i.e., yes/no where 'yes' means correct response and no means incorrect response. Score 1 and 0 was assigned to 'yes' and 'no' response respectively. In all, the maximum possible knowledge score was 64 for contraceptive methods.

(2) Section II- Adoption scale:

In order to measure adoption of contraceptive methods, interview schedule was made. The complete procedure of the scale construction has been given here under:

This section of the schedule was developed with a view to know the extent of adoption of rural and urban tribal women about contraceptive methods on the basis of suggestions received from the experts of extension educa. The test was divided into 8 aspects of contraceptive methods. The weightage of each aspect is given below as suggested by the scientists.

All statements related to the adoption of contraceptive methods were listed under each aspect. These items were discussed with concerned SMS and Extension personnel in order to ensure that no important practice has been left out from the list.

3.3 MEASUREMENT OF VARIABLES:

3.3.1 Measurement of independent variables

Part-1-(A) Socio-Economic status:

In the present project, age, education, size of land holding, social participation, media exposure, family income, occupation of wife and husband, type of house, social circle, material availability in the house were classified for measurement.

(i) **Age:** Age of the respondents were categorized into three categories.

(1) Young age - Below 25 years

(2) Middle age - 25-35 years

(3) Upper middle age - More than 35 years

(ii) **Education :** Educational status of the respondents were measured with the help of socio-economic status scale developed by G. Trivedi (1963) and scoring was done as per the scale but into seven groups as per their educational level.

(1) Literate - No literacy

(2) Can read only Can read and write

(3) Can read and write

(4) Up to primary level Literate

(5) Up to middle level

(6) Secondary and higher secondary level Educated

(7) Graduate or post Graduate

(iii) **Family income :** Income of family were categorized into three groups.

(1) Less than Rs. 1500 -Below poverty line

(2) Rs. 1500-3000 - Average income

(3) Rs. 3000 & above - Above average income

- (iv) **Occupation of wife and husband:** Occupation of wife and husband were classified into seven categories.

Occupation of wife	Occupation of husband
House wife	Unemployed
Agriculture	Agriculture
Small Business	Labour
Service	Business
Labour	Business
Business+Agriculture	Service+ Agriculture
Other	Business

- (v) **Availability of material in the house:**

- (1) Radio
- (2) Television
- (3) Tap recorder
- (4) Video cassette player
- (5) Cycle/Scooter/Motor cycle/Moped etc.

Part B (i)- Source of information utilized by tribal women regarding contraceptive methods:

This part was designed to find out various sources of information utilized by the urban and rural tribal women for seeking information about contraceptive methods. A number of questions related to this aspect of study were developed. After doing thorough screening, as many as 12 sources were included in this part of the schedule.

Part B(ii) – channel of information utilized by tribal respondents:

It was designed to know about the various channels preferred by the tribal respondents for seeking information about recommended contraceptive practices. After having a thorough search, 13 channels of information that should be utilized by the tribal respondents were included in this section

3.3.2 Measurement of dependent variables:

Part II- Measurement of knowledge:

To measure the level of existing knowledge of tribal women, a knowledge test was already developed was used for this project. (Section I). Aspects of contraceptive methods were included in knowledge test. Each selected practice was assigned to each incorrect answer. Therefore possible knowledge index for each respondent was calculated by using the following formula:

$$\text{Knowledge index} = \frac{\text{Total Knowledge score obtained by the respondents}}{\text{Maximum obtainable score}} \times 100$$

Part III – Measurement of Adoption:

To measure the extent of adoption, scale was prepared (section li) for this study purpose and eight sections of practices of contraceptives were selected. Each practice was further divided into sub- practices and score assigned against each practice in contraceptives. The possible maximum score one can obtain was 30. The quotient was calculated using the formula and respondents were categorized accordingly.

$$\text{Adoption index} = \frac{\text{Total Adoption score obtained by an individual}}{\text{Maximum obtainable score}}$$

Part IV: Constraints faced by the tribal respondents:

To study the constraints faced by rural and urban tribal women in adoption of contraceptive methods, all possible constraints were listed with the help of available literature, review and discussion with functionaries and experts. The constraints were grouped into six heads i.e., constraints related to methods (6 items), financial constraints (2 items), technical constraints (2 items), social constraints (5 items), constraints related to health (8 items) and miscellaneous constraints (7 items). Response of rural and urban tribal women were recorded on 3 point continuum with more severe, and least severe which were assigned 3, 2 and 1 score respectively. To find out the priority of each statement (constraint), frequencies of the respondents under both categories of responses were calculated and multiplied with the respective scores.

3.4 FIELD PROCEDURE AND METHOD OF DATA COLLECTION:

The data collection for the study was done with the help of well structured pre-tested interview schedule by way of personal interview technique with the residence. The interviews were conducted in Hindi and local dialect at the residence of respondents. Since majority of respondents were illiterate, personal interview method helped the student in collecting valid and reliable information. Interview provided a situation where face to face discussion could take place and the interviewer found an opportunity to motivate the respondents. The attention was given to the convenience of the respondents regarding clear understanding of the question.

The relevant information was elicited from the respondents and recorded by the researcher personally.

3.5 STATISTICAL ANALYSIS OF DATA:

The data so collected were processed, tabulated and analyzed using frequency, percentage, mean score, mean percent score(MPS),

3.5.1 Frequency and percentage:

Simple comparisons were made on the basis of frequency and percentage.

3.5.2 Mean Score:

Mean score for each item was calculated by adding the weights given to the item by all the respondents and then divided by number of respondents.

Formula,
$$MS = \frac{\text{Total score of a practice}}{\text{Total number of respondents}}$$

3.5.3 Mean per cent Score (MPS):

Mean per cent score was obtained by multiplying score of the respondents by hundred and dividing by maximum obtainable score under each practice.

Formula,

$$MPS = \frac{\text{Total score obtained by the respondents}}{\text{Maximum obtainable score}} \times 100$$

3.5.6 Rank:

Ranks were awarded in the descending order according to the frequencies/MPS. This was used to find out the knowledge of methods, adoption and constraints related to contraceptive methods.

RESULT AND DISCUSSION

To make a research more scientific and sound, the sequels needs to be presented statistically and interpreted logically. The chapter of the project aims to highlight the findings in the form of analysis of data, interpretation of results and their explications.

The investigation was carried out into two categories of respondents i.e., rural tribal and urban tribal women. The results and their interpretation have been presented under following heads

4.1 Socio-economic status of the respondents

4.2 Knowledge and knowledge gap among rural and urban tribal women regarding different available contraceptives by the respondents for population control

4.3 Adoption level of the contraceptives by the respondents for population control.

4.1 SOCIO-ECONOMIC STATUS OF RURAL AND URBAN TRIBAL WOMEN

4.1.1 Age of respondents

All women included in the study were married women below the age of 45 years. The Table indicates age wise distribution of the respondents.

It can be seen from the table that the women in the age group of 25 to 35years formed the largest group (40%) followed by those in the 35 to45 years age group (31.7%). When we compared the age distribution of women from rural and urban women, we found that a large group (43.3%)

belongs to more than 35 years age in rural area whereas in urban area, women between the age of 25 to 35 years (40%) formed the majority. Thus the women from the rural area were comparatively older than those in the urban area.

Table 4.1. Age wise distribution of respondents

S. No	Age distribution	Rural tribal (n=30)		Urban tribal (n=30)		Total (n=30)	
		F	P	F	P	F	P
1.	Below 25 years	7	23.33	10	33.33	17	28.3
2	25-35 years	10	33.33	14	46.66	24	40
3	More than 35 years	13	43.33	6	20.0	19	31.7
	Total	30	100.0	30	100.0	60	100.0

F= Frequency, P= Percentage, n= Number of respondents

4.1.2 Education of respondents

Education is considered to be one of the most important variables affecting fertility behavior. Education provides a wide arrange of general information including attitudes favorable to birth control, Knowledge and access to modern and effective methods of contraception .

Table4. 2. education wise distribution of respondents

S.N o.	Age distribution	Rural tribal (n=30)		Urban tribal (n=30)		Total (n=30)	
		F	P	F	P	F	P
1.	Illiterate	27	90	23	76.69	50	83.35
2	Can read	1	3.33	2	6.66	3	5.00
3	Can read and write	1	3.33	0	0.00	0	1.66
4.	Primary education	1	3.33	2	6.66	3	5.00
5	Up to middle	0.0	0.00	1	3.33	1	1.66
6	Secondary or higher secondary	0.0	0.00	2	6.66	2	3.33
	Total	30	100.0	30	100.0	60	100.0

F= Frequency, P= Percentage, n= Number of respondents

Table 2 indicates the education level of the respondents. Data indicated that the literacy level of women in this study was found to be very low (16.6%). Very few women (10%) had studies beyond primary level. When we compare the rural and urban tribal women, we found that literacy level among urban woman was higher (23.3%) than rural woman (10%).

As many as 80 per cent of women in their child bearing years in rural Gujrat are still illiterate. The education of women plays an important role in changing their attitude and behavior. It helps to improve their quality of life.

4.1.3 Occupation of respondents

Women's occupation has often been considered as one of the important variables that influence fertility.

Table 4. 3. Occupation wise distribution of respondents

S.No.	Occupation	Rural tribal (n=30)		Urban tribal (n=30)		Total (n=30)	
		F	P	F	P	F	P
1.	Housewife	7	23.33	12	40.00	19	31.66
2	Agriculture	13	43.33	0	0.00	13	21.66
3	Small business	0	0.0	1	3.33	1	1.66
4.	Service	0	0.00	2	6.66	2	2.66
5	Labour	10	33.33	15	50.00	25	41.66
6	Other	0	0.0	0	0.00	0	0
	Total	30	100.0	30	100.0	60	100.0

F=Frequency, P= Percentage, n= Number of respondents

Table 3 gives a clear picture of women's occupation. A large number of respondents 25 (41.66%) belonged to labour class. Majority of women were engaged in agriculture 13 (43.3%) in rural areas whereas, a large group of women 15 (50%) were working independently and belonged to labour class in urban areas.

4.1.4 Occupation of husband

It is generally observed that the occupational status of husband is another important variable that influence fertility knowledge. Table 4 reveals that a large majority 60 (50%) of respondents husbands belonged to labour class group and second largest group belonged to agriculture category 18 (30%). When we compare according to rural-urban setting 18 (60%) tribal males were engaged in agriculture only in rural areas while nearly half 18 (60%) respondents husbands belonged to labour class in urban areas.

Table 4.4. Occupation wise distribution of respondent's husband

S.No	Occupation	Rural tribal (n=30)		Urban tribal (n=30)		Total (n=30)	
		F	P	F	P	F	P
1.	Unemployed	7	00.00	4	13.33	4	6.66
2	Agriculture	13	60.00	0	00.00	18	30.0
3	Labourer	0	40.00	18	60.00	30	50
4.	Business	0	00.00	5	16.66	5	8.33
5	Service	10	00.00	3	10.00	3	5
6	Service+ Agriculture	0	00.00	0	00.00	0	0.0
7.	Business+ Agriculture	0	00.00	0	00.00	0	0.0
	Total	30	100.0	30	100.0	60	100.0

F=Frequency, P= Percentage, n= Number of respondents

4.1.5 Total family income

Table 5 gives a clear picture of respondent's total income. Nearly half of the respondents (48.3%) had their income less than Rs.1,500 per month. When we compare the data, 20 per cent respondents have an income less than Rs.1500 per month in urban area while in rural area, more than three fourth respondents (76.6%) have an income less than Rs.1500 per month. Data clearly indicates that tribal people living in rural areas have low economic status. It is surprising that only 1 (3.3%) respondents had their salary more than Rs.3000 per month in rural areas.

Table 4.5. Total family income wise distribution of the respondents

S.No	income distribution	Rural tribal (n=30)		Urban tribal (n=30)		Total (n=30)	
		F	P	F	P	F	P
1.	Less than Rs.1500/month	23	76.66	6	20.00	29	48.33
2	Rs.1500-3000 above/month	6	20.00	14	46.66	20	33.33
3	Rs.3000 above/month	1	3.33	10	33.33	11	18.33
	Total	30	100.0	30	100.0	60	100.0

F=Frequency, P= Percentage, n= Number of respondents

4.1.6 Availability of material

Radio, T.V., tape recorder and two wheelers like bicycle/moped/motor bike or socio-economic status which shows the development or standard of living of respondents.

Table 4. 6. Distribution of respondents according to availability of material

S.N o.	Occupation	Rural tribal (n=30)		Urban tribal (n=30)		Total (n=30)	
		F	P	F	P	F	P
1.	No item	26	86.66	5	16.66	31	51.6
2	Radio	1	3.33	3	10	4	6.7
3	T.V.	0	0.0	10	33.33	10	16.7
4.	Tape	0	0.0	1	3.33	1	1.66
5	Cycle/Scooter/Motor Cycle/Bide/Moped	3	10	11	36.67	14	23.33
	Total	30	100.0	30	100.0	60	100.0

F=Frequency, P= Percentage, n= Number of respondents

It is very surprising that more than half 31 (51.6) respondents didn't had any mentioned item inn their home while nearly one-fourth (23.3%) respondents had two wheelers and half 10 (16.7%) of the respondents had television, 4(6.7%) respondents had radio and only 1 (1.6%) respondents had tape recorder in their home. It was very surprising that not a single respondent had television and tape recorder in rural areas,

3(10%) used two wheelers and a very few 1(3.3%) had radio in rural areas. A large number of respondents 26(86.6%) didn't have any entertainment facility and 10 (33.3%) respondents were regularly watching television and only 3(10%) women had radio and only 1(3.3%) women had tape recorder. So, it is clear from the table that rural women were less associated with media and facilities than urban women.

4.2 KNOWLEDGE REGARDING DIFFERENT AVAILABLE CONTRACEPTIVES FOR POPULATION CONTROL

After having a look on the respondent's socio-economic status, level of knowledge as mentioned under the objective 2, has been studied here. It is logical to argue that knowledge about contraceptives is a necessary pre-condition to practice it or to express a positive intention for future use. Therefore, first of all, the extent of knowledge about contraceptive methods has been studied here and distribution of the respondents to depict the knowledge level of contraceptives for population control has been already given in table.

Different methods of contraception are available for the couples in the reproductive age group. Some methods are advised for birth spacing whereas other is for sterilization, which is normally advocated after getting the desired number of children. Knowledge level of major methods on different stages of family life cycle has been presented. Major aspects of particular method wise knowledge level have been given in below Table.

As mentioned earlier in the chapter of methodology (section-I), a knowledge test was used to assess the knowledge of respondents. On the basis of the knowledge test, different methods of contraception viz., (i) General information related to family planning methods (ii) Condom (iii) Oral pills (iv) Cooper-T (v) Sterilization were included in the study and analyzed each method have importance on every stage of reproductive life. Government approved methods like condom use after marriage and

oral pills, Copper-T (IUDS) use for spacing between two children and sterilization (tubectomy/vasectomy) use after two children, when family completed.

In order to increase the level of adoption of contraceptive methods, the level of knowledge of the tribal women has to be higher as per many research findings. The investigator has tried to determine the knowledge level of rural and urban tribal women.

4.2.1 Level of knowledge of respondents about contraceptive methods for population control

The get an overall view of the selected respondents, they were categorized into three knowledge strata on the basis of knowledge score obtained viz., low, medium and high. These categories were framed on the basis of calculated mean and standard deviation. The results have been presented in Table7.

The perusal of data presented in Table7 visualizes that nearly three-fourth respondents 44 (73.3%) belonged to average knowledge category, followed by 9(15.0%) respondents who possessed high knowledge regarding contraceptive methods. Further, it was observed that only 7 (11.6%) of the total respondents could be placed in the category of low knowledge about contraceptive methods.

Table4.7 Distribution of respondents according to their level of knowledge about contraceptive methods.

S.No.	Level of knowledge	Rural tribal (n=30)		Urban tribal (n=30)		Total (n=30)	
		F	P	F	P	F	P
1.	Low knowledge (below 6.34)	6	20	1	3.33	7	11.66
2	Average knowledge (6.34 to 25.54)	20	66.67	24	80	44	73.34
3	High knowledge (above 25.54)	4	13.33	5	16.67	9	15.0
	Total	30	100.0	30	100.0	60	100.0

F=Frequency, P= Percentage, n= Number of respondents

A close observation of data makes it clear that more than half 100(66.6%0) of the rural tribal respondents possessed average level of knowledge followed by 6 (20%) with low level of knowledge and only 4 (13.3%) respondents possessed high knowledge regarding contraceptive methods. Whereas, majority of urban tribal respondents 24 (80%) were found to have average level of knowledge, followed by 5 (16.6%) respondents belonged to the high knowledge category while only 1 (3.33%) respondents had low level of knowledge.

It is concluded that majority of the respondents of both categories fell under average level of knowledge category about contraceptive methods. At the same time, it is to be noted that urban tribal

number,5 (16.6%) is higher than of 4(13.3%) rural tribal having higher extent of knowledge regarding contraceptive methods.

In other words, it is concluded that urban tribal of the study area possessed higher knowledge about contraceptive methods as compared to rural tribals. It may be due to the reason that urban tribal possessed high economic status, and their literacy rate was on the higher side and furthermore, urban tribals were found to be relatively more exposed to the various communication media in the urban area as against rural area.

Based on the results, it is recommended and suggested that both the categories of women need to be enlightened by way of education, for acquisition of higher level of knowledge about population control measures. Rural tribal women are needed to be emphasized more for knowledge up gradation of contraceptives as their level of knowledge is comparatively lower than urban tribals, That task of knowledge up gradation can be given to PHC, NGOs of the area, Aanganwadis, school staff of the areas who can be entrusted the responsibilities, school staff of the areas who can be entrusted the responsibilities for time bound education programme about contraceptive methods of the study area.

After distributing the targeted respondents under different strata of knowledge level of contraceptive methods for population control, it was thought proper to analyze the knowledge level of tribal women in the context of major practices included in the study. There were altogether five practices, identified for the purpose of analysis of knowledge level of tribal women. Results are given in Table 8.

Table 4.8. Overall knowledge of respondents regarding major aspects of contraceptive methods

S. No.	Occupation	Rural tribal		Urban tribal		Total	
		MPS	Rank	MPS	Rank	MPS	Rank
1.	Family planning methods	25.75	II	33.60	III	29.70	III
2	Condom	40.00	I	48.38	I	44.13	I
3	Oral pills	21.38	IV	24.50	IV	22.88	IV
4.	Cooper-T	4.71	v	13.57	V	9.14	V
5	Sterilization	24.73	III	47.91	II	36.27	II

As far as level of knowledge of respondents about contraceptive is concerned. The respondents have been categorized into three groups as given in Table7. Therefore, five major aspects of contraceptive methods viz., family planning methods, condom, oral pills, Copper-T and sterilization (tubectomy and vasectomy). It was also felt that major aspects wise knowledge of respondents regarding contraceptive methods should also be studied so that the picture may become more clear. With this view, all the five major aspects were ranked on the basis of MPS of knowledge of respondents. The data are given in Table8.

A perusal of data in Table8 indicates that out of total five major aspects of contraceptive methods, both the groups of respondents had maximum knowledge about temporary methods i.e., “condom” which acquired overall MPS 44.13 ranked first. It was followed by (permanent method) “sterilization” , “family planning method” and oral pills which were ranked second, third and fourth with their respective total MPS 36.27, 29.70 and 22.88. As regard the knowledge level of all the respondents, one spacing

method i.e. (IUDS) cooper-t was placed at very bottom with overall MPS of 9.14.

Table also expressed that there had been significant difference between rural tribal and urban women with regard to their level of knowledge about all the major aspects of contraceptive methods except one, i.e., “oral pills”. Meaning, urban tribal women of the study area possessed higher knowledge about contraceptive methods than those of rural tribal .

On the basis of ranking pattern of knowledge, it can be concluded that rural and urban tribal women of the study area possessed high level of knowledge with regard to “condom” followed by “sterilization” (vasectomy and tubectomy), knowledge of “Family planning methods” and oral pills. Almost all the rural and urban women had least knowledge about Copper-T.

In conclusion, it can be stated that urban tribal women of the study area possessed higher knowledge about different methods of contraception as compared to rural tribal women.

On the basis of results of table, it is strongly recommended and suggested that Government, NGOs and medial staff should make it a point and direct their concerted efforts to equip the rural the rural and urban tribal’s with latest technologies if contraceptive methods and provide and provide knowledge about advance methods of contraception. A strategic and well-planned intensive training programme in a phased and planned manner for the married couples would definitely enable them to adopt contraceptive methods for population control but rural tribal women need more training regarding all these aspects. Therefore, training of tribal’s regarding contraceptive methods should be prioritized by the government and non-government organization, health institution and extension agencies.

4.3 ADOPTION LEVEL OF RESPONDENTS REGARDING CONTRACEPTIVE METHODS

Part III deals with the adoption of contraceptive methods among rural and urban tribal women.

Overall ranking pattern for both the types of respondents regarding their adoption about contraceptive methods shows that they possessed highest adoption about “condom” ranked as first with MPS 29.06 followed by “oral pills” was ranked at second place with total MPS 19.39 and “female sterilization” which had been ranked third with MPS 19.33 . It is very strange that a large number of respondents adopted traditional methods viz., “herbal medicine or ; plants” and other methods like withdrawal, self-control, abortion as a contraceptive method and “safe period method” and ranked IV, V and VII. Not a single respondent adopted male sterilization and ranked lastly. When we compare the data, highest adoption of “condom method” ranked at first in both areas bu the adoption rate is higher in urban areas than rural areas. Female sterilization and oral pills is also popular method in urban areas and ranked II and III with MPS 29.56 and 17.56, while in the rural areas, we found that oral pills and herbal medicine are most popular method and occupied on II and III position.

Findings are in conformity with the findings of Ingle et al.(1999) wherein their study, they reported that 25 per cent of the eligible couples are currently using any contraceptive method and amongst the current users, the commonest method was tubectomy (59%).

Table4.9. Overall adoption of respondents regarding major aspects of contraceptive methods .

S. NO	Major aspects	Rural Tribal		Urban Tribal		Total	
		MPS	Rank	MPS	Rank	MPS	Rank
1.	Condom	21.89	I	36.22	I	29.06	I
2.	Oral pills	21.22	II	17.56	III	19.39	II
3.	Cooper-T	2.22	VI	10.22	IV	6.22	VI
4.	Safe periods	9.11	V	0.22	VII	4.67	VII
5.	Female sterilization	9.11	V	29.56	II	19.33	III
6.	Male sterilization	0.00	VII	0.00	V	0.00	VIII
7.	Herbal medicine and plants	19.57	III	4.44	VI	11.98	VI
8.	Other methods	14.00	IV	3.78		8.89	V

Women's showed negative respondents towards male sterilization and not a single respondent's husband adopted this method. It might be due to the least knowledge about this method as has been evidently visualized in Table 9. Tribal people still believes in traditional method because these herbs and plants are easily available in the area and they do not have any side effects. Women showed negative response towards (IUDS) Copper-T because of its side effects or this might be one reason that there may not be trained staff in PHC so it is necessary to give proper training to medical staff especially for IUD insertion.

4.4 CONSTRAINTS IN ADOPTION OF POPULATION CONTROL MEASURES AMONG RURAL AND URABAN TRIBAL WOMEN

The constraints, which “put shackles on” to the tribal respondents in the study area were critically analyzed in this section. In the present context, the term constraint refer to all those barriers and barricades, which were faced by tribal respondents in adoption of population control measures. So it was felt incumbent to several difficulties faced by tribal women in the use of contraceptive for birth control.

The responses of the rural and urban tribal women were recorded on a three point continuum i.e. most severe, severe and least severe. The frequencies of respondents under each category were calculated and the ranks were accorded accordingly. Effects were further made to analyze and discuss the constraints taken under different categories viz., constraints, related to methods, financial constraints, technical constraints, social constraints, constraints related to health and miscellaneous constraints. The results are presented in the following tables.

4.4.1 Distribution of respondents on the basis of constraints faced by them in adoption of contraceptive methods

In order to describe the sample, the rural and urban tribal respondents were suitably categorized into three categories viz., least severe and most severe constraints. The categories about the intensity of constraints were made on the basis of mean score and standard deviation of the score obtained by the respondents.

A perusal of the data accorded in Table 10 clearly indicate that majority of tribal respondents 160 (53.3%) suffered severely with the problems in adoption of contraceptive methods, where as considerable number of respondents 72 (24%) reported that they have perceived the constraints with least severe magnitude. Further relatively less number of respondents 68 (22.7%) was reported in the category of most severe constraints in adoption of contraceptive methods.

Table 4.10 Distribution of respondents on the basis of constraints faced by rural and urban tribal women

S.No.	Constraints	Rural Tribal (n=30)		Urban Tribal (n=30)		Total (n=60)	
		F	P	F	P	F	P
1.	Least sever (less than 33.06)	7	23.33	7	23.33	14	23.33
2.	Sever (33.06 to 35.92)	18	60.00	14	46.7	32	53.34
3.	Most sever (more than 35.92)	5	16.67	9	30.00	14	23.33
	Total	30	100.0	30	100.0	60	100.0

F= Frequency, P= Percentage, n= Number of respondents.

A close observation of the data indicates that the number of rural tribal respondents 18 (60.0%) in the category of severe constraints was much higher than that of urban tribal women 14 (46.7%). Obviously the number of urban tribal respondents in the category of most severe constraints was more 9 (30%) than that of rural tribal respondents 5 (16.6%). An overview of the data shows that the respondents in general and rural tribal in specific have perceived the constraints severe in adoption of contraceptive methods in the study areas. This may be due to lower socio-economic status, illiteracy or poor educational standard, rigid social system that might have lead to severe problem for them.

4.4.2 Constraints perceived by the rural and urban tribal respondents regarding contraceptive methods

Scientific research in the field of contraceptive technology is moving very fast. There is no dearth of technical know-how in these days of advanced technology. But the most complex and significant problem of our age is timely dissemination of contraceptive technology and its proper utilization by the married couples. There may be innumerable constraints before the tribal women, consequently they are not adopting the contraceptive method to the extent as expected. Therefore, one of the objectives of the study was to find out the constraints being faced by the respondents in adoption of contraceptive methods. An attempt has been made to identify the constraints in adoption of contraceptive methods. The constraints perceived by the respondents have been presented as under. The perusal of Table 11 revealed that technical constraints in contraceptive methods were perceived as most important constraints by respondents with MPS 68.83 and were ranked first. This was followed by other constraints; constraints related to method, constraints related to health, social constraint aspects. They had MPS 61.88, 56.56, 55.71 respectively. The constraints, which were perceived with less intensity, was financial constraints (50.83) and ranked at VI.

A close observation of data indicates that technical constraints were faced maximum in both areas but the number is higher in urban areas with MPS 71.33 than rural areas with MPS 66.33. the reason might be illiteracy and lack of awareness so there is need by concerned agencies to technical know-how about contraceptive methods.

Table4. 11. Constraints perceived by the rural and urban tribal Respondents regarding contraceptive methods

S.no	CONSTRAINTS	Rural tribal		Urban tribal		Total	
		MPS	Rank	MPS	Rank	MPS	Rank
1.	Constraints related to methods	57.78	III	55.33	VI	56.56	III
2	Financial constraints	50.33	VI	51.33	VI	50.83	VI
3	Technical constraints	66.33	I	71.33	I	68.83	I
4.	Social constraints	53.27	V	53.47	V	53.37	V
5	Constraints related to health	55.00	IV	56.42	III	55.71	IV
6	Other constraints	60.62	II	63.14	II	61.88	II

Other constraints were faced by rural and urban tribal women equally and ranked II but the number is again higher in urban areas with MPS 63.14 than rural areas with MPS 60.62 Other constraints are lack of regular supply, doubt to infertility in future, desire for more children, lack of privacy, desire for son etc. Urban tribal women stated constraints related to health is III important constraint with MPS 56.42 while rural women show attention on constraints related to methods with MPS57.78.

4.5 STRATEGIES FOR ADOPTION OF POPULATION CONTROL MEASURE

Based on the overall outcome of the study including researcher's own experience , the following strategy for adoption of population control measure in the study areas suggested Population control programmes will be successful if strategy made from administrative level to grass root or community level.

I. STRATEGY AT ADMINISTRATIVE LEVEL

1. Farming of rules by the government in distribution of amenities services and privileges.
2. To build a strong commitment on the part of top level programme managers to popularize spacing methods by giving proper direction to their performance in recruiting spacers by taking steps to improve the quality of services ensuring reliability of performance and periodically and systematically reviewing their performance.
3. Programme has developed in such a way that if focuses on the appropriate location of clinics, proper distribution and counseling to increase knowledge and adoption of contraceptives.
4. Family planning counseling centers should be concentrate more in rural areas.
5. Efforts must be made for improvement of female education. Education has a substantial effect on the commencement of the onset of fertility transition even in the absence of a strongly organized national family planning programme .
6. Programme should not be imposed but it should be made in this manner that couple take interest for adoption of contraceptives.
7. Husband is a main source of information regarding use of contraceptives so programme should target male member also.

8. There should be more intervention and choices of male methods of contraception.
9. Proper communication strategy for rural people to transmit quick information about population control methods.

II. STRATEGY AT HEALTH AGENCY LEVEL:

1. It has been observed that the area of training remained unexpected by concern agencies. This has resulted in poor knowledge and adoption of contraceptives. Timely training on population control measures should find its place in yearly action plan of Department of health and concern agencies.
2. Involvement of panchayat (local self –government) in programme planning, implementation and monitoring successfully promote the program.
3. An alternative approach to popularizing male sterilization must be adopted through client counseling and education using communication strategies including mass media.
4. For each primary care unit on the periphery at least one female primary health care worker should be recruited who in addition to a basic nine month training course should have had six weeks of training in population control measures.
5. Quality of family planning services and proper follow –up must be ensured. The role of family planning/social workers need to be increased to minimize the technical and socio-cultural constraints that women face in acquiring services.

III. STRATEGY AT COMMUNITY LEVEL:

1. Efforts must be intensified to postpone marriage among adolescent girls, It is important to raise awareness among girls; schools and communities about the health consequences of early pregnancy. Legislation prohibiting marriage for girls under 18 years must be strictly implemented.

2. One to one interaction for counseling and promotion of contraceptives ensures use by them.
3. Contact and inform to formal and non –formal village leaders, members of women's and youth organization and teachers about the high risk of over population and control measures for knowledge and adoption in the tribal community.
4. Group talks should be given to women. Tribal women would brought together by prior intimation to the community through local multipurpose workers and community health guides. The main objective covered reproductive organs of male and female, population problem, need for population control, various risk factors and associated dangers of population explosion, knowledge about different methods of contraceptive methods.

Chapter 5

Summary and conclusion

The reference of the study so bought out relating to the specific objectives including the possibilities of future prospects and strategy for knowledge and adoption of contraceptive in this chapter.

Single greatest threat to india's health, political, economic and social development is uncontrolled population growth with it population already exceeding one billion .It is all set to overtake China and become the most populous country in the world in 2045.

India is overwhelmingly rural. Out of more than one billion of people inhabiting the territory, more than 80 percent lives in 5,55,089 villages and only a small part 20 percent

Since long, the tribal and rural area of our country remained isolated from the modern developing civilization because of various reasons. Lack of communication and transportation facilities like in the urban area may be the main reason for their backwardness. Thus benefits of medical aid education and better living were confined to urban people only .even now, hospitals and specialized clinics are concentrated in big towns and cities. The villages are not only deficient conditions, illiteracy, lack of privacy and above all the poverty. These are factors add in the unhealthy and unchecked growth of tribal population Because of ignorance ,tribal masses cannot understand the direct impact of high population growth, which pres them to lead starved or semi-starvation life. They put all these consequences to the God and luck.

Major findings of the study (conclusion)

- 1) It was found that a large group (40%) belong to higher middle age group (35-45) years in rural areas whereas in urban areas, (45.3%) women between middle age (25-35) group formed the majority.
- 2) Relatively, literacy level among urban women was higher (22.6%) as against that in the rural women (8.1%).
- 3) A number of respondent were engaged in agriculture (42.7%) In rural areas as compared to 41.66% percent belong class in urban areas.
- 4) 20 percent respondent have an income was less than 1500 Rs/month in urban area while in the rural areas, , more than three –fourth respondent (77.3%) have an income less than 1500 Rs/month.
- 5) A large number of respondents (85.3%) did not have any entertainment facility like T.V,radio,tap recorder and vehicles in rural areas, while 37.33 percent respondent use two wheelers in rural areas and 34.7 percent urban women regularly watching television.
- 6) Data show that not a single respondent living in pucca house in rural areas while 38.7 percent respondent living in pucca house in urban house.
- 7) Data indicated that both groups of tribal respondent had maximum knowledge about temporary methods i.e.,”condom”.
- 8) It can be stated that urban tribal women of the study area possessed higher knowledge about different methods as compared to rural tribal women.
- 9) Although knowledge regarding copper-T is lowest among all methods yet knowledge of this method is least among rural areas than urban areas.
- 10)Urban women possessed highest knowledge about “knowledge about sterilization” with MPS 90.67 while rural women showed highest knowledge about “is this permanent method” with MPS 56.67.
- 11)It was found that more than three fourth respondents (82.7%) had neutral attitude towards population control methods in the study area.

- 12) The number of rural tribal respondents in neutral category was reported to be more 144(96.0%) than the urban tribal respondents i.e., 104(69.3%).
- 13) It was noted that the numbers of tribal respondents from urban areas were relatively more 46(30.7%) in favorable attitudes category than rural tribal respondent.
- 14) It was found that rural and urban tribal respondent possessed highest adoption about condom ranked as first but the adoption rate is higher in urban areas than rural areas.
- 15) Female sterilization is second popular adopted method in urban areas and oral pills are most popular method in rural areas and occupied II position.
- 16) Tribal women showed negative responses towards the male sterilization and not a single respondent's husband adopted this method.
- 17) Data indicated that the number of rural tribal respondent 90(60%) in the category of severe constraints was much higher than that of urban areas but the number was higher in urban areas than rural areas.
- 18) It was noted that husband was one of the most important source of information in both rural and urban areas.

RECOMMENDATION

1. it is recommended and suggested that the tribal women of saberkatha district are in need of still more education with regards to two important methods e, e. "cooper-T" and "male sterilization" Both of these two areas contraception.
2. It is recommended that aware men and women regarding devastating consequences of over population.
3. It is suggested for increasing knowledge that educates rural masses about family planning and use of overpopulation.
4. It is stated that mobilization of medical personnel in the rural areas for taking the problem of overpopulation.

5. It is stated identification of active members of social system and their involvement in lowering the population and awareness regarding birth control methods.
6. The tribals are needed to trained more about awareness and education regarding gender inequalities.
7. Fertility behaviour and contraceptive use of both men and women is influenced by a strong desire to acquire a minimum number of surviving sons in the family. Since women exhibit a stonger desire for sons.
8. measures related to improving tribal women's status in society would be one way of hasrening the erosion of prevailing social norms, which support and sustain son preference in the society.
9. It is suggested for proper direction and tanning of field workers, enable them to educate and motivate couples to use contraceptive methods at every stage of reproductive life.
10. The main factor affecting fertility behavior is age at marriage so age at marriage will have to be raised beyond nineteen among tribal area. It is important in this context that various media and communication channels should be geared up to make the tribal population aware of the benefits of late marriage and the adoption of small family.
11. It is recommended stongely and suggested that the agencies (government, university and NGOs) should make a point and divert their concerted efforts to equip the rural and urban tribals with latest technologies of population control measure. The staretegic and well planned intensive traning programe in the phased way for the needy clientele would definitely enable them to adopt contraceptive methods but rural tribals need regarding population all these aspects. Therefor, traning of tribls regarding population control measures should be prioritized by the concerned agencies that would control the overpopulation.

APPENDIX

INTERVIEW SCHEDULE PART-I

(A) Basic Information and Socio-economic status of the Tribal Women

- Name of Respondent:W/O
.....
 - Age
 - Caste
 - Name of Village/Werd
 - BlockDistrict
 - Type of Residence: (I) Rural
(II)Urban
 - Occupation of Huband:
Unemployed / Agriculture/ Labour/ Business/ Service/ Service+Agriculture/ Small
Business +Agriculture /Other
 - Occupation of Wife:
House wife /Agriculture/ Business/ Service/ Labour/ Small Business +Agriculture
/Other
 - Education :
 - (a) Illiterate
 - (b) Can read
 - (c) Can read and write
 - (d) Up to Primary Education
 - (e) Up to Primary Education
 - (f) Secondary or Higher Secondary
 - (g) Graduate and above
10. Total Income of Family
- (i). 1500Rs/Month
 - (ii).Between 1600 Rs. To 3000 Rs./Month
 - (iii)More than 3000Rs.

11. Total Agriculture land

- (i). Landless
- (ii). Less than one hectare
- (iii). Between one to two hectare
- (iv). Two to four hectare
- (v). More than four hectare

12. Social Participation

- I. No member of any Organization
- II. Member of one organization
- III. Member of more than one organization
- iv Officer of organization

13. Type of House

- (i). Kachcha House/Hut
- (ii) Semi-Pucca House
- (iii) Pucca House

14. Availability of Material in the House:

- (a) Radio
- (b) Television
- (c) Tap-Recorder
- (d) Video Cassette Player
- (e) Cycle/Scooter/Motor Cycle/Moped etc.

PART II

Knowledge Test of Tribal Women

(1) Family Planning Methods

(2) Heard the name of family planning?

(3) (i). Yes (ii) No

(2) If yes, then what do you mean by family planning ?

(i) Planned Family (ii) Big Family

(iii) Small Family (iv) Joint Family

(v) Less fertility (vi) Other

(3) Is it right to accept family planning ?

(i) Yes (ii) No

(4) If yes, then why family planning is essential ?

(i) To control over population

(ii) More pregnancy downs the mother's health

(iii) To make high economic standard (iv) Other

(5) Do you know the methods of family planning ? (i) Yes (ii) No

(6) If yes, then explain the method (i) Yes (ii) No

(i) Self Control (ii) Safe Periods

(iii) Different exercise methods (iv) Withdrawal method

(v) Condom/Nirodh (vi) Foaming Tablets

(vii) Oral pills (viii) Cooper-T

(ix) Female Sterilization(Tubectomy)

(x) Male Sterilization(Vasectomy)

(xi) Other method

(7) Just after marriage, till the women not conceive, which method used?

- (i) Condom (III) Copper-T
- (iii) Sterilization (iv) Ayurvedic methods
- (v) Other method

(8) For spacing between two children, which method can use ?

- (i) Oral Pills (ii) Cooper-T
- (iii) Sterilization (iv) Ayurvedic (v) Other method

(9) After two children, when family completed, which method one can use?

- (i) Male Sterilization (ii) Female Sterilization
- (iii) Condom (iv) other method

(A) Condom

(1) Heard the name condom (i) Yes (ii) No

(2) Material used to made condom

- (i) Rubber(latex) (ii) Plastic (iii) Other material

(3) Name of condom, which is available in the market.

- (i). Niroth (ii) Masti (iii) Kohinoor (iv) Mood (v) Other

(4) When to use ?

- (i) At the time of Sex (ii) Every time

(5) Do you read the method of use ?

- (i) Yes (ii) No

(6) How many times, one Condom can use ?

- (i) Only one time (ii) More than one time (iii) Don't know

(7) Advantage of Condom

(i) Prevents from Sexual disease (ii) Safe and economic

(iii) Convenient in use (iv) Easily available

(v) No side effects on body (vi) Don't know

(B) Oral Pills

(1) Heard about oral pills. (i) Yes (ii) No

(2) Which Brand of pills available in the Market.

(i) Mala-D (ii) Mala-N (iii) Pearl (iv) other (v) Don't know

(3) During Menstruation cycle, on what day one can use oral pills?

(i) From Fifth day (ii) From First day.

(iii) After Ten days (iv) Don't know

(4) Colour of pills.

(i). White and Red colour (ii) Only white colour

(iii) Only red colour (iv) Don't know

(5) Compare to other methods, what is the advantage of oral pills

(i) . Convenient in use (ii) prevent from ovarian cancer

(iii) protects from acne and pimples (iv) Other

(6) When not to use oral pills?

(i) If the women is pregnant (ii) Breast feeking mother

(iii) If women is suffering from Diabetes, hysteria, Jaundice, Cncer etc.

(iv) Don't know

(7) Do you know about emergency pills ? (i) Yes (ii) No

(8) When to use

(i). If unsafe sex occurred (ii) When condom fail

(iii) If any one has suffered from sexual abuse like rape etc.

(iv) Don't know

(C). Copper-T

(1) Heard about Copper-T .

- (i) Yes (ii) No

(2) Shape of Copper-T

- (i) T-Shape (ii) S Shape (iii) Don't know

(3) Material Used to make Copper-T

- (i) Plastic and Copper (ii) Only Copper
(iii) Only Plastic (iv) Don't know

(4) How many times, Copper-T can prevent pregnancy?

- (i) 2 to 3 years (ii) 10 to 12 years
(iii) Whole life (iv) Don't know

(5) Advantage of Copper-T

- (i) Economic (ii) Convenient
(iii) Long time use method (iv) No obstacle during sex
(v) other

(D) Sterilization (Operation) Male/Female

(1) Do you know about sterilization.

- (i) Yes (ii) No

(2) Who can be sterilized?

- (i) Women (ii) Men (iii) Women and men both (iv) Don't know

(3) Is male and female sterilization a permanent method ?

- (i) Yes (ii) No

(4) Which sterilization is easier?

- (i) Male Sterilization (ii) Female Sterilization (iii) Don't know

(5) Time taken during male sterilization.

- (i) 5 to 10 minutes (ii) 3 to 4 hours (iii) Don't know

(6) Is female sterilization a painful surgery method?

- (i) Yes (ii) No

(7) Precautions needed after male sterilization

- (i) Use a condom till two days after sterilization
(ii) Prevent from wetness the space of operation
(iii) Avoid heavy and tiring work till two days
(iv) Don't use a bicycle till seven days
(v) Use of a condom till three months, after sterilization
(vi) Don't know

(8) Is sterilization effective, just after operation.

- (i) Yes (ii) No

(9) Appropriate age of women for sterilization.

- (i). 25year (ii) 22year (iii)28year (iv) 30year (v) Don't know

(10) After how many children, a married couple can use sterilization.

- (i) After three children (ii) After two children

- (iii) After five children (iv) After four children (v) Don't know

PART III

Adoption of Contraceptive methods for population control

S.No.	Method	Ever using	Used some time	Use Currently	Will Use in future	Used after marriage	Used after birth of child	Never used
1.								
2.								
3.								
4.								
5.								
6.								
7.								

PART IV

Constraints in Adoption of Population Control measures

S.No.	Constrains	Intensity		
		Most Severe	Severe	Least Severe
A	Constraints related to methods:			
1.	Methods failed			
2.	Lack of Knowledge about methods			
3.	Unavailability to methods			
4.	More requirement of Methods			
5.	Low quality of methods			
6.	Inconvenient in use			
B.	Economical constraints:			
1.	High rate of method			
2.	Not available free of cost			
C.	Technical constraints:			
1.	How to use method?			
2.	No organization available to arrange training of technical knowledge			
D.	Social Constraints:			
1.	Against Religion			
2.	Social insecurity			
3.	Hesitation			
4.	Objection by relatives			
5.	Objection by Husband			
E.	Heath Constraints:			
1.	Weakness during work			
2.	Side effects on body			
3.	Lose/gain weight			
4.	Difficult to get pregnant			
5.	Pain in waist/body			
6.	Irregular Menstruation			
7.	White discharge			
8.	Afraid from Surgery and pain			
F.	Miscellaneous constraints:			
1.	Illiteracy or poor education			
2.	Difficulty to conceive in future			
3.	Desire for more children			
4.	Lack of privacy			
5.	Desire for son			
6.	Other			