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RESEARCH ARTICLE

FAMILY PLANNING AWARENESS IN RURAL, URBAN AND TRIBAL POPULATIONS

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ABSTRACT

Millions of women worldwide want to prevent pregnancy, but they are focusing on termination of unwanted pregnancies rather than following suitable contraceptive methods – either male or female. This study was made to evaluate the knowledge and practice of temporary or permanent family planning methods used by women and men of rural, urban, and tribal areas.

Objectives

1. To evaluate the awareness of men and women regarding family planning.
2. To ascertain the implementation of various family planning methods among the populations.
3. To establish the reason for not using certain contraceptive methods.

INTRODUCTION

With a population of greater than 1.3 billion people, a high fertility rate leading to rampant population growth which is a burden not only to individuals and families, but to the entire nation. Millions of women in India desire the reproductive freedom to prevent pregnancy, but they are focusing on the termination of unwanted pregnancies rather than using safer, regular contraceptive methods – either male or female. In India in the last year alone, 15.6 million pregnancies ended in abortion (World contraception day survey 2015). Of the 48.1 million pregnancies in India in the last year, about half were unintended. Unwanted pregnancies are a result of host of factors. The immediate cause is unprotected sexual intercourse, which itself is the result of factors such as lack of awareness, religion, illiteracy, fear of social disapproval etc. According to a recent survey, India is one among the countries with a high percentage of unprotected sex. So study was done to evaluate the knowledge and practice of temporary and permanent family planning methods used by women and men of rural, urban and tribal areas. Family planning reduces the number of unintended and unwanted pregnancies and thereby saving women from high risk pregnancies and unsafe abortions. Other benefits accruing from family planning methods include prevention of cancers, sexually transmitted infections and infection with the Human Immunodeficiency Virus. Furthermore, investing in family planning as a component of good reproductive health has benefits that go beyond the obvious prevention of unwanted pregnancy and reduction of disease burden. The social and economic benefits for global development goals should not be overlooked. Though all the Family planning methods are supplied at free of cost (ref1) by Government, and the P.H.Cs and R.H.Cs are provided with the facilities like Infra-structure, material and professionals but acceptance by both genders is not proportionate to awareness. The job of family planning remains unfinished despite great progress over the last several decades. More than 120 million women worldwide want to prevent pregnancy but they and their partners are not using contraception. Reasons for unmet need are many. These people need help now. Because of this reason, a proforma was made to study the knowledge of various temporary and permanent family planning methods:

- Their usage
- Duration of usage
- Side effects
- Contraindications
- Myths and superstitions

Although the respondents reported that family planning services are available in their areas, we found that some women do not use the modern family planning methods because of the negative attitude, myths and beliefs that surround the use of family planning methods. We found that there was a common belief among female respondents that contraceptives affect male reproductive organs, causing men to be impotent. In the same pro forma, few questions were included to get the information whether PHCs, medical staff,

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ANMs, who are provided with various family planning kits, are properly advising and educating the women in the reproductive age group in their particular area. The results were tabulated.

MATERIALS AND METHODS

The project was approved by the College of Medicine Research and Ethics Committee (COMREC) prior to conducting the study. A descriptive cross-sectional study was done on 1000 participants (both male and female) with qualitative and quantitative analysis. The study was conducted from 2017 July first to 2018 July first.

Proforma were distributed to

1. Women attending family welfare clinic of NRIIMS.
2. Attendants of the patients
3. Patients attending PHC & RHC (Padmanabham mandalam… Potnur, Pandrangi etc. & s. kota) affiliated to NRIIMS.
4. House wives (door to door visit) of urban area, Akkayapalem, Gajuwaka.
5. Medical professionals (by verbal & written survey)
6. Residants of tribal areas (Lotheru, Balluguda, Devuduvalasa- Araku, Bangarumetta – Paderu)

RESULTS

A well-structured questionnaire was used for data collection on general information, knowledge and attitude regarding family planning methods, and contraceptive practices. Collected data was analyzed with regard to the information given by the subjects in the set questionnaire. The completed copies of the questionnaire were serially numbered for control and recall purposes. Data collected was checked for completeness and accuracy on a daily basis. Results were tabulated as follows

Table 1. Age distribution of the study group (1000)

Age in years	No. of patients	Percentage
18 – 25	620	62%
26-35	213	21.3%
>35	167	16.7%

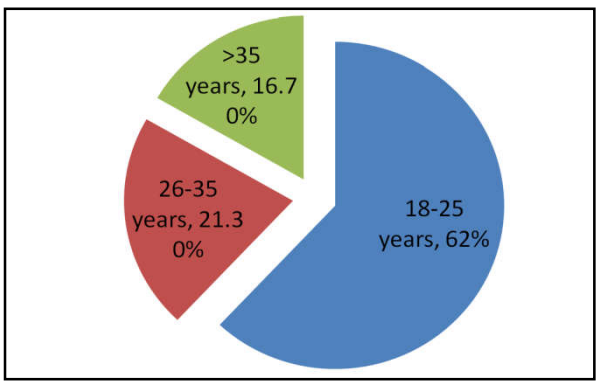


Table 2. Gender and Habitance

Gender	Rural	Urban	Tribal	Total
Female	450	160	150	760
Male	150	40	50	240
Total	600	200	200	1000

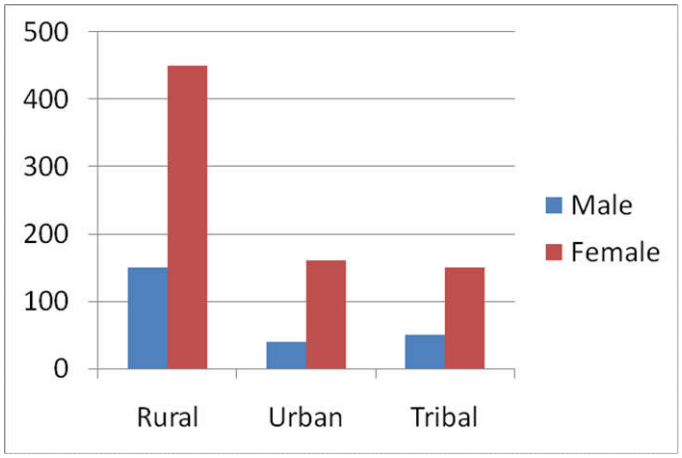


Table 3. Educational status of study group

Educational status	Number	Practice of contraception
Literate	350	173
Illiterate	650	104

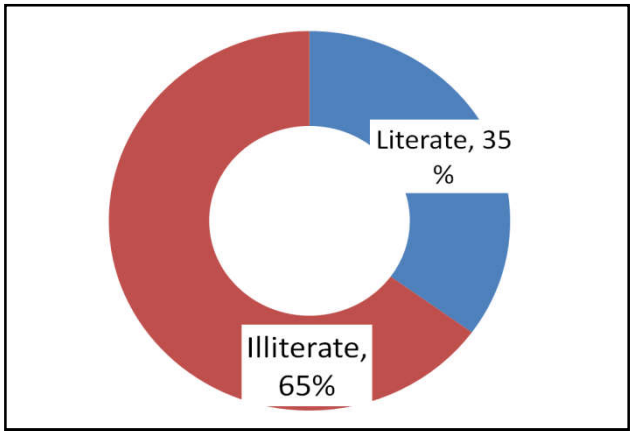


Table 4. Aware VS Unaware

	Rural		URBAN		Tribal	
	M	F	M	F	M	F
Aware	20	120	30	85	10	12
Unaware	70	390	20	65	50	128

Table-5

	Rural	urban	Tribal	Total	
Aware	140	115	22	277	χ^2 =122.2408 Awareness among the groups is highly significant
Unaware	460	85	178	723	
	600	200	200	1000	

χ^2 value indicates that the differences in awareness in three groups is significant.

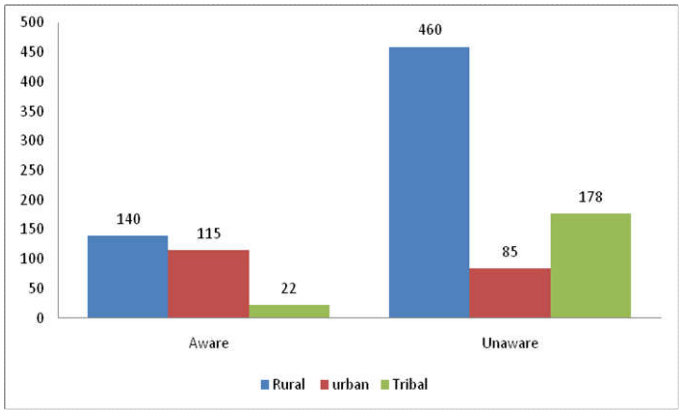


Table 6.

	Rural			χ^2 =0.0729 Awareness among Males and females not significant
	Male	Female		
Aware	20	120	140	
Unaware	70	390	460	
Total	90	510	600	

As χ^2<3.84 which indicates that the awareness in both genders in rural population is uniform.

Table 7.

	Urban			χ^2 =0.1698(<3.84) Awareness among Males and females not significant
	Male	Female		
Aware	30	85	115	
Unaware	20	65	85	
Total	50	150	200	

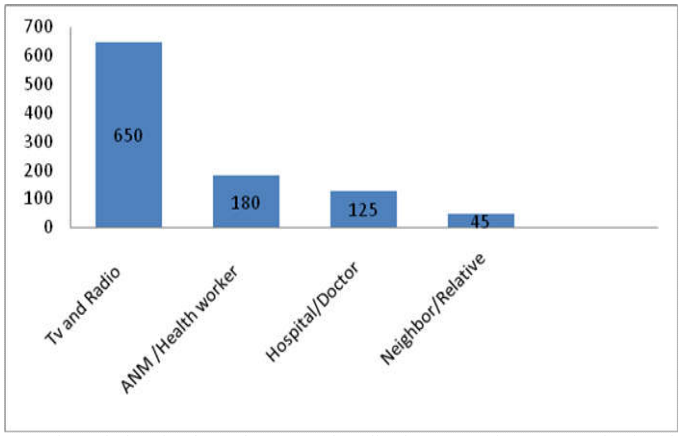
As χ^2<3.84 which indicates that the awareness in both genders in urban population is uniform.

Table 8.

	Tribal			χ^2 =2.8166 (<3.84) Awareness among Males and females not significant
	Male	Female		
Aware	10	12	22	
Unaware	50	128	178	
Total	60	140	200	

As χ^2<3.84 which indicates that the awareness in both genders in tribal population is uniform.

Table 9.



More knowledge is through TV and radio in comparison to professional counselor.

Table 10.

Procedure	Knowledge	Practice	χ^2>3.84 it is highly significant
Vasectomy	100% (both sex)	10%	
Tubectomy	100% (both sex)	70%	

As χ^2>3.84 which indicates that the practice of vasectomy is significantly low in spite of 100% knowledge among the study population; Both genders are aware of permanent sterilization methods but in practice Tubectomy (any procedure) is more accepted.

Table 11. Non Acceptance Males

Myths	%
Impotence	85%
Loss of libido	80%
Failure	75%
Hydrocele	2%
Hernia	4%
Decreased performance at work place	85%

Most common myths for non acceptance of vasectomy are Impotency and decreased performance followed by loss of libido.

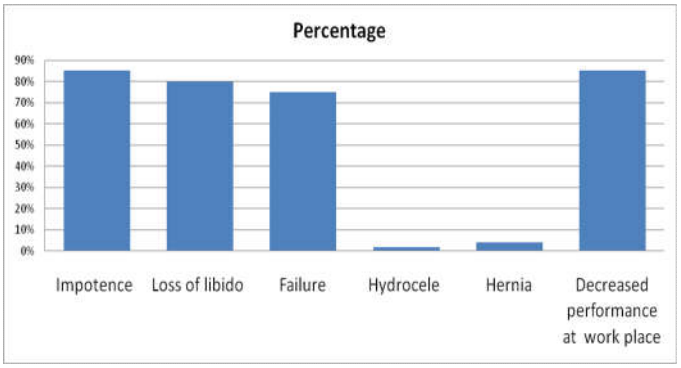
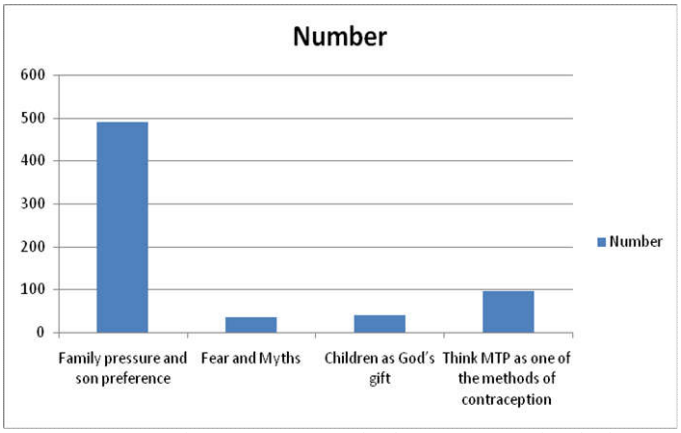


Table 12. Non-Acceptance-Females

Reason	Number
Family pressure and son preference	490
Fear and Myths	35
Children as God's gift	40
Think MTP as one of the methods of contraception	95



Most common cause for non acceptance of Tubectomy among females is son preference.

Table 13. Showing knowledge regarding various contraceptive methods

Method	Knowledge	Practice
Permanent		
Vasectomy	100%	10%
Tubectomy	100%	70%
Conventional	70%	20%
Interval	80%	60%
Laparoscopic	50%	30%
Temporary		
Condom	550	180
Female	100	3
Male	450	150
OCP	455	185
Injectable CON	137	34
Other methods	140	140

65% of the study population is aware of condom usage out of which only 28.15% are using; 45.5% of the study population is aware of OCPs out of which only 40.65% are using; 13.7% of the study population is aware of Injectable contraceptives out of which only 24.81% are using.

DISCUSSION

During the course of literature review of many books, articles and literatures the study revealed that the family planning among Tribal areas is limited. One of the studies from Nepal (Ref-1). Out of 1000 participants 60%, 20% and 20% are rural, urban and tribal respectively.59.2% of women and 62.5% men are from Rural, 21% of women and 16.6% of men are of urban habitants From Tribal area 20% of women and

20.8% of men participated.(Table1&2).The participation is more in Rural group as in this group postnatal mothers ,women who attended Family welfare clinic of NRIIMS. In the present study 83% of participants are between 18-35yrs (ref10, 11). 65% of participants are illiterate and not reached secondary education.35% are literate out of which 40% belong to medical profession. Urban males and females are having more awareness than rural and urban. In 75% of males and 53% of females from urban awareness is recorded. 13.3% of males and 26.6%of females from Rural and 20% of males and 8% of females only are aware. As $\chi^2<3.84$ which indicates that the awareness in both genders in urban, Rural and Tribal population is uniform. When both temporary and permanent methods are evaluated 100% of Tribal males and 85.3% of females, 46.6% Rural males and 86.6% females 50% of Urban males and40.6% of females are unaware. In awareness there is a significant variation between both genders in all groups. There is lot of difference between urban and other two groups. Unawareness is very high in Rural & Tribal females 86.6% and 85.3% respectively. Though knowledge of permanent family planning methods is 100% Tubectomy is more accepted. Non acceptance in female is because of preference for son and for inheritance as family tradition. (Ref-2) Vasectomy acceptance is low because of myths and misbelieves among both genders. (Ref-5) Table 13 depicts the percentages of knowledge of temporary methods their acceptance which is very low. Though sources of knowledge are many fold but problems in accessing family planning services, in reaching targets, husbands and family forbid them from using family planning services, and services available but no proper counseling. (Ref-3). According to a key informant, family planning provider's absenteeism was also an obstacle to family planning use. (Ref-5) Though some studies in literature showed that the contribution towards family planning by Health centers is 58.7%, Village health team 20%, Health education14%, radio6% and community leaders1%.(ref8) Our study is done by distributing pro forma at PHC and RHC where medical staff(interns, Trained Nurses, medical officers and specialists)present. (Ref-4) For further improvement in utilization of family planning services it is followed to educate by mouth of spread in post-natal wards. Fully fledged Family welfare services at NRIIMS. Visual projections in cinema halls, Whats App and advertisements in T.V. channels. Taking services to people, assuring availability of service providers at the centers and constant pursuance of all the temporary methods after delivery and abortion will add to proper implementation. Other obstacles to family planning use were: fear of side effects, fear of cost of managing side effects, fear of children dying less than 5 years of age, lack of men's and community leader's participation in family planning programme, the desire for many children which decreased with education level.

Conclusion

India is the second most populous country of the world. The Government of India launched a family welfare program in 1950's to accelerate the economic and social development by reducing the population growth.

But this program has met with only marginal success especially in acceptance of male methods by both genders. This is because people of India being multi linguistic, multi religious and multiethnic, have different levels of awareness and acceptance of methods of family planning. It is thus, necessary to develop special program to tackle the needs of different groups. The study highlights that knowledge and awareness will not always lead to the use of contraceptives. There is still a need to educate and motivate the couples and improve family planning services to achieve more effective and appropriate use of contraceptives and to arrest the trend towards increase in population. The professional's involvement in counseling at P.H. and R.H. centers is more stressed. As during our survey, it was understood that people living in remote areas are not aware of most of the temporary methods.

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