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KNOWLEDGE AND USE OF FAMILY PLANNING METHODS AMONG CURRENTLY MARRIED WOMEN IN URBAN SLUM OF DELHI

VIPRA TALANI

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KNOWLEDGE AND USE OF FAMILY PLANNING AMONG CURRENTLY MARRIED WOMEN IN URBAN SLUM OF DELHI

By:

VIPRA TALANI

Post Graduate Diploma in Health and Hospital Management

(PG/10/118)

International Institute of Health Management Research, New Delhi

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Sigma Research and Consulting Pvt Ltd
C 23, South Extension I, First Floor
New Delhi 110 049

t (+ 91 11) 4619 5555
f (+ 91 11) 4619 5500
www.sigma-india.in

Ms. Vipra Talani
International Institute of Health Management Research (IIHMR)
Plot No.3 Sector 18A, Dwarka
New Delhi 110 075

TO WHOMSOVER IT MAY CONCERN

This is to certify that **Ms. Vipra Talani** has worked with us as a research trainee from February 1, 2012 to April 30, 2012. During this period she has worked on the project **"Knowledge and Use of Family Planning among Currently Married Women in Urban Slum of Delhi"** as a part of her dissertation and closely worked with our research, field and data processing unit and learnt many aspects of social and market research.

During this period, we found her to be sincere, good and energetic at learning research and related aspects.

We wish her all the best in her future endeavours.

Dr. U.V. Somayajulu
CEO and Executive Director

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CERTIFICATE OF APPROVAL

The following dissertation titled " **Knowledge and use of family planning among currently married women in urban slum of Delhi**" is hereby approved as a certified study in management carried out and presented in a manner satisfactory to warrant its acceptance as a prerequisite for the award of **Post- Graduate Diploma in Health and Hospital Management** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

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Name	Signature
RAJIB DASGUPTA	
NITISH KUMAR DOGRA	

CERTIFICATE FROM DISSERTATION ADVISORY COMMITTEE

This is to certify that **Ms. Vipra Talani**, a graduate student of the **Post- Graduate Diploma in Health and Hospital Management** has worked under our guidance and supervision. She is submitting this dissertation titled **"Knowledge and Use of Family Planning among Currently Married Women in Urban Slum of Delhi"** in partial fulfillment of the requirements for the award of the **Post- Graduate Diploma in Health and Hospital Management**.

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Faculty Mentor: JkDogra

Designation: NITISH DOGRA

IIHMR
New Delhi

Date : 4.5.2012

Organizational Advisor: *Dr U V Somayajulu*

Designation: *CEO and Executive Director*

Organization: *Sigma Research and Consulting Pvt Ltd*

Address: *C23, South Extension I, First Floor, New Delhi 110 049*

Date: 27.04.2012

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PGDHHM/10/118

IIHMR, New Delhi

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ABBREVIATIONS

1. FGD – Focus Group Discussion
2. DMPA - Depot Medroxyprogesterone Acetate
3. NET-EN - Norethisterone enanthate
4. NFHS- National Family Health Survey
5. RFP – Request for Proposal
6. FHI - Family Health International
7. IDI- In-depth interview
8. SOP- Standard Operating Procedure
9. UHI- Urban Health Initiative
10. BOP- Bottom of Pyramid
11. SEC- Socio Economic Class
12. NCR- National Capital Region
13. NGO- Non Government Organization
14. SHG – Self Help Group
15. UNFPA- United Nation Family Planning Association
16. WHO- World Health Organization
17. IUCD- Intrauterine Contraceptive Device
18. INR- Indian Rupee
19. J.J.- Jugghi-jhopadi
20. ASHA- Accredited Social Health Activist

PART -1

INTERNSHIP REPORT

1.1 ORGANIZATION PROFILE

Sigma Research and Consulting is a research and consulting organization offering fully fledged research services in the social and development sector, and all India data collection / field and tabulation services across all sectors.

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The core values and foundation on which the structure of Sigma rests are

- Ethics
- Integrity
- Tenacity

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- Training /capacity building/ conducting workshop
- Report preparation
- Preparation of presentation

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- FGDs
- Rural studies
- Studies on sensitive issues
- Training on field operations
- Quality assurance
- Field audit /monitoring of field work

Data Processing

- Data entry
- Data validation
- Tabulation
- Analysis
- Multivariate analysis
- Data entry and software development

Specific services offered

Questionnaire / instrument development, Sampling, House listing and mapping, Recruitment of Field staff and Training, Field work (quantitative as well as qualitative), Data processing, Tabulation plan, Content analysis (in case of qualitative), Report preparation, Presentation preparation.

1.2 Internship work

Involved under a project on Continuing Use of Depot Medroxyprogesterone Acetate (DMPA) in India– a Study of User Experience and Support Systems in Private Sector Facilities

I. About DMPA

The contraceptive injection called Depot Medroxy Progesterone Acetate (DMPA) is similar to the hormone called progesterone, which is produced in the female body by the ovaries. Each injection of DMPA gives protection from pregnancy up to 12 weeks. This contraceptive injection mainly works by stopping ovaries from releasing an egg (ovulation).If no egg is released then there is no chance of getting pregnant. It is very effective contraceptive. It is more than 99% effective which means less than one woman in every 100 will fall pregnant in a year if they are using the contraceptive injection correctively.

Globally, injectables are the fourth most popular contraceptive method (after female sterilization, intrauterine devices and oral contraceptives). Depot Medroxy Progesterone Acetate (DMPA) and Norethisterone enanthate (NET-EN) are two widely available injectable formulations globally; the most popular among these is DMPA. Asian countries like Bangladesh, Nepal, Sri Lanka and Pakistan have made DMPA widely available by offering it in the public health system. However, availability of DMPA in India is limited, largely due to its non-availability in the government public health system. Currently, 55% of urban woman and 45.9% of rural women in India know about the existence of injectables, as per NFHS -3. However use of injectables in India is much lower. Injectables use in India is currently 0.1% (combined figure for DMPA and NET-EN). As specified in the RFP there has been a long felt need for understanding the perceptions and experiences of the users and providers of injectible contraceptives in India. Paucity of information in an organized manner to understand the dynamics of injectable contraceptive use in India has been acknowledged and therefore, this study is being proposed to address gaps in knowledge by scientifically documenting DMPA user's experience in terms of side effects, perceptions of provider care and product, and the impact of DMPA on daily life and work and also asses provider perspectives on DMPA (knowledge on DMPA, counseling, and perceived

ease of provision), as well as the appropriateness of systems in existing facilities to support DMPA provision in India's private sector. While the public sector does not currently provide DMPA, the information learned during this study will highlight service related issues that would need to be addressed in considering public sector distribution of DMPA and in furthering women's right to reproductive health.

Work Assigned: Initially an overview was given on Depot Medroxyprogesterone Acetate (DMPA) followed by 8 days training (from February 8 2012 to February 16 2012) on qualitative research given by FHI 360(Family Health International).It was a Study of User Experience and Support Systems in Private Sector Facilities .Its objectives were about research ethics, SOPs of In-depth interviews (IDIS), transcription and translation. Practice session was also conducted in training. During the training there was a visit to Agra to know the scenario of the DMPA which was done in the UHI clinics as UHI is covering maximum clinics which are offering DMPA services. After the training, pretest of this study was conducted in Meerut on 19th march 2012 where IDIs with the users, Provider's Interview (structured questionnaire), facility checklist (structured questionnaire) was taken in the ABT clinics. After the pretest, transcription and translation was done and tool problems was discussed which was then send to the FHI.

II. Involved under DANONE –Study on Food Beliefs

Context

Consumption of food is a vital part of the chemical process of life but sometimes food is more than just vital. People of different cultures share different assemblages of food variables. Different cultures have different food choices. Why these choices? What determines them? Within the same culture, the food habits are not necessarily homogeneous. Different religious sects have different eating codes. Men and women, in various stages of their lives, eat differently. Different individuals have different tastes. Some of these differences may be out of preference or may be prescribed.

Need and Scope of Study

The proposed study helps in understanding the needs of BOP market, getting ideas about the business model that could be used which would make a difference in the lives of BOP. The objective of the study is to investigate food behavior by characterizing food styles and food environments in which Danone operates and to identify factors of change so that Danone may equip itself for strategic positioning.

Broad Information Areas

The study addressed a series of issues relating to key themes about food in India.

The themes had been grouped under five major themes:

- Aspirations and preoccupation regarding food
- Practices and representations associated with food : classifications, combinations, associated values
- Delegation of trust
- Relationship between food and health
- Public concerns regarding sustainable development

Methodology

The method was largely qualitative using Observation, In-Depth Interviews (IDIs) and Focus Group Discussion (FGD).

Study Area

The study was carried out in SEC C, D and E areas in 4 northern states of India viz. Delhi NCR, Haryana, Uttar Pradesh and Punjab. The target groups for the study comprised of:

- Mothers
- Children
- Mothers-in-law
-
- Key informants: retailers, hawkers, school teachers, school cooks, doctors, NGO/ SHG

Target Group

- Children aged 6-10 years. Other target groups within the household include mothers and mothers-in-law/ grandmothers.

-Key informants like retailers (2 kind of retailers: mobile and non-mobile ones), doctors, school cook (or person responsible for preparing mid day meals), school teacher, Non Governmental Organization (NGO)/ Self Help Group (SHG) functionaries, if any.

The study was carried out in two phases viz. first (IDIs and observations) and second phase (FGDs). There were 10 research instruments used for the IDI component of the study while for the FGD component 2 research instruments were developed.

Work Assigned

Work was to analyze the content of all the FGDs and IDIs. The analysis heads were decided based on the indicators and in consultation with client. The responses for each indicator were extracted from the IDIs and FGDs and trend analyzed. Content Analysis was done on Excel spread sheet. Findings and verbatim from the spread sheet were used for presentation

DISSERTATION REPORT

CHAPTER 1 INTRODUCTION

Globalization of urbanization is seen as one of the most important social changes of the 20th Century. In 2007, the United Nations projected that 3.3 billion persons worldwide would be living in urban areas in 2008, constituting more than half of the world's population (UNFPA, 2007). There are marked differentials in the level of urbanization between developed and developing countries. More than three-quarters of the population in developed countries live in urban areas, compared with less than half of the population in developing countries. Nevertheless, by 2015 more than half of the population in developing countries is projected to live in urban areas. From 2000 to 2030, the world's urban population is projected to grow at an average annual rate of 1.8 percent, nearly double the rate expected for the total population (United Nations, 2005). Population growth will be particularly rapid in the urban areas of less developed regions, averaging 2.3 percent per year during this period, and almost all of the world's population growth is expected to take place in the urban areas of less developed regions.

As per the Census of 2011, Delhi is home to around 1.6 million persons, 93% of whom live in urban areas. Nearly 2 lakh persons migrated into Delhi every year during the decade 1991-2001. Most of these migrants land up in slums whose population is enumerated to be 3 million or 24% per cent of the urban population of Delhi. However, not only is the slum population underestimated by the census but urban poor also residing in other locations like unauthorized and resettlement colonies. It is estimated that nearly half of Delhi’s population resides in urban poor habitations. While there exist a variety of policies and programs for slum development, health, status of women, employment and nutrition there is a considerable scope for making them more effective in improving health and living conditions of the urban poor. The key problems relate to the rapid increased in the population of slum dwellers which outstrips the meager resources and services which exist, lack of convergence and coordination of efforts from among various programs and stakeholders and lack of linkages with the community.

The rapid population growth has caused a host of serious problems, including crowding, degradation of the environment, the development of slums, disparities in living conditions and access to services, and increasing vulnerability of the urban population, particularly the urban

poor, to diseases and poor health. Poor people in urban areas of developing countries face a daily struggle to meet their basic needs for shelter, food, water, education, and health. Government authorities are hard pressed to cope with this 'new urban revolution', in light of the explosive growth of cities. Until recently, urban health was not the main focus of public health policies in most by developing countries since the majority of the population lived in rural areas. It was often assumed that the heavy concentration of health facilities and personnel in urban areas, particularly in the private sector, would automatically take care of the increasing urban population and its health needs. However, the rapid growth of cities in developing countries, together with the growth of the urban poor and inequities created within cities, made this position untenable (Rossi-Espagnet, 1984)

Today the world population is around 7 billion and India harbors 1.2 billion. One of the reasons for uncontrolled growth of the population is unregulated fertility. Unregulated fertility many a times leads to unintended pregnancies leading to many unwanted or mistimed births. Therefore it is important to know the determinants of reproductive health among married women.

World Health Organization (WHO) defines reproductive health as a "State of complete physical, mental and social well being in all matters relating to reproductive system, its function and progress1. [WHO (1994) Challenges in reproductive health research. Biennial Report 1992-93]

Family planning is defined by WHO as “a way of thinking and living that is adopted voluntarily, upon the basis of knowledge, attitudes and responsible decisions by individuals and couples, in order to promote the health and welfare of family groups and thus contribute effectively to the social development of a country”.

India is the first country in the world to launch a family planning program across the country in 1952. Unfortunately, it has lagged behind many countries in family planning because of its vast population with various castes, religions, illiteracy, poverty, ignorance, strong cultural beliefs.

The National Family Welfare Program in India has traditionally sought ‘to promote responsible and planned parenthood through voluntary and free choice of family planning methods best

suited to individual acceptors' (Ministry of Health and Family Welfare, 1998a). In April 1996, the program was renamed the Reproductive and Child Health Program and given a new orientation to meet the health needs of women and children more completely. The program now aims to cover all aspects of women's reproductive health throughout their lives. With regard to family planning, the new approach emphasizes the target-free promotion of contraceptive use among eligible couples, the provision to couples of a choice of contraceptive methods (including condoms, oral pills, IUDs, and male and female sterilization), and the assurance of high-quality care. An important component of the program is the encouragement of adequate spacing of births, with at least three years between births (Ministry of Health and Family Welfare)

Unwanted pregnancies are a major public health problem for both developing and developed nations. Unplanned/mistimed pregnancies generally result from ineffective use of contraceptives and result in induced abortions. Unintended fertility remains a major concern in developing countries,

Many studies have shown that awareness of Family Planning is widespread and over 60% people have attitudes favorable to restricting or spacing births.(Govt. of India, Central Health Education Bureau, New Delhi, Swasth Hind, 30(12), 1986.) Yet, the rate of contraceptive use by eligible couple in India is 43.5% as opposed to 87% in Japan and China (Govt. of India, Ministry of Health and Family Welfare, New Delhi, Annual report, 1993-94.) This is the challenge faced by the Government in tackling the problem of population explosion.

Regarding the trend on family planning in slum areas, as per NFHS 3, 2005-06 carried out in eight Indian cities (Chennai, Delhi, Hyderabad, Indore, Kolkata, Meerut, Mumbai and Nagpur) women in slum areas are much less likely to use modern spacing methods but are generally more likely to use permanent methods. The use of modern methods of contraception is generally lowest among poor women. More than one fifth (22%) of the currently married women in Delhi slums reported to use any modern spacing method while 28% reported permanent method

A sizable proportion of the population in most Indian cities lives in slum areas. Most of the cities have grown rapidly over the past few decades due to their natural increase and to migration from rural areas and from smaller urban cities. The growth rate of the slum population in most cities

has been much higher than the growth rate of the non-slum population. From 1991 to 2001, the population of India grew at an average rate of 2 percent per annum, the urban population grew at 3 percent, mega cities grew at 4 percent, and slum populations increased by 5 percent (Source : NFHS 3, 2005-06, Health and Living Conditions in Eight Indian Cities). Thus, slums remain the fastest growing segment of the urban population, with almost double the overall growth of the urban population.

This rapid population growth has caused a host of serious problems, including crowding, degradation of the environment, the development of slums, disparities in living conditions and access to services, and increasing vulnerability of the urban population, particularly the urban poor, to diseases and poor health. Primary health care facilities have not grown in proportion to the explosive growth of urban population, especially for the poor. Also, it is generally seen that the health facilities may not be in physical proximity to urban slum neighborhoods.

New Delhi, a city with over 15 million people[i] and one of the most rapidly growing metropolises attracts 250,000 new migrants a year, who come from smaller cities, towns, and rural areas of India. However, Delhi's urban housing sector has not managed to keep up with the growth in population. As a result, over 4 million people (approximately 25% of Delhi's population) live in densely populated, unauthorized and unorganized squatter settlements called slums.

Most of these slums, with densely crammed dwellings typically not larger than 48 square feet housing between six to eight people, are situated on unoccupied government land. Access to safe water and basic sanitation facilities is limited: one water pump supplies over 1000 people with clean water, and where latrines exist, one serves approximately 27 households. Unemployment is high and most households earn less than INR 1500 a month (US$ 30). Despite living in the national capital, with relatively easy access to health services, the health situation of slum dwellers is poor. The mortality rate for children under five is 149 per 1000 live births compared to 40 per 1000 live births in all of Delhi state. In addition, 40% of children are severely malnourished and only one out of three children is immunized against childhood diseases, compared to two out of three in all of Delhi state.

CHAPTER 2 LITERATURE REVIEW

The National Family Health Survey of 1998–99 indicated a contraceptive prevalence of 48.2% (NFHS 1998–99), with female sterilization accounting for 34.2% while male sterilization declined from 3.4% in the 1992–93 survey to 1.9% in 1998–99. Condom use recorded only a marginal increase to 3.1%, compared to 2.4% in 1992–93. Use of oral contraceptive pills by women increased marginally to 2.1% in 1998–99.

Das and Deka (1982) have considered the cultural factors in fertility as there is evidence that the fertility behavior changes with different cultural settings.

Gautam and Seth (2001) in their study among rural Rajputs and SCs found out that raise in education besides providing knowledge and the contraceptive methods helps in improving acceptance of family control devices (Meerambika Mahapatro et al., 1999; Sushmita and Bhasin, 1998 and Varma et al., 2002)

According to a study conducted in tribal areas of Andhra Pradesh , knowledge of contraceptive methods is fairly high (81 percent) and similar observations were made from earlier studies on tribal and rural populations. Effect of education and monthly income seem to have no influence on the knowledge of contraceptive methods, while the level of knowledge is found to be more among mothers with one child (younger mothers) than those having 2 or more children. **(**Knowledge and Use of Contraception among Racha Koyas of Andhra Pradesh P. Durga Rao and M.Sudhakar Babu)

Narayan Das (1983) studied the socio-cultural determinants of fertility. In several studies on modernity and fertility, education is found to be the prime influencing factor. Education may have a direct influence on fertility, since education affects the attitudinal and behavioural patterns of the individuals.

Lactation amenorrhea, which lasts for two to three years in some societies, gives scope for longer birth intervals, thus affecting the fertility among such women (McNeilly, 1979). As Anand (1968) and Chandrasekhar (1972) put it, the family welfare programs, their reception, impact and utility have affected fertility in every society in this era of rapid population growth. Because of the government's policy on birth control, exhaustive efforts are made by the government to popularize the different family welfare methods.

However, besides several cultural factors, non-availability and/or lack of knowledge, attitude towards desired family size, traditional beliefs and practices play an important role in family planning. A number of KAP studies have been taken up covering different population groups. Gautam and Seth (2001) in their study among rural Rajputs and SCs found out that raise in education besides providing knowledge and the contraceptive methods helps in improving acceptance of family control devices. There are other studies also in the similar lines taken up among tribal and rural populations (Meerambika Mahapatro et al., 1999; Sushmita and Bhasin, 1998 and Varma et al., 2002).

Jejeebhoy (2000) for example has noted that as high as 34 percent of the adolescent girls aged 15-19 years in India are already married and presumably sexually active, while fewer than 10 percent of unmarried girls are reported to be sexually experienced.

Bongaarts (1983) has demonstrated that 96 percent of variation in the fertility levels among societies is explained by the variation in age at marriage, use of contraception, induced abortion and breastfeeding or lactational amenorrhea. Further, Mauldin and Ross (1991) have demonstrated that CPR alone can explain 85 to 87 percent of the variance in TFR.

"Unmet need for family planning", which refers to the condition of wanting to avoid or postpone childbearing but not using any method of contraception, has been a core concept in international population for more than three decades (Casterline and Sinding, 2000; Freedman, 1987).

CHAPTER 3 NEED AND SCOPE OF STUDY

India will become the most populous country in the world in another few years. Population explosion has been India's major problem since independence. It is a major obstacle to the overall progress of the nation. Adoption of family planning methods is one of the best solutions to tackle this problem.

The nationwide Family Planning Program was started in India in 1952, making it the first country in the world to do so. In spite of this about 56% eligible couples in India are still unprotected against conception (Govt. of India, Ministry of Health and Family Welfare, New Delhi, Annual report, 1999-2000).

CHAPETER 4 OBJECTIVES

Broad Objective

To study the knowledge level and use of family planning methods among young (15-29) married women residing in Delhi slums

Specific Objectives

1. To assess the **knowledge** of the married women on contraceptive methods.
2. To know **use and preference** of contraceptive methods among the married women.
3. To know the **decision making** among women in using contraception

CHAPTER 5 METHODOLOGY

5.1 Study design

The methodology adopted includes quantitative research techniques of data collection. The quantitative survey was carried out to assess knowledge & awareness among currently married women about family planning in Delhi slums.

5.2 Study area

The study was conducted in J.J Colony Dwarka (New Delhi) and Shahdara (Older Delhi) of Delhi.

5.3 Respondent groups

As mentioned above, the target group for the study includes women who are currently married within 2 years.

5.4 Sampling Design

5.4.1 Mapping and house listing

The study covered 2 regions as mentioned earlier. Among the number of slum clusters in all areas, instead of doing complete enumeration of population, I propose to segment the clusters where each segment will have 200 households.

In each slum, a mapping and house listing exercise will be carried out. Location and layout maps would be prepared for each slum. The location map will feature all the segments, nearby localities, access route to the slum and important structures within the slum and a detailed layout sketch map depicting all the residential as well as non residential structures with important land map marks. Along with the mapping activity, house listing operation will be carried out which will consist a description of every structure, the name of head of the household and address in such a way that during main

survey the residential household can be traced. The house listing will identify the eligible women.

5.4.2 Selection of households

From the house listing, a sampling frame would be generated which will provide the information of the eligible respondents. Out of the eligible respondents from the sampling frame, required number of respondents would be selected using random sampling method.

5.5 Study Instruments

There would be one type of study instruments which include two sections:

1. Background Section: Household socio economic and demographic information.
2. Section-2- Knowledge and awareness about Family planning for currently married women.

5.6 Implemented Plan

Step 1: House Listing & Mapping

Step 2: Data Collection

Step 3: Data Entry

Step 4: Data Analysis & Report Writing

All the filled questionnaires that were reviewed in the field were scrutinized before being entered. All open ended questions were coded and scrutinized / edited before starting the data entry.

Analysis of the quantitative data was carried out with the help of SPSS 16.0 on Pentium 4 machines. Analysis plan and dummy tables would be prepared before the ending of Questionnaires.

CHAPTER 6 RESULTS AND FINDINGS

Demographic Profile

Table 6.1 presents the age group of interviewed women. Table suggests that most of the women (46 percent) belong to the age group of 20-24 years. Similar is in the case of (J.J colony) Dwarka (49 percent) and Shahdra (67 percent).

Majority (31 percent) of women have two children followed by one (29percent) and three (24percent) children. Only 11percent of the women have more than 3 children and percentage of women having no children is lowest (6percent).When compared between the two slums, percentage of women having one child in SHAHDRA is highest (45percent) whereas percentage of women having three children is maximum (32percent) in (J.J colony) Dwarka .

Majority of the women were having one boy (36percent) and one girl (44percent). Similarly in SHAHDRA almost half of the women were having one girl (52percent) and one boy (40percent). In case of (J.J colony) Dwarka most of the women were having one girl (37percent) and two boys (36percent).

Majority (85 percent) of the women is more than3 months. Similar is the case of (J.J colony) Dwarka (84 percent) and SHAHDRA (86 percent).

Almost half (48 percent) of the women have male youngest child. Similarly in (J.J colony) Dwarka (47 percent) and SHAHDRA (50 percent) youngest child is boy.

Almost more than half (59 percent) of the women are illiterate. Only 5 percent of the women are $11^{th}/12^{th}$ pass. Same is the case illiterate in (J.J colony) Dwarka (61 percent) and SHAHDRA (57 percent).

Almost half (48 percent) of the husband of women respondents are illiterate and very few (4 percent) of them are graduate. Similarly in (J.J colony) Dwarka (44 percent) and SHAHDRA (55 percent) most of them are illiterate. More than one fourth (27 percent) husband of respondent in

(J.J colony) Dwarka and less than one fourth (19 percent) in SHAHDRA as well as total have taken secondary education.

Majority (92 percent) of the women respondents are nonworking. This means that they are housewives and do their household work such as washing clothes, cooking, cleaning etc. Same is the case in (J.J colony) Dwarka (91 percent) and SHAHDRA (93 percent).

Maximum (89 percent) women are Hindu. Similar is in the case of (J.J colony) Dwarka (91 percent) and SHAHDRA (86 percent). But Muslim women (11 percent) are more in SHAHDRA (14 percent) as compared to (J.J colony) Dwarka (8 percent)

Maximum (75 percent) husbands are unskilled worker such as labors, toy sellers, guard etc. It means that didn't get any skilled training. Similar is in the case of (J.J colony) Dwarka (76 percent) and SHAHDRA (74 percent). Some are skilled labor (15 percent) such as electrician, ear cleaner, and plumber etc who gets training

Almost one third (31 percent) of the age of respondent at the time of marriage is 18 years. Similar is in the case of (J.J colony) Dwarka (30 percent) and SHAHDRA (31 percent).

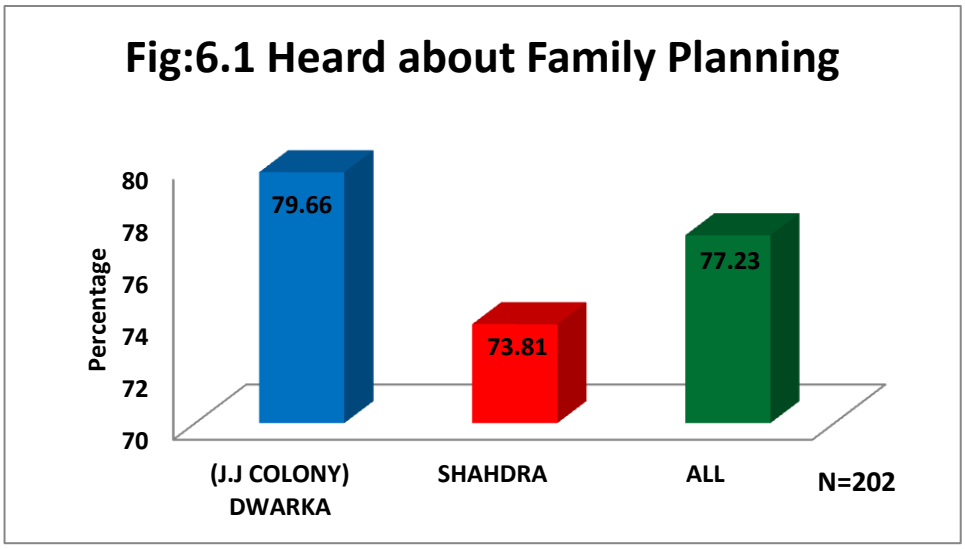
Table 6.1	DWARKA		SHAHDRA		ALL	
Age of Respondent						
15-19 years	3.4		2.4		3.0	
20-24 years	49.2		66.7		56.4	
25-29 years	47.5		31.0		40.6	
Total no of children						
No Children	6.8		4.8		5.9	
1-2	76.6		47.5		59.4	
3 and more than 3	19		45.7		34.7	
Total no of Boys and girls						
	Boys	Girls	Boys	Girls	Boys	Girls
1&2 Children	67.8	59.3	59.5	64.3	64.3	61.4
3& more than 3 children	6.8	10.2	4.8	0.0	6.0	6.0
Age of Youngest Child						
1 Month	3.4		4.8		4.0	
2 Months	1.7		4.8		3.0	
3 Months	3.4		-		2.0	
More than 3 Months	84.4		85.7		85.1	
Gender of Youngest Child						
Male	47.5		50.0		48.5	
Female	45.8		45.2		45.5	
Education of Respondent						
Illiterate	61.0		57.14		59.41	
primary (1-5)	10.17		16.67		12.87	
Middle (6-8)	16.95		14.29		15.84	
Secondary (9-10)	6.78		7.14		6.93	
Above Secondary	5.08		4.76		4.95	
Education of Husband						
Illiterate	44.07		54.76		48.52	
primary (1-5)	8.47		11.90		9.90	
Middle (6-8)	11.86		11.90		11.88	
Secondary (9-10)	27.12		19.06		23.76	
Secondary & above	8.48		2.38		5.94	
Occupation of Respondent						
Housewife	91.53		92.86		92.1	
Unskilled Worker	6.78		7.14		7.0	
Skilled Worker	1.69		.00		1.0	

Occupation of Husband			
Unskilled Worker	86.43	83.33	85.15
Skilled Worker	13.56	16.67	14.85
Religion of Respondent			
Hindu	91.53	85.71	89.11
Muslim	8.47	14.29	10.89
Age of Respondent at the time of Marriage			
Below 15 Years	13.6	14.3	13.9
15-18 Years	66.1	61.2	64.3
18 Years & above	20.3	23.8	21.8
TOTAL (N)	**101**	**101**	**202**

AWARENESS

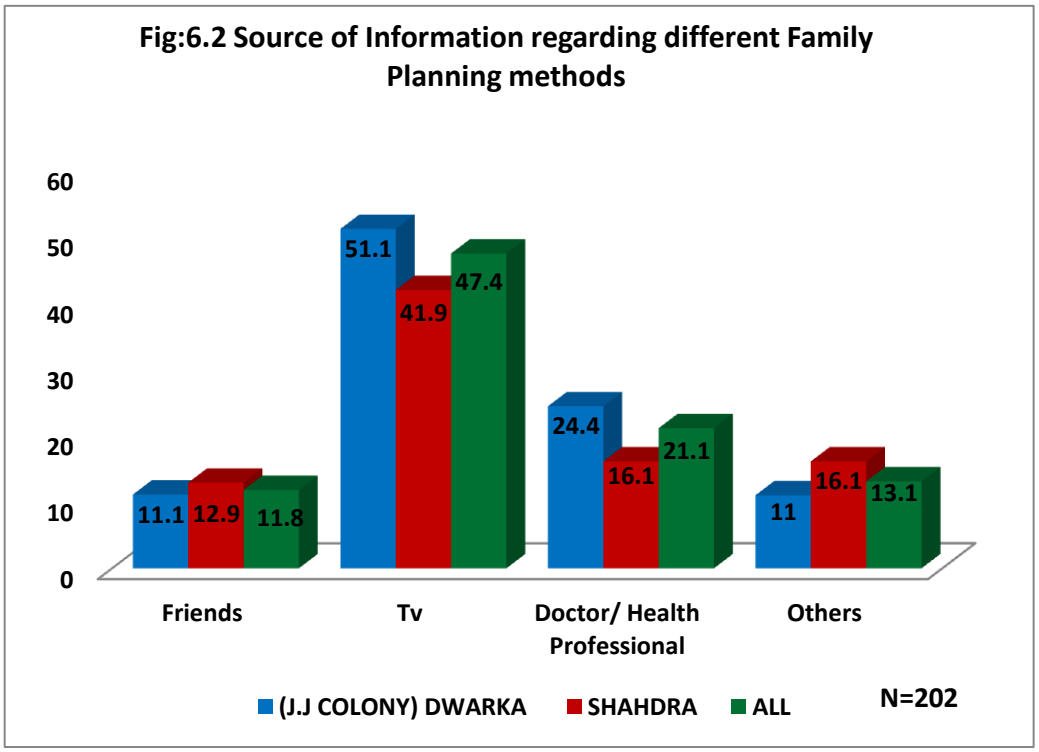
Heard about Family Planning

Fig: 6.1 depict awareness about Family Planning among women respondents. This table suggests that almost more than three fourth (77 percent) of the women heard about family planning. Similar is in the case of (J.J colony) Dwarka (80 percent) and SHAHDRA (74 percent).



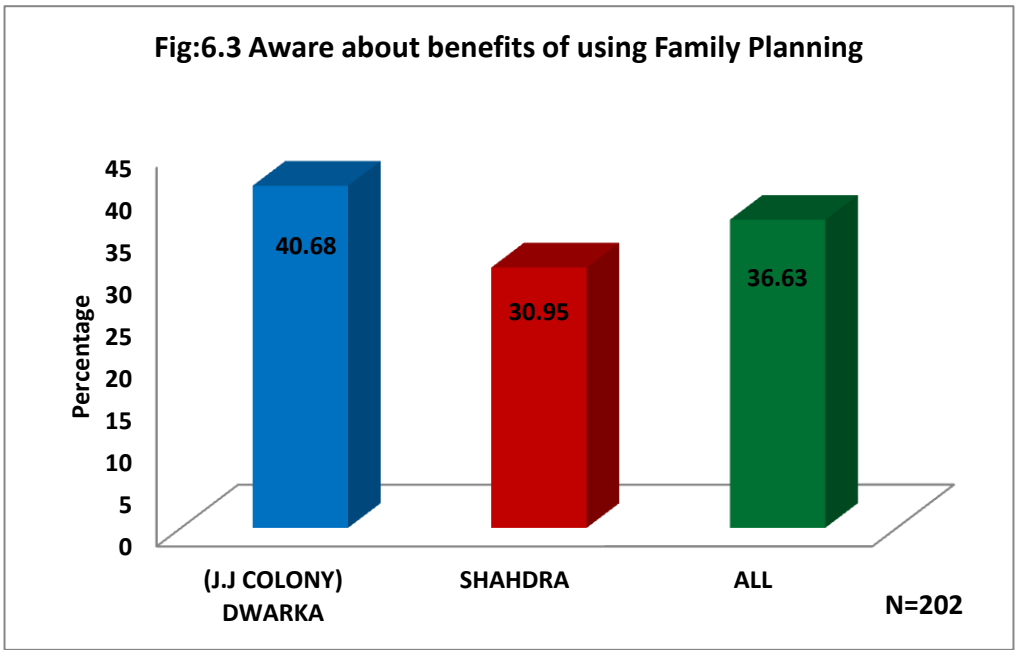
Source of Information regarding different Family Planning methods

Fig: 6.2 depict awareness Source of Information regarding different Family Planning methods among women respondents. This table suggests that almost half of the women (47 percent) avails the information regardin6g family planning through Health Professionals. Similar is in the case of (J.J colony) Dwarka (51 percent) and SHAHDRA (42 percent). Other source of information in SHAHDRA is Doctor (13 percent).



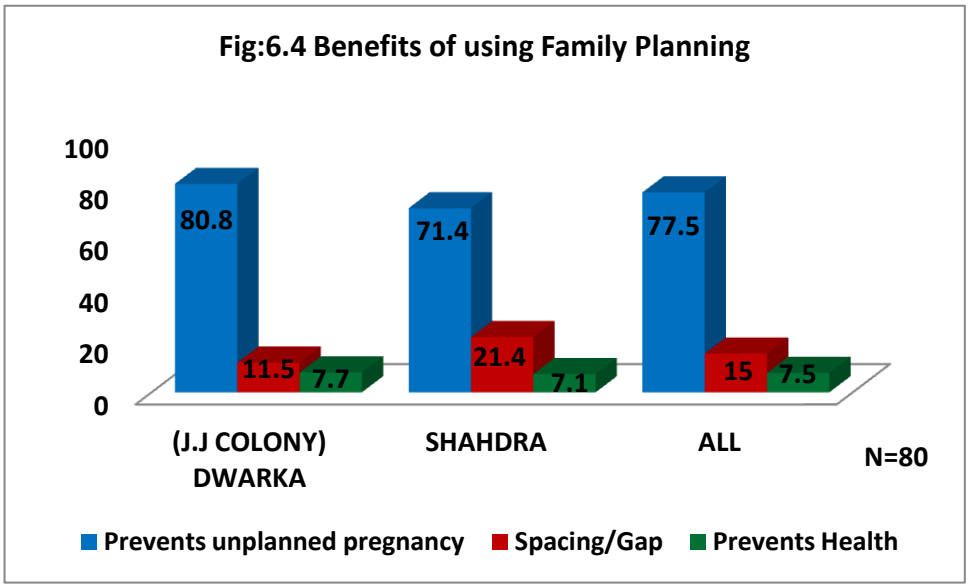
Aware about benefits of using Family Planning

Fig: 6.3 denote awareness about benefits of using Family Planning among women respondents. This table suggests that slightly less than two-third (63 percent) of the women respondents is unaware about the benefits of using family planning methods. Therefore just slightly more than one third of the women (36 percent) are aware about benefits of Family Planning. Similar is in the case of (J.J colony) Dwarka (41 percent) and SHAHDRA (31 percent).



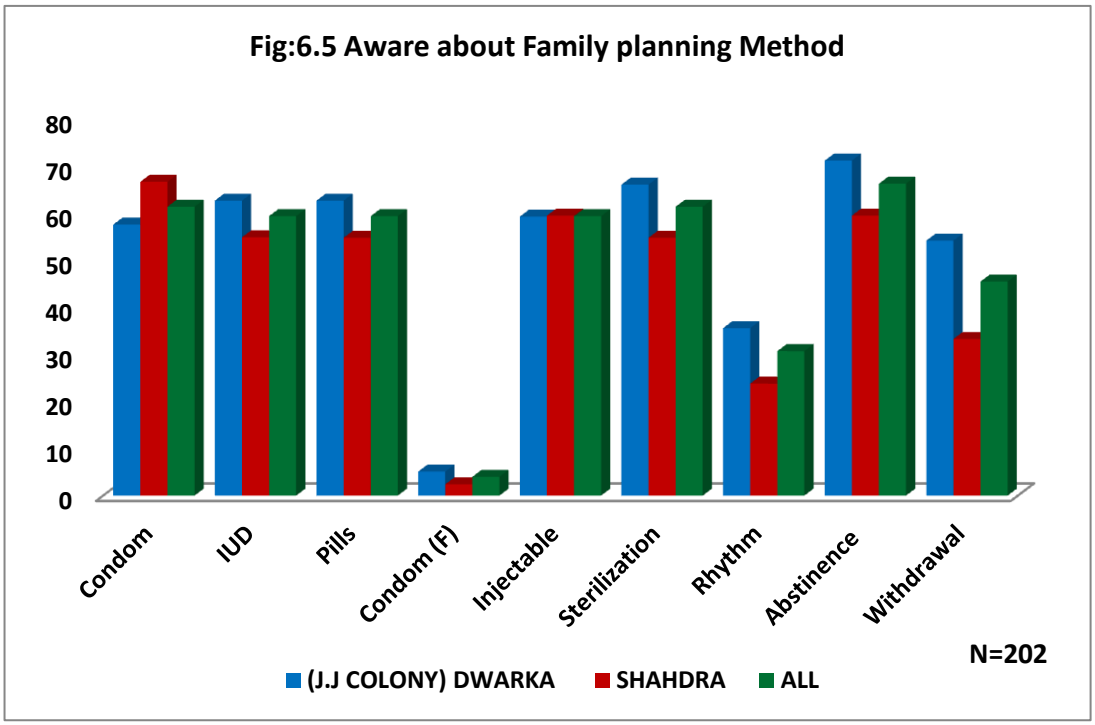
Benefits of using Family Planning

Fig: 6.4 describes about various benefits of using Family Planning. This table interprets that almost three-fourth of the women (77 percent) knows that using Family Planning methods prevents unplanned pregnancy. Similar is in the case of (J.J colony) Dwarka (81 percent) and SHAHDRA (71 percent). Other benefits which they are aware of are spacing/gap (15 percent) between two children and prevention of health of women (7 percent).



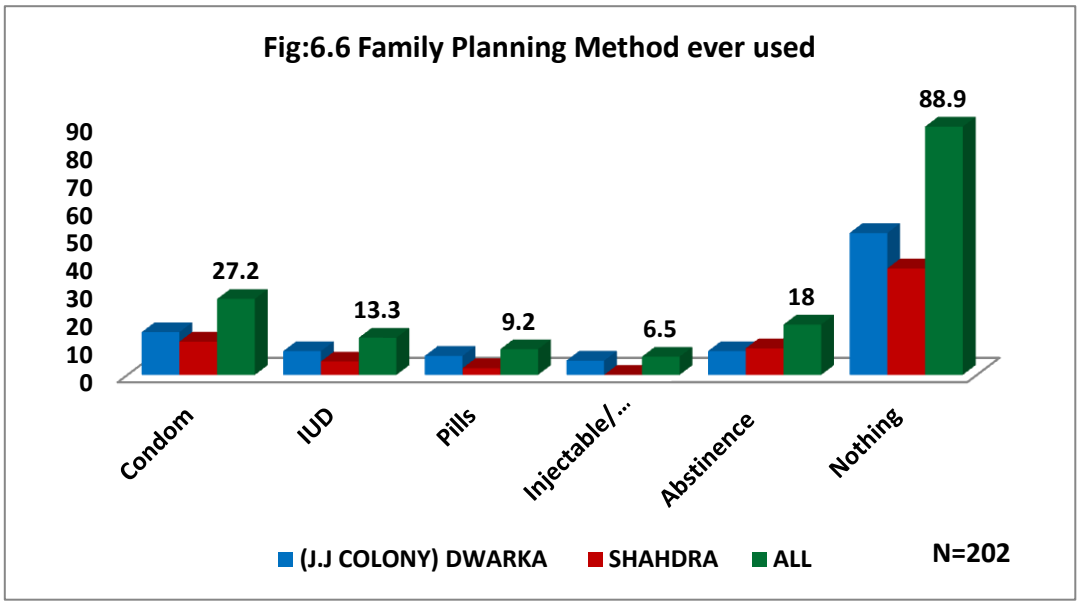
Aware about Family planning methods

Fig: 6.5 describe awareness of women respondent about Family planning methods. This table interprets that two third (66 percent) of women are aware about Abstinence as traditional contraceptive method and condom (61 percent) as modern contraceptive method. Same is the scenario of abstinence in (J.J colony) Dwarka (59 percent) and SHAHDRA (71 percent). Almost all (96percent) the women are unaware about female condom and more than two-third of women don't know about Rhythm as a traditional method of contraception.



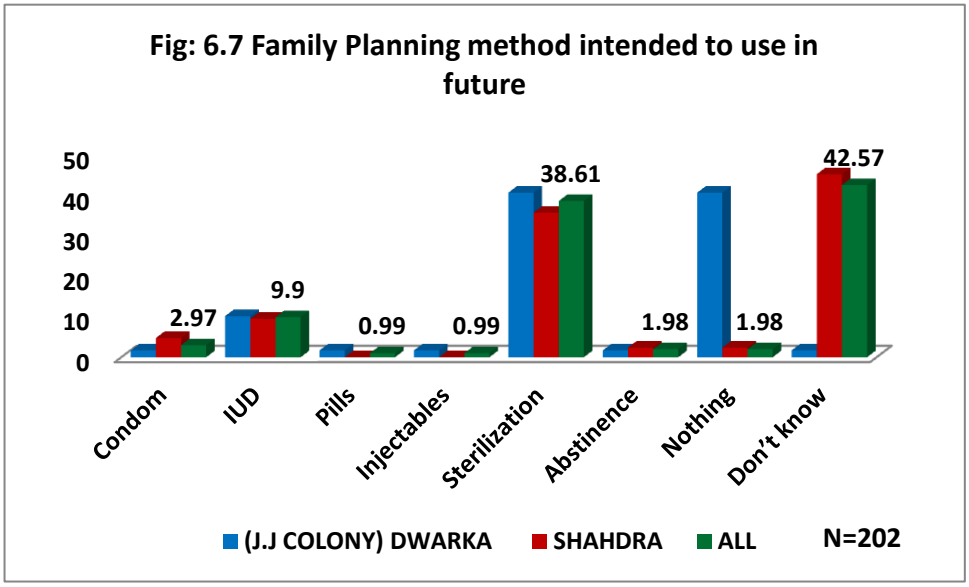
Family Planning Method ever used

Fig: 6.6 depict about the Family Planning methods ever used by women respondents. This table suggests that majority of women used abstinence as traditional Family Planning method followed by condom and sterilization (61 percent) Female condom is unaware in the two slums. Similar is in the case of (J.J colony) Dwarka (51 percent) and SHAHDRA (38 percent) where women are not using any contraception.



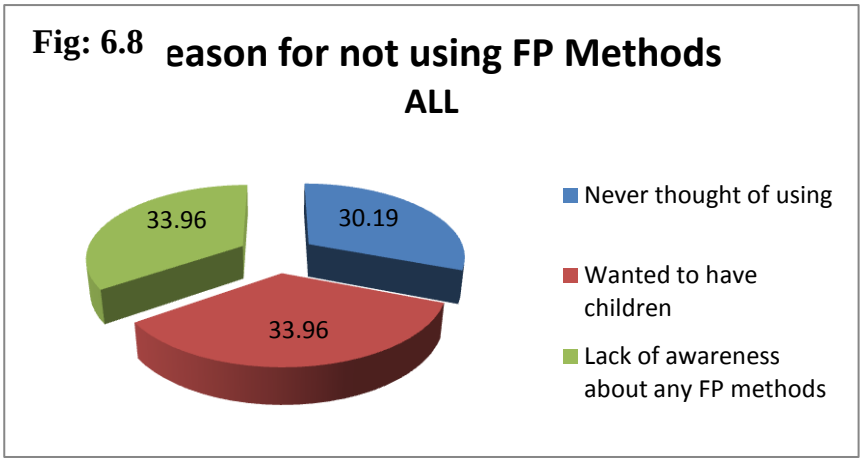
Family Planning intended to Used in future

Fig: 6.7 reveals that almost one third (39 percent) of women respondents want to choose sterilization (tubectomy) as their future family planning method. Same is in the case of (J.J colony) Dwarka and SHAHDRA. Majority (42 percent) of the women like in SHAHDRA (45 percent) don't know which method they will use in the future and in (J.J colony) Dwarka (41 percent) most of the will not use contraceptive in future.



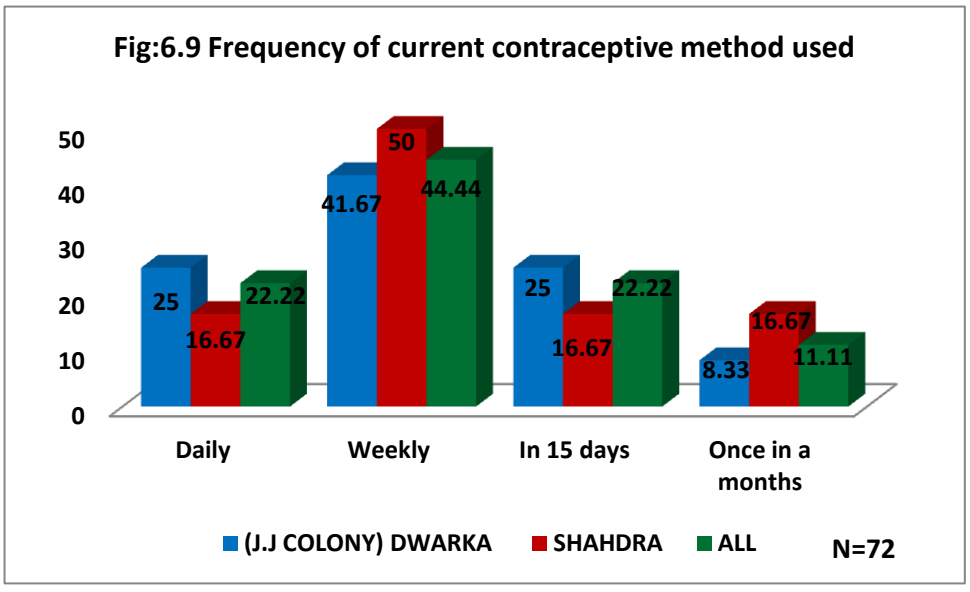
Reasons for not using FP methods

Fig: 6.8 reveal that one third of women never thought of using family planning methods having the maximum percentage in SHAHDRA. It was seen that in (J.J colony) Dwarka area 40% were not aware of any method of family planning with over all percentage of both areas 52%.



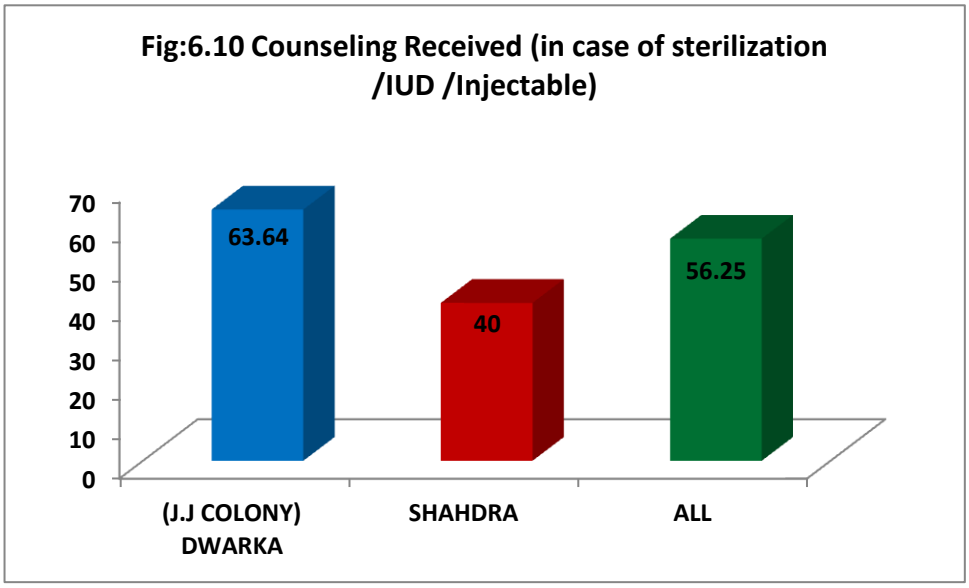
Frequency of current contraceptive method used

Fig:6.9 denotes frequency of current contraceptive method used. It was seen that approx 20% women in both areas used current method of contraception daily and out of them almost half(50%) of them in SHAHDRA and 44% in both the areas used them weekly.



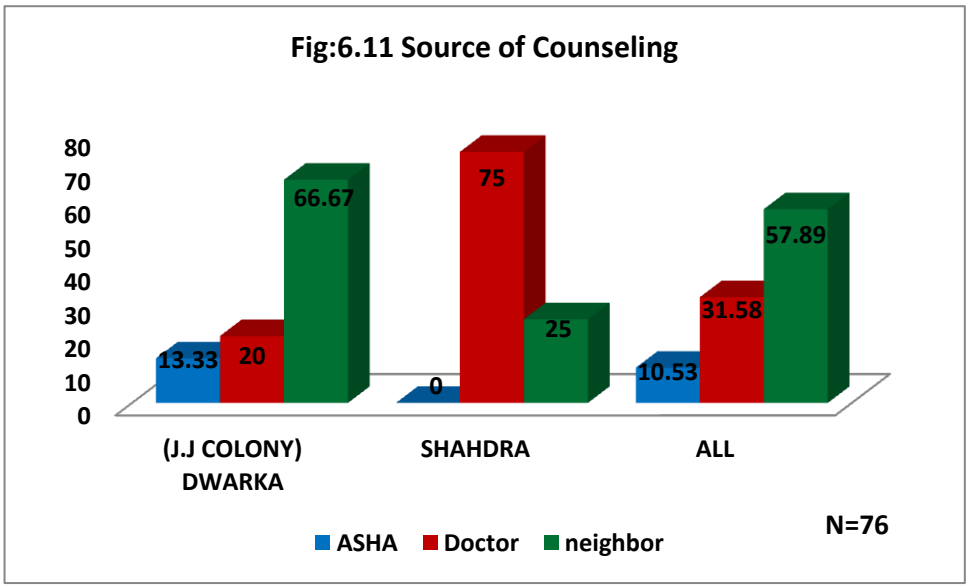
Counseling Received (in case of sterilization/IUD/Injectable)

Fig: 6.10 depict the counseling received by respondents in case of sterilization/IUD/Injectables. It was seen that almost 60 % women in (J.J colony) Dwarka had received counseling in case of sterilization / IUD /injectables with overall percentage of 56 percent.



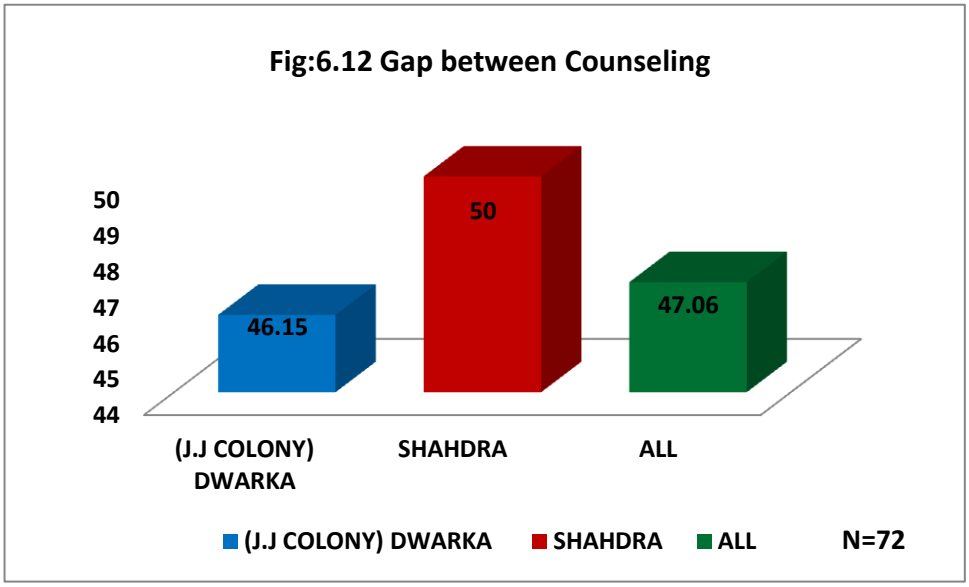
Source of Counseling

Fig: 6.11 revels various source of counseling in case of taking injections, IUDs and sterilization. Majority (57 percent) of the respondents attain counseling from their neighbors. But in Shahdra, doctor was the source of counseling in almost three fourth of women (75%) and in Dwarka neighbors (67 percent) were the source of counseling.



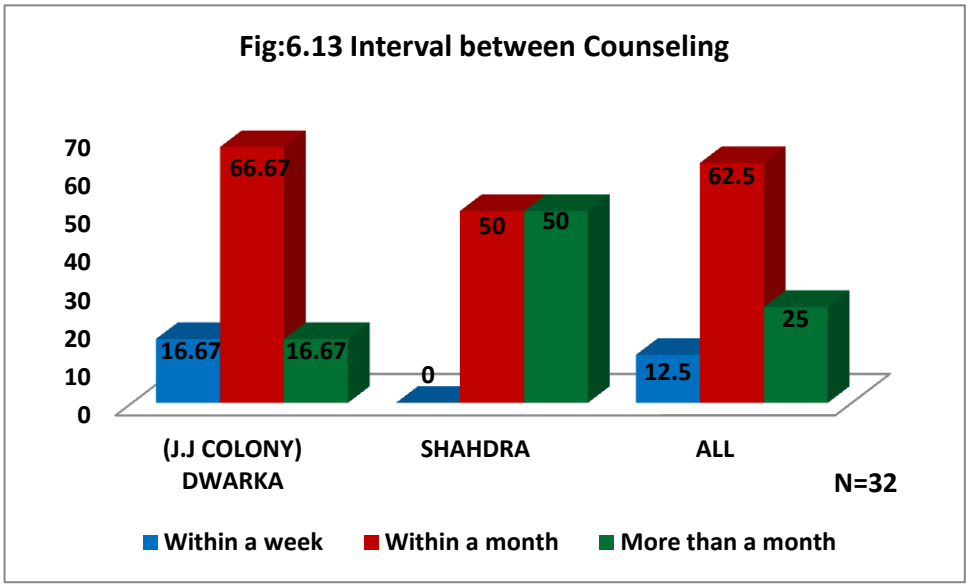
Gap between Counseling

Fig: 6.12 describes gap between counseling and contraceptive method used. Almost half (47 percent) the women said their no gap between counseling and using the FP method. Same is the case in both the areas- Dwarka (46 percent) and Shahdra (50 percent).



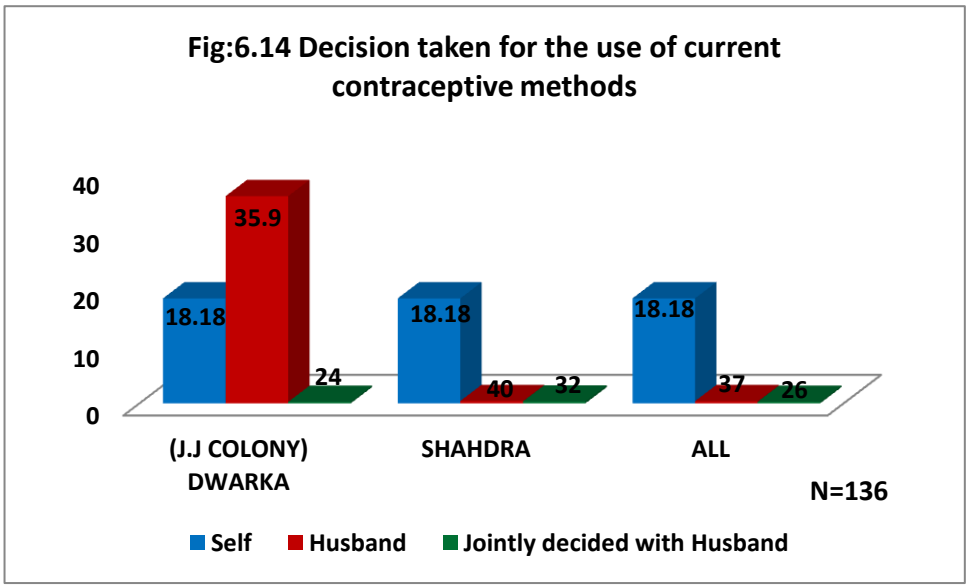
Interval between Counseling

Fig: 6.13 interpret the interval between counseling in case of women taking injections/sterilization/IUD. Majority (62 percent) of women use the method after taking counseling within a month. But in Shahdra percentage of interval within a month (50 percent) and more than a month (50 percent) is same.



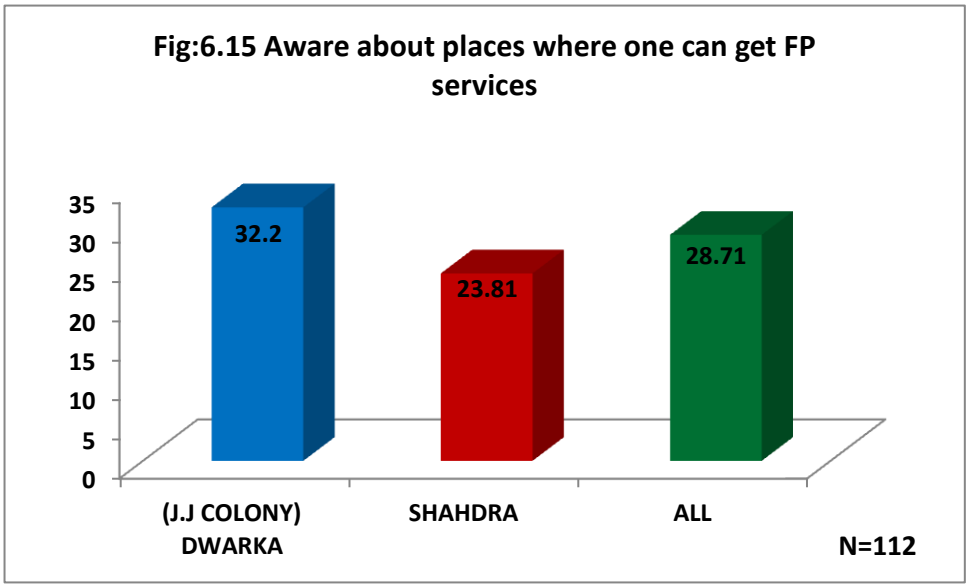
Decision taken to use current contraceptive methods

Fig: 6.14 depict the decision taken for the use of current contraceptive method. It shows that most (19 percent) of the respondent takes the decision on their own without the involvement of her husband and in-laws. Same is in the case of Shahdra (19 percent). But in Dwarka (36 percent) majority of the women take the collective decision with their husband in using contraceptive method.



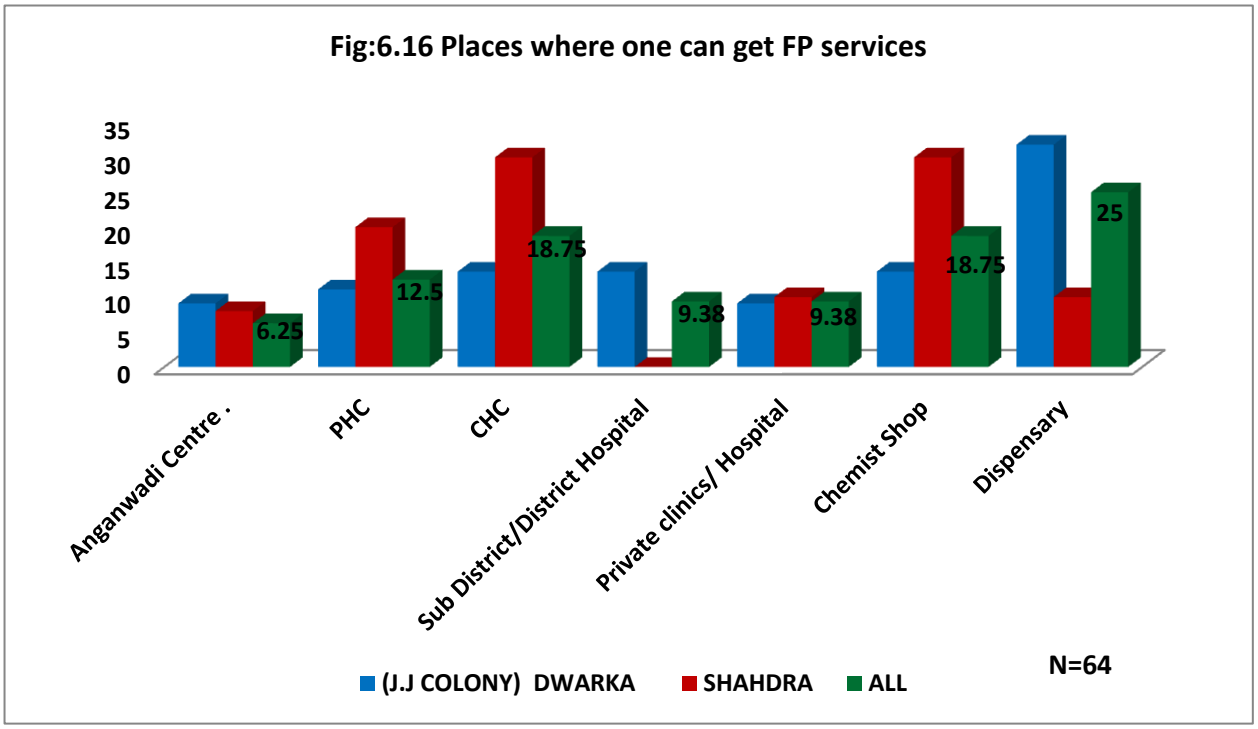
Aware about places where one can get FP services

Fig: 6.15 shows knowledge of awareness about places where one can get Family Planning services. It was seen that almost 70 percent of women don't know the place to get family planning services. In case of Dwarka (32 percent) and Shahdra (24 percent) very few women know the places where one can get FP services



Places where one can get FP services

Fig: 6.16 describe various places where women can get family planning services. It shows that one fourth (25 percent) of the women avail family planning services from nearby dispensary of their area. Similar is in the case of Dwarka (32 percent). But in case of Shahdra (30 percent) of women avail family planning services through Chemist Shop



Ideal Gap/Difference between first and the next child

Fig: 6.17 revels the ideal gap between first and the next child. The table depicted that majority (58 percent) of the women believed that there should be gap of 2-3 years between first and next child. Only 20 percent of women said that there should be gap of 5 years. Same is in case of both the areas.

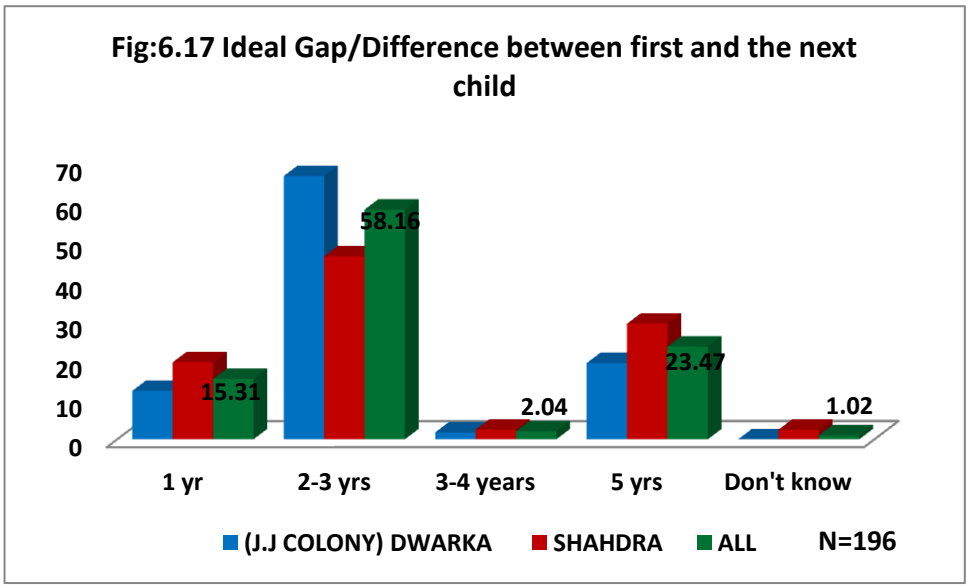


Fig:6.17 Ideal Gap/Difference between first and the next child
70
60
50
40
30
20
10
0
15.31
58.16
2.04
23.47
1.02
1 yr
2-3 yrs
3-4 years
5 yrs
Don't know
(J.J COLONY) DWARKA
SHAHDRA
ALL
N=196

CHAPTER 7 DISCUSSION AND CONCLUSION

The results of the present study reveals that in almost both the slum average age of respondent at the time of marriage was between 15-17 years old (60%) which is less according to the government of India norms . It has been seen that age at marriage has an indirect relation with the number of children a women have as it has been observed the women marrying at less age have more children compared to women marrying at high age. Almost around 40% of the women respondents and same for their husbands were illiterate, only. 90% of the respondents were housewife's and79% of their husbands are unskilled labor. It was revealed that overall 60 percent of the women respondents were aware of condom as a method of contraception. Awareness about female condom is negligible around 5%, injectible was found to be most popular method known after abstinence

Sterilization was commonly aware between the two slums where maximum awareness was seen in JJ Colony/.Awareness about the benefits of family planning method was only about 36% with minimum awareness in SHAHDRA area. When asked about the benefits of family planning it was seen that very least knowledge was available to the women about the actual benefit of family planning. The women are mostly unknown of the facts that contraceptive method can be used for training. Only 60 percent of the women had received counseling while using any method of contraception.

Ideal decision making behavior of the respondent were the husbands'=in both the slums in which majority of the husband as a sole m=decision maker in Shahdra. Neighbor was found to be the source of counseling for women about the awareness of contraception followed by doctor and husband. It can be seen that awareness through frontline health workers like AWW and ASHA's are not still visible .This is the major loophole , if worked on can lead to increase in number of users. The major issue seen was that around one third of the women are not taking any action for preventing unwanted pregnancy in future, as around 23 percent of women didn't knew what they will use in future. Sterilization was also most common method seen after the marriage.

Hence the study depicts that still in 2012 the situation of urban slums have not been perfect .The slum in Shahdara in more vulnerable to unintended pregnancies and over crowding. J.J colony is

New Delhi slum in which the indicators are fine, the reason behind that in Shahdra no other NGO is working for the upliftment of the community. Education of respondent and age at marriage was seen to be the most important factor related to use of contraception

RECOMMENDATION

- Strengthening the role of Anganwadi and ASHA's as they are the key persons or health workers which can change the behaviors of the women
- Involvement of male in choosing the contraception is also necessary this can be done through creating awareness' in the community through mid media and mass media. Different IEC materials should be used to create awareness
- Community leaders and various stake holders should be involved by create impact on community by spreading the knowledge about contraception and warning them about the ill effects of early marriage.
- Government and non government should use mass media often to disseminate the information
- In depth research on behavior of male participation on contraceptive usage should be studied.
- Hence there is a high need of Urban Health Mission in Delhi

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ANNEXURES

Knowledge and Use of Family Planning among Currently Married Women Of Urban Slum of Delhi

NAME	
ADDRESS	
PHONE NO.	

INTRODUCTION AND INFORMED CONSENT

Namaste. My name is **VIPRA** and I am from IIHMR, New Delhi. We are conducting a survey about the health of women. We would very much appreciate your participation in this survey. We would be discussing various aspects related to family planning and facilities providing FP services. This information will help us to assess FP need. This interview will take approx. 10-15 minutes. We assure you that the information provided by you will be kept strictly confidential and use only for research purposes. Your participation in this survey is voluntary and you are free to stop the interview any time.
However, we hope that you will take part in this survey since your participation is important and will give us new insights into this issue.
Before starting the interview, do you want to ask me anything about the survey?
May I begin the interview now?

Signature _____
Date:

Q. No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
1	Age (in completed years)	☐☐	
2	Total No. Of children Boy Girl		
3	Age of youngest child Gender	☐ Male.....01 Female.....02	
4	Education	Illiterate.....01 Primary (1-5).....02. Middle (6-8) .....03 Secondary (9&10... .....04 Sr. Secondary (11&12).....05 Graduate .....06 Post Graduate .....07 Others (Specify) _____	

Q. No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
5	Education of Husband	Illiterate.....01 Primary (1-5).....02. Middle (6-8) .....03 Secondary (9&10... .....04 Sr. Secondary (11&12).....05 Graduate .....06 Post Graduate .....07 Others (Specify) _____	
6	What is your Occupation?	Housewife.....01 Unskilled worker.....02 skilled worker .....03 Self Employed/Professional.....04 Petty Trader.....05 Shop owner.....06 Others(Specify)_____ None.....98	
7	What is your Husband's Occupation?	Unskilled worker.....01 skilled worker .....02 Self Employed/Professional.....03 Petty Trader.....04 Shop owner.....05 Others(Specify) None.....98	
8	What is your religion?	Hindu .....01 Muslim .....02 Christian .....03 Sikhs.....04 Others (*Specify*) _____	
9	How old were you when you got married? (to be calculated)	☐ ☐ _____(in yrs)	
10	Have you ever heard about family planning (FP) methods?	Yes .....01 No..... 02	**If Yes – Skip to Q. No. 17**

Q. No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
11	Who gave you the information regarding different family planning methods?	Friends/ ……1 Mother……..2 Husband……3 Relatives……4 In-laws……5 Doctor……6 Health professionals…7 T.V. ……8 Neighbours……9 Others (Specify)_____ Don't Know……98	
12	Are you aware of the benefits of using FP methods?	Yes No	
13	What are the benefits of using (any) FP method?	Prevents unplanned pregnancy…….1 Spacing/Gap……2 Prevents Health……3 Others (Specify)_____	
14	If Yes in Q14 What are the family planning methods are you aware of? RECORD SPONTANEOUS RESPONSE AND THEN ASK AIDED.	Condom(M…… IUD…… Pills…… Condom(F) …… Injectables…… Sterilization…… Rhythm…… Abstinence…… Withdrawal…… Others (specified)_____ Don' know……8	

	14(a) Spontaneous		14(b) Aided	
	Y	N	Y	N
Condom(M……	1	2	1	2
IUD……	1	2	1	2
Pills……	1	2	1	2
Condom(F) ……	1	2	1	2
Injectables……	1	2	1	2
Sterilization……	1	2	1	2
Rhythm……	1	2	1	2
Abstinence……	1	2	1	2
Withdrawal……	1	2	1	2

Q. No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
15	What are the family planning methods you hav2e ever used?	**Ever Used** **Y N** Condom (M)..... 1 2 IUD..... 1 2 Pills..... 1 2 Condom (F)..... 1 2 Injectables..... 1 2 Sterilization..... 1 2 Rhythm..... 1 2 Abstinence..... 1 2 Withdrawal..... 1 2 Others specified)_____ Nothing.....8	
16	What are the family planning methods you are currently using?	**Currently Using** **Y N** Condom (M)..... 1 2 IUD..... 1 2 Pills..... 1 2 Condom (F)..... 1 2 Injectables..... 1 2 Sterilization..... 1 2 Rhythm..... 1 2 Abstinence..... 1 2 Withdrawal..... 1 2 Others (specified)_____, Nothing...1.....8	
17	What are the family planning methods to be used in future?	Condom (M).....1 IUD.....2 Pills.....3 Condom (F).....4 Injectables.....5 Sterilization.....6 Rhythm.....7 Abstinence.....8 Withdrawal.....9 Others (specified)_____ Nothing 98	

Q. No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
18	If No then what are the reasons for never using any family planning method?	Never thought of using.....01 Wanted to have a child.....02 Opposition from family.....03 Lack of sexual satisfaction.....04 Husband don't like to use.....5 Don't know place to obtain .....6 Lack of awareness about any FP method.....7 Other (specify)_____	
19	What was your age when you used contraceptive for the first time?	☐ ☐ _____(in yrs)	
20	How often are you using the current contraceptive method? (If using pills/condom)	Daily ..... 1 Weekly ..... 2 In 15 days.....3 Once in a month ..... 4 More than 6 months..... 5 Others (Specify)_____ Don't Know.....8	
21	For how long have you been using this method?	Less than 2 yrs.....1 3yrs.....2 3-5 yrs.....3 >5 yrs.....4 Others (Specify)_____ Don't Know.....8	
22	Did you receive any counselling on FP method (In case the current use is sterilization/IUD/injectables in Q14 d)	Yes.....1 No.....2	
23	If Yes then who counselled you?	ANM ..... 1 AWW ..... 2 ASHA ..... 3 Skilled birth attendant ..... 4 Unskilled birth attendant / Dai ..... 5 Medical officer ..... 6 NGO ..... 7 Doctor.....8 Others (specify)_____ Don't know.....98	
24	Is there was gap between counselling and	Yes.....1 No.....2	**If No then Skip Q. No. 25**

Q. No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
	method adopted?		
25	If Yes then how much?	Within a week.....1 Within 15 days.....2 Within a month.....3 More than a month.....4 Others (specify)_____ Don't know.....8	
26	Who took the decision to use current contraceptive method?	Self.....1 Husband.....2 Jointly decided with Husband.....3 Mother- in-law.....4 Other relatives.....5 Others(Specify)_____	
27	Are you aware about the places where one can get FP services? If yes, then please tell me the places?	Yes No Anganwadi centre.....1 Sub centre.....2 Primary health centre.....3 Community health centre.....4 Sub district / district hospital.....5 Private clinics/ hospitals.....6 VHN Days.....7 NGO.....8 Chemist Shop.....9 Don't know.....98 Others (specify)_____	
28	What do you think should be the ideal gap/ difference between first and the next child?	1 year.....1 2-3 years.....2 5 years.....3 No gap.....4 Don't know.....8 Others (specify)_____	

Thank you

FIELD WORK