PART I

Internship Report

1.1Introduction to Organization

The **"Jansankhya Sthirata Kosh"** (JSK) (National Population Stabilisation Fund) has been registered as an autonomous Society established under the Societies Registration Act of 1860. JSK has to promote and undertake activities aimed at achieving population stabilisation at a level consistent with the needs of sustainable economic growth, social development and environment protection, by 2045.

Aims & Objectives of JSK

a) i) To provide or undertake activities aimed to achieve population stabilization, at a level consistent with the needs of sustainable economic growth, social development and environment protection, by 2045.

ii) To promote and support schemes, programmes, projects and initiatives for meeting the unmet needs for contraception and reproductive and child health care.

iii) To promote and support innovative ideas in the Government, private and voluntary sector with a view to achieve the objectives of the National Population Policy 2000.

iv) To facilitate the development of a vigorous people's movement in favour of the national effort for population stabilization.

v) To provide a window for canalizing contributions from individuals, trade organizations and others within the country and outside, in furtherance of the national cause of population stabilization.

b) There shall be no discrimination on the ground of religion, community, caste or class, while carrying out the objects of the Kosh.

c) All the incomes, earnings, moveable and immoveable properties of the Kosh shall be solely utilized and applied towards the promotion of its aims and objects only, as set out in the Memorandum of Association and no part of the income and property of the Kosh shall be paid or transferred directly or indirectly by way of dividend, bonus, profits in any manner whatsoever to the present or past members of the Kosh or to any person through

any one or more of the present or past members. No member of the Kosh or any person have a claim on any movable and immovable property of the Kosh or make any profits whatsoever by virtue of her/his membership. The accounts of the Kosh will be audited as required under the Rules.

IIHMR (International Institute of Health Management Research)

The International Institute of Health Management Research (IIHMR), New Delhi, a premier research and training institution in India, was established in 2007 with a mission to improve the standards of health of all people through better management of health care. It is a unique institution exclusively concerned with management education, training, and research in the health sector with multi faceted background of research faculty. The Institute has emerged as a centre of national repute with extensive international networking.

IIHMR has strength of conducting large scale programme, studies / evaluation studies, training, consultancy and related activities in Health sectors (see the project list file attached). Institute has carried out a study on Independent Evaluation of National Leprosy Eradication Programme in India (NLEP)-2008 supported by WHO. The project emphasized on seven major components: achievement of selected indicators, integration of Leprosy Services, quality of care including POD and medical rehabilitation, management of drug supplies, quality of data and reporting, role played by NGO/CBO, and community awareness about leprosy. The study covered 19 states. Another large scale study was conducted on Measurement of Client Satisfaction in Employees State Insurance Corporation (ESIC) Hospitals. It was carried out in 21 ESIC Hospitals spreading over 17 states in India regarding OPD satisfaction, IPD satisfaction, Dispensary staff and patient's satisfaction, ESIC staffs satisfaction, Patient's attendant satisfaction and Employer's satisfaction. Apart from that many short term study also conducted like Out of Pocket Revenue Models in Indian Health care system supported by European Commission (2008), and Access Variety and Cost in regional health care supported by European Commission (2009).

IIHMR is uniquely poised to take on this endeavour particularly because it's sister institution in Jaipur is a WHO collaborating centre for district health systems. IIHMR, Delhi itself is a

Knowledge partner for the National Rural Health Mission (NRHM) with regard to District Health Action Plans of Haryana state. The institute has experiences in national level consultancy and networking. Recently the institute had conducted a national level Geographic Information System (GIS) meet on health facility and services in collaboration with WHO country office India and Ministry of Health Family Welfare, Government of India. The institution is poised to spearhead issues which are at the interface of environment of health.

1.2 Department Profile - Research & Consultancy:

The research for two years at International Institute for Health Management Research (IIHMR), New Delhi has voyaged a series of projects, studies and development. The Institute has played a major responsibility in the promulgation of some of the sheer ground reality by undertaking surveys, health data generation to exploratory and impact studies of health services and health care programmes.

The Research Department focus on health systems and health care research. It conducts and designs policy analysis and review and undertakes intervention research, evaluation studies and operation research studies. The key areas of research mainly include assessment surveys and studies in important health programmes, strengthening management of district health systems; involvement of PRIs and NGOs in reproductive and child health services; and alternative management approaches in implementing population programmes with district as the unit.

There has been an expansion in the nature and scope of projects and research studies. The interpretative research has been stressed upon thus influencing policy making at the state and central government levels. Some of the projects and studies specifically address the health research and population issues that have a direct impingement on clinical, health services research and other related industries. The Institute has also undertaken projects aiming at facilitating health sector reforms, developing implementation processes in decentralized district planning, implementing quality assurance in health care, strengthening information

systems, and enhancing community participation. New research dimensions in health financing and human resource development have also been explored.

During the period of my Internship I was placed with the Research Department in the project **"To Study the Quality of IUCD Services for Promoting the Spacing Between Children in Madhya Pradesh"** .The project was funded by JSK (Jansankhya Sthirita Kosh), MOHFW, Govt. of India. The main aim of this study is to support population stabilization efforts, particularly in the major northern states (Uttar Pradesh, Bihar, Madhya Pradesh and Rajasthan) where the challenges are high. Madhya Pradesh is one of the states which require special attention in order to check its fertility trend (3.1 in 2005-06 compared to 3.4 in 1998-99 (NFHS-3)).The Objective of the project was to study the quality of IUCD services so as to promote the spacing between children and to examine and assess retention/ discontinuation rate and various factors responsible for its discontinuation. And after analyzing and assessing provide the solution so that its acceptance can be increased. The study was based on some secondary and primary data collection. For primary data collection 3 districts (1 highest, 1 Medium and 1 Lowest IUCD acceptors/ IUCD performance districts) will be chosen randomly through simple random sampling (SRS) among the districts with 1,000 IUCD acceptors per 10,000 unsterilized couples. The study tools involve data collection, both quantitative and qualitative data. For quantitative, data will be taken from secondary and primary study. For primary study, the structured questionnaire (household and individual) will be prepared. For qualitative data collection, some Focused Group Discussions (FGDs) and in-depth interviews will be conducted among ANMs, health care provider and other stakeholders. After conducting and analyzing the survey we will be able to identify the gaps in implementation of IUCD Services, reasons for the retention and discontinuation of IUCD use, knowledge and practice of other methods rather than IUCD, and document guidelines for Policy Makers/Programme Managers to strengthen IUCD services.

1.3Responsibilities allotted

Following responsibilities have been allocated to me in the Project:

a) **Literature Review:** Literature review for this project has be done so as to assess and find out the scenario in other countries and India, the knowledge of which can be utilized for this study and to find out the secondary data.

b) **Questionnaire Design:** In order to conduct the study in the field, the questionnaires were designed. The questionnaire were both Quantitative and Qualitative, which has been prepared for primary data collection. Since Madhya Pradesh is basically a hindi speaking state, these questionnaires have been translated in Hindi also, for better understanding of supervisors, investigators and people in the field.

c) **Recruitment of investigators & supervisors:** There was a need to hire supervisors and investigators to conduct the survey in the field. For this purpose people were hired from the same locality. Telephonic interviews were conducted for the selection of investigators and supervisors required for field study.

d) **Training of investigators & supervisors:** Investigators and Supervisors have been provided 2 day training for this project in Bhopal. The training provede them with the basics of using questionnaire in the field and method of probing.

e) **Field study:** I have been allotted the Katni district for field survey. The target sample is 500 Quantitative Questionnaire & 20 Qualitative Questionnaire. Information on districts with 1,000 IUCD acceptors per 10,000 unsterilized couples has to be find out. Within the district, 2 blocks have to be selected randomly and from each block a sample of 250 questionnaire has to be collected. For this ,first we contacted the BMO (Block Medical Officer) who facilitate during the survey in his block. The information on IUCD acceptors was obtained from CHCs/PHCs. After listing all the IUCD acceptors at selected CHCs level, 167 IUCD acceptors were selected randomly and their interviews were conducted either at the PHC/ SC/ Anganwadi centers.

1.4 Learning & Conclusion

The above study regarding quality of IUCD services in Madhya Pradesh provided me with a good exposure of the field work and actual collection and compilation of data from the field. It also gave me an experience on the technique of dealing with the managerial issue as a Technical Research Officer. From the knowledge and gained in the field I personally feels that the quality of IUCD services and there by the utilization of IUCD can be increased by participative involvement of service providers such as ANMs, since they are the people who can motivate others to use IUD by demonstrating its advantages. For this purpose their trainings should be conducted and some motivation should be provided. There is a need to put efforts in order to increase the awareness among the community regarding IUCD services.

PART II

Dissertation on

"A Comparative Study of IUD Use in EAG States between NFHS-2 and NFHS-3"

Chapter 1

Introduction

Since the 1970's, India's economic growth rate has risen, poverty has declined, and social indicators have improved. Nevertheless, over a quarter (28.6%) of India's population currently lives below the national poverty line, and 80% of the entire population lives on less than $2 per day. Twenty-eight percent of the population lives in urban areas. India's social indicators remain weak by most measures of human development, and living standards are still among the poorest in the world.

Currently, India's annual population growth rate is 1.74%. India is the second most populous country in the world, contributing about 20% of births worldwide. Out of India's more than one billion people, one-third is under 15 years of age and 50% are of reproductive age.

In 1952, the Indian Government was one of the first in the world to formulate a national family planning programme, which was later expanded to encompass maternal and child health, family welfare, and nutrition. India is committed to promoting a small family norm and supporting population control and development programmes. Since the 8th Five Year Plan (1992-97), the government identified "human development" as its main focus, with health and population stabilization listed as two of six priority objectives.

2000: The National Population Policy advocated a holistic, multisectoral approach towards population stabilization, with no targets for specific contraceptive methods except for achieving a national average total fertility rate (TFR) of 2.1 by the year 2010. This resulted in a shift in implementation from centrally fixed targets to target-free dispensation through a decentralized, participatory approach. The target-free approach was recast as the community needs assessment approach.

After doing situational analysis of the country, the small family norm is widely accepted (the mean ideal family size currently reported by young people is 2.5 children) and general awareness of contraception is universal (99% awareness of a contraceptive method). India's TFR declined from six children per woman in the 1960s to just under three children, 2.85, at

present. Contraceptive use is generally rising. Nevertheless, much work remains for India's family planning programme.

There is a societal preference in India for early marriage soon followed by child-bearing. Marriage is almost universal with little social acceptance of never-married women. Although the average age at marriage for women is 19 years, this conceals regional variations with some states having an average of only 16 years of age. Approximately half of all women have given birth by the time they reach 20 years. However, evidence has emerged indicating that young couples, despite community norms that favour a first child soon after marriage, would prefer delaying the first birth until they have spent more time together.

In 2000 the contraceptive prevalence rate (CPR) among married women was 48.3%.

Contraceptive use in India is characterized by:
• the predominance of non-reversible methods, particularly female sterilization;
• limited use of male-/couple-dependent methods;
• high discontinuation rates; and
• negligible use of contraceptives among both married and unmarried adolescents.

Three out of four users rely on sterilization in India, overwhelmingly female sterilization. Sterilization accounts for roughly 85% of all modern contraceptive methods used. Although reported by a negligible minority, sterilization is the most common method used even among married adolescents. The central government has banned the use of quinacrine for female sterilization.

Less than 7% of currently married women use the officially sponsored spacing methods (pills, IUD and condoms). The reported use of traditional contraceptive methods and male/ couple dependent methods is low.

Over the past decade, two new methods of contraception were introduced in India.
1. The CopperT-380A, which enables protection for a period of 10 years; and

2. Emergency oral contraception, available by prescription, which is expected to decrease the number of unwanted births and unsafe abortions.

The public sector provides five contraceptive methods – female sterilization, male sterilization, the IUD, oral contraceptive pills and condoms. Methods that are perceived as less effective (including pessaries, spermicides, and diaphragms), or are controversial (such as injectables and implants) are dropped from the public programme, simply not introduced, or given low priority by health workers.

Most women and men do not have access to a wide choice of contraceptives, particularly those who are dependent on the public sector (76% of current users of modern methods). Inadequate knowledge of contraceptive methods and incomplete or erroneous information about where to obtain methods and how to use them are the main reasons cited for not accepting family planning. Contraceptive use is lowest in the states of Meghalaya (20%), Bihar (25%), and Uttar Pradesh (28%).

There is still a substantial unmet need for contraception. Despite improved availability and access to contraceptive services, a substantial proportion of pregnancies (21% of all pregnancies that result in live births) are mistimed or unplanned. While the family planning needs of the majority (86%) of women who wish to stop childbearing are being satisfied, the needs of women who wish to delay or space childbearing remain largely unsatisfied (only 30% of these women have their needs met). For this reason, young women are more likely to report an unmet need for contraception. The desire to limit family size and to space the next birth are the main reasons given by the majority of those who seek an abortion, highlighting the large unmet need for contraception among women in India.

1.1 Current Family Planning Efforts

The National Population Policy provides a framework for achieving the twin objectives of population stabilization and promoting reproductive health within the wider context of sustainable development. The Tenth Five Year Plan (2002-2007) outlines efforts in three broad areas:

1. Meeting the unmet need for contraception;
2. Reducing infant and maternal mortality; and
3. Enabling families to achieve their reproductive goals.

With regard to addressing the unmet need for contraception, the government is focusing particularly in areas where fertility declines have been lagging. Issues such as adolescent reproductive health, unintended pregnancy and access to safe abortion are addressed. Counselling, access to and provision of good quality services and follow-up care are emphasized.

Health and family planning workers are required to regularly visit households in their assigned areas in order to provide information related to health and family planning, counsel and motivate women to adopt appropriate health and family planning practices, and deliver other selected services. Uncertain of the consequences of the new target approach however, many states set local goals based on the previous year's centrally assigned targets. Women's involvement in decentralized decision-making has yet to be fully operationalized at the grassroots level. In many states, the involvement of the community and other stakeholders, including Panchayati Raj Institutions, in needs assessments is reported to be minimal.

The contraceptive prevalence rate (any methods) in the country is 53 percent, 4 percentage point up from RCH Round - I, comprising of prevalence of about 46 percent of modern methods and 7 percent of traditional methods. Thirty-five percent of the couples adopted sterilization. The percent user of the two male methods sterilization and condom is only 6 percent. By residence, female and male sterilization together account for 57 percent of contraceptive prevalence in urban areas and 72 percent in rural areas. There has been positive association between contraceptive use and female education, economic development and availability of health facility. In most of the states/union territories the current use of any method of contraception exceeds 50 percent of eligible women except in Meghalaya (17 percent), Lakashadweep (30 percent), Bihar (31 percent), Goa (34 percent), Manipur (34 percent), Uttar Pradesh (36 percent), Jharkhand (38 percent), Arunachal Pradesh (39

percent), Nagaland (40 percent), Chhatisgarh (47 percent), Rajasthan (47 percent), and Uttaranchal (49 percent).

In order to facilitate the preparation of area-specific programmes, with special emphasis on eight states that have been lagging behind in containing population growth(contributes 45% of the population of the country) to manageable limits, the Government of India has constituted an Empowered Action Group in the Ministry of Health and Family Welfare w.e.f. 20th March,2001. EAG i.e. Empowered Action Group states include- Bihar, Jharkhand, Uttar Pradesh, Uttaranchal, Rajasthan, Orissa, Madhya Pradesh and Chhatisgarh

1.2 Background

India launched the National Family Welfare Programme in 1952 with the objective of reducing the birth rate to the extent necessary to stabilize the population, consistent with the requirements of the national economy. Since its inception, the programme has experienced significant growth in terms of financial investment, type and quality of services, and the range of contraceptive methods offered. In the beginning of the programme, a majority of the couples adopted terminal methods such as vasectomy and tubectomy to limit their family size. Only in 1966, temporary methods like the intrauterine contraceptive devices (IUCD) and condoms were introduced in the family planning programme. IUCD insertions picked up only from the year 1970-71 after the introduction of the copper T device. The IUCD's many advantages also make it a very good alternative for reducing unmet need for long-term contraception around the world. Between 5 and 17 percent of all married women of reproductive age in 53 less-developed countries do not want to have more children but are not using a contraceptive method (Ashford, 2003). Because the IUCD can be provided in primary health centres and posts at low cost, it can complement female sterilization and vasectomy to help women achieve their fertility goals, especially in rural areas. Despite these advantages, the IUCD is underused. Only 5 percent of married women in developing countries other than China (1% in Africa, 4% in Asia outside China, and 8% in Latin America and the Caribbean) use the method (Salem, 2006).

The IUCD is underused in the Indian Family Planning Program especially in EAG states and repositioning it will have several advantages. It increases choice for a long-acting and safe contraceptive to achieve optimal birth intervals (3-5 years); with the Copper T-380A, a woman can protect herself against pregnancy for up to 12 years. This is particularly attractive for those couples who have achieved their desired family size but do not want to adopt a permanent method like sterilization. The IUCD is a highly effective contraceptive method (pregnancy rate < 1%) and does not require constant attention. It does not interfere with intercourse and there is a quick return of fertility once woman stops using the method. As the IUCD can be used for at least 10 years, its use will be less expensive than most temporary methods. This is an important consideration for countries where contraceptive security is an issue, such as with the Ministry of Health and Family Welfare (MOHFW). Currently, the IUCD is the most reliable temporary method in the government programme (Dawn, 1992). A prospective acceptor usually analyses the pros and cons of a method in terms of its effectiveness, safety and incidence of side effects. In the case of IUCD, which is the most popular non-terminal method, acceptance largely depends on the magnitude of its side effects which in turn, influences the continuation rate (FPAIPP Bulletin, 1996). However, there are only a few in-depth studies on IUCD retention and/or discontinuation rates. Since October 1997, the services and interventions under the Family Welfare Programme and the Child Survival and Safe Motherhood Programme have been integrated with the Reproductive and Child Health Programme. In the National Population Policy, 2000, the Government of India set as its immediate objective the task of addressing unmet need for contraception to achieve the medium-range objective of bringing the total fertility rate down to replacement level by 2010 and in the long run goal is to stabilize the population by 2045. One of the socio demographic goals identified for this purpose is to achieve universal access to information/counselling and services for fertility regulation and contraception with a wide range of choices (Ministry of Health and Family Welfare, 2000).

1.3 IUD (Intra Uterine Devices)

An intrauterine device (IUD) usually is a small, flexible plastic frame. It often has copper wire or copper sleeves on it. It is inserted into a woman's vagina through her uterus. Almost all brands of IUDs have two strings, or threads, tied to them. The strings hang through the opening of the cervix into the vagina. A provider can remove the IUD by pulling gently on the strings with forceps.

The type now most widely used is: Copper bearing IUDs (made of plastic wit copper sleeves and/or copper wire on the plastic). Tcu380A and MLCu-375 are this type.

Hormone-releasing IUDs (made of plastic; steadily release small amounts of hormone progesterone or another progestin such as levenorgesterel). LNG-20 and Progestasert are this type.

IUDs work chiefly by preventing sperm and egg from meeting. Perhaps the IUD makes it hard for sperm to move through the woman's reproductive tract, and it reduces the ability of sperm to fertilize the egg. It could also prevent the egg from implanting itself in the wall of the uterus. It is very effective as commonly used and shows a rate of only 3 pregnancies per 100 women.

1.3.1 Historical development of IUD

Surprisingly, knowledge of the basic principles of the intrauterine device seems to go back many hundreds of years, it is known that the Greeks used a similar device. In 1868 a product was made that partially went through the vagina. Then in 1909 Dr R Richter produced the first real IUD, further research into this was made in the 1920s by Ernst Grafenberg. They were initially made of silkworm gut and then later out of a silver ring. More lately they have been made out of plastic and copper. In 1996 IUDs were made that produced hormones as well. The IUD is still popular as a form of contraception. It is about an inch across and is inserted into the vagina, a very simple procedure for a doctor to perform. If an IUD is inserted no more than five days after ovulation, then this will also probably prevent a pregnancy due to recent intercourse. Certain problems such as pelvic inflammatory disease

have been linked with the use of the IUD but there have been many improvements since this discovery. They are considered to be about 96% effective.

Intrauterine contraception is the most cost-effective reversible method of contraception today. The history of intrauterine contraception is remarkably short. Many IUD designs and shapes are a direct result of clinician's efforts to improve the performance of IUDs and reduce the overall level of their side effects. However only a few of these have ever been commercialized. The illustration shows a number of intrauterine devices dating from the beginning of the development of intrauterine contraception and including currently available IUDs. The two most successful copper IUDs currently on the market are the TCu380A IUD (Gravigard®) and Multiload® (ML) Cu375 IUD. Dr Tatum, USA, conceived the plastic T-IUD and Dr Zipper, Chile, invented the use of copper to optimise the contraceptive effectiveness. The Multiload® (ML) IUD, invented by the Dutch gynecologist Dr Willem van Os in 1974, is still used by many women. Terms used for these devices differ between the United Kingdom and the United States. In the US, all devices which are placed in the uterus to prevent pregnancy are referred to as intrauterine devices (IUDs) or intrauterine contraceptive devices (IUCDs). In the UK, only copper-containing devices are called IUDs (or IUCDs), and hormonal intrauterine contraceptives are called Intra-Uterine System (IUS). This may be because there are ten types of copper IUDs available in the UK, compared to only one in the US.

1.3.2 Advantages:

1. A single decision leads to effective long-term prevention of pregnancy.
2. Long lasting. The most widely used IUD (outside China), the Tcu-380A, lasts at least 10 years. Inert IUDs need never be replaced.
3. They are very effective and very little need be remembered.
4. No interference with sex.
5. Increased sexual enjoyment because there is no need to worry about pregnancy.
6. It can be inserted be inserted immediately after childbirth (except hormone releasing IUDs) or after induced abortion (if there is no evidence of infection).

1.3.3 Disadvantages:

1. Common side effects: Menstrual changes (common in the first 3 months but likely to lessen after three months:

- Longer and heavier menstrual periods
- Bleeding or spotting between periods
- More cramps or pain during periods

2. Other uncommon side effects and complications:

- Severe cramps and pains beyond the first 3 to 5 years after insertion
- Heavy menstrual bleeding or bleeding between periods, possibly contributing to anemia.
- More likely with inert IUDs than with copper or hormone releasing IUDs.

3. Other uncommon side effects and complications:

- Severe cramps and pain beyond the first 3 to 5 days after insertion
- Heavy menstrual bleeding or bleeding between periods, possibly contributing to anemia. More like with inert IUDs than with copper or hormone-releasing IUDs
- Perforation (piercing) of the wall of the uterus (very rare if the IUD is properly inserted).

4. Does not protect against sexually transmitted diseases (STDs) including HIV/AIDS. Not a good method for women with recent STDs or with multiple sex partners (or partners with multiple sex partners).

5. Pelvic inflammatory disease (PID) is more likely to follow STD infection if a woman uses an IUD. PID can lead to infertility

Chapter 2 Methodology

2.1 Data

NFHS-2: NFHS-2 covered a representative sample of over 91,000 ever-married women age 15-49 years across all 26 states of India. NFHS-2 also provided estimates at the regional level for five states (Bihar, Jammu and Kashmir, Madhya Pradesh, Rajasthan, and Uttar Pradesh) and estimates for three metro cities (Chennai, Kolkata, and Mumbai), as well as slum areas in Mumbai.

The sample size for each state was specified in terms of a target number of completed interviews with eligible women. The target sample size was set considering the size of the state, the resources available for the survey, and the aggregate level (urban/rural, region, metropolitan cities) at which separate estimates were needed.

1991 Population	Target Sample Size
>25 million	4,000
2-25 million	3,000
< 2 million	1500

The urban and rural samples within each state were drawn separately and, to the extent possible, the sample within each state was allocated proportionally to the size of the state's urban and rural populations. In states where the proportion of urban population was not sufficiently large to provide a sample of at least 1,000 completed interviews with eligible women, the urban areas were appropriately oversampled (except in Goa, Sikkim, and the six small northeastern states where the target sample size was only 1,500 eligible women each).

NFHS-3: The third National Family Health Survey (NFHS-3) was conducted in 2005-06. In addition to the indicators covered in NFHS-2, NFHS-3 provides information on several new and emerging issues such as perinatal mortality, male involvement in the use of health and family welfare services, adolescent reproductive health, high risk sexual behavior, family life education, safe injections, and knowledge about tuberculosis. A major new component of

NFHS-3 is blood testing for HIV prevalence and behavior-related information among adult men and women. In addition to interviewing ever-married women age 15-49, NFHS-3 included never married women age 15-49 and both ever-married and never married men age 15-54 as eligible respondents.

Interviews were conducted with 124,385 women age 15-49 and 74,369 men age 15-54 from all 29 states. Throughout India, 102,946 women and men were tested for HIV in NFHS-3. NFHS-3 provides estimates of HIV prevalence for adult women and men at the national level, for Uttar Pradesh and for five high HIV prevalence states (Andhra Pradesh, Karnataka, Maharashtra, Manipur, and Tamil Nadu). NFHS-3 also provides estimates of population and health indicators for slum and non-slum populations for eight cities, namely Chennai, Delhi, Hyderabad, Indore, Kolkata, Meerut, Mumbai, and Nagpur. Fieldwork for NFHS-3 was conducted in two phases from November 2005 to August 2006.

2.2 Parameters selected

The parameters selected for comparison of IUD services among the two national surveys are as follows:

- Knowledge of IUD as a method of contraception among currently married women (taking residence i.e. Urban & Rural as a base).
- Current use of IUD as a method of contraception by currently married women, considering the following background characteristics:
    - Age
    - Residence
    - Education
    - Religion
    - Caste/Tribes
    - No. of living children
    - Total no. of IUD users

2.3 Methods

- Frequency, Cross tables and Graphs has been used for analysis.

Chapter 3 Results and Findings

Knowledge of IUD as a Contraceptive Method

The provision of contraceptive information is fundamental to the ability of women and men (including adolescents) to make informed choices about reproductive health decisions, as lack of knowledge of contraceptive methods can be a major obstacle to their use. In NFHS surveys for Family Planning women and men were asked about their knowledge of each of 10 methods (modern and traditional) of contraception**.**

3.1 Bihar

Knowledge of contraception is almost universal in Bihar. Female sterilization is the most widely known method, known by virtually all married women and men. Adults are less likely to know about temporary contraceptive methods. The government family planning programme promotes three temporary methods: pill, IUD, and condoms. Of these three methods, married women are most likely to know about the pill (96%) and men are most likely to know about condoms (91%).Knowledge of sterilization has been high in Bihar since NFHS-1, and knowledge of temporary contraceptive methods has increased substantially over time from NFHS-2 to NFHS-3 like knowledge of the pill increased by 19 percentage points, knowledge of condoms increased by 15 percentage points since NFHS-2 and the knowledge of IUD has shown a slight increase as compared to other temporary methods

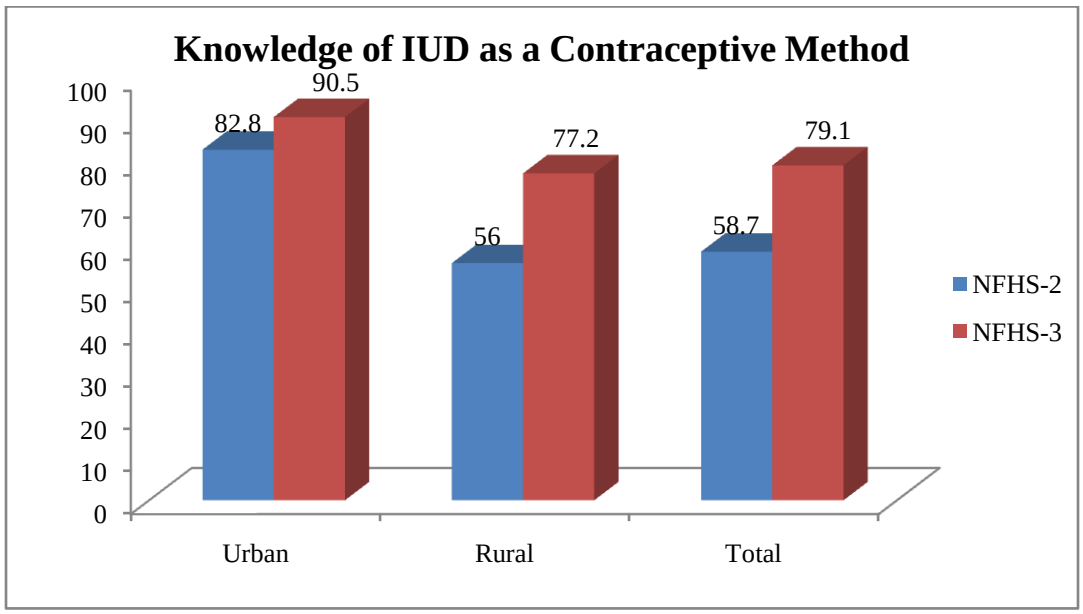
3.1.1 **Knowledge of IUD as a Contraceptive method**

Fig 3.1.1 shows the extent of knowledge of IUD as contraceptive method among currently married women has overall increased from NFHS-2 to NFHS-3. When the status of knowledge is compared on the basis of residence, it states that rural sector has shown a marked increase in the knowledge (21%) as compared to the Urban sector (7.7%).

Table 3.1.1

Percentage of currently married women who have knowledge of IUD Contraceptive method by residence			
	Urban	**Rural**	**Total**
NFHS-2	82.8	56	58.7
NFHS-3	90.5	77.2	79.1

Figure 3.1.1



3.1.2 Prevalence of IUD use by Background Characteristics

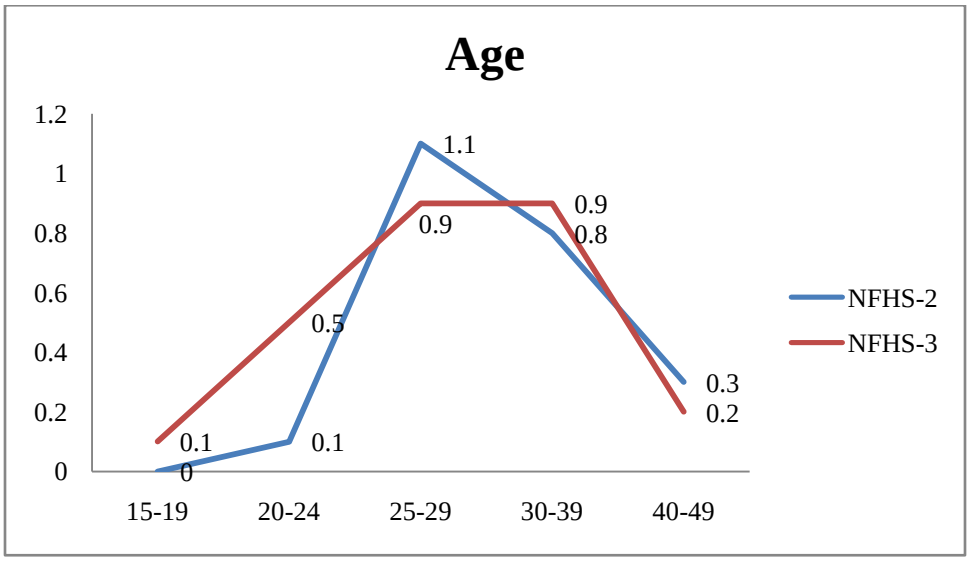
Percent distribution of currently married women currently using IUD, according to background characteristics, Bihar.

3.1.2.1 Age: The graph below shows the trend of IUD user based on Age as a background characteristic. It indicates that the maximum no. of women using IUD as contraceptive in NFHS-2 lies in the in the age group 25-29 where as no of current user has decreased in NFHS-3 by 0.2% on the other hand in NFHS-3 the age group 20-24 has shown a marked increase of 0.4%.

Table 3.1.2.1

Age					
	15-19	**20-24**	**25-29**	**30-39**	**40-49**
NFHS-2	0	0.1	1.1	0.8	0.3
NFHS-3	0.1	0.5	0.9	0.9	0.2

Figure 3.1.2.1

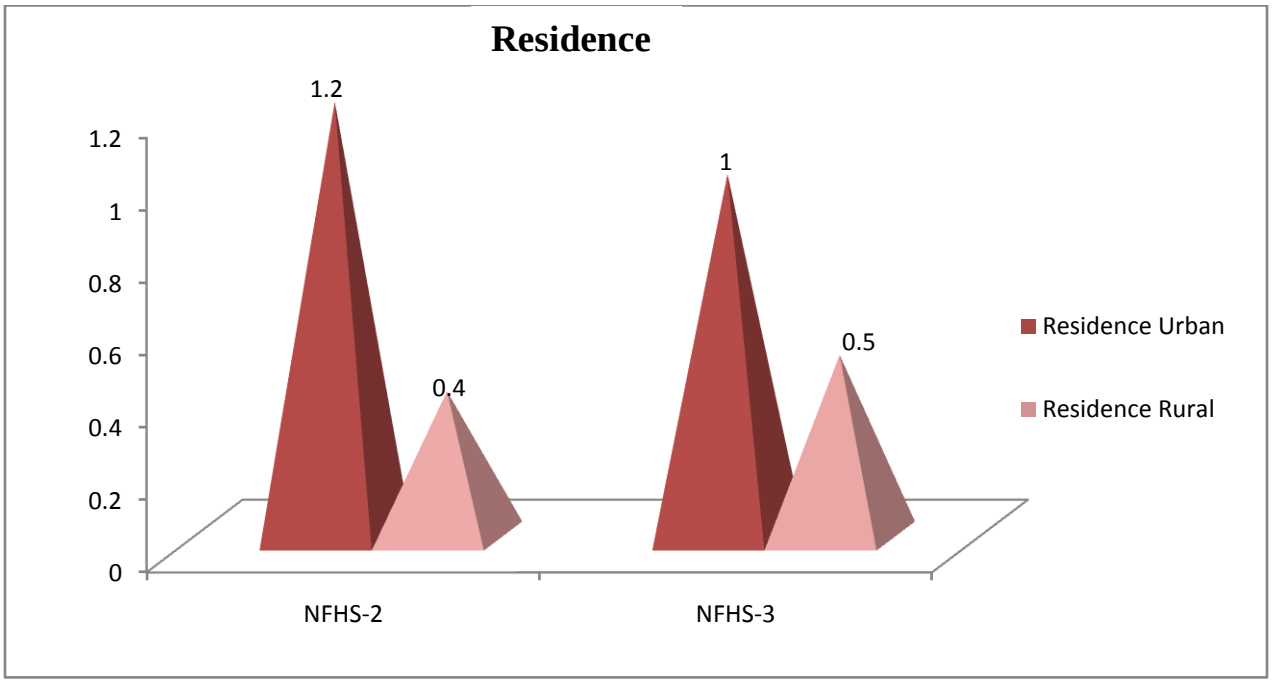


3.1.2.2 Residence: The percentage of current IUD users has decreased in Urban area where as it has shown a slight increase in Rural area from NFHS-2 to NFHS-3.

Table 3.1.2.2

	Residence	
	Urban	**Rural**
NFHS-2	1.2	0.4
NFHS-3	1	0.5

Figure 3.1.2.2

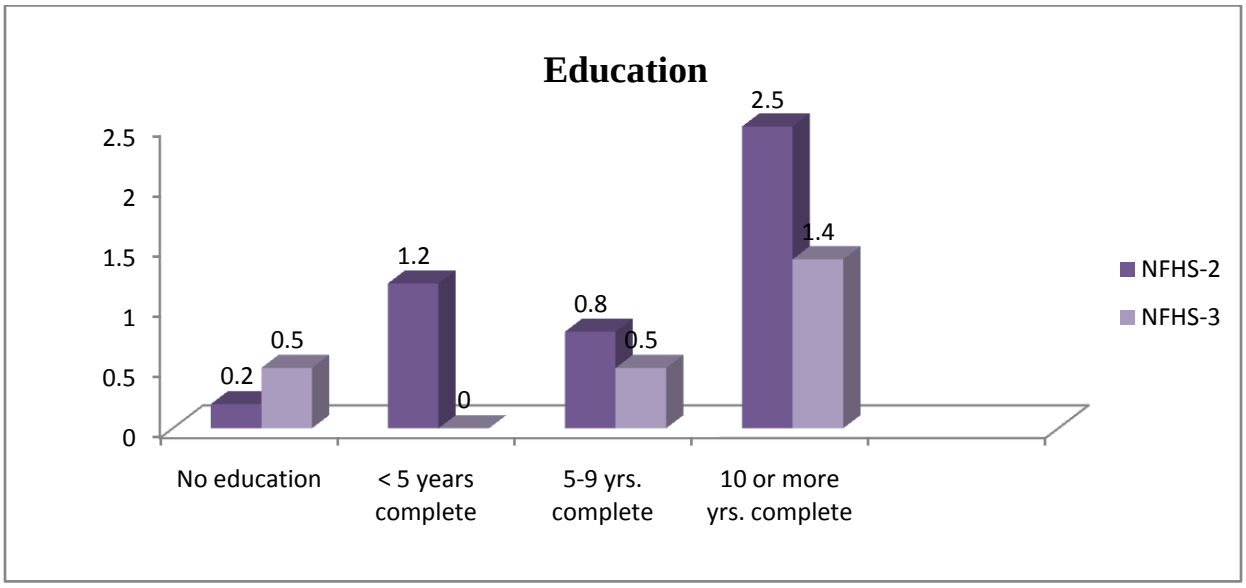


3.1.2.3 Education: There has been a continuous decrease in the percentage of IUD users among the literates where as the usage has increased among illiterates from NFHS-2 to NFHS-3.

Table 3.1.2.3

Education				
	No education	**< 5 years complete**	**5-9 yrs. complete**	**10 or more yrs. complete**
NFHS-2	0.2	1.2	0.8	2.5
NFHS-3	0.5	0	0.5	1.4

Figure 3.1.2.3

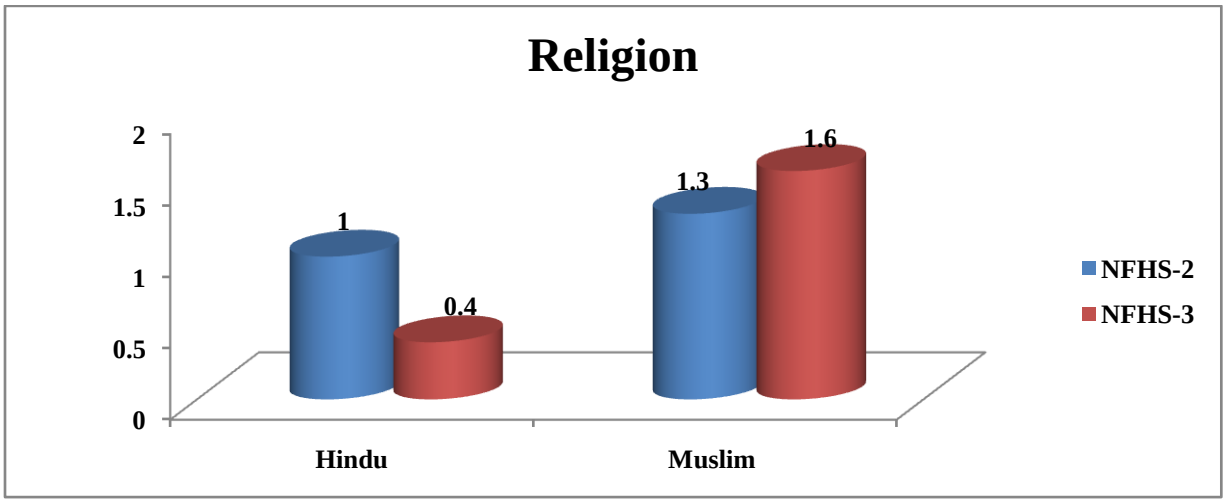


3.1.2.4 Religion: From NFHS-2 to NFHS-3 the Hindu community has shown a decrease in current IUD usage where as there is an increase of IUD usage in Muslim community.

Table 3.1.2.4

Religion		
	Hindu	**Muslim**
NFHS-2	1	1.3
NFHS-3	0.4	1.6

Figure 3.1.2.4

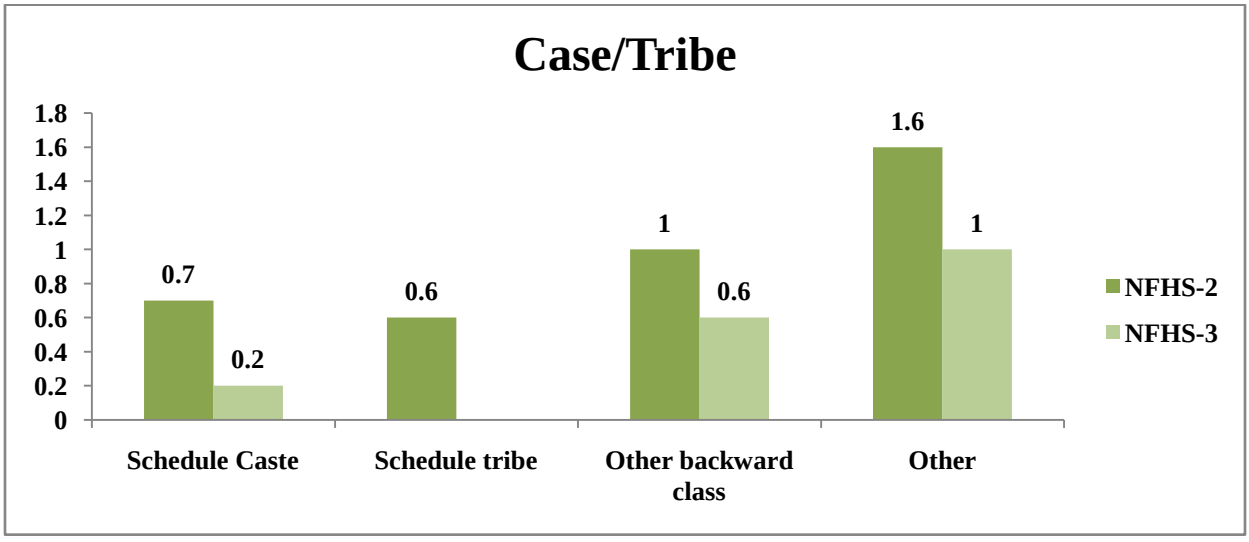


3.1.2.5 Caste/Tribe: The schedule caste, OBCs and other cases has shown a marked decrease in IUD usage from NFHS-2 to NFHS-3.

Table 3.1.2.5

Caste/ Tribe				
	Schedule Caste	**Schedule tribe**	**Other backward class**	**Other**
NFHS-2	0.7	0.6	1	1.6
NFHS-3	0.2	NA	0.6	1

Figure 3.1.2.5

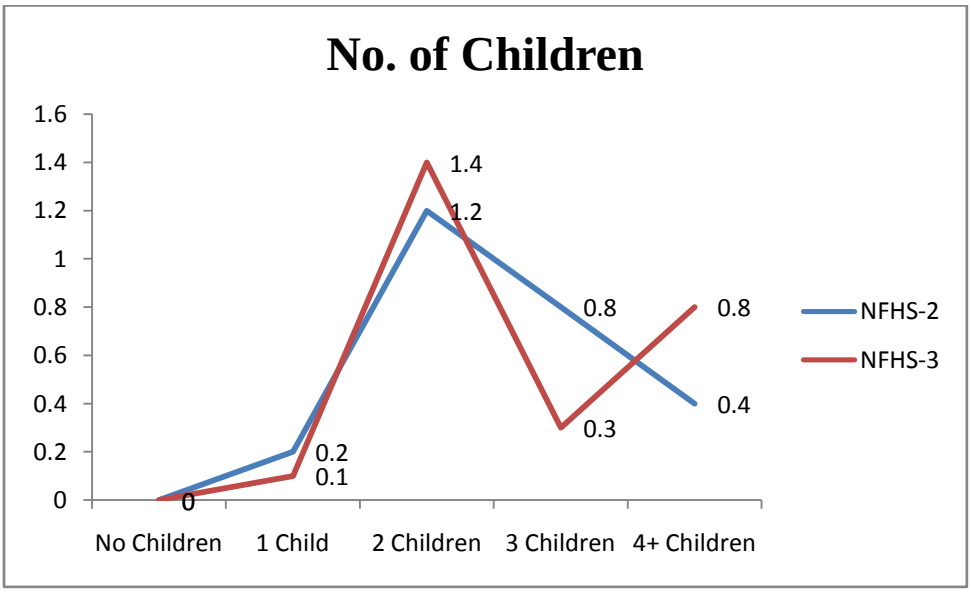


3.1.2.6 No. of Living Children: Percentage of IUD usage has increased has increased among the women who are having 2 or 4+ children.

Table 3.1.2.6

No. of living Children					
	No Children	**1 Child**	**2 Children**	**3 Children**	**4+ Children**
NFHS-2	0	0.2	1.2	0.8	0.4
NFHS-3	0	0.1	1.4	0.3	0.8

Figure 3.1.2.6

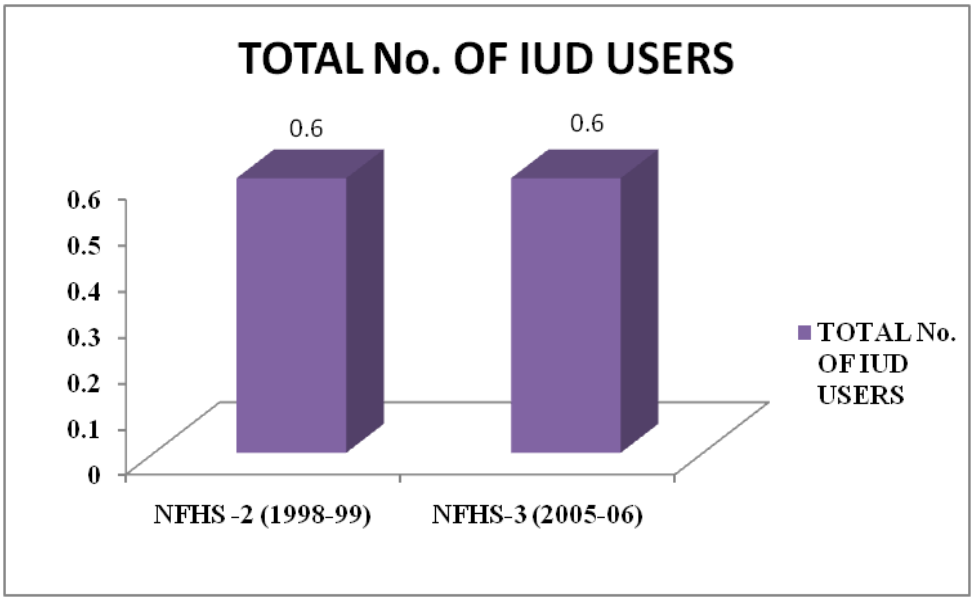


3.1.3 Percent distribution of currently married women currently using IUD, according to NFHS-2 & NFHS-3 Survey in Bihar

Table 3.1.3

	TOTAL No. OF IUD USERS
NFHS -2 (1998-99)	0.6
NFHS-3 (2005-06)	0.6

Figure 3.1.3



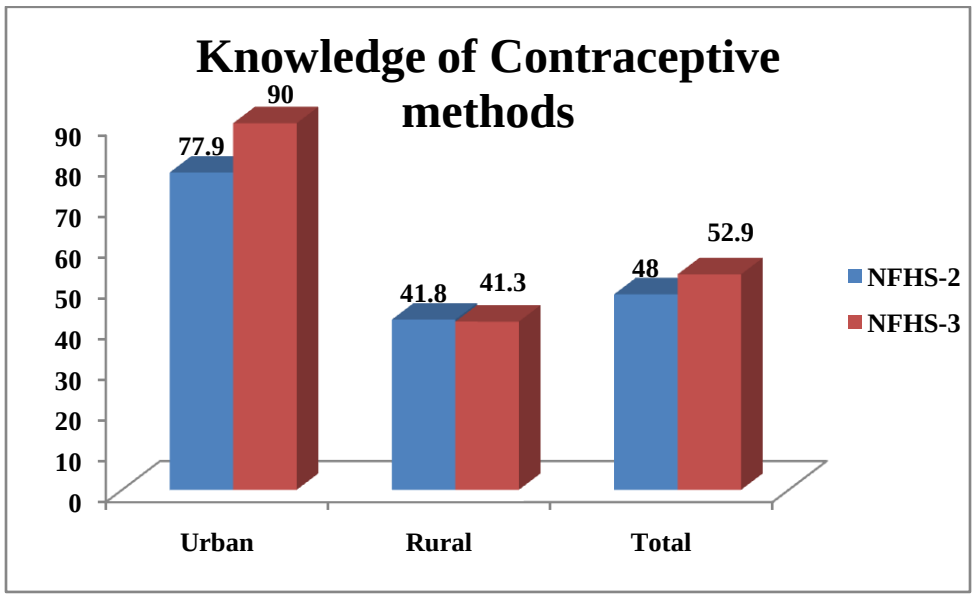
3.2 Jharkhand

3.2.1Knowledge of Contraceptive methods: As indicated from the graph that the overall knowledge among the currently married women has increased from NHFS-2 to NFHS-3. There is a significant increase in the knowledge status of the women in urban sector from 77.9% in NFHS-2 to 90% in NFHS-3.

Table 3.2.1

Percentage of currently married women who have knowledge of IUD Contraceptive method by residence			
	Urban	**Rural**	**Total**
NFHS-2	77.9	41.8	48
NFHS-3	90	41.3	52.9

Figure 3.2.1



3.2.2 **Current use of Contraception by Background Characteristics**

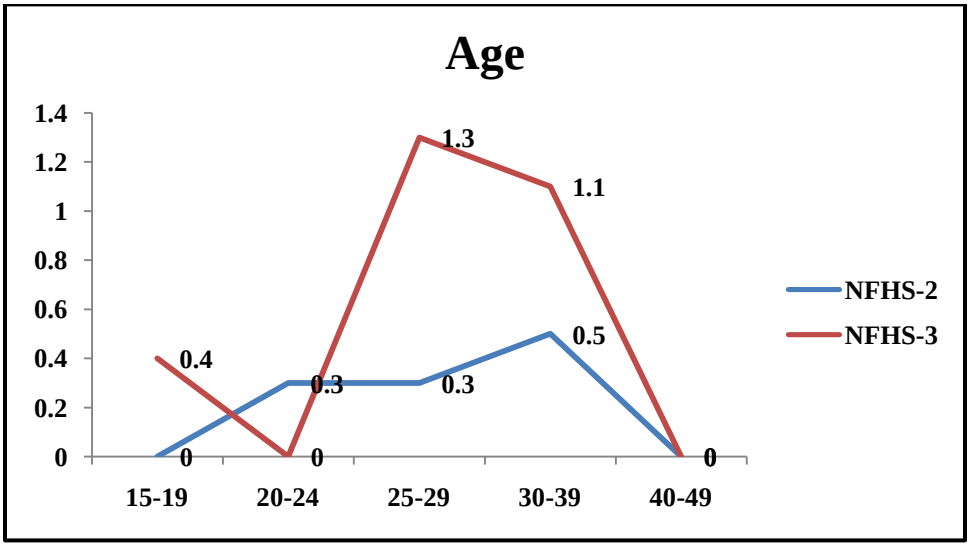
Percent distribution of currently married women currently using IUD, according to background characteristics, Jharkhand

3.2.2.1 Age: The graph clearly indicates that except age group 20-24 every other age group has shown a decrease in the use of IUD from NFHS-2 to NFHS-3.

Table 3.2.2.1

AGE					
	15-19	**20-24**	**25-29**	**30-39**	**40-49**
NFHS-2	0	0.3	0.3	0.5	0
NFHS-3	0.4	0	1.3	1.1	0

Figure 3.2.2.1

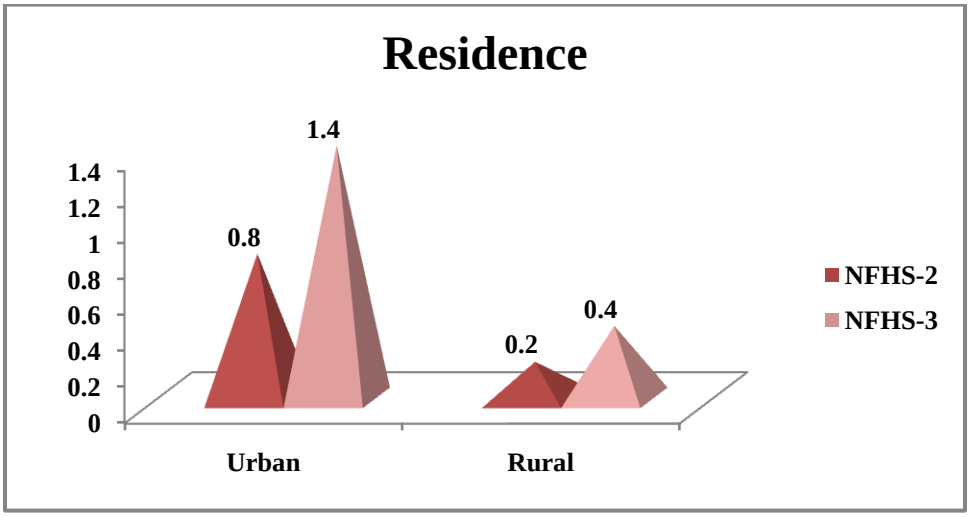


3.2.2.2 **Residence:** The use of IUD has overall increased in both Urban and Rural areas from NFHS-2 to NFHS-3.

Table 3.2.2.2

Residence		
	Urban	**Rural**
NFHS-2	0.8	0.2
NFHS-3	1.4	0.4

Figure 3.2.2.2

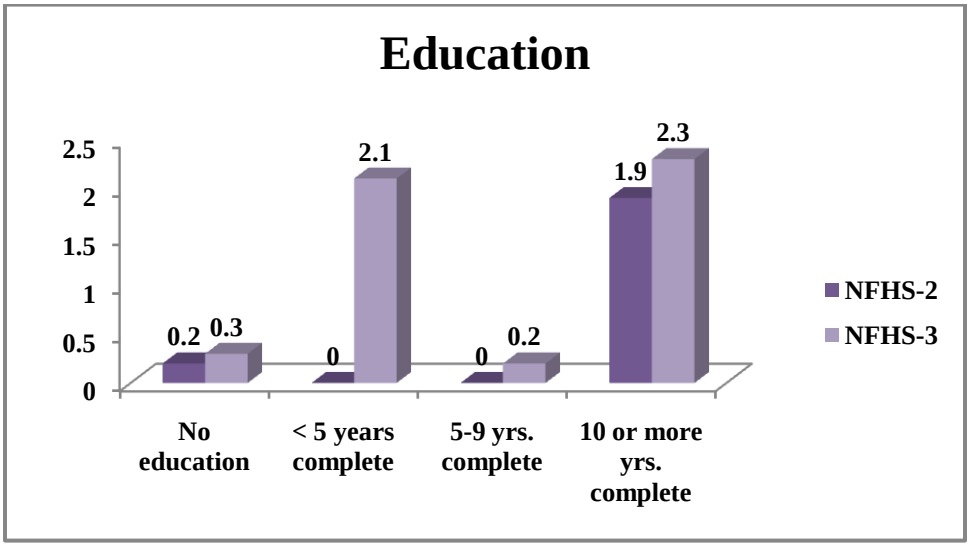


3.2.2.3 Education: The graph shows an overall increase in the use of IUD in all the levels of literacy. There is a marked increase in the usage among the women having more than 5 years of education.

Table 3.2.2.3

Education				
	No education	**< 5 years complete**	**5-9 yrs. complete**	**10 or more yrs. complete**
NFHS-2	0.2	0	0	1.9
NFHS-3	0.3	2.1	0.2	2.3

Figure 3.2.2.3

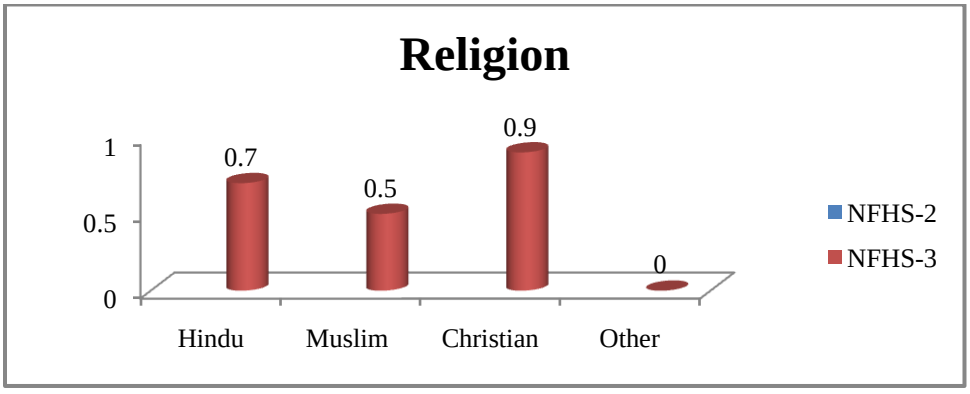


3.2.2.4 Religion: The data for NFHS-2 is not available but from the data of NFHS-3 it is evident that Christians are using the IUDs more than Hindus and Muslims.

Table 3.2.2.4

Religion				
	Hindu	**Muslim**	**Christian**	**Other**
NFHS-2	NA	NA	NA	NA
NFHS-3	0.7	0.5	0.9	0

Figure 3.2.2.4

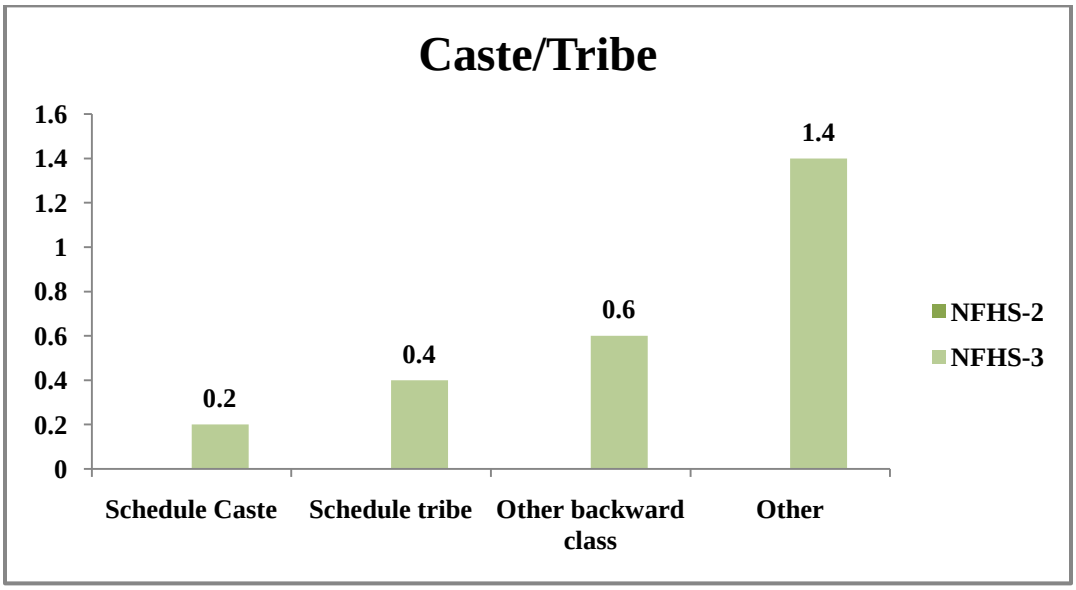


3.2.2.5 Caste/Tribe: The NFHS-2 data for caste & tribe is not available but the castes other than SC, ST & OBCs are using the IUDs maximum among the group in NFHS-3 data.

Table 3.2.2.5

	Caste/ Tribe			
	Schedule Caste	**Schedule tribe**	**Other backward class**	**Other**
NFHS-2	NA	NA	NA	NA
NFHS-3	0.2	0.4	0.6	1.4

Figure 3.2.2.5

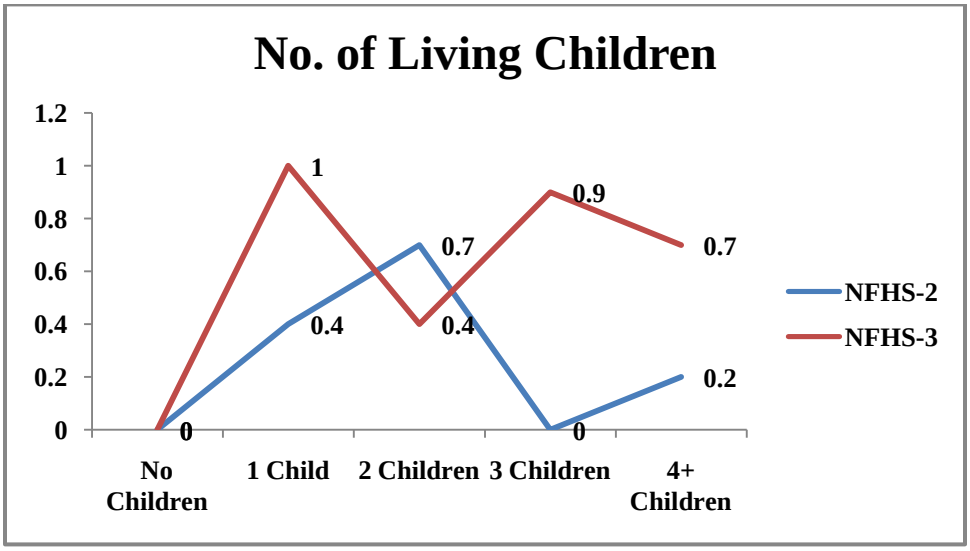


3.2.2.6 **No. of living Children:** There is a decrease in the use of IUD among the women having 2 children from NFHS-2 (0.7%) to NFHS-3 (0.4%). The usage of IUD among women having 2, 3 and 4+ children have increased from NFHS-2 to NFHS-3.

Table 3.2.2.6

No. of living Children					
	No Children	**1 Child**	**2 Children**	**3 Children**	**4+ Children**
NFHS-2	0	0.4	0.7	0	0.2
NFHS-3	0	1	0.4	0.9	0.7

Figure 3.2.2.6

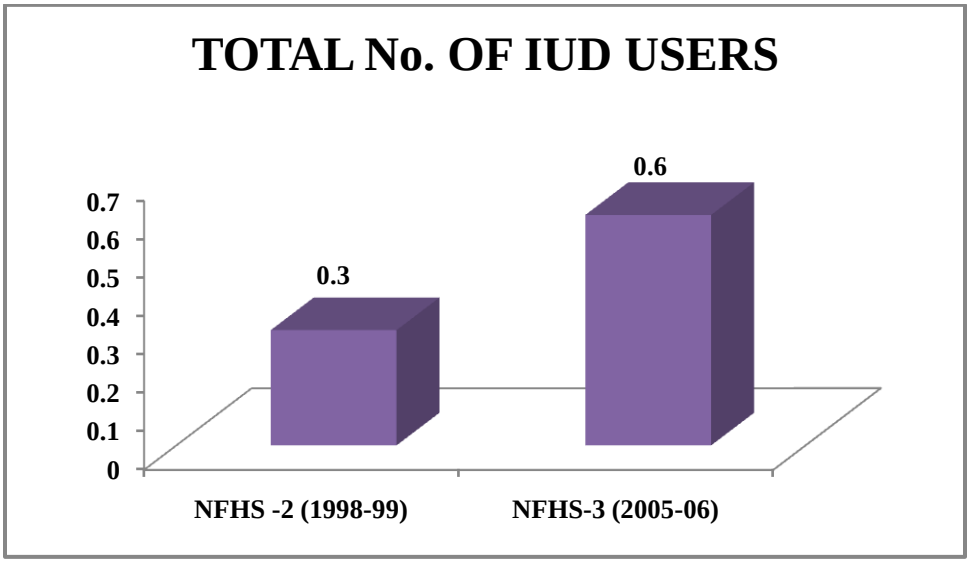


3.2.3 Percent distribution of currently married women currently using IUD, according to NFHS-2 & NFHS-3 in Jharkhand: The graph shows a marked increase in the percentage of current IUD users from NFHS-2 to NFHS-3 by 0.3 %.

Table 3.2.3

	TOTAL No. OF IUD USERS
NFHS -2 (1998-99)	0.3
NFHS-3 (2005-06)	0.6

Figure 3.2.3



3.3 Madhya Pradesh

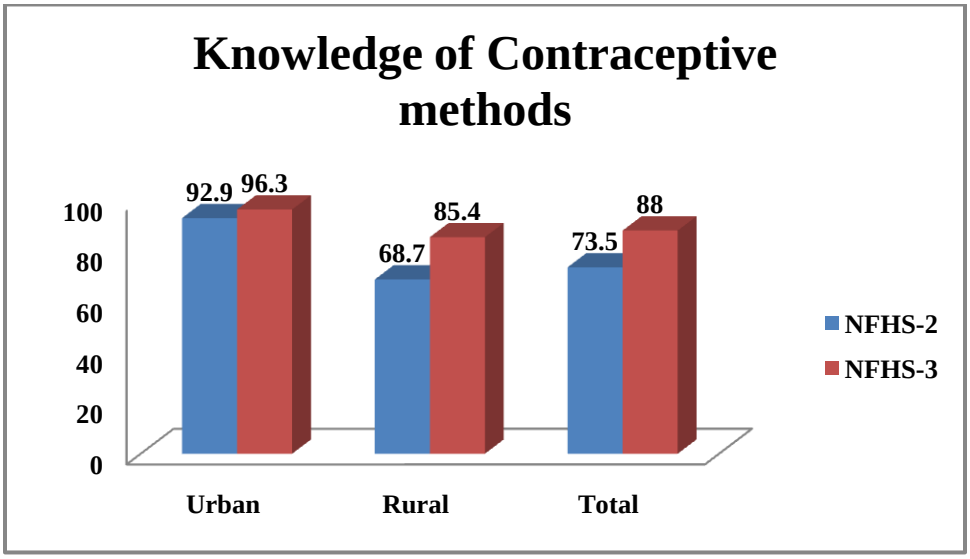
3.3.1 Knowledge of IUD as a Contraceptive method

Percentage of currently married women who have knowledge of IUD Contraceptive method by residence in Madhya Pradesh. There is an overall increase in the knowledge level of the currently married women regarding IUD as a contraceptive method. Both the women from urban as well as rural have shown a marked increase in the knowledge of IUD.

Table 3.3.1

	Urban	Rural	Total
NFHS-2	79.3	40.2	50.1
NFHS-3	91.2	64.2	71.3

Figure 3.3.1



3.3.2 **Current use of Contraception by Background Characteristics**

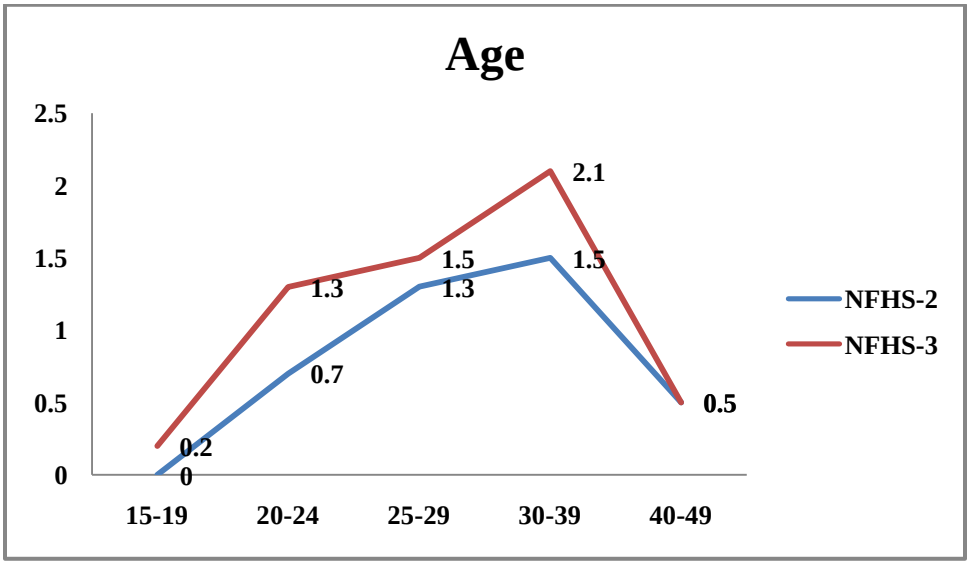
Percent distribution of currently married women currently using IUD, according to background characteristics, Uttar Pradesh.

3.3.2.1 Age: The percentage of IUD users has increased among age group 20-24 and 40-49 where as there is a decrease in the percentage of the IUD users in other age groups from NFHS-2 to NFHS-3.

Table 3.3.2.1

	Age				
	15-19	**20-24**	**25-29**	**30-39**	**40-49**
NFHS-2	0.4	0.8	1.5	0.8	0.2
NFHS-3	0	1.2	0.8	0.6	0.4

Figure 3.3.2.1

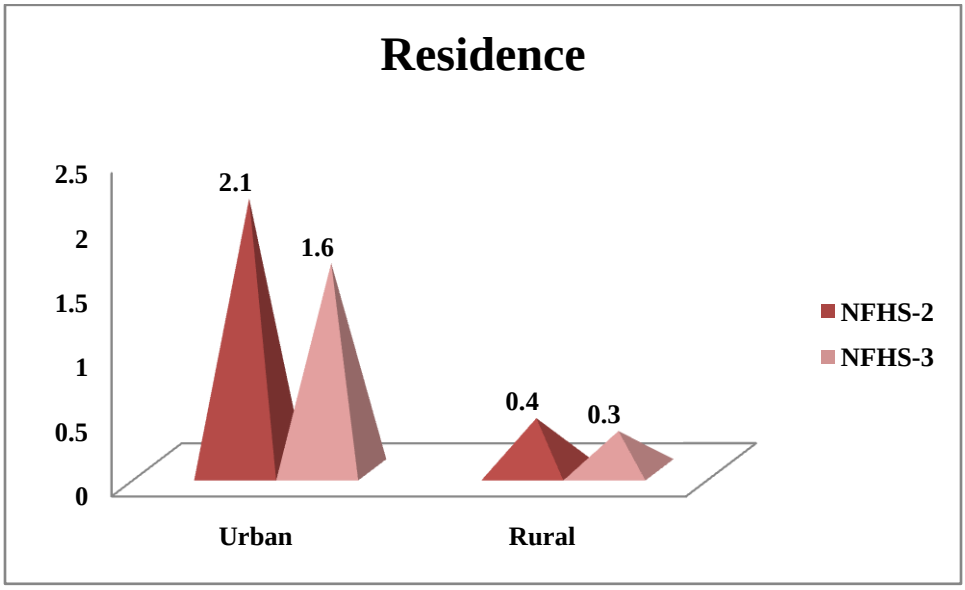


3.3.2.2 Residence: There is an overall decrease in the use of IUD as a contraceptive by currently married women of both urban and rural area from NFHS-2 to NFHS-3.

Table 3.3.2.2

Residence		
	Urban	**Rural**
NFHS-2	2.1	0.4
NFHS-3	1.6	0.3

Figure 3.3.2.2

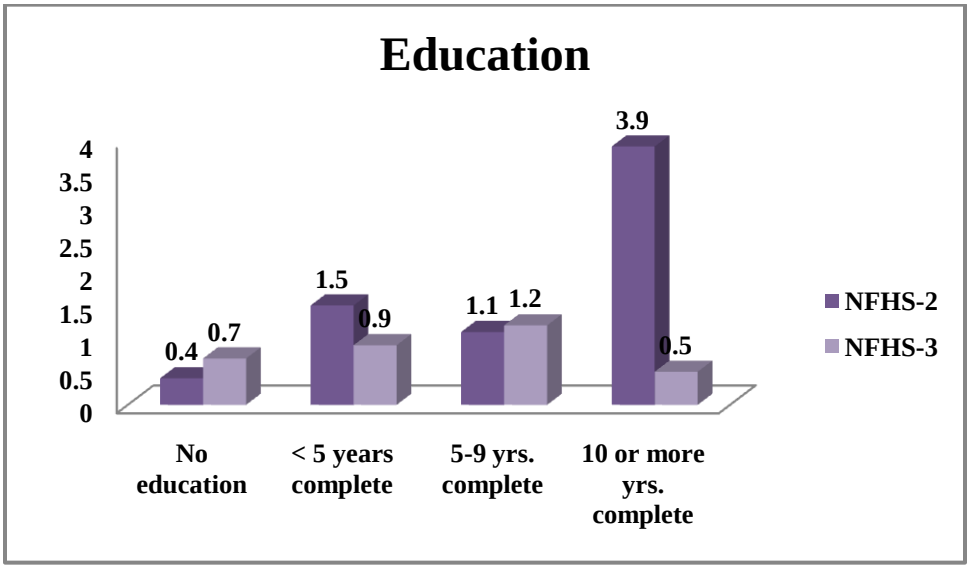


3.3.2.3 **Education:** There is a sharp decrease in the percentage of IUD users having 10 or more years of education from NFHS-2 to NFHS-3. The percentage of illiterate women using IUD has increased from NFHS-2 to NFHS-3.

Table 3.3.2.3

Education				
	No education	**< 5 years complete**	**5-9 yrs. complete**	**10 or more yrs. complete**
NFHS-2	0.1	0.5	0.8	6.2
NFHS-3	0.3	0	0.7	3.3

Figure 3.3.2.3

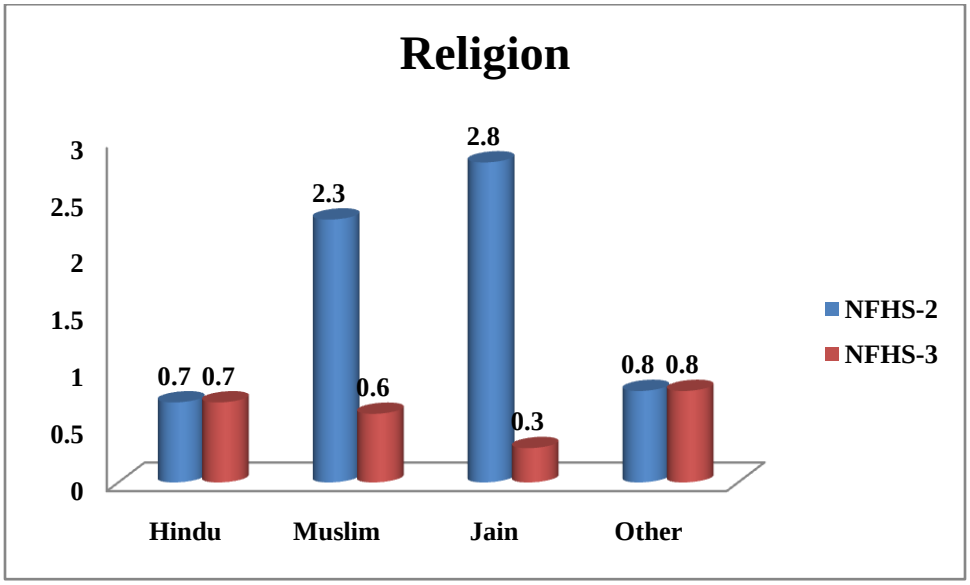


3.3.2.4 Religion: There is a decrease in no. of Muslim and Jain IUD users from NFHS-2 to NFHS-3 where as the percentage of Hindu IUD users remained the same from NFHS-2 to NFHS-3.

Table 3.3.2.4

Religion				
	Hindu	**Muslim**	**Jain**	**Other**
NFHS-2	0.7	2.3	2.8	0.8
NFHS-3	0.7	0.6	0.3	0.8

Figure 3.3.2.4

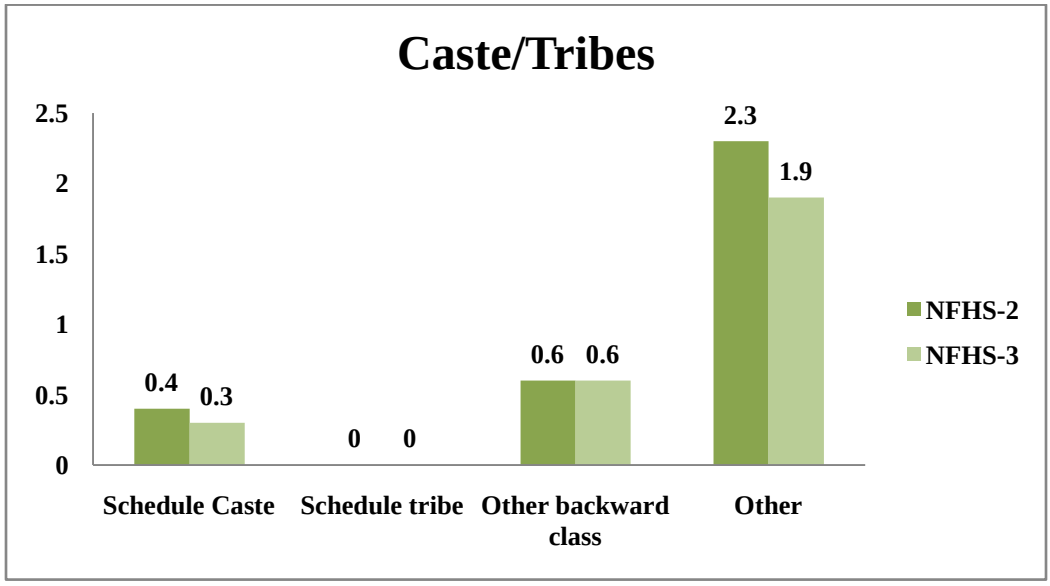


3.3.2.5 Caste/ Tribe: The graph shows a marked decrease in the percentage of IUD users among Schedule Caste and Other castes from NFHS-2 to NFHS-3. The percentage of OBC IUD users remained the same.

Table 3.3.2.5

Caste/ Tribe				
	Schedule Caste	**Schedule tribe**	**Other backward class**	**Other**
NFHS-2	0.4	0	0.6	2.3
NFHS-3	0.3	0	0.6	1.9

Figure 3.3.2.5

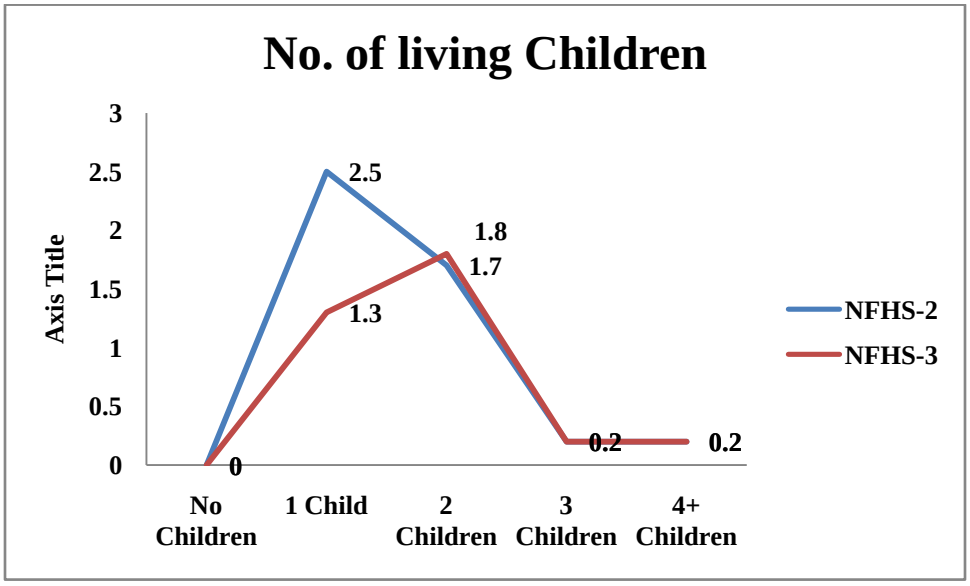


3.3.2.6 No. of living Children: In NFHS-2 the maximum numbers of IUD users were the women having 1 child which has decreased from 2.5% to 1.3% in NFHS-3. In NFHS-3 the maximum no. of IUD users were the women having two children.

Table 3.3.2.6

No. of living Children					
	No Children	**1 Child**	**2 Children**	**3 Children**	**4+ Children**
NFHS-2	0	2.5	1.7	0.2	0.2
NFHS-3	0	1.3	1.8	0.2	0.2

Figure 3.3.2.6

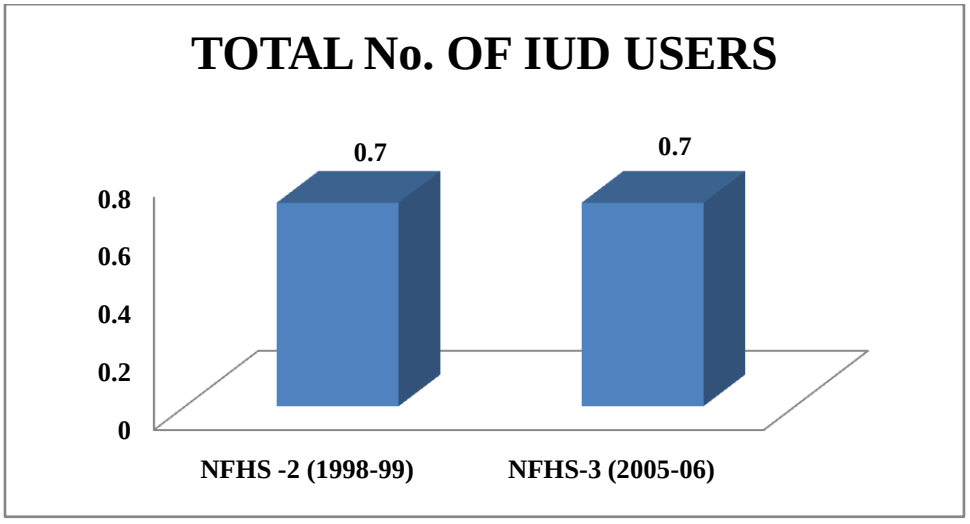


3.3.3 **Percent distribution of currently married women currently using IUD, according to NFHS-2 & NFHS-3 in Madhya Pradesh**

Table 3.3.3

	TOTAL No. OF IUD USERS
NFHS -2 (1998-99)	0.7
NFHS-3 (2005-06)	0.7

Figure 3.3.3



3.4 Orissa

3.4.1 Knowledge of Contraceptive methods:

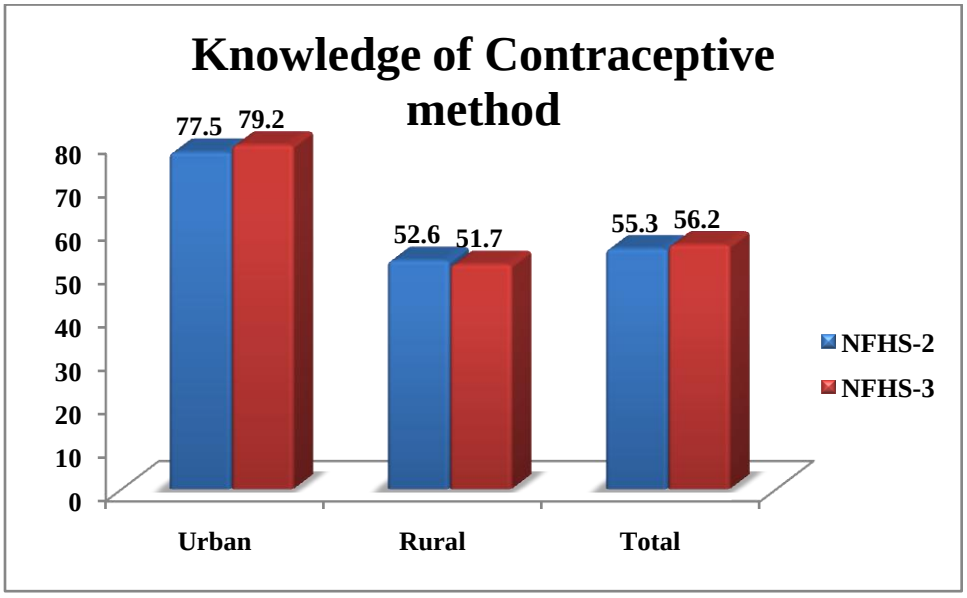
Percentage of currently married women who have knowledge of IUD Contraceptive method by residence.

As indicated from the graph that the overall knowledge among the currently married women has increased from NHFS-2 to NFHS-3. Urban women shows an approximate 2% increase in the knowledge status from NFHS-2 to NFHS-3.

Table 3.4.1

	Urban	Rural	Total
NFHS-2	77.5	52.6	55.3
NFHS-3	79.2	51.7	56.2

Figure 3.4.1



3.4.2 Prevalence of IUD as Contraceptive by Background Characteristics

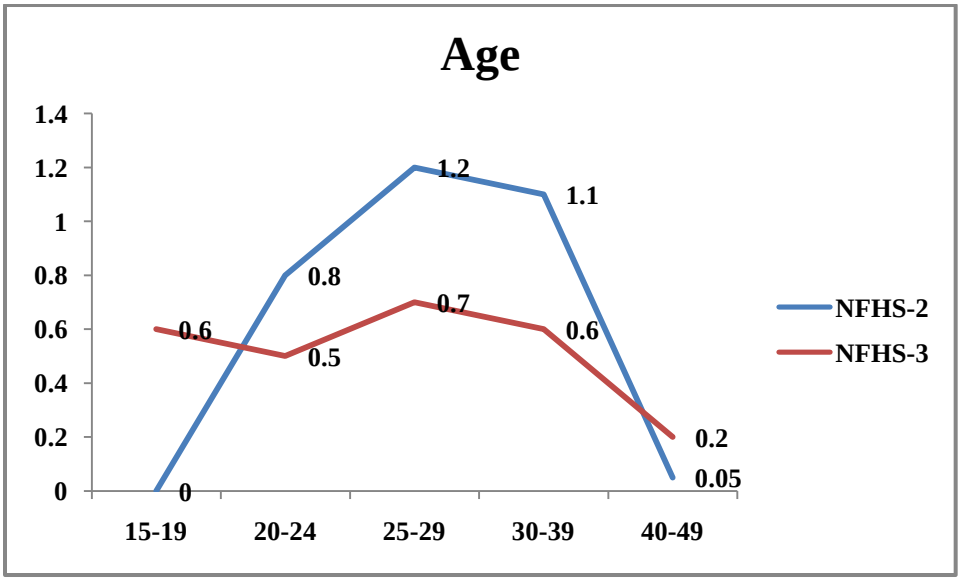
Percent distribution of currently married women currently using IUD, according to background characteristics.

3.4.2.1 Age: There is an overall decrease in the percentage of IUD users in the age group 20-24, 25-29 and 30-39 where as there is an increase in the percentage of the IUD users in age groups 15-19 and 40-49 from NFHS-2 to NFHS-3.

Table 3.4.2.1

AGE					
	15-19	**20-24**	**25-29**	**30-39**	**40-49**
NFHS-2	0	0.8	1.2	1.1	0.05
NFHS-3	0.6	0.5	0.7	0.6	0.2

Figure 3.4.2.1



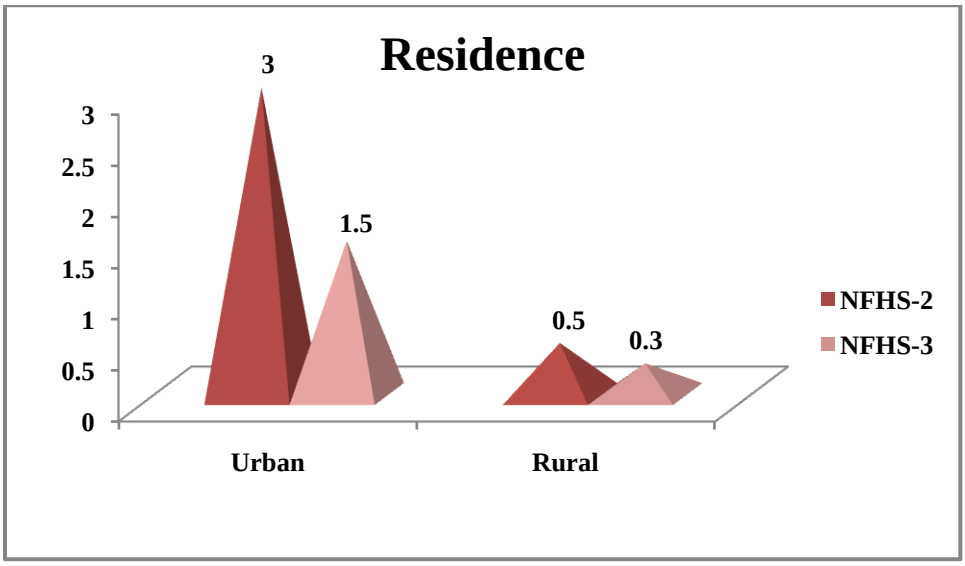
3.4.2.2 Residence: There is an overall decrease in the use of IUD as a contraceptive by currently married women of both urban and rural area from NFHS-2 to NFHS-3.

Table 3.4.2.2

Residence		
	Urban	**Rural**

NFHS-2	3	0.5
NFHS-3	1.5	0.3

Figure 3.4.2.2

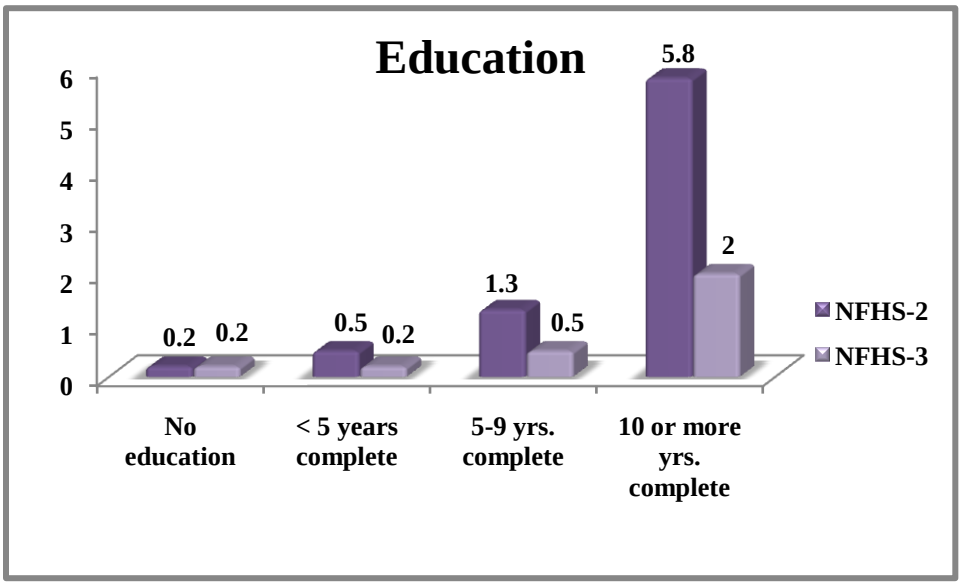


3.4.2.3 **Education:** There is an overall decrease in the usage of IUD with literacy levelfrom NHFS-2 to NFHS-3.Women having 10 or more years of education shows a sharp decrease in the percentage of IUD usage from NFHS-2 to NFHS-3.

Table 3.4.2.3

Education				
	No education	**< 5 years complete**	**5-9 yrs. complete**	**10 or more yrs. complete**
NFHS-2	0.2	0.5	1.3	5.8
NFHS-3	0.2	0.2	0.5	2

Figure 3.4.2.3

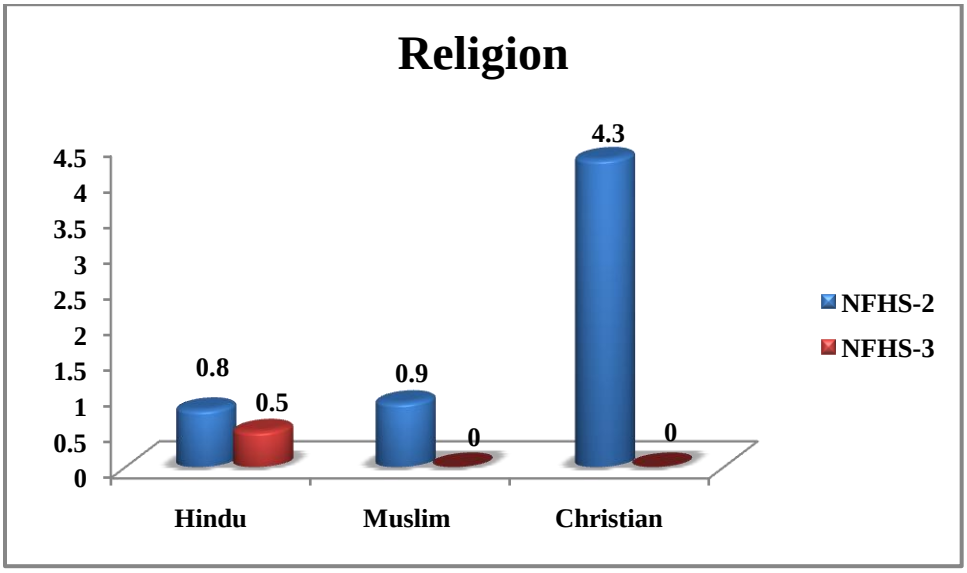


3.4.2.4 Religion: Figure indicates that Muslim and Jain community has altogether stopped the usage of IUD from NFHS-2 to NFHS-3 ,even percentage of Hindu IUD users has also declined from NFHS-2 to NFHS-3.

Table 3.4.2.4

Religion			
	Hindu	**Muslim**	**Christian**
NFHS-2	0.8	0.9	4.3
NFHS-3	0.5	0	0

Figure 3.4.2.4

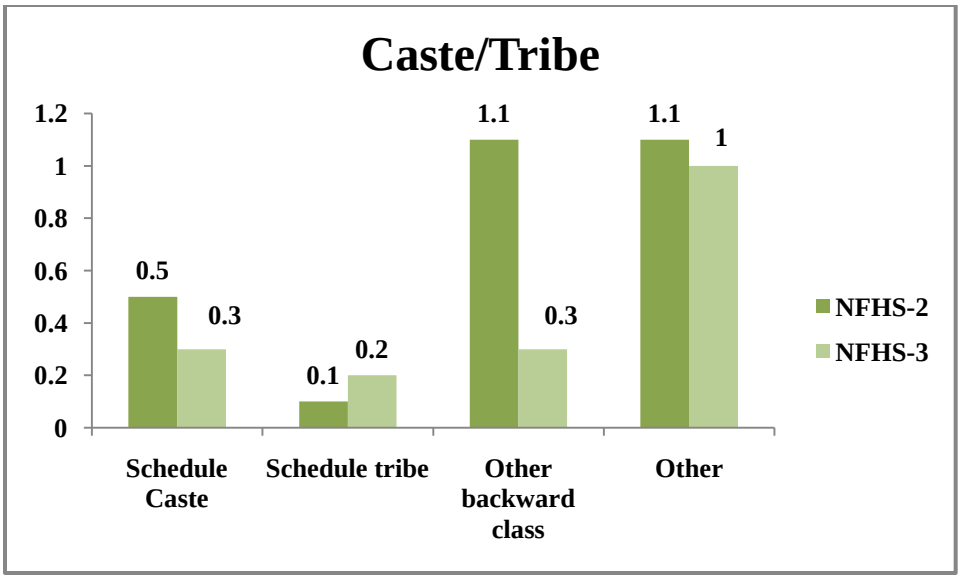


3.4.2.5 Caste/ Tribe: The graph shows a marked decrease in the percentage of IUD users among Schedule Caste and Other castes from NFHS-2 to NFHS-3. The percentage of OBC IUD users almost remained the same.

Table 3.4.2.5

Caste/ Tribe				
	Schedule Caste	**Schedule tribe**	**Other backward class**	**Other**
NFHS-2	0.5	0.1	1.1	1.1
NFHS-3	0.3	0.2	0.3	1

Figure 3.4.2.5

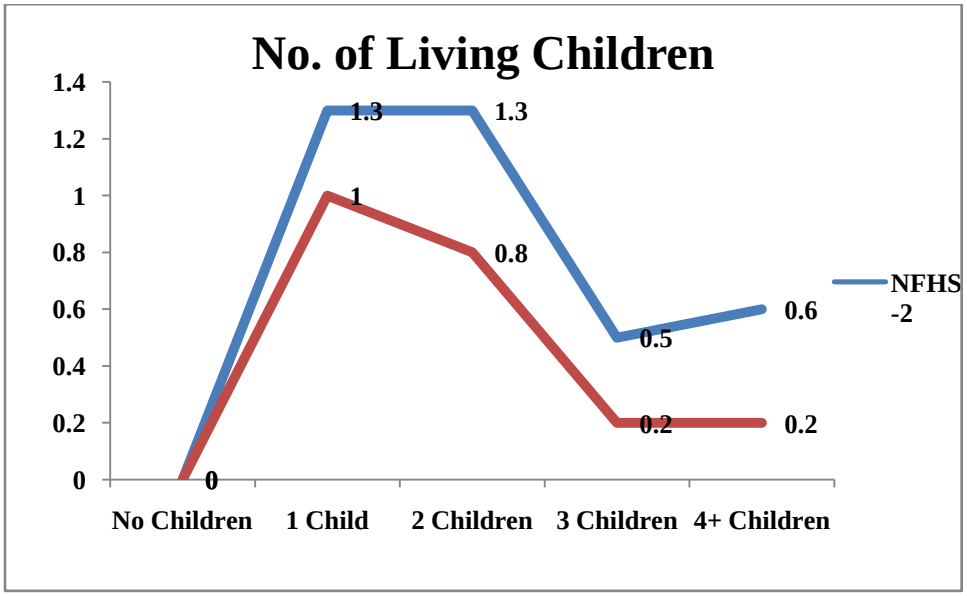


3.3.2.6 No. of living Children: In NFHS-2 the maximum numbers of IUD users were the women having 1 or 2 but during the time period of NFHS-3 its use is even declined in these groups.

Table 3.4.2.6

No. of living Children					
	No Children	**1 Child**	**2 Children**	**3 Children**	**4+ Children**
NFHS-2	0	1.3	1.3	0.5	0.6
NFHS-3	0	1	0.8	0.2	0.2

Figure 3.4.2.6



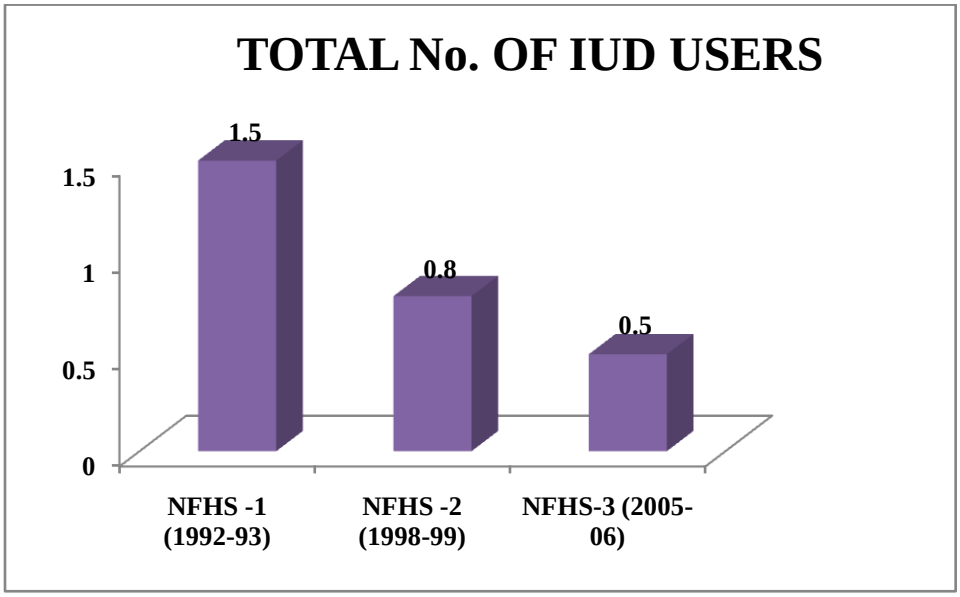
3.4.3 Percent distribution of currently married women currently using IUD, according to 3 NFHS in Orissa

As indicated in the figure prevalence rate has decreased from NFHS-2 to NFHS-3

Table 3.4.3

	TOTAL No. OF IUD USERS
NFHS -2 (1998-99)	0.8
NFHS-3 (2005-06)	0.5

Figure 3.4.3


TOTAL No. OF IUD USERS
1.5
0.8
0.5
1.5
1
0.5
0
NFHS -1 (1992-93)
NFHS -2 (1998-99)
NFHS-3 (2005-06)

3.5 Rajasthan

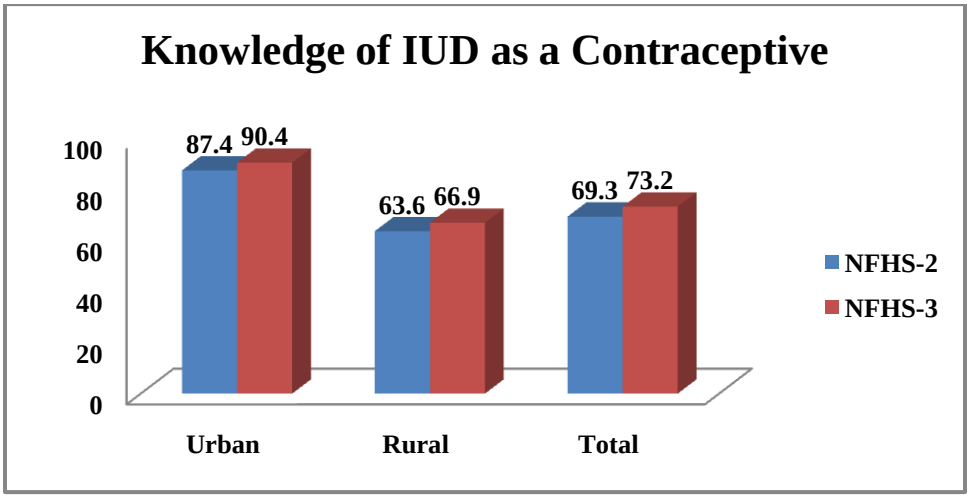
3.5.1 Knowledge of IUD as a Contraceptive methods

Percentage of currently married women who have knowledge of IUD Contraceptive method by residence. The graph below shows that there is an overall increase in the knowledge status of IUD among the rural and urban area.

Table 3.5.1

	Urban	Rural	Total
NFHS-2	87.4	63.6	69.3
NFHS-3	90.4	66.9	73.2

Figure 3.5.1



3.5.2 Current use of Contraception by Background Characteristics

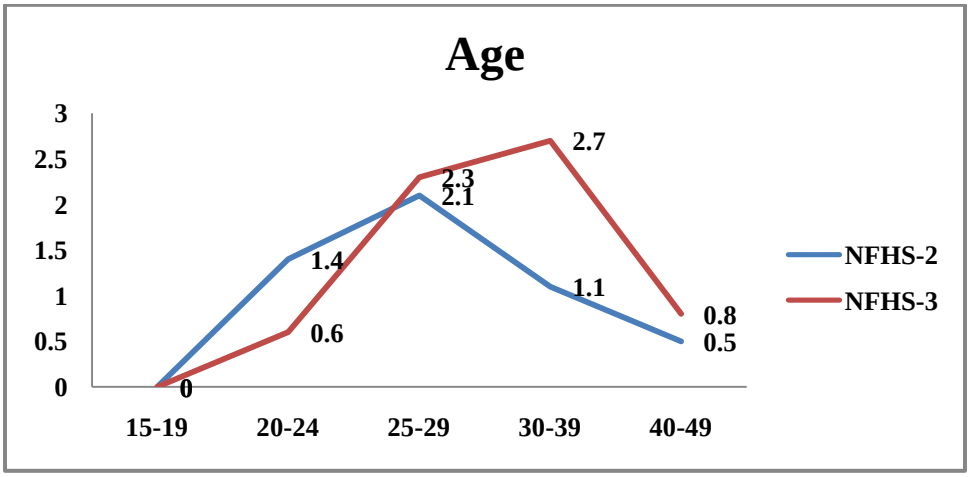
Percent distribution of currently married women currently using IUD, according to background characteristics, Rajasthan.

3.5.2.1 Age: On the basis of age as a background characteristic, there is an overall increase in the use of IUD among all the age group**.**

Table 3.5.2.1

AGE					
	15-19	**20-24**	**25-29**	**30-39**	**40-49**
NFHS-2	0	1.4	2.1	1.1	0.5
NFHS-3	0	0.6	2.3	2.7	0.8

Figure 3.5.2.1

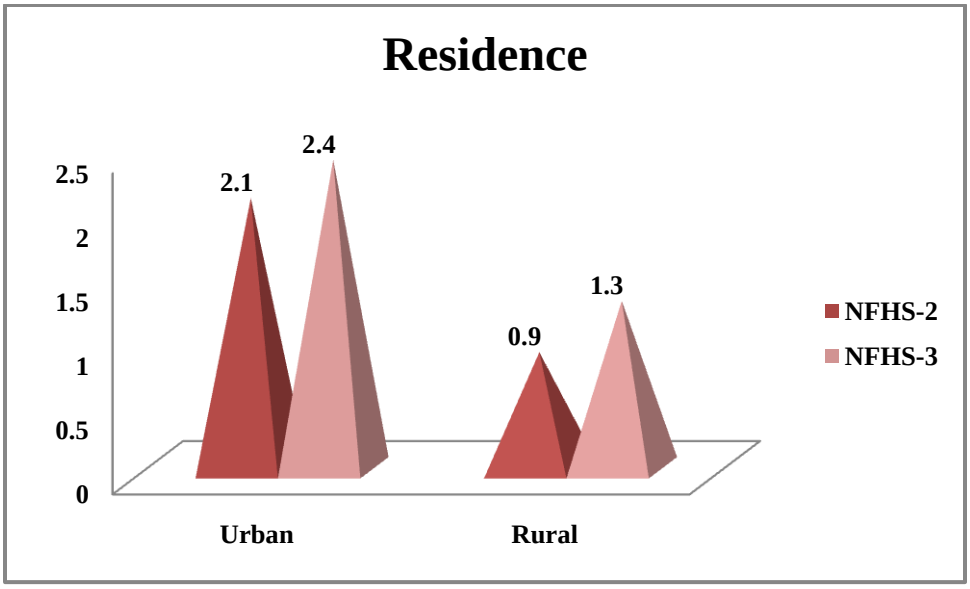


3.5.2.2 Residence: The use of IUD has increased in both the urban and rural areas in Rajasthan

Table 3.5.2.2

Residence		
	Urban	**Rural**
NFHS-2	2.1	0.9
NFHS-3	2.4	1.3

Figure 3.5.2.2

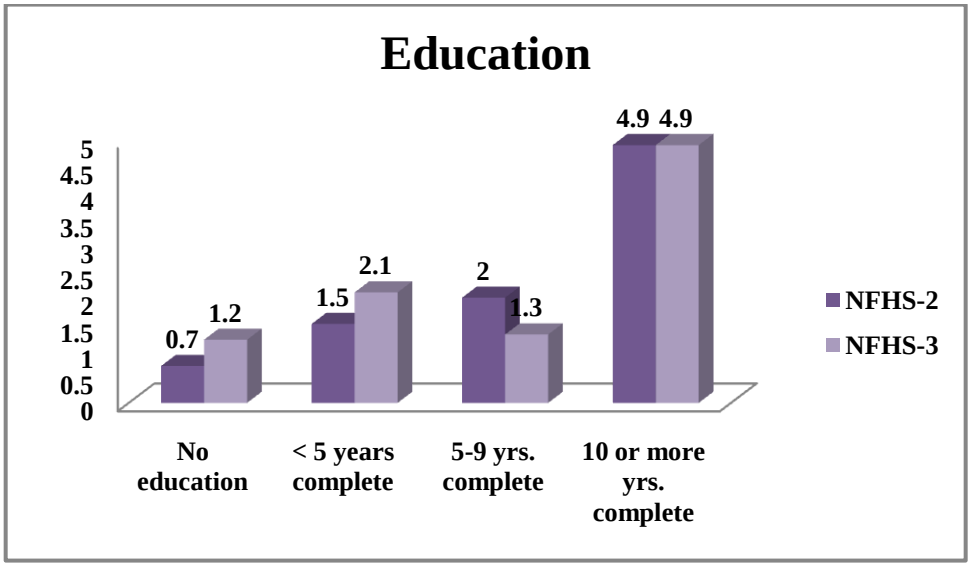


3.5.2.3 Education: It is evident from the graph below that as the educational level increased in Rajasthan, the use of IUD has decreased.

Table 3.5.2.3

Education				
	No education	**< 5 years complete**	**5-9 yrs. complete**	**10 or more yrs. complete**
NFHS-2	0.7	1.5	2	4.9
NFHS-3	1.2	2.1	1.3	4.9

Figure 3.5.2.3

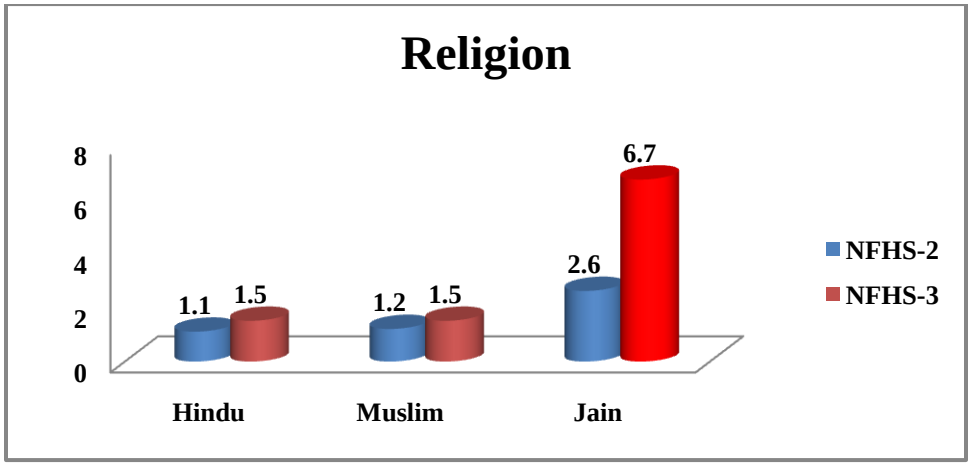


3.5.2.4 Religion: In Rajasthan the use of IUD has increased among the women of all religion.

Table 3.5.2.4

Religion				
	Hindu	**Muslim**	**Jain**	**Other**
NFHS-2	1.1	1.2	2.6	8.6
NFHS-3	1.5	1.5	6.7	

Figure 3.5.2.4

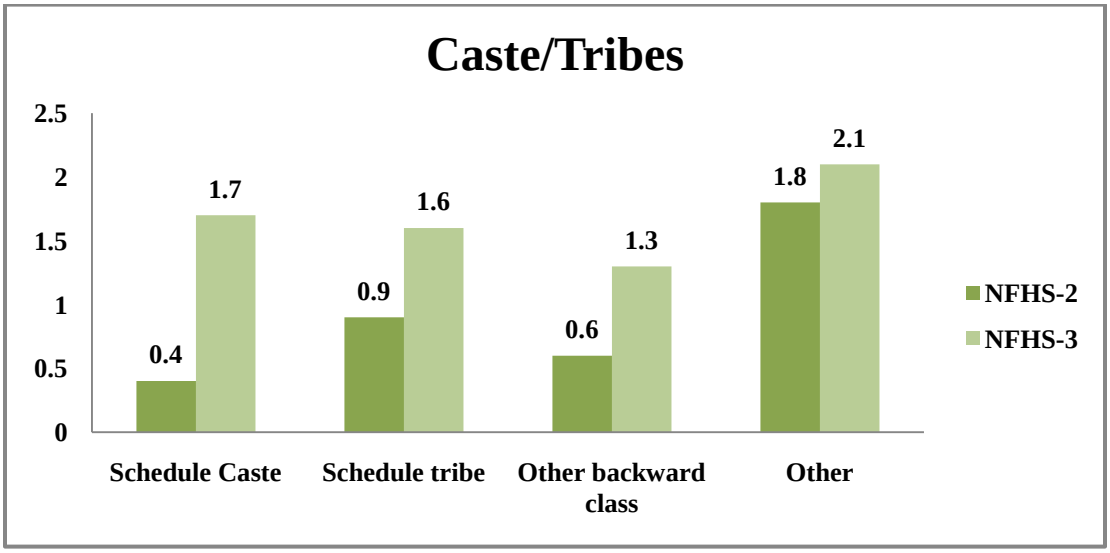


3.5.2.5. Caste/Tribe: The use of IUD has increased in all the castes and tribes.

Table 3.5.2.5

Caste/ Tribe				
	Schedule Caste	**Schedule tribe**	**Other backward class**	**Other**
NFHS-2	0.4	0.9	0.6	1.8
NFHS-3	1.7	1.6	1.3	2.1

Figure 3.5.2.5

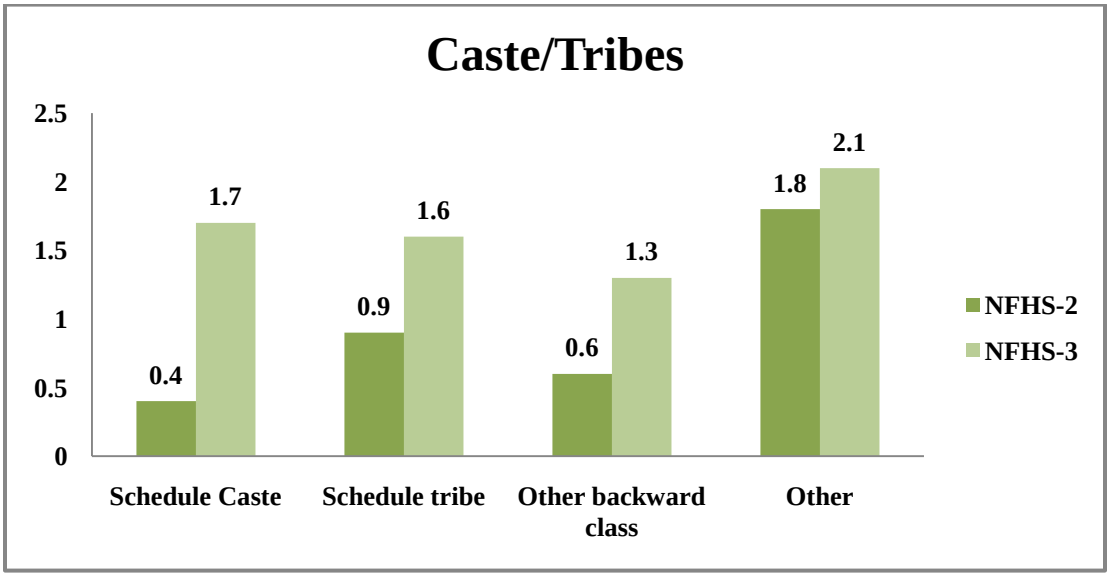


3.**5.2.6 No. of living children:** the women having only one child have shown a decrease in IUD usage.

Table 3.5.2.6

No. of living Children					
	No Children	**1 Child**	**2 Children**	**3 Children**	**4+ Children**
NFHS-2	0	1.3	2.5	1.2	0.8
NFHS-3	0	0.4	3.6	1.2	1.7

Figure 3.5.2.6

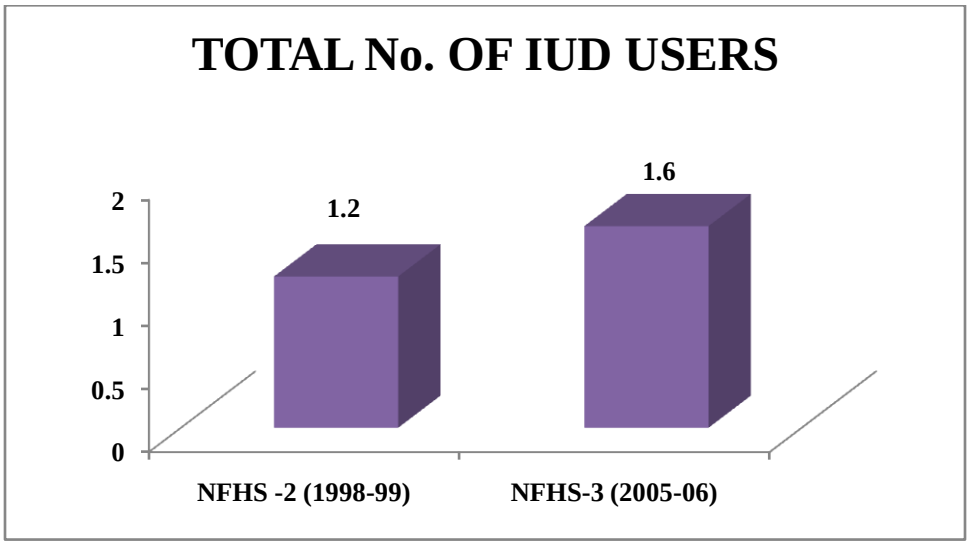


3.5.3 Percent distribution of currently married women currently using IUD, according to 3 NFHS in Rajasthan. The overall usage of IUD has increased in Rajasthan.

Table 3.5.3

	TOTAL No. OF IUD USERS
NFHS -2 (1998-99)	1.2
NFHS-3 (2005-06)	1.6

Figure 3.5.3



3.6 Uttranchal

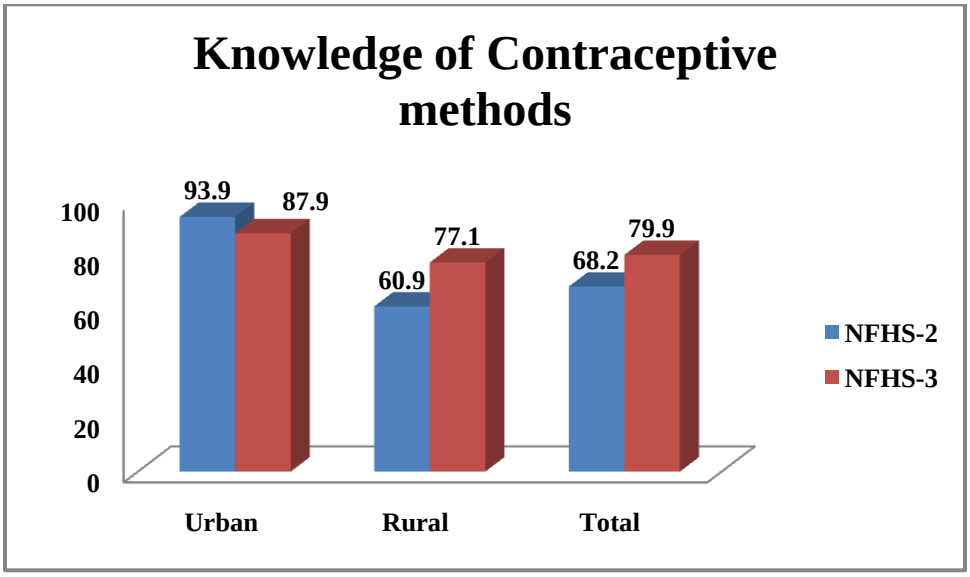
3.6.1 Knowledge of IUD as a Contraceptive methods

Percentage of currently married women who have knowledge of IUD Contraceptive method by residence. The table and graph below shows that there is an overall increase in the knowledge status of IUD in the state but the in urban area there is a decline in knowledge.

Table 3.6.1.1

	Urban	Rural	Total
NFHS-2	93.9	60.9	68.2
NFHS-3	87.9	77.1	79.9

Figure 3.6.1.1



3.6.2 Current use of Contraception by Background Characteristics

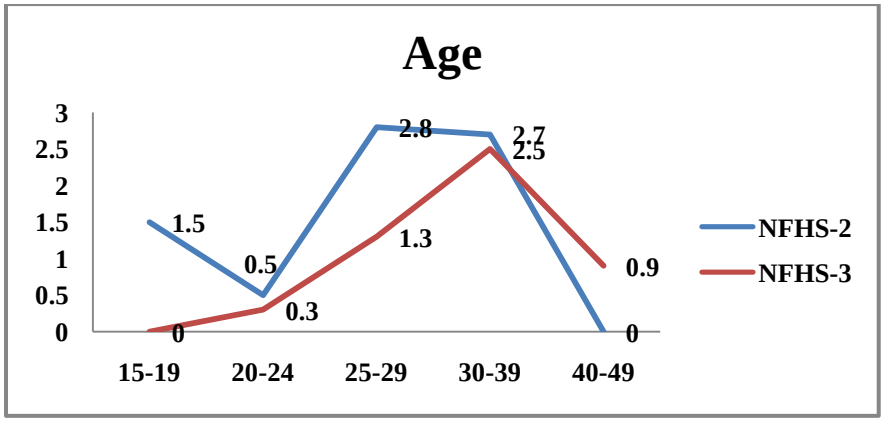
Percent distribution of currently married women currently using IUD, according to background characteristics, Uttaranchal

3.6.2.1 Age: on the basis of there is an overall decline in the usage of IUD

Table 3.6.2.1

AGE					
	15-19	**20-24**	**25-29**	**30-39**	**40-49**
NFHS-2	1.5	0.5	2.8	2.7	0
NFHS-3	0	0.3	1.3	2.5	0.9

Figure 3.6.2.1

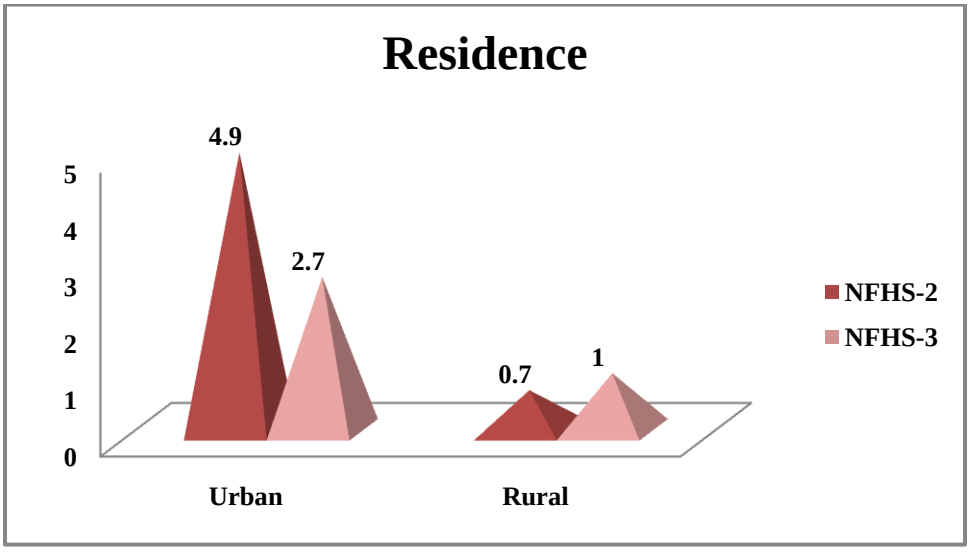


3.6.2.2. Residence: The usage of IUD has decreased in both rural and urban area.

Table 3.6.2.2

Residence		
	Urban	**Rural**
NFHS-2	4.9	0.7
NFHS-3	2.7	1

Figure 3.6.2.2

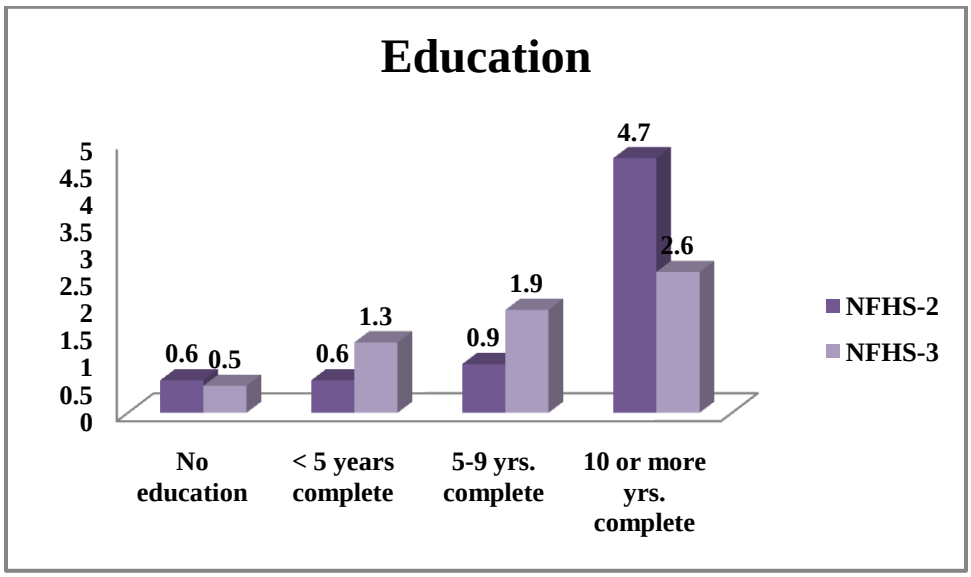


3.6.2.3 Education: There is a mixed trend of IUD usage on the basis of education the usage is decreasing among the women having more than 10 years of education.

Table 3.6.2.3

Education				
	No education	**< 5 years complete**	**5-9 yrs. complete**	**10 or more yrs. complete**
NFHS-2	0.6	0.6	0.9	4.7
NFHS-3	0.5	1.3	1.9	2.6

Figure 3.6.2.3

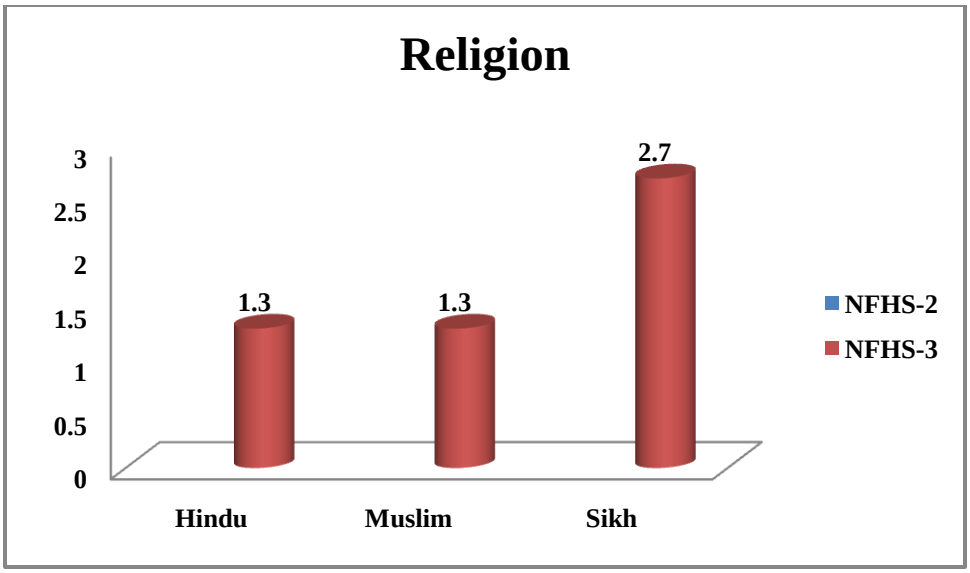


3.6.2.4 Religion: NFHS-2 Data is not available

Table 3.6.2.4

Religion			
	Hindu	**Muslim**	**Sikh**
NFHS-2			
NFHS-3	1.3	1.3	2.7

Figure 3.6.2.4

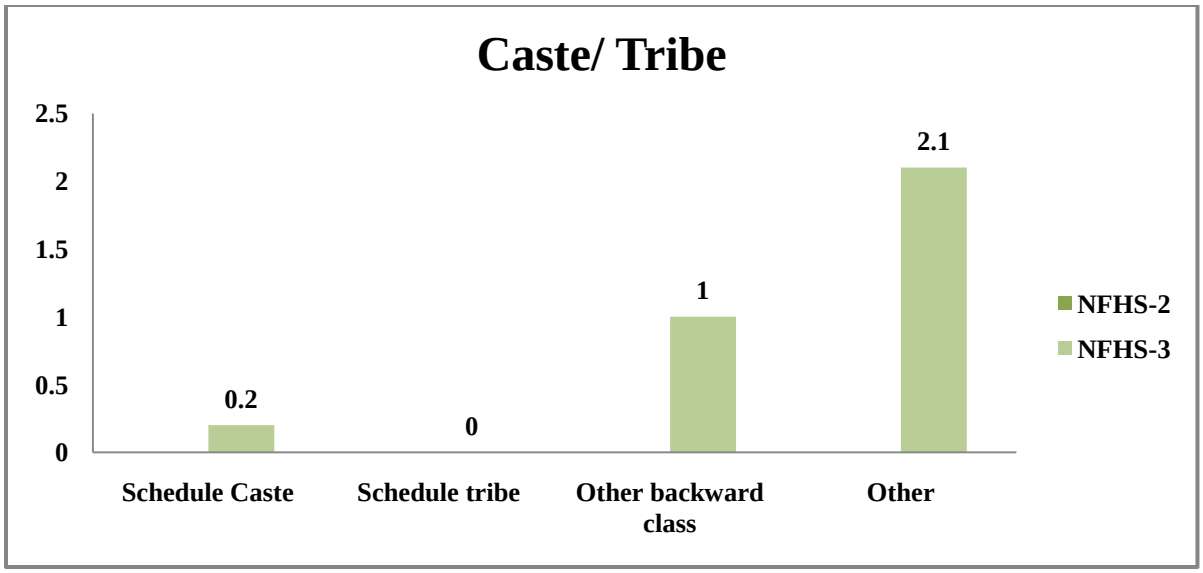


3.6.2.5 Caste/Tribe: NFHS-2 Data is not available

Table 3.6.2.5

Caste/ Tribe				
	Schedule Caste	**Schedule tribe**	**Other backward class**	**Other**
NFHS-2				
NFHS-3	0.2	0	1	2.1

Figure 3.6.2.5

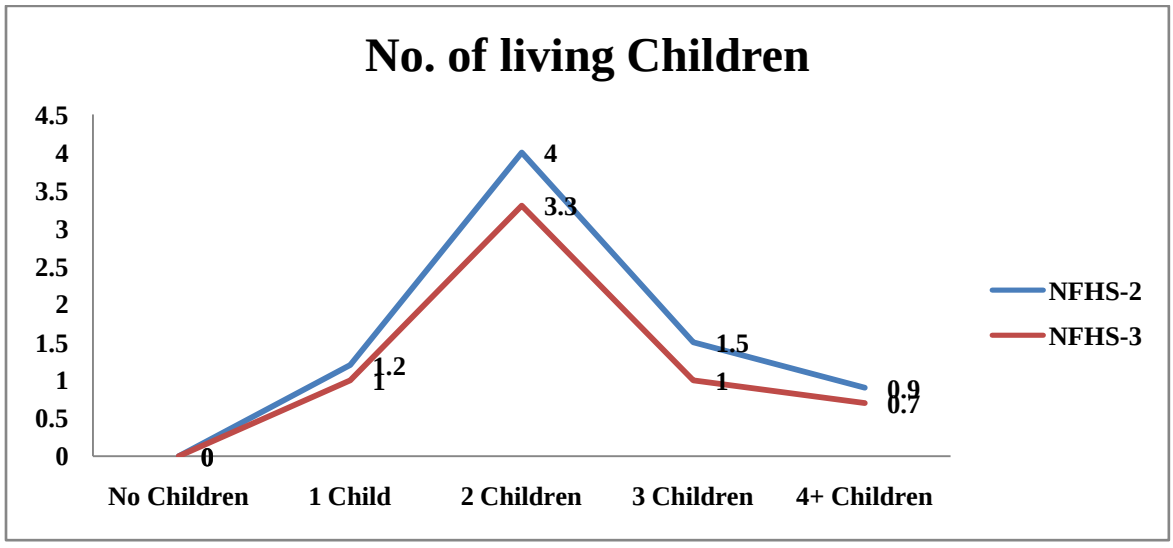


3.6.2.6 No. of living children: there is an overall decrease in the usage among the women having one or more children.

Table 3.6.2.6

No. of living Children					
	No Children	1 Child	2 Children	3 Children	4+ Children
NFHS-2	0	1.2	4	1.5	0.9
NFHS-3	0	1	3.3	1	0.7

Figure 3.6.2.6

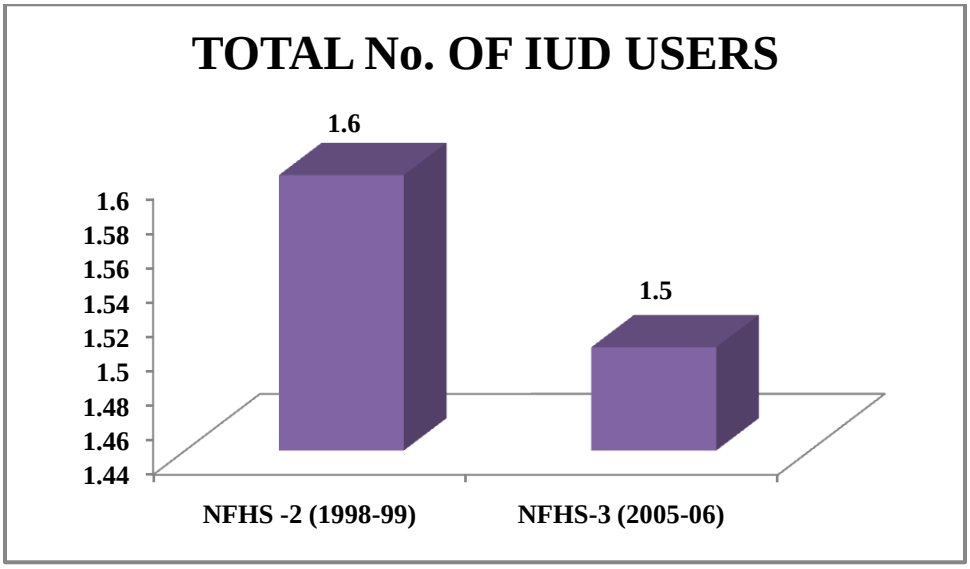


3.6.3 Percent distribution of currently married women currently using IUD, according to 3 NFHS Uttranchal. It can be concluded from the graph below that the usage of IUD has decreased in Uttaranchal.

Table 3.6.3

	TOTAL No. OF IUD USERS
NFHS -2 (1998-99)	1.6
NFHS-3 (2005-06)	1.5

Figure 3.6.3



3.7 Chattishgarh

NFHS- 2 data is not available.

3.8 Uttar Pradesh

3.8.1 Knowledge of Contraceptive methods

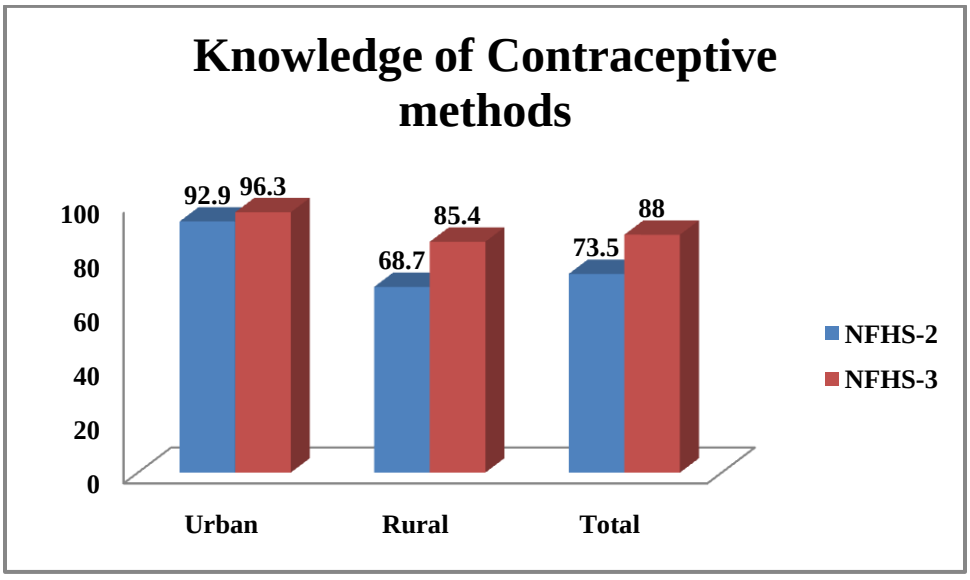
Percentage of currently married women who have knowledge of IUD Contraceptive method by residence in Uttar Pradesh. There is an overall increase in the knowledge level of the currently married women regarding IUD as a contraceptive method. Both the women from urban as well as rural has shown increase in the knowledge of IUD, but awareness in rural people seems to have increased more i.e. by 16%.

Percentage of currently married women who have knowledge of IUD Contraceptive method by residence

Table 3.8.1

	Urban	Rural	Total
NFHS-2	92.9	68.7	73.5
NFHS-3	96.3	85.4	88

Figure 3.8.1



3.8.2 Current use of Contraception by Background Characteristics

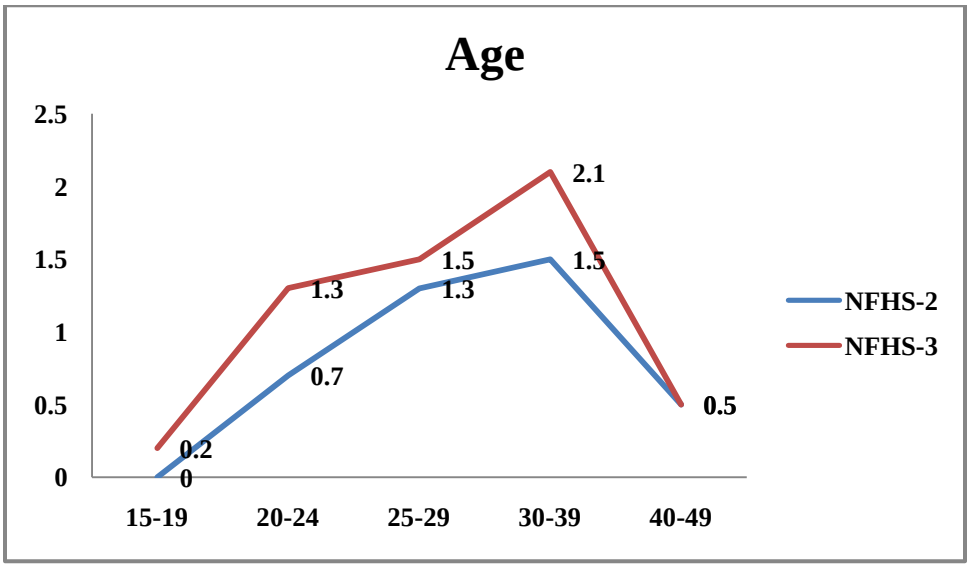
Percentage distribution of currently married women currently using IUD, according to background characteristics, Uttar Pradesh.

3.8.2.1 Age: The percentage of IUD users has increased among all the age groups but age group 20-24 & 30-39 has increased the usage a little more i.e. by 0.6%.

Table 3.8.2.1

AGE					
	15-19	**20-24**	**25-29**	**30-39**	**40-49**
NFHS-2	0	0.7	1.3	1.5	0.5
NFHS-3	0.2	1.3	1.5	2.1	0.5

Figure 3.8.2.1

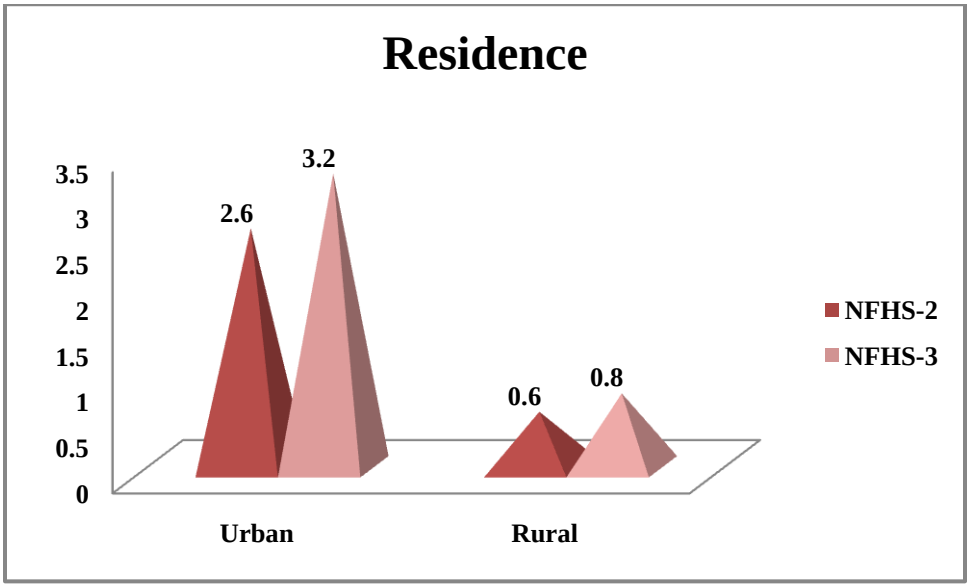


3.8.2.2 Residence: There is an overall increase in the use of IUD as a contraceptive by currently married women of both urban and rural area from NFHS-2 to NFHS-3 but percentage increase is much higher in urban residence.

Table 3.8.2.2

Residence		
	Urban	**Rural**
NFHS-2	2.6	0.6
NFHS-3	3.2	0.8

Figure 3.8.2.2

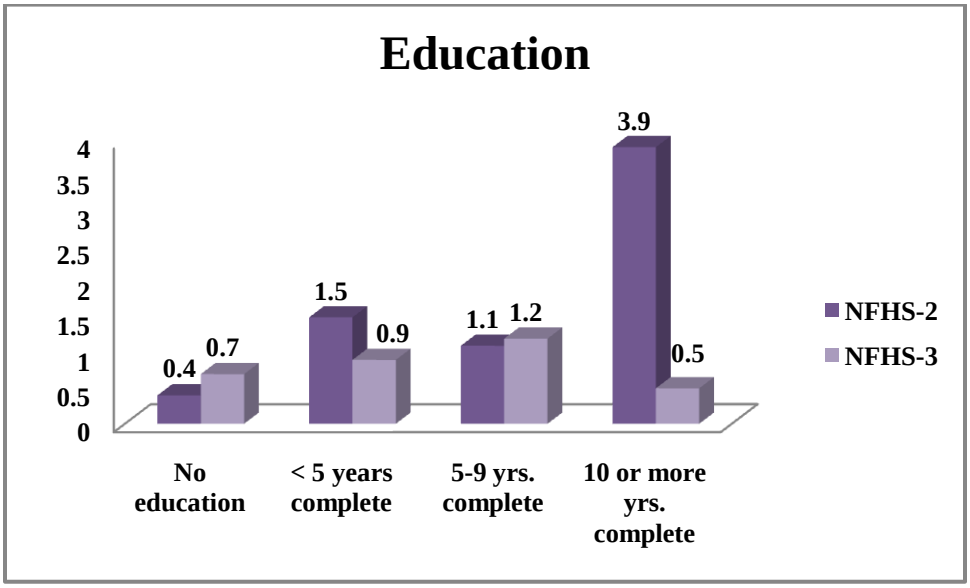


3.8.2.3 Education: There is a sharp decrease in the percentage of IUD users having 10 or more years of education from NFHS-2 to NFHS-3. The percentage of illiterate women using IUD has increased from NFHS-2 to NFHS-3.

Table 3.8.2.3

Education				
	No education	**< 5 years complete**	**5-9 yrs. complete**	**10 or more yrs. complete**
NFHS-2	0.4	1.5	1.1	3.9
NFHS-3	0.7	0.9	1.2	0.5

Figure 3.8.2.3

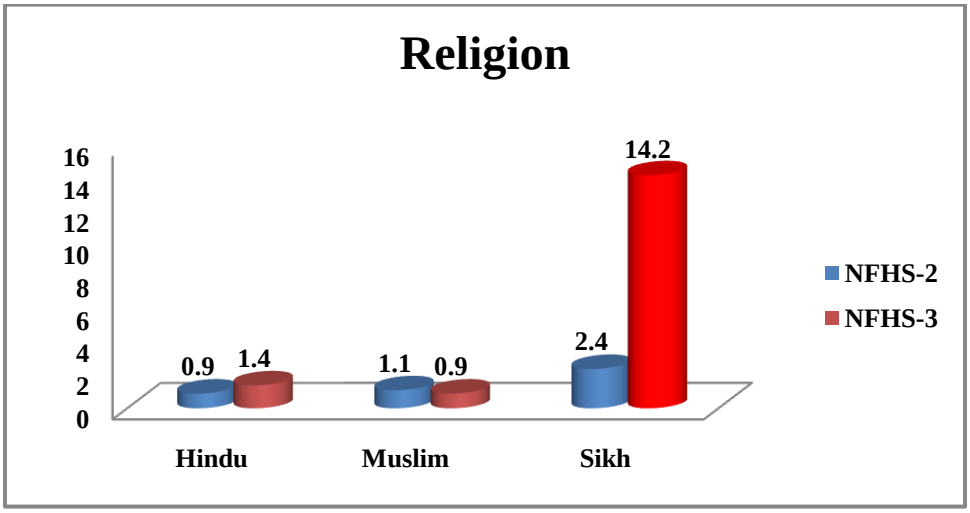


3.8.2.4 Religion: Currently married women of Sikh community have shown a remarkable increase of 12 **%** in IUD usage from NFHS-2 to NFHS-3. Hindu Community has also shown an increase in percentage use but Muslim Community has decreased its usage.

Table 3.8.2.4

Religion				
	Hindu	**Muslim**	**Sikh**	**Other**
NFHS-2	0.9	1.1	2.4	NA
NFHS-3	1.4	0.9	14.2	5.5

Figure 3.8.2.4

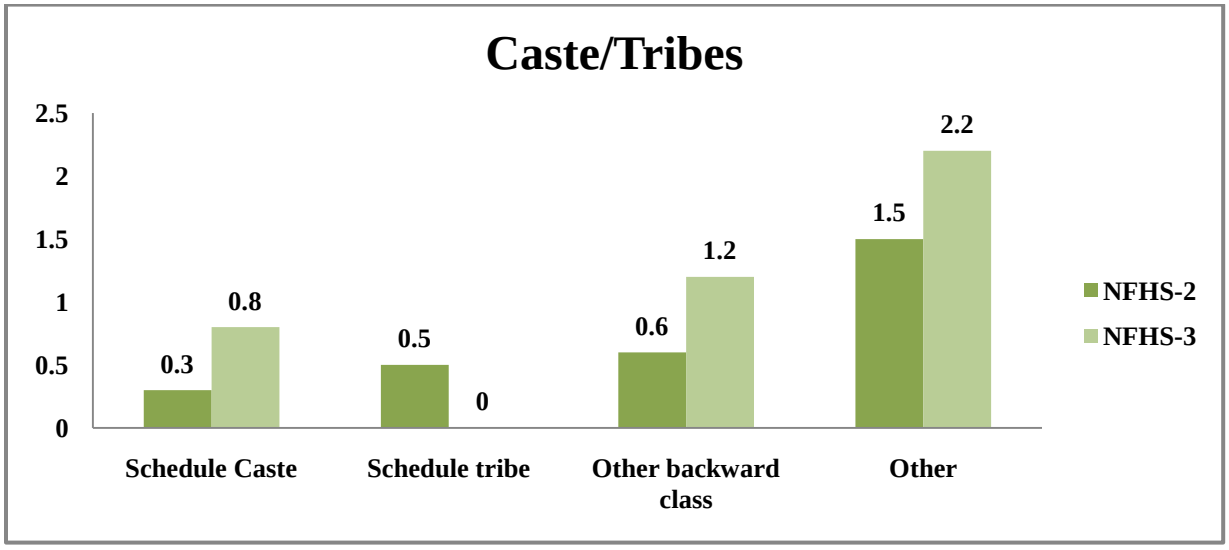


3.8.2.5 Caste/ Tribe: The graph shows a marked increase in the percentage usage of IUD among all the Castes except Schedule Tribe which altogether have seen to stop the usage of IUD.

Table 3.8.2.5

Caste/ Tribe				
	Schedule Caste	**Schedule tribe**	**Other backward class**	**Other**
NFHS-2	0.3	0.5	0.6	1.5
NFHS-3	0.8	0	1.2	2.2

Figure 3.8.2.5

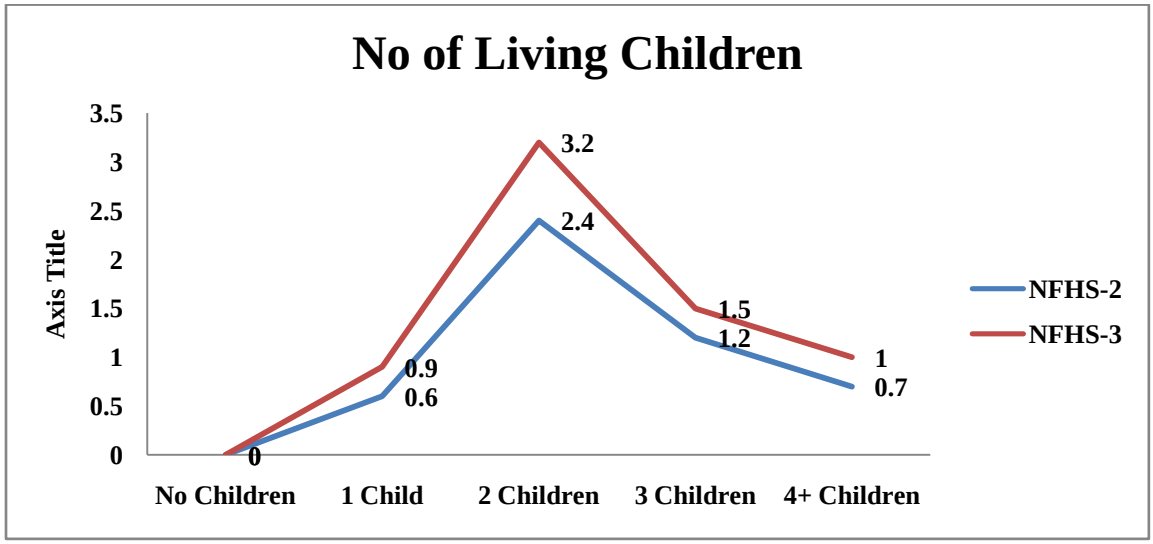


3.8.2.6 No. of living Children: In NFHS-2 the maximum numbers of IUD users were the women having 2 children which have further increased from 2.4% to 3.2% in NFHS-3.

Table 3.8.2.6

No. of living Children					
	No Children	**1 Child**	**2 Children**	**3 Children**	**4+ Children**
NFHS-2	0	0.6	2.4	1.2	0.7
NFHS-3	0	0.9	3.2	1.5	1

Figure 3.8.2.6

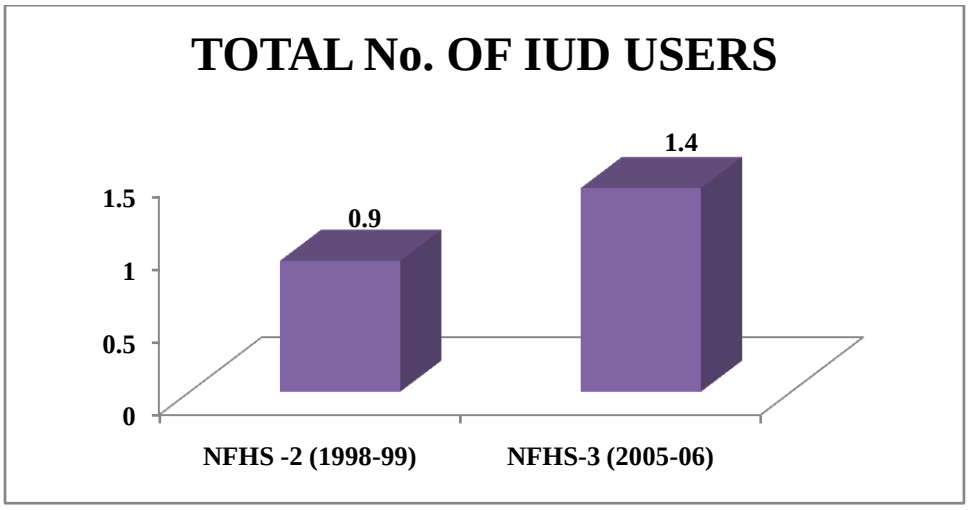


3.8.3 **Percent distribution of currently married women currently using IUD, according to NFHS-2 & NFHS-3 in Uttar Pradesh:** The graph shows a 0.5% increase in the percentage of current IUD users from NFHS-2 to NFHS-3.

Table 3.8.3

	TOTAL No. OF IUD USERS
NFHS -2 (1998-99)	0.9
NFHS-3 (2005-06)	1.4

Figure 3.8.3



Chapter 4. Summary and Discussion

On the basis of inclusive literature review and analysis of the data of National level surveys, a conclusion can be derived that overall knowledge of IUD use in India has increased by 3.7% from NFHS-2 & NFHS-3 as indicated in Fig. 4.1. When analysed on the basis of residence, Rural area has shown a significant increase in the knowledge level as compared to the urban area Figure 4.2 indicates overall prevalence of IUD has slightly increased by 0.1% among the currently married women from NFHS-2 to NFHS-3. But when analysed on the basis of residence it is revealed that prevalence of IUD has decreased in urban area by 0.2%

Figure 4.1

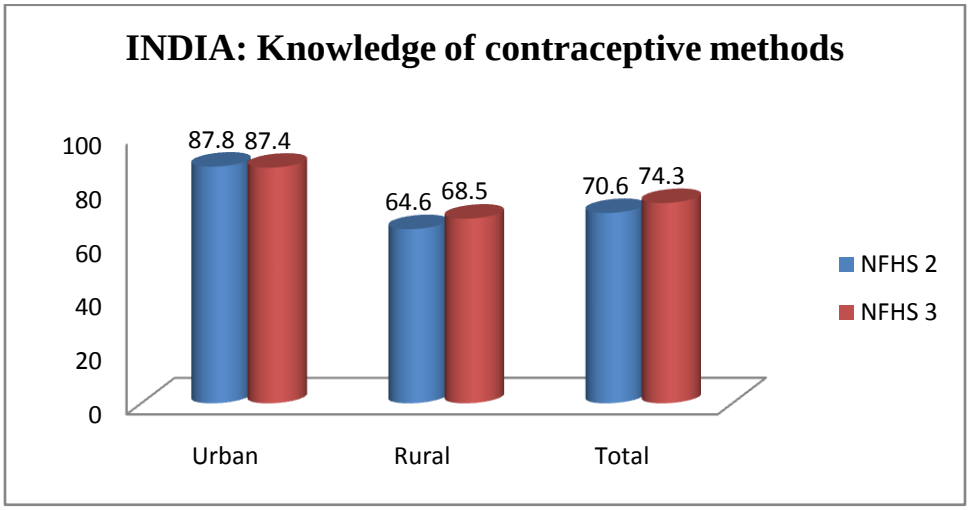
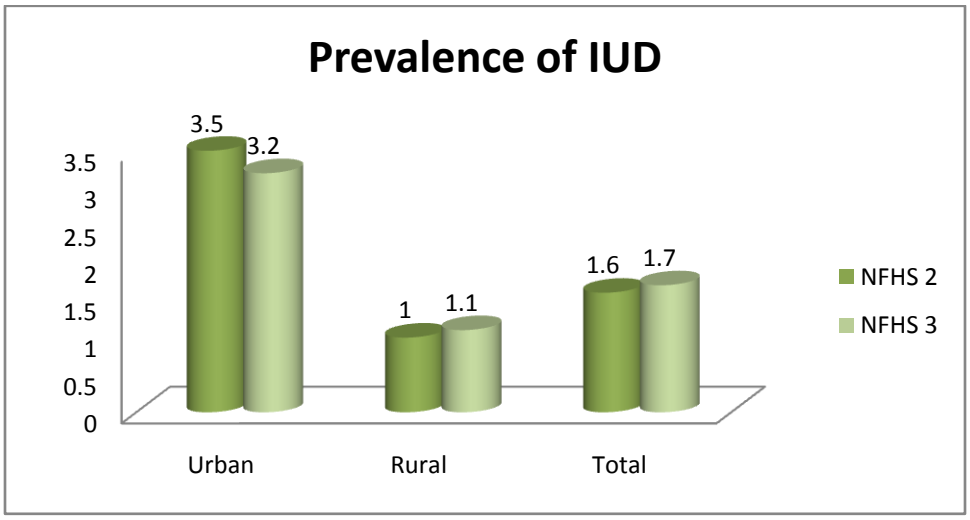


Figure 4.2



When the data of EAG states regarding Knowledge status & Prevalence of IUD is analysed and compared with the above data of India, the following picture has come up

Figure 4.3

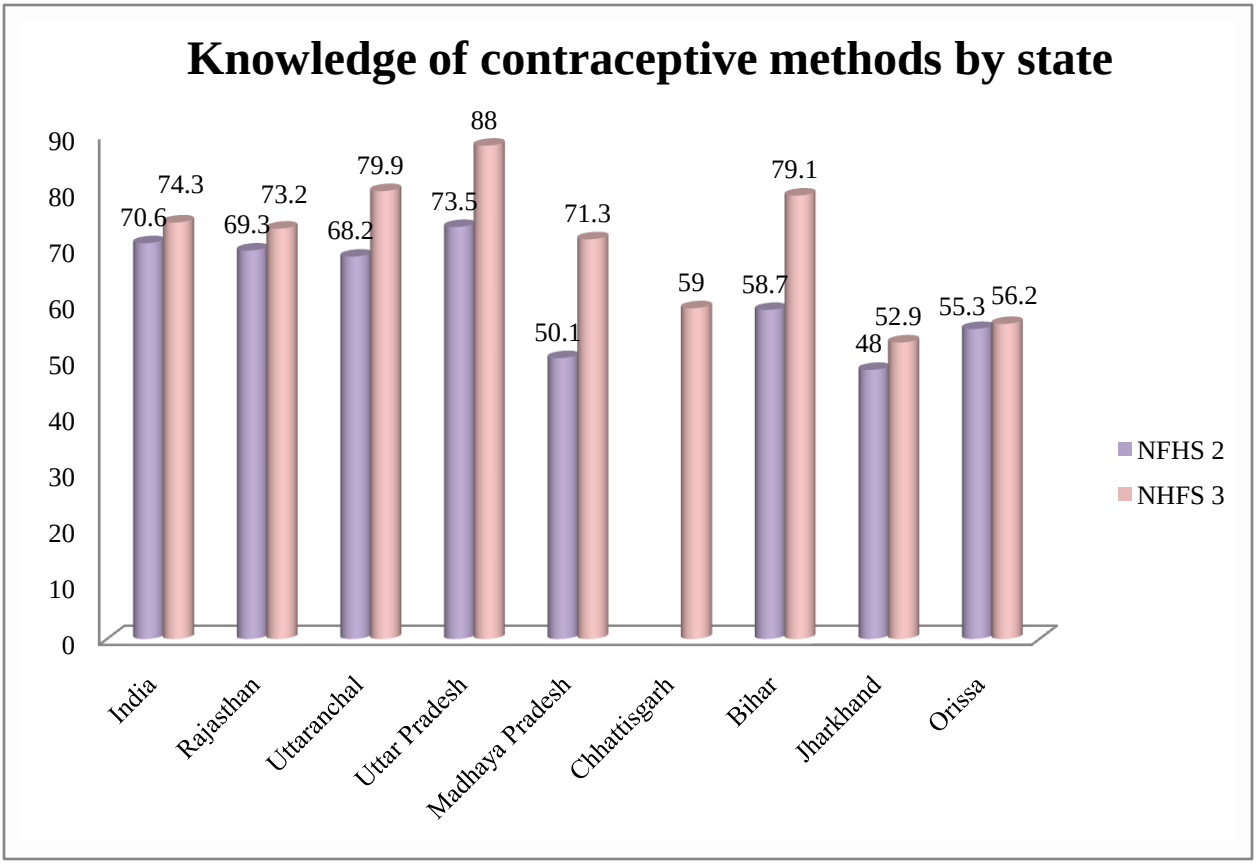


Figure 4.3 shows state level variations in knowledge level status of IUD as a contraceptive method. It is evident from the figure that there is an overall increase in the knowledge status of IUD as a method of contraception in all the EAG states. With the exception of Orissa and Chhattisgarh, all other EAG States has shown a marked increase in the knowledge status which is more than the percentage increase in the knowledge status in India (3.7%). Madhya Pradesh and Bihar has shown a significant increase of more than 20% followed by Uttar Pradesh and Uttaranchal with an increase of more than 10%.

Figure 4.4

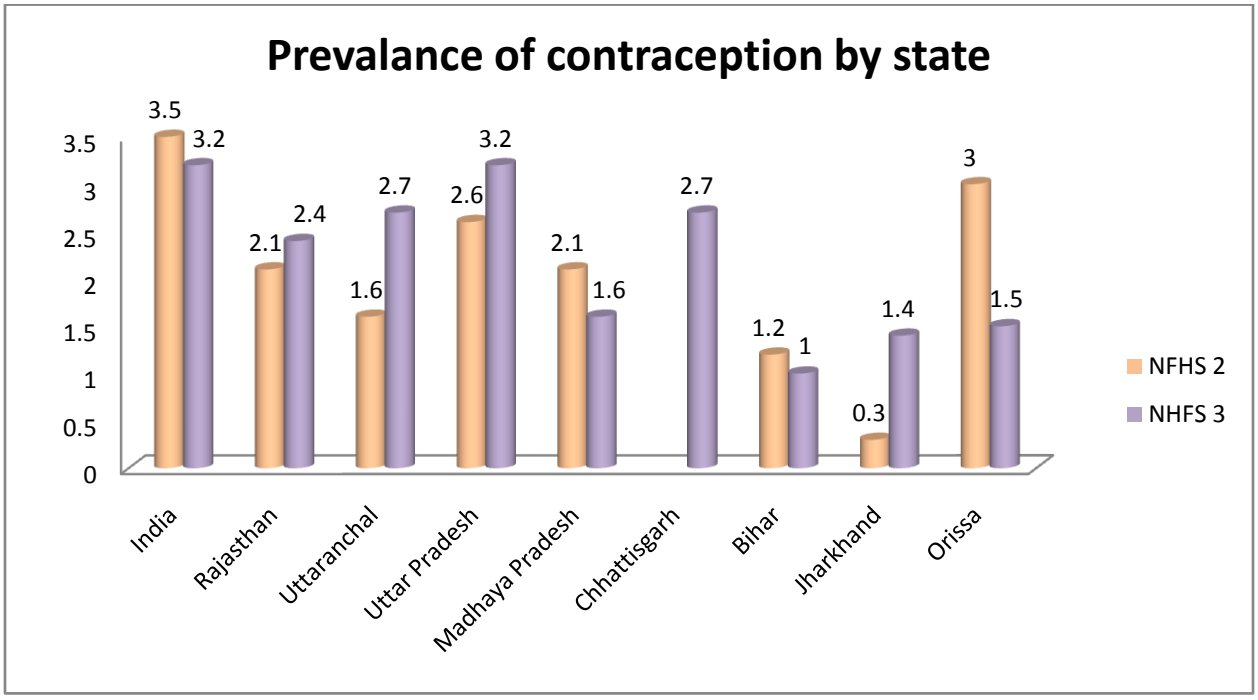


Figure 4.4 shows that the overall prevalence of IUD at national level has decreased by 0.3% from NFHS-2 to NFHS-3. When the data of Prevalence of IUD among EAG states is analysed, it has been found out that there is an increase in the prevalence of IUD except in the states of Madhya Pradesh, Bihar and Orissa (Chhattisgarh data is not available). Orissa has shown an approximate 50% decline in the prevalence of IUD. Uttaranchal and Jharkhand have shown a marked increase in IUD usage of more than 1%.

Conclusion: From the above trend analysis it has been found out that in spite of an increase in the knowledge status of IUD in India by 3.7%, its prevalence has declined. All the EAG states when compared with India have shown a marked increase in the knowledge status but its use has declined. Although there is a significant increase in the knowledge level in the state of Madhya Pradesh and Bihar, the prevalence rate has decreased in these states between two NFHS. Uttaranchal and Uttar Pradesh have shown a proportional increase in both the parameters simultaneously i.e. knowledge and prevalence. Besides that IUD prevalence has also declined when compared according to various background characteristics.

Limitations

1. The study was based on the family planning data of EAG states in NFHS-2 & NFHS-3. The entire NFHS-2 data of Chhattisgarh was not available or accisible .

2. Similarly some of the NFHS-2 data of Uttaranchal was also not available as these states were formed after the survey.

3. The study was based on the data of NFHS but there are other national level surveys which could have provided some information of IUD usage.

Recommendations

Although it has not been revealed from this study but from inclusive literature review it has been revealed that Government and various policymakers need to focus on following recommendations especially in EAG states.

1. Female literacy level needs to be focused.
2. Knowledge & awareness about IUD method have to be given emphasis not only in rural area but also in urban area.
3. Unmet need of IUD services have to be fulfilled.
4. Qualities of services at PHC, Sub center level have to be improved.
5. Healthcare Workers, ANM s, AWW s, ASHAs need to be trained properly.
6. Continuous monitoring should be done.

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