

ASSESSMENT OF FACTORS INFLUENCING THE CHOICE AND
USE OF TEMPORARY CONTRACEPTIVE METHODS FOR
BIRTH SPACING AMONG MARRIED WOMEN IN
RURAL TRIVANDRUM

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Dr. Parvathy Mini Pradeep

Declaration

I hereby declare that this dissertation titled “*Assessment of Factors Influencing the Choice and Use of Temporary Contraceptive Methods for Birth Spacing among Married Women in Rural Trivandrum*” is the bonafide record of my original field research .It has not been submitted to any other university or institution for the award of any degree or diploma. Information derived from the published or unpublished work of others has been duly acknowledged in the text.

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Certificate

Certified that the dissertation entitled '*Assessment of Factors Influencing the Choice and Use of Temporary Contraceptive Methods for Birth Spacing among Married Women in Rural Trivandrum*' is a record of the research work undertaken by Dr. Parvathy Mini Pradeep, in partial fulfilment of the requirements for the award of the degree of "Master of Public Health" under my guidance and supervision.

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List of Abbreviations

WHO	-	World Health Organisation
USAID	-	United States Agency for International Development
HRP	-	Human Reproductive Programme
FP	-	Family Planning
EC	-	Emergency Contraceptive
IUD's	-	Intra Uterine Devices
IUCD	-	Intra Uterine Contraceptive Device
LHW	-	Local Health Worker

Abstract

Introduction: There is near universal awareness of limiting (sterilization) and spacing (IUD, Pills and Condom) techniques among women in Kerala, however the practice varies. According to DLHS-3 report, there is still 7.1% unmet need for spacing and it is 21.9% for women with 1 child. This study aims to find the contraceptive use among young married women between ages 20 – 29 years and also to find the factors that influence the choice and use of temporary contraceptives for birth spacing.

Methods: A community based cross sectional study was conducted in 3 block panchayats in rural parts of Trivandrum district. A total of 294 women (between 20-30 years, who were currently married and not yet taken permanent methods of contraception) were interviewed for the study. An interview schedule was created using socio demographic and other factors which was then translated to Malayalam which was used for data collection.

Results: Current temporary contraceptive usage was found out to be 24.1% .It is significantly affected by greater age at marriage ($p=0.001$), college education ($p=0.021$), employment ($p=0.014$), ability to choose their own employment ($p=0.065$), Christian community ($p=0.032$). In the study, 42.5% had ever used any contraceptives. This was affected by same factors but also others like higher socioeconomic status ($p=0.007$), motivation by family members ($p=0.046$), desire to have more than 1 child ($p=0.057$) and having only 1 child ($p=0.085$). By logistic regression, age at marriage (OR-2.44, $p=0.006$), religion (OR-2.20, $p=0.020$) were found as significant factors in deciding current contraceptive usage when adjusted for other factors.

Conclusion: Age at marriage, education and religious beliefs affects the temporary contraceptive usage. Women who are motivated by family members and with ability to raise opinion about themselves also have increased usage. The general awareness about emergency contraceptives and injectable form of contraceptive is low compared to other methods.

Chapter – 1

Introduction and Literature Review

1.1 Introduction

According to World Health Organization (WHO), 'Family planning allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility'. Thus the use of contraceptives for birth spacing and limiting is a universally known fact, but, all over the world, health issues related to lack of contraceptive use falls completely upon women.¹ A woman's reproductive history divides into three parts: the period prior to marriage, the closed intervals between marriage and first birth and between births, and the terminal open interval following the last birth.² A woman in a developing country has 97 times more chance of death related to pregnancy than a woman in a developed country.³ The risks associated with women, in this context, are mainly

- 1) Pregnancies at very Young (<18 Years) and Old (>34 Years) aged mothers,
- 2) High Parities,
- 3) Pregnancies with Short Inter Pregnancy Intervals, and
- 4) Pregnancies that would end in Unsafe Abortion.⁴

Poor use of Family Planning measures is one of the major cause of maternal deaths, child deaths, unintended pregnancies and Abortion(MTP or unsafe).⁵ In a report by HRP (Human Reproductive Program), it states that spacing of births can not only have positive effect on mother's health and increase child's survival, it will help

reduce poverty, create opportunities for women to take paid employment, empowers young women and increases socio-economic and health benefits in general.⁶ Thus use of contraceptives especially for birth spacing has increased benefits to the woman (directly) as well as her family and society (indirectly).

1.1.1 Global Scenario

A global estimate of the incidence of unsafe abortion, which mostly results due to non-use of family planning methods is over 14 unsafe abortions for every 100 live births, amounting to 68,000 abortion-related maternal deaths each year.⁷ Abortions are always the best indicators for lack of birth spacing and lack of use of contraceptives in a fertile woman. Unsafe abortions are greater among adolescents and aged women with unplanned pregnancies.⁸ In Indian surveys, since 1960's, substantial proportions of woman who want to stop or delay births do not practice contraception.⁹ These are the women with Unmet Need (women who are fecund and sexually active but are not using any method of contraception, and report not wanting any more children or wanting to delay the birth of their next child).¹⁰ Family planning plays an important part in deciding fertility and thereby women's health. The various uses of contraception are (a) delay the first pregnancy, (b) lengthen the interval between births, (c) reduce the total number of pregnancies, thereby reduce maternal morbidity and mortality to a large extent.¹¹ The use of temporary methods during closed birth intervals corresponds to birth spacing and the use of any method of contraception in the terminal open interval following a woman's last birth corresponds to birth limiting.² Birth interval is the time from one child's birth date until the next child's birth date.¹¹ A study from India found, in consensus to other international studies, that short spacing of pregnancies is a major

reason for early childhood deaths.¹² Latest studies by USAID claim 3- 5 year birth interval like Optimal Birth Spacing Initiatives(OBSI)¹³ as better than the earlier 2 – 3 years birth interval for reduction in risk of miscarriage, new-born death, and maternal death. ^{14,15}In this context , the group had come up with a preamble which states that; ‘ In choosing the timing of the next pregnancy, individuals and couples should consider health risks and benefits along with other circumstances such as their age, fecundity, fertility aspirations, access to health-care services, child-rearing support, social and economic circumstances, and personal preferences’ .¹⁴

1.1.2 Developing Countries and Indian Scenario

According to WHO estimates, around 222 million women in developing countries would like to delay or stop childbearing but are not using any method of contraception. One in three deaths related to pregnancy and child birth can be averted if all the women had access to contraceptive services (According to UNFPA report). In resource poor countries the most important factors affecting maternal deaths are(a) Low social status of some women and some families (b)Poverty at family and/or at community level(c)Lack of access to modern family planning which results in high fertility with unplanned pregnancies.⁸ Access to safe and voluntary family planning counselling and services is essential to reduce the number of unintended pregnancies and short birth intervals. Many demographic factors (age of the mother at the time of delivery, order of birth and birth interval) and socio demographic characteristics (maternal education, standard of living of family) influence the child survival during infancy. ¹⁶ Understanding the factors of unintended pregnancies will enable policy makers to reduce the obstacles that prevent families from having their desired number

of children, and improve maternal and child health.¹⁷ Infant mortality in the population will decline as the level of contraceptive use rises. An analysis of DHS data in a study showed that shorter birth interval are associated with higher child mortality.¹⁸ A study states that an increase in the birth interval by 10 percent reduces mortality by 1.1 infant deaths per 1,000 live births.¹⁹ Healthy timing and spacing of pregnancy (HTSP) is a critical, essential and preventive child survival intervention to help women, couples and families to delay pregnancies or space birth of their children, with both health and non-health benefits to women, children, men, the family and the community.²⁰ A study from Cambodia had women stating a wish to implement birth spacing for economic reasons, health issues (weakness after repeated pregnancies).²¹ Some studies from Zambia and Egypt shows that birth spacing is more influenced by non-economic factors like health of the child and mother than cultural, social or economic factors.^{22,15} A study from neighbouring country Pakistan also shows that even with 73% current usage of modern methods of contraceptives, use of temporary contraceptives is very low and in that half is with condoms.²³ On analysing data in a study on NFHS data in India, it was found that, even if sterilization is done after 25 years of age in many states of the country, the women will already be having more number of kids than the total fertility rate (TFR) of the country.²⁴ In Namibia, the young women (aged 15-24) have been acknowledged to be an 'at risk' population in the country for reproductive health issues and that has helped to gain importance to the group even at community level.²⁵

1.2 Review of Literature

Factors Affecting Birth Spacing

1.2.1 Age at Marriage

The woman's age at marriage is a great factor deciding the birth spacing. In India, child birth with mainly male preference as early as possible, after marriage, is the rule rather than the exception even today. Hence, the age at which a girl gets married and thereby assumes the responsibilities of home and reproduction assumes importance in a study of women's health.¹¹ A study in south India states that the knowledge and awareness of spacing techniques is lower among 20 – 24 year women than 25 – 34 year old women.²⁶ Another study revealed that total unmet need (limiting and spacing) and unmet need for spacing reduces as the age of the women increases.²⁷ Early age at marriage opens up a wider span of sexual exposure to the females and that most of these women have two to three children by the age of twenty-four.⁹ Even if the age at marriage is low, if the women get motivated and start using temporary contraceptives at a smaller age, they can acquire knowledge and habit of using contraceptives for spacing births.²⁴ This aspect is lacking in Indian context where the age of marriage can go as low as it wants within each state. Yet another study shows that girls who marry at age less than 18yrs prefer more permanent contraceptives than temporary ones.²⁸ Older the woman, less restricted is her life and more is her likelihood of using contraceptives, according to a study done in 4 villages in rural West Bengal, India.²⁹

1.2.2 Socio Economic Status

Socioeconomic factors can complicate the chances of preventing maternal death

or poor pregnancy outcomes.⁸The effect of wealth on family planning is immense .A study from Peru on its family planning policies showed that with the policies(to provide family planning for the poor) actually benefitted the rich rather than the poor and the people in the lower quintiles increased the use of traditional methods and decreased modern methods use.³⁰ Studies show that a lower socio economic status triggers the sterilization of women rather than reversible methods due to the incentive attached to it and also pressure from health workers.¹⁰ A study shows the influence of socio cultural beliefs ,customs and factors on the woman's knowledge and practice of breast feeding ,which is a known method of spacing.³¹ Socio cultural Norms even affect the choice of method as seen in a study here traditional methods of family planning are the main method of fertility regulation and is practiced strictly for culturally generated reasons in both rural and urban Ethiopia .³² Standard of living is also a crucial factor in accessing knowledge on family planning.²⁶A study in sub Saharan Africa also states that fewer number of less wealthy women use contraceptives and they have fears of side effects and most of them are less educated.³³

1.2.2.1Education

It is often seen from studies that higher the education of the woman (or partner) better chances of spacing and contraception. It is mainly due to the fact that the awareness is developing from a younger age and is practiced due to better understanding of various issues related to lack of child spacing like maternal and child health issues, socio economic factors etc.^{19, 34, 35, 36} Many studies show the change in acceptance level of spacing methods when women are given proper information(IEC) and counselling(health education) on the same.^{37, 38, 15} . A contrast to this finding was a

study in which women with better education showed more interest to compress their childbearing to fewer years and participate in non-childbearing activities and hence have short birth spacing.³⁹ Another study showed that higher the education level of mother more chances of sex selective abortion and lesser spacing.⁴⁰ Another study among young school going adolescent girls in East Godavari District revealed that the knowledge about menarche, menstrual hygiene were also poor.⁴¹ So having education is different but giving proper education about all aspects of personal hygiene is also important. A study done in K S Hedge Hospital, Mangalore, also supports the fact that higher the education of the couple as such, higher was the contraceptive acceptance by the couple.⁴² A study done in Accra and Ghana, also supports the fact that higher the education of woman (also the couple) higher the chance of using contraceptive methods for reducing parity.⁴³

1.2.2.2 Employment

In developed countries, the women are involved in employment according to the education status of the woman. Educated women are more likely to be engaged in occupations that are not readily compatible with bearing children.³⁹ These occupation mostly decides the timing of the first birth and the spacing of the next births. The women delay the first birth to have a longer working life and then space the next births closely so as to minimise the loss of leave and wages attached to child birth.⁴⁴ An above mentioned study in Accra and Ghana found that employment had a negative effect on contraceptive use because women who are self-employed (major part of study) do not fear maternity leaves.⁴³

1.2.3 Religion

There is a disparity among studies on religion as a factor influencing spacing. One of the studies found out that there is more spacing methods among Hindus and Sikhs³⁶ and two other studies showed more spacing of births and child survival among Christians.^{14,35,42} There is a comparatively lower use of any method for spacing among Muslims.^{9,45} A study in Karnataka ,shows that Muslim women showing a strong inclination towards not using any contraceptives and having more number of children for having a male child.⁴⁶

1.2.4 Gender Issues

The gendered aspect of birth spacing is an understudied area. There are studies that mention the presence of decision making potential playing a crucial role in birth spacing and limiting.⁵ Women oblige to not using spacing methods due to lesser economic importance, family pressure, male resistance to family planning.^{21,8,47,38} In a study, husbands were found to show more concern on the health of the child rather than the mother.²² In contrast to this, another study done in Nepal among men, they admitted that they take decisions mostly by themselves about their wife's health issues as well as on family planning.⁴⁸ In the Indian context, a woman is not empowered to take decisions on family planning or use of health care ,thereby creating a wide gap in contraceptive knowledge and actual practices between women's reproductive intentions and contraceptive behaviours.⁹ According to a study, the couples joint reproductive decisions and use of available household resources to access services and practice healthy behaviours influence birth spacing.¹³ In another study it was found that men considered family planning as female sterilisation and contraceptive use as birth

spacing.⁴⁹ Another study in a colony resettlement in Delhi, showed that contraceptive usage was higher in houses where a joint decision was taken by the spouses.⁵⁰

1.2.5 Myths and Misconceptions

Misconceptions about Birth spacing play a crucial role in the lack of usage of various methods. Many studies have shown that fear of side effects on health of women is a general concern amongst the people thereby leading to reduced usage of birth spacing methods.¹⁵ In a study, many women repeatedly stated that modern family planning would cause birth defects, fertility and adverse health effect.³⁷ The influence of such myths and misconceptions in Indian communities make it difficult and time consuming for providers (health workers) to counsel for spacing thereby leading to increase in limiting methods.⁵ A study from Pakistan on IUCD usage revealed that misconceptions can be present among both users as well as the providers. Misconceptions in users can vary from usage related health issues to distrust on the provider and among providers it was due to lack of knowledge about usage leading to inadequate counselling.⁵¹ The study from Pakistan also highlights the fact that usage of temporary contraception by women mainly depends on their personal perception of methods even in a Muslim predominant country as Pakistan.²³ A study was conducted in Western Nepal to find out the reality of rumour about a few women getting sick from using hormonal contraceptives which could create enough pressure to reduce the use of these types of contraceptives. The study revealed that women who used these methods (long term) were 100% devoid of side effects.⁵² This shows that misconceptions about health effects of contraceptives can be verified and rectified through research. A study done among men from Nigeria shows that men had misconceptions about the side

effects of using contraceptives. They feared that if any illness was to occur, the indirect costs will be high and also they will not get assistance from anyone during difficulties, hence they opt for sterilizations and abortions.⁵³

1.2.6 Health System

The belief on the health care system and provider is crucial for the increase in birth spacing method usage among women. Women who experience any side effects in contraceptive usage, tend to run to and discuss more to a health care provider.⁵⁴ There are studies that show that health workers do not impart sufficient knowledge to women on spacing techniques especially breastfeeding leading to incorrect use of methods.⁵ An interventional study shows that the incorporation of ASHA as well as Anganwadi Worker for providing data and advice on spacing helped to get better results in the experimental area.³⁸ Positive interactions and experiences with providers at health care centres help women open up about their illnesses even on reproductive issues.²¹ In a community based intervention study in Meerut, it was found that prior to the study the community health workers knew nothing of the lactational amenorrhea method and that along with various beliefs and practices exist within the community shows that such studies educate the masses as well as providers so that there is proper use of various methods for birth spacing.⁵ In a study mean reported as being ignored by government health workers in matters concerning reproductive health and family planning, the reason being the health workers now being prepared to include men.⁴⁹ A study in Vishakhapatnam among female medical students showed that in final year MBBS students with good knowledge about Emergency Contraceptives(EC) in only 68%.⁵⁵

1.2.7 Survival Status and Sex of Index child

When it comes to sex of index child there is a difference among various studies. A shorter birth intervals can be when the index child is male¹³ but short birth intervals can also be seen with a female index child.³⁹ This can be largely due to cultural variations in the two settings (Ethiopia and Mozambique). In another study from Tamil Nadu, it was found that sex of index child did not act as an important factor in birth spacing though there is a greater interval after the birth of a male child. The study also showed that survival of the index child did play an important role.⁵⁶ A study done in Manipur found that survival status of the index child is also a factor that can influence child spacing patterns among couples.⁵⁷ Yet another study done in 3 countries Nepal, India and Bangladesh, showed that male child preference was strong and affects contraceptive use both for spacing as well as limiting.⁵⁸ Another study from Bangladesh showed that the increase in family size and desire for a larger family (number of children will be more) when there is child mortality.⁵⁹ In the study done in rural West Bengal, the mind-set of the people was that the measure of family size and its composition was related to the total number of living children and also to the total number of sons that again was positively associated with the use of contraception.²⁹

1.2.8 Media Exposure

Many studies reveal that media exposure for women work towards increasing the birth interval between births as well as lengthen the period between first birth and marriage.⁵⁶ DLHS report also showed the influence of media as a positive factor for contraceptive use⁶⁰ but its effect on spacing is not known

1.3 Rationale

India was the first country to start a National Family Planning Programme (1952) with the objective of “reducing birth rate to the extent necessary to stabilize the population at a level consistent with requirement of national economy.”⁶¹ The program was successful for couples who have reached their desired family size but failed to educate the masses about the concept of Birth Spacing and its advantages.³⁸ In the ‘80s, India adopted the “cafeteria approach” to raise the prevalence of contraceptive methods among eligible couples.⁹ The country had taken up various positions to reduce fertile periods in women. India had tried the ‘Target Driven Approach’, Sterilization camps, ‘Minimum Needs Approach’, became a member of United Nations, entered conferences and in the end the reduction in values have not been up to mark. In India, people often equate the term family planning with sterilization, although government policies aim to promote the use of reversible methods.³⁵ Three-quarters of contraceptive users in India are sterilized i.e. 3 out of 4 contraceptive users are sterilized (NFHS1) which is five times the level in developing countries.² There is near universal awareness of limiting (sterilization) and spacing (IUD, Pills and Condom) techniques among women in Kerala, India. The practice however varies in the state. The total women using any type of method for contraception is 64.4% and modern method (IUD, Pill, Condom) is 55.9%. There is still 7.1% unmet need for spacing and it is 21.9% for women with 1 child (total unmet need for limiting and spacing – 15.8%). When the government health facility is utilized by 62.9% of sterilizations only 21.2% have availed the same for Spacing methods.⁶⁰ There are less number of studies on the utilization of health care by women and even less studies on the utilization of health care facilities for reproductive health issues by married women. There should be lesser

victim blaming and more understanding of the barriers that make it difficult for women to receive adequate, appropriate and timely care.⁴⁷ These barriers are to be identified and studied vastly to draw out policy recommendations that can help women reduce their unmet needs.

1.4 Research Questions

The following were the research questions

- What are the current practices of temporary contraceptives for birth spacing among married, non-sterilized women in the age group 20 -29yrs in Rural Trivandrum?
- What are the various socio demographic factors that influence the choice and use of temporary contraception for birth spacing among the currently married women of age group 20 – 29 years?
- What is the awareness among the currently married women of 20 -29years about various types of contraceptives for birth spacing?

1.5 Objectives

- To assess the current practice of temporary contraceptives for birth spacing among the married, non-sterilized women in the age group 20 – 29 years.
- To assess the socio demographic factors influencing the choice and use of temporary contraception for birth spacing among the married women of age group 20 – 29years.
- Assess the awareness of contraceptives for birth spacing among currently married women of age group 20 – 29 years.

Chapter 2

Methodology

- 2.1 **Study type** : Study was a community based cross sectional survey
- 2.2 **Study setting**: Rural Trivandrum District, Kerala, India
- 2.3 **Sample size estimation**: Using data from DLHS 3 report,⁶⁰ sample size was calculated with an anticipated prevalence of temporary contraceptive use of 16% using data from DLHS 3 report and precision of 6%. A design effect of 2 was used as it was a cluster sampling. Using Open Epi Version 3.01, the result was found to be 287 which was rounded off to **300**.
- 2.4 **Sample Selection Procedure**
- 2.4.1 **Study population**: Women living in rural parts of Trivandrum who are married and are in the age group of 20 – 29years. The study will be conducted among married women of age 20 – 29 years. This age group has been selected because in Kerala the age at marriage is 22.6 years (SRS 2010) and the mean age at sterilization is 26.8 years (DLHS -3 Report).
- 2.4.1.1 **Identifying cluster**: Study clusters have been identified by Multistage Cluster Sampling method. From the total of 11 block panchayats in Trivandrum District, 3 Block Panchayats was randomly selected using the lottery method. Then within these 3 block panchayats, 2 gramapanchayats were selected from each block. This was also a random selection using lottery technique. Thus, there was a total of 6 gram panchayats involved. From each of the gram

panchayat, 5 wards were selected. Thus there was a total of 30 wards in the study. The ward was considered as a cluster. These wards were also selected randomly using the lottery technique. From each ward, a total of 10 women were selected who met the inclusion criteria. Thus there were 300 women from the clusters in total. The total number of clusters was 30.

2.4.1.2 **Selection of households and study participants:** Principal Investigator (PI) recruited the participants based on the inclusion or exclusion criteria. The recurrent process was done through the household visits by the PI. In each cluster, 10 participants were selected [total participants (300) / total number of clusters (30)] and were interviewed. Finding 10 eligible participants from a ward is usual but in the condition of non-availability of expected participants in any cluster, adjacent ward will be considered for the data collection. Within a cluster, the first house was selected by taking a random street from the centre of the ward. The same procedure was continued until the total sample of 10 participants in each cluster is obtained. This process was followed in all the selected 30 clusters in three blocks till a sample size of 300 participants is obtained. Selection of the participants were done on the basis of lottery method if more than one participant was found eligible and present in the household.

2.5 **Data Collection Technique:** Data will be collected by using structured interview schedule, developed by the researcher based on the objectives of the study by considering inclusion and exclusion criteria as stated below

❑ **Inclusion Criteria**

- Currently married Women

- Age group 20 – 29yrs.
- Women with or without children

❑ **Exclusion Criteria**

- Mentally ill women
- Women who have undergone sterilization
- Women with partner who has undergone sterilization

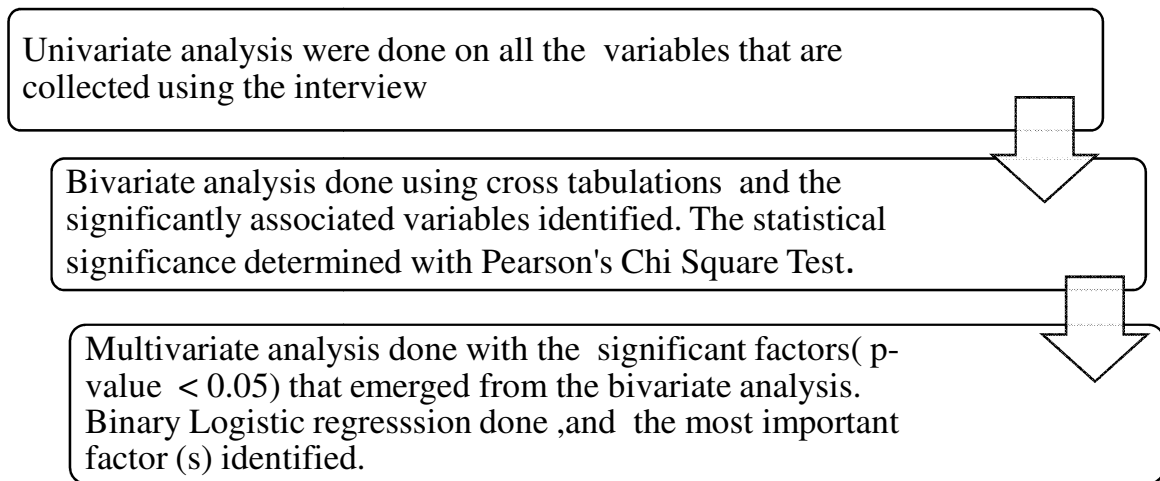
2.5.1 Plan for Data Collection and Analysis:

Data was collected using a structured interview schedule. The interview schedule was used to collect details on age at marriage, socio economic factors, religion, myths and misconceptions, gender issues, health care, survival status of index child and media exposure(Refer to Annexure II). The interview was conducted by the principle investigator itself. Self-reporting was considered as final source of information.

At the first step, all the data sheets were checked manually and were corrected. Later, the data were cleaned using computerized cleaning process. Then, data were entered into Epi Data software, version 3.1 into an already prepared data entry platform (in same software). Data analysis process using SPSS software, version 21, were started once the data entry process finished. In addition to descriptive data analysis, statistical tests were also performed to find out the significant relation between the different variables. Data analysis were done on the basis of research objectives (Diagram 1). Non

response rate were calculated using the information gathered through the screening process section of the interview schedule.

Diagram1: Statistical Analysis in SPSS



2.6 **Expected Outcome:** This study shall provide an understanding of the awareness about various contraceptive methods and the factors affecting the choice and use of Temporary contraceptives for birth spacing by young, married rural women. This study will help to further understand the barriers for using temporary contraceptives which might be the reasons leading to increased use of sterilization(male or female) as a family planning method, shown by the young age at sterilization in the state. As public health relevance, this study may contribute to frame some appropriate strategies in promoting the women, especially the ones in their younger age, take up temporary contraceptives for birth spacing and not opt for permanent sterilization as a family planning measure

2.7 **Ethical Consideration**: The study was conducted after obtaining an approval from the Institutional Review Board of Sree Chitra Thirunal Institute for Medical Sciences and Technology (Refer to Annexure V). Written informed consent for participating in the study was taken from the study participants (See Annexure I). Consent form has also research subject information sheet containing the information about the study, purpose of the study, and the contact details of principal investigator (PI) and Member secretary. It has been translated into local language, Malayalam (Refer Annexure III, Annexure IV). One copy of the signed informed consent form including research subject information sheet also handed over to the participants. In case of illiterate study participants, research subject information was explained to participant before taking her thumb impression and the same witnessed by a literate person. Respondents had the right in either accepting or refusing to participate, and in withdrawing participation at any time of the study without any explanation and consequence. Respondents were informed the voluntary nature of participation, study objectives and the potential benefits and risks of participation. Utmost priority was given to protect the privacy and confidentiality of the personal information of the participants and the collected information will not be shared with anyone not involved in the study. At no stage will the identity of the participants be revealed and for this a unique identification number with block, cluster, and participant code was assigned to each participant. All hard copies of filled interview schedules and consent forms will be kept under the custody of principal investigator and will be destroyed properly when they are deemed no longer needed or after one year of dissertation report submission,

whichever comes first. The participants were also given a chance to ask any question, query or doubt related to the study(Refer to Annexure I)

2.8 Project management

2.8.1 Staffing and work plan

The principal investigator collected data by interviewing the participants. Interviews were done at a time and place that is convenient to the investigator and participant. The participants were asked for consent for the study before interview is performed.

2.8.2Administration: The study was administered by the principal investigator.

2.8.3Plan for dissemination

- The final thesis report will be submitted to institute for evaluation.
- The findings from the study will be presented in scientific meetings and conferences.
- The findings will be published in peer reviewed scientific journals.

2.8.4 Data storage, transfer and management

The data collected using interview schedule will be stored in a safe manner. Backup of data in external drives will be done regularly to avoid any scope of data loss. Principal investigator will ensure that the risk of disclosure is minimized by only reporting data in aggregate form. The data from this project will not be made available for any other purpose outside the narrow confines of

what's applicable for the study. Copies of the complete report shall be submitted for evaluation to the Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences and Technology, Thiruvananthapuram.

2.9 Variables for study

Socio Economic Factors

1. Income of the House hold
2. Educational Status (years of schooling)
3. Employment Status.
 - a. Type of employment
 - b. Current status of employment (employed /not employed)
 - c. Contribution to family income.

Religion

1. Religious inclination
2. Religion difference in couple

Myths& Misconceptions

1. Knowledge of spacing
2. Individual Perception of Spacing (use/importance, benefits)

3. Knowledge of various techniques
4. Modern (IUD, Condom, Pills)
5. Traditional (withdrawal, rhythm, lactational amenorrhea)

6. Knowledge about usage of technique

7. Knowledge of availability
8. Setting (Medical [government, private, pharmacy] institution, Local Health Worker)
9. Type of provider (doctor, nurse, local health worker)

☐ Health Care

1. Setting used (government, private)
2. Type of interaction with provider
3. Advice provided by provider

☐ Index Child

1. Sex of index child
2. Health of index child
 - Long term illness
 - Frequent illnesses
 - Past hospitalizations (last 6 months)

❑ Outcome Variable

1. Current Use of temporary contraceptives for Birth Spacing.
2. Ever used Temporary Contraceptives for spacing.

Awareness about temporary contraception will be assessed by using some of the variables like types of methods heard, availability of various methods, advice provider of methods, ever used any of the mentioned methods.

Chapter 3

Results

A total of 294 women were interviewed for the study from 3 block panchayats in rural Trivandrum. The data were entered into Epidata (version 3.1) and then exported to SPSS (version 21) where the data was cleaned and used for the analysis.

3.1 Univariate Analysis

The Age group of the population as pre-determined 20 – 29yrs and the mean age of the population under study was 24.74 (SD 2.07). Women belonging to a nuclear family were 217(73.8%) of the population and 77(26.2%) belonged to a non-nuclear type of family. 219(74.5%) women were currently living with their spouse but 75(25.5%) women were having husbands who were currently living away from the houses. (Table 1).

The socio economic status was sub divided as BPL card availability, level of education and employment. Women who belonged to BPL were 179(60.9%) and APL were 115(39.1%). The number of women who had school education was 104(35.4%) and those with college education were 190(64.6%). Women who were currently employed were 200(68.5%) and the unemployed women in the study were 92(31.5%). Women who took their own decision about their employment were 135(66.2%), and women with husband and other people taking decision for employment were 41(20.1%) and 28(13.7%) respectively. The women who contributed Rs 10,000 or less than that amount to family income were 77(42.5%), and the women who contributed Rs 10,000

to Rs 20,000 to family income were 82(45.3%). The women who had and contributed more than Rs 20,000 to family income were 22(12.2%).

Based on religion, the number of women in Hindu religion were 197(67%), the women in Christian religion were 55(18.7%) and Muslim women in the study population were 42(14.3%).

Table1: Socio demographic characteristics of study population

Characteristic	n (%)	N
Type of family		
Nuclear Family	217(73.8)	294
Non-Nuclear Family	77(26.2)	
Living with Spouse		
With Spouse	219(74.5)	294
Without Spouse	75(25.5)	
Level of education		
School education	104(35.4)	294
College education	190(64.6)	
Current status of employment		
Employed	200(68.5)	292
Unemployed	92(31.5)	
Decision on Employment		
Self	135(66.2)	
Husband	41(20.1)	204
Others	28(13.7)	
Contribution to family income		
≤10,000	77(42.5)	
10,000-20,000	82(45.3)	181
>20,000	22(12.2)	
Economic Status		
BPL	179(60.9)	294
APL	115(39.1)	
Religion		
Hindu	197(67)	294
Christian	55(18.7)	
Muslim	42(14.3)	

The health seeking behaviour of family was also analysed (Table 2). The family when they had any family member other than the woman (participant) sick the type of facility taken for cure were asked and the women who took family members to Government hospital in city were 74(25.2%) and women who took members to private hospital in city were 53(18%). The women who took their ailing family member to PHC nearby were 149(50.7) and to private clinics nearby their residence were 18(6.1%). When the woman (participant) was the ailing member in the family, the number of people using medical store nearby became 193(66.3%) and the people who visited the PHC became 86(29.8%) and the women who used either a government hospital or private clinic were 10(3.5%).

Table 2 : Health Seeking behaviour characteristic of sample population

Characteristic	n (%)	N
Health care facility for family		
Government hospital	74(25.2)	
PHC nearby	149(50.7)	294
Private Hospital	53(18)	
Private Clinic nearby	18(6.1)	
Health Facility for woman's ailments		
Medical Store	193(66.3)	
Pharmacy	86(29.8)	289
Others*	10(3.5)	

* Includes private and government hospitals

The age at marriage of the participating women were analysed and the median age was identified as 21 years (minimum 18yrs to 26yrs and range of 8).The age at marriage as above the median value of marriage age which were 66(23.3%) and less than median age at marriage which were 217(76.7%) . The previous pregnancy related details are studied in Table 3.The ideal age gap between 2 children in a family was agreed to be 0-1 years by 4(1.4%), 1-2 years by 14(13.9%), 2-3years by 125(42.5%) and lastly 3-4 years by 124(42.2%). The current number of children for the woman, in the family were also noted. There were no children (also includes currently pregnant women) for 99(33.7%) women, 1 child only for 118(40.1%), and women with 2 or more children were 77(26.2%). The women who desired only 1 child were 127(43.2%) and those who wanted 2 children were 148(50.3%). The women who wanted 3 children in their family were 19(6.5%).The women who could discuss their desired family size with their husband were 131(44.6%) and the women didn't discuss with their husband were 163(55.4%).

Women who had planned their previous pregnancies were 134(45.6%) and who didn't plan their pregnancies were 86(29.3%). The women who have had an abortion in their married life were 71(24.1%) and those that didn't have any abortions were 213(72.4%). The health status of previous child was good or healthy for 148(50.3%) and 39(13.3%) women had unhealthy child.

Table 3: Previous births and related details about study population

Characteristic	n (%)	N
Ideal age gap between children		
0-1 yrs.	4(1.4)	294
1-2yrs	14(13.9)	
2-3yrs	125(42.5)	
3-4yrs	124(42.2)	
Number of children		
No child	99(33.7)	294
1 child	118(40.1)	
≥2 children	77(26.2)	
Desired number of children		
1 child	127(43.2)	294
2 children	148(50.3)	
3 children	19(6.5)	
Discussed with husband		
Yes	131(44.6)	294
No	163(55.4)	
Planning of Previous Pregnancies		
Planned	134(45.6)	220
Never planned	86(29.3)	
Ever had Abortions		
Yes	71(24.1)	284
No	213(72.4)	
Health condition of previous child*		
Healthy	148(50.3)	187
Unhealthy	39(13.3)	
*Considers children with long term illnesses or get frequently ill		

The current use of temporary contraceptives in the study population was 71(24.1%) and the women who ever used any form of temporary contraceptive for birth spacing were 125(42.5%) (Table 4). The modern methods of contraceptives (Pills, IUD's, Condom, Emergency Contraceptive) were used by 58(81.7%) and traditional methods (rhythm, withdrawal) were used by 13(18.3%)of them. Women who got professional motivation (doctors, nurses or Local Health Worker) for contraceptive usage were 50(70.4%) and those who got non- professional motivation were 21(29.6%).

Women who had never had a local health worker visit them were 18(6.1%), who gets a visit ever month were 101(34.4%) and gets a visit once in 2 months or more were 175(59.5%). Women who felt their local health worker was them providing adequate information on family planning were 258(87.8%), there was mutual understanding of information being provided were 209(71.1%), the health worker was responsive to their queries 234(79.6%), health worker was providing and maintaining privacy were 242(82.3%) and health worker gave proper solutions to problems related to temporary contraceptive usage were 222(75.5%).

Women who had intention of taking contraceptive in their future were 159(54.1%) and the women who have not yet decide whether or not to use any method in future were 126(42.9%). The most commonly suggested method for use was IUD's which was 64(40.3%) then Female Sterilization which is 50(31.4%) then pills which was 33(20.8%).Male methods like male sterilization and condoms were given as option by 12(7.5%).

Table 4: Details related to Family Planning and Contraceptive Usage in the study population

Characteristics	n (%)	N
Current usage		
Yes	71(24.1)	294
No	223(75.9)	
Ever used Methods		
Yes	125(42.5)	294
No	169(57.5)	
Methods used		
Modern	58(81.7)	71
Traditional	13(18.3)	
Motivator for usage		
Professional	50(70.4)	71
Non Professional*	21(29.6)	
Local Health Worker visits		
Never seen	18(6.1)	294
1 month	101(34.4)	
≥2 months	175(59.5)	
Health Worker Characteristic		
Adequate information	258(87.8)	294
Mutual understanding of Information	209(71.1)	
Responsive to queries	234(79.6)	
Maintaining privacy	242(82.3)	
Solutions to problems with usage	222(75.5)	
Intention to use in future		
Yes	159(54.1)	294
No	9(6.1)	
Not yet decided	126(42.9)	
Method intended for future use		
IUD's	64(40.3)	159
Female Sterilization	50(31.4)	
Pills	33(20.8)	
Male Methods**	12(7.5)	
*includes husband, mother, friends relatives **Includes condoms and Male sterilization		

The awareness about various contraceptives available currently in health care facilities were analysed. The total women in the study (100%) had heard about the pills and Condom/Nirodh. When 51% of the women had at least heard about Emergency Contraceptives (EC) only 25% women in the entire study had even heard about Injectable form of temporary contraceptive. The knowledge about traditional methods were also varying, but more than 95% of the women knew the 2 types of traditional methods (rhythm and withdrawal) that were asked in the interviews.

The use of contraceptives varied even in this population. The women who had heard of pills was high but its usage was only 29.5%. The usage of condoms was higher when compared to pills but was only 50.5%. The use of other methods like Emergency contraceptives and IUD's were 8.1% and 22.8%. The use of injectable was nil in the population. The use of traditional methods was also less than the knowledge about the method. The use of rhythm method and withdrawal method was only 42.7% and 33.4% respectively. The values are provided in Table 5.

Table 5: Knowledge and Use of Temporary Contraceptives in the study

population

Method	Heard of method	Total	Used	Total
Pills	292(100)	292	86(29.5)	292
IUD's	284(97.3)	292	66(22.8)	289
Injectable	73(25.1)	291	-	-
Condom/Nirodh	292(100)	292	146(50.5)	289
Emergency Contraceptive	149(51)	292	23(8.1)	285
Rhythm Method	283(98.3)	288	120(42.7)	281
Withdrawal Method	279(95.5)	292	96(33.4)	287
Male Sterilization	286(99)	289	-	-
Female Sterilization	286(99)	289	-	-

The awareness about availability is also noted about every method in Table 6. Government hospital was considered to be providing pills by 57(19.8%), IUD's 273(96.8%), injectable 58(90.6%), condom 3(1.1%), Emergency Contraceptives 44(27.5%), and sterilizations by 90% of the women. Private hospitals was considered by less number of women as facility with availability of methods .It was 14.3%,51.8%,50%,1.1%, 13.1%,59.4%,63.7% for pills, IUD's, injectable, condom, EC, rhythm, withdrawal, male and female sterilization respectively. The pharmacy was considered the place of availability for methods as 35.5%, 7.8%, 64.3%, and 73.1% for pills, injectable, condoms and EC. The local health worker was considered a person who will be able to provide the following methods pills, condoms and EC by 61.1%, 58.9% and 7.5%.

Table6: Awareness about Availability of contraceptive methods

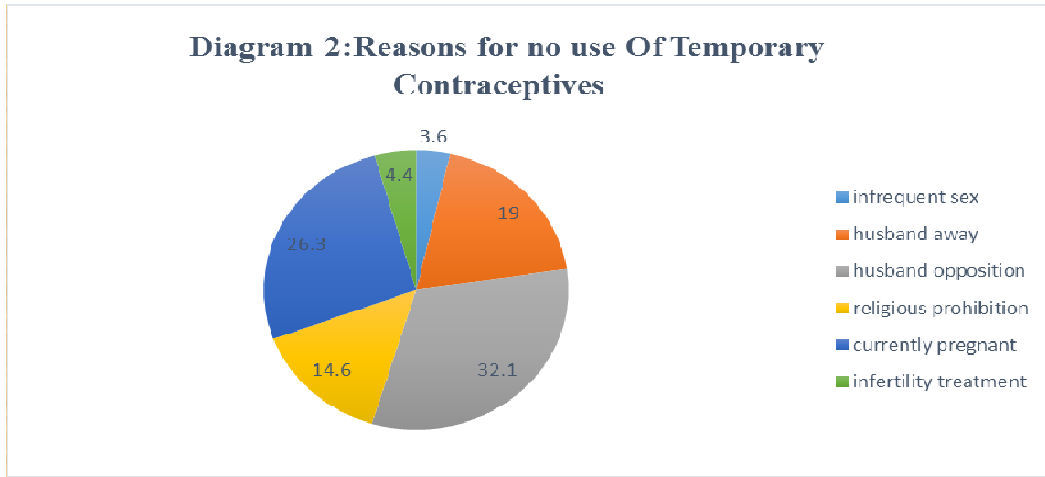
Method	Availability				N
	Government hospital	Private Hospital	Pharmacy	LHW	
Pills	57(19.8)	42(14.3)	154(35.5)	176(61.1)	288
IUD's	273(96.8)	146(51.8)	-	-	282
Injectable	58(90.6)	32(50)	5(7.8)	-	64
Condom	3(1.1)	3(1.1)	183(64.3)	168(58.9)	285
Emergency contraceptive	44(27.5)	21(13.1)	117(73.1)	12(7.5)	160
Male sterilization	260(91.9)	168(59.4)	-	-	289
Female sterilization	264(91.3)	184(63.7)	-	-	289

On seeking advice about various methods doctor, nurse and local health worker was considered as given in Table 7.50.4% for pills, 97.5% for IUD's, 100% for injectable, 10.8% for condoms, 90.4% for EC,30.2% for Rhythm, 16.3% for withdrawal, 97.5% and 98.9% for male and female sterilizations respectively was the proportion of women who gave answers as doctor being the person who can give advice for each of those methods. Nurse was least of the 3 categories. IUD's, EC, Rhythm, Withdrawal, Male and Female sterilization were 2.5%, 9.6%, 1.9%, 2%, 2.1%, 2.1%. Women who thought LHW can be approached for advice on method usage were 66.2% for pills, 49.3% for IUD's, 39.5% for injectable, 94.1% for condom, 18.6% for EC, 80.5% for rhythm, 85% for withdrawal, 9.9% for male sterilization, 8.5% for female sterilization .

Table7: Awareness on seeking advice about each method

Method	Advice Provider			N
	Doctor	Nurse	Local health worker	
Pills	143(50.4)	-	188(66.2)	284
IUD's	275(97.5)	7(2.5)	13(49.3)	282
Injectable	76(100)	-	30(39.5)	76
Condom	25(10.8)	-	209(94.1)	222
Emergency Contraceptive	141(90.4)	15(9.6)	29(18.6)	156
Rhythm	48(30.2)	3(1.9)	128(80.5)	159
Withdrawal	25(16.3)	3(2)	130(85)	153
Male sterilization	275(97.5)	6(2.1)	28(9.9)	282
Female sterilization	279(98.9)	6(2.1)	24(8.5)	282

According to 137 women, the various reasons for lack of use of temporary contraceptives were as given in Diagram 2. The common reasons for non-use of temporary contraceptives were infrequent sex by 5(3.6%) women, husband away from house by 26(19%) women, opposition to use by 44(32.1%) women, prohibition by their religion by 20(14.6%) women, current state of pregnancy by 36(26.3%) women and undergoing infertility treatment by 6(4.4%) women.



3.2 Bivariate Analysis

The factors identified from literature review were taken from the previous analysis and cross tabulated with the outcomes of interest: current use of temporary contraceptive and ever use of temporary contraceptive (Table 8-10). Current use and ever use of temporary contraceptives for spacing for age at marriage less than 21yrs (median) was 41(18.9%) and 83(38.2%). The same for age at marriage more than 21yrs was 26(39.4%) and 35(53%) .This difference in groups were significant with both outcomes having a p-value of 0.001 and 0.033.

Education was also seen to have a significant difference between both the groups (current use 0.021 and ever use 0.0001) .The school qualification group showed 17(16.3%) and 28(26.9%) and college educated group showed 54(28.4%) and 97(51.1%) current use and ever use respectively.

Currently employed women showed 57(28.5%) and 94(47%) current use and ever use whereas unemployed women showed 14(15.2%) and 30(32.6%) for the same. This difference between groups were significant with p value of 0.014 and 0.021

When women took decision for their own employment there was 44(32.6%) and 73(54.1%) current use and ever use of contraceptives for spacing. The other category showed 14 (20.3%) and 24(34.8%) of use (current and ever). There was significance only for the ever used group (p value 0.013).

BPL card holders were having 40(22.3%) of current contraceptive usage and 65(36.3%) ever use whereas APL card holders showed 31(27%) and 60(52.2%). The significance in the group was only for ever used contraceptives for spacing (0.007).

Religion is another variable that showed a significant difference amongst the groups which was significant for the current use of temporary contraceptives for birth spacing (p value 0.032). Hindus had 45(22.8%), Christians 20(36.4) and Muslims had 6(14.3%) of current use where as they all had 87(44.2%), 23(41.8%) and 15(35.7%) of ever use which was not significant in the difference (p value 0.599).

Table 8: Bivariate analysis of socio demographic factors with outcome variables

Characteristic	Current use	p-value	Ever use	p-value
Age at marriage				
<21	41(18.9)	0.001*	83(38.2)	0.033*
≥21	26(39.4)		35(53)	
Education				
School	17(16.3)	0.021*	28(26.9)	0.0001*
College	54(28.4)		97(51.1)	
Current occupation				
Employed	57(28.5)	0.014*	94(47)	0.021*
Unemployed	14(15.2)		30(32.6)	
Decision of Employment				
Self	44(32.6)	0.065	73(54.1)	0.013*

Others	14(20.3)		24(34.8)	
Socio Economic Status				
BPL	40(22.3)	0.362	65(36.3)	0.007*
APL	31(27)		60(52.2)	
Religion				
Hindu	45(22.8)	0.032*	87(44.2)	0.599
Christian	20(36.4)		23(41.8)	
Muslim	6(14.3)		15(35.7)	

*p-value<0.005

The outcome variables were then cross tabulated with certain details collected pertaining to previous child births of the women. Women with planned pregnancies gave 36(26.9%) and 69 (51.1%) of current use and ever use of temporary contraceptives and the ever use was significantly associated with the not planned category of women with 21(24.4%) and the p value was 0.0001.

In the current number of children, no child category women were 19(19.2%) who were currently using contraceptives and 49(49.5%) was the ever use of temporary contraceptives. The women having a child or more were 52(26.7%) current users and 76(39%) ever used contraceptives for spacing. The association was not significant. This has been shown in Table 9.

Women with desire to have only 1 child were 32(25.2%) current users and 62(48.8%) ever used any method and the women with desire of more than or at least 2 child were 39(23.4%) current users and 63(37.7%) ever used any temporary contraceptives. The association was however not significant in both variables.

Women who discussed with their husband about their desired number of children in family were 30(22.9%) current users and 65(49.6%) ever users. Among the women who never discussed about family size with husbands were 41(25.2%) current users and 60(36.8%) ever users of temporary contraceptive for birth spacing. The association with ever used any contraceptives for spacing is significant (p value 0.027).

Table 9: Bivariate analysis of previous births and related matters of participants

Characteristic	Current use	p-value	Ever use	p-value
Planning of pregnancies				
Planned	36(26.9)	0.159	69(51.1)	0.0001*
Not planned	16(18.6)		21(24.4)	
Number of children present				
No child	19(19.2)	0.157	49(49.5)	0.085
≥1 child	52(26.7)		76(39)	
Desired Number of children				
1 child	32(25.2)	0.714	62(48.8)	0.057
≥ child	39(23.4)		63(37.7)	
Discussed with husband				
Yes	30(22.9)	0.595	65(49.6)	0.027*
no	41(25.2)		60(36.8)	

*p-value<0.005

The outcome variables were further tested with health care related factors for the significance (Table 10). The women who found it easy to access the health care facility were 41(24.4%) current users and 64(38.1%) were ever users of contraceptives for spacing. The women with difficulty in accessing any health care facility were 30(23.8%) current users and 61(48.4%) were ever users of temporary contraceptives. The association was not highly significant.

Women who were motivated by health care professionals were 50(100%) current users and 28(56%) ever users. The women who were motivated by family members like husband, mother, friends / enemies were 20(95.2%) current users and 17(81%) were ever users. The association was significant for ever users of temporary contraceptives (p value-0.046).

The women who felt their local health worker had a good character were 62(23.6%) current users and 114(43.3%) ever users. The women who felt their local health worker had a bad character towards them were 9(29%) and 11(35.5%) but this variable association was not at all significant with outcome variables.

Table10: Bivariate analysis of Health Care Related factors

Characteristic	Current Use	p-value	Ever Use	p-value
Health care facility accessibility				
Easy	41(24.4)	0.906	64(38.1)	0.077
Difficult	30(23.8)		61(48.4)	
Motivator for usage				
Professional	50(100)	0.120	28(56)	0.046*
Non-professional**	20(95.2)		17(81)	
Local Health Worker Character				
Good	62(23.6)	0.502	114(43.3)	0.402
Bad	9(29)		11(35.5)	

*p-value<0.005 ** includes husband, mother, friends/relatives.

3.3Multivariate analysis

The factors that were found significant ($p < 0.05$) were considered for a multivariate analysis of the outcome variable current temporary contraceptive usage. The multivariate analysis for ever used temporary contraceptives was not done due to the fact that some cells in the previous analysis yielded very low values. A binary logistic regression analysis was done with the variables age at marriage, educational qualification, current status of occupation and religion. Using Backward LR, 2 factors, namely age at marriage and religion, were found to have significant effect on the outcome. The end result has been shown in Table 11.

Age at median which is categorised with the median value(21) was seen to have an Odd's Ratio of 2.44 and 95% confidence interval(CI) of 1.285 – 4.647 when compared to the reference category. This was significant with a p-value of 0.006.

Regarding religion, Christians compared to Hindus showed an Odd's Ratio of 2.20 and CI of 1.09 – 4.44 with a significance of 0.027. Muslim category shows an Odd's Ratio of 0.66 and a 95% CI of 0.23 – 1.84. This category however doesn't have a significant association as the p-value is 0.429.

Table 11: Result of Multivariate Analysis of factors affecting current use of temporary contraceptive

Characteristic	Odd's Ratio	95% Confidence Interval	p-value
Age at marriage			
<21	1		
≥21	2.44	1.28-4.64	0.006
Religion			
Hindu	1		
Christian	2.20	1.09-4.44	0.027
Muslim	0.66	0.23-1.84	0.429

Chapter 4

Discussion

This study aimed at assessing the current use of temporary contraceptives for birth spacing among young married women and to understand the factors that influence the choice and use of these temporary contraceptives. It also aimed at finding the awareness about the various temporary contraceptive methods that are available.

For the study purpose, 372 houses were approached. The consent for study was given by 294 houses. The women were interviewed either alone or in the presence of a family member like husband, mother or mother in law. The participants were mainly interviewed in their house and the premises of the same due to which participation from other family members were unavoidable. The interviews done in the presence of other family members especially husbands have been biased and the women were not freely communicating in presence of mother in laws.

4.1 Basic Characteristics

The study participants were different when compared to other rural parts of any state in India or in other studies. Women with college education, currently employed and having at least Rs 10,000 income to contribute for their family were a common finding throughout the study. In this study, the type of employment of women ranged from tea shop worker/owner to software engineers. The women who were able to contribute a fair amount of money to family income to were seen to have a say over decisions about their affairs. The religion of women was taken into account and it is to

be noted that majority of the people who declined the study belonged to the Muslim community and the representation of the same community is low in the entire study.

There is a huge disparity in the health seeking behaviour of the family when compared to the women in the family. The family members usually use a PHC for their ailments and then a government hospital but when it comes to women in the house seeking a treatment, a medical store is the usual option then only comes the PHC and its pharmacy. This is in contrast to the decision making potential of the women in employment. This can be to reduce treatment expenses as seen in other studies.⁶²

Knowledge about the age gap between 2 consecutive births in women were influenced by the prevailing children and their age gap or the gap between marriage and the pregnancy or birth of child. When some women had knowledge about spacing between children, vast majority of them did not attach any importance to spacing of the first child. There was a small number of women who already had 3 children within the age of 30 and another small group of women who wanted to have 3 children as part of family (6.5%). In this study, the desire for 3 children was shown by Hindu women than the Muslims who have been identified in studies to have a higher inclination towards increased parity.

There was a higher number of women who had planned their pregnancies (45.6%) but the abortion rate (24.1%) was still high in the population. It was possible to see that the women who discussed their pregnancies and desired number of children with their husband (44.6%) were also low but high when compared to other studies on the topic. Maybe if the women were more open to discussion with family about their parity, there could come a change in use of temporary contraceptives.

The women had given acceptable answers when enquired about their children and their health status, hence the data on the health status can be biased. Also, the data collection was during the monsoon months so the health status and hospitalizations of kids were mostly for fever related ailments.

The current usage of temporary contraceptives was 24.1% and the maximum usage was modern methods (81.7%). Regarding the women who had never seen a health worker visit their house (6.1%) were the employed women who worked for longer hours than the rest of the women and that too at a distance from their house. Around 46.5% women in the population had not yet decided whether to use any form of contraceptives in the future which can be due to the same reasons that were told about currently not using any contraceptives.

4.2 Factors affecting Usage of temporary Contraceptives for Birth Spacing

On further analysis, getting married at a later age and being employed made women more users of contraceptives for birth spacing. The reason can be that education for these women is also increasing thereby affecting family planning positively. Higher socio economic status and ability to take their own decision for employment influences their chance of ever using any contraceptives. Planning the pregnancies by discussing with their spouses increases the use of temporary contraceptives among women. These can be due to the increased decision making potential of women in the family which is as a result of more education and employment status of women as in some other studies where men consider the views of their partners about family size and take joint decisions.^{13, 50}

The study also shows that the chance of ever using any temporary contraceptives by women increased with increased motivation from family members rather than health professionals like doctor, nurses or local health workers. This, again, shows that the effect of women able to talk and take decisions along with their husbands are able to accept temporary contraceptives better.

Out of all the factors affecting temporary contraceptive usage the major finding was that age at marriage and religion are strongest factors in this population. The study analysis showed that compared to women who married at a younger age, the women who married late (cut off for categorization was median value of age at marriage which is 21yrs) had more chance of using temporary contraceptives for spacing births as in another study from south India.²³ Another study done in urban and rural Bangladesh also had similar findings as in this study.⁶³ This could be due to more exposure and decision making potential among older women. Better education is also seen among older women in the study population.⁶⁴

Religion had emerged as a factor affecting contraceptive use. The study showed that women in the Christian community had more chance of using temporary contraceptives and Muslims had more chance of not using any temporary contraceptives for spacing. Christians have pre-marital counselling that affects contraceptive usage and also certain studies have shown the usage of contraceptives to increase among Christians compared to other religions.⁴² Muslims in general have more religious prohibition and increased male child preference, thereby usage of any form of contraceptives for family planning is less as shown in other studies. . It should also be noted that a reason for women who didn't use temporary contraceptives for birth

spacing (currently) was religious prohibition. So, religion can act as a barrier as well as promote birth spacing thereby contraceptive usage. Another study, done in urban slums of Lucknow city, also found that the usage of any contraceptive method was lowest among Muslim community women.⁶⁴

4.3 Awareness about temporary contraceptive

As stated before, this population also showed almost complete knowledge about the major contraceptives, but there is lesser knowledge, on the whole, about Injectable form of contraceptives and emergency contraceptives. The women who have even heard of such methods are very less and usage is very sparse. A study had shown that providing injectable form with community based discussions about the drug can increase its use as family planning measure.⁶⁵ A study from sub Saharan Africa shows that the use of injectable form of birth was high in their study population.³³ These recommendations can be incorporated into other societies too. The most used methods are condoms (modern method) and rhythm method (traditional). The awareness about whom to approach for advice about a method shows that the role of nurses in family planning is negligible. The women have not considered the nurse a person of importance when it comes to family planning. All the procedure that require the need of a surgical procedure and a hospital were more importantly the methods that had nurses being asked for advice. From the study it was found that in the absence of the doctor the nurse was being approached for advice.

4.4 Minor Findings from study

- ❑ Out of the total study population, 74(25.1%) of the couples were in an intercaste marriage.

- ❑ Out of 284 women, 25% women have had an abortion in their married life.
- ❑ According to 124(42.6%) participants, the word family planning means 'birth spacing', while, 104(36.4%) participants thinks it is 'pregnancy prevention' and 48(16.3) participants think it means 'birth control'. This shows the lack of proper knowledge about the difference between the terms which shows the interactions between the professionals are not adequate for the complete knowledge about birth spacing.
- ❑ Among 209 participants who have ever used any method, 39(18.7%) have had problems with contraceptive usage.
- ❑ Health Care facility accessibility was easy as mentioned by 168(57.1%) and not easily accessible by 126 (42.9%) participants.

4.5 Strengths of the study

- ❑ It is a community based study.
- ❑ Since the study was done by a single investigator, there is no chance of inter observer bias.

4.6 Limitations of the study

- ❑ Sample size is not adequate.
- ❑ Response rate is only 79%.
- ❑ Purely a quantitative study.

- ❑ Causal relationship cannot be assessed.

4.7 Conclusion

This study shows that the use of temporary contraceptives for birth spacing is happening but not adequately or based on knowledge provided by professionals. A factor that can affect the temporary contraceptive usage positively is late age of marriage, which may be due to better education among these women. The Christian women have a better chance of using contraceptives than women of other religion. There should be better decision making potential for women to voice their own family planning opinions. The motivation of family members about family planning can be affective in increasing the use of spacing techniques among married women. The lack of involvement of nurses or the failure of women to recognize nurses as a health care worker that can provide assistance in contraceptive usage should be rectified. Serious insights should be made understand the lack of knowledge about emergency contraceptive s and injectable type of temporary contraceptives which are available even with the PHC's and local health workers.

References

- 1 Annex A. 2.1 Global patterns of health risk. http://www.who.int/entity/healthinfo/global_burden_disease/GlobalHealthRisks_report_part2.pdf (accessed Feb 15, 2014).
- 2 Pathak KB, Feeney G, Luther NY. Alternative contraceptive methods and fertility decline in India. 1998. <http://scholarspace.manoa.hawaii.edu/handle/10125/3486> (accessed Feb 14, 2014).
- 3 Reducing maternal mortality in developing countries. GiveWell. 2009. <http://www.givewell.org/international/technical/programs/maternal-mortality> (accessed Feb 15, 2014).
- 4 Cleland J, Conde-Agudelo A, Peterson H, Ross J, Tsui A. Contraception and health. *The Lancet* 2012; 380: 149–56.
- 5 Sebastian MP, Khan ME, Kumari K, Idnani R. Increasing Postpartum Contraception in Rural India: Evaluation of a Community-Based Behavior Change Communication Intervention. *International Perspectives on Sexual and Reproductive Health* 2012; 38: 068–77.
- 6 Organization WH, others. The human reproduction programme at World Health Organization: providing the foundation for sexual and reproductive health: cutting-edge global research on family planning and improving adolescent sexual and reproductive health. 2012. <http://apps.who.int/iris/handle/10665/76235> (accessed Oct 27, 2014).
- 7 AbouZahr C. Global burden of maternal death and disability. *Br Med Bull* 2003; 67: 1–11.
- 8 Phillip Neilburg. Improving Maternal Mortality and Other Aspects of Women's Health ,The United State's Global Role. 2012.

- 9 SENGUPTA R, DAS A. Contraceptive practices and unmet need among young currently married rural women in empowered action group (EAG) States of India. *Journal of Family Welfare* 2012; 58: 1–14.
- 10 WHO | Unmet need for family planning. http://www.who.int/reproductivehealth/topics/family_planning/unmet_need_fp/en/ (accessed March 6, 2014).
- 11 Kumar NA, Devi DR. Health of Women in Kerala: Current Status and Emerging Issues. Working paper, 2010 <http://csesindia.org/admin/modules/cms/docs/publication/24.pdf> (accessed Feb 15, 2014).
- 12 Bhalotra S, Van Soest A. Birth spacing, fertility and neonatal mortality in India: dynamics, frailty and fecundity. IZA Discussion Papers, 2006 <http://www.econstor.eu/handle/10419/33968> (accessed Oct 27, 2014).
- 13 RamaRao S, Townsend J, Askew I. Correlates of inter-birth intervals: implications of optimal birth spacing strategies in Mozambique. *Frontiers in Reproductive Health, Population Council*, 2006 http://www.nestragel.net/pdfs/frontiers/FR_FinalReports/Mozam_OBSI.pdf (accessed Feb 14, 2014).
- 14 Report of a WHO Technical Consultation on Birth Spacing. 2005.
- 15 Abdel-Tawab N, Lūzā SF, Zaki A. Helping Egyptian women achieve optimal birth spacing intervals through fostering linkages between family planning and maternal/child health services. *Frontiers in Reproductive Health, Population Council*, 2008 http://pdf.usaid.gov/pdf_docs/pnadm580.pdf (accessed Feb 14, 2014).
- 16 Syamala TS. Relationship Between Socio Demographic Factors and Child Survival: Evidences from Goa, India. *J Hum Ecol* 2004; 16: 141–5.
- 17 Dibaba Y. Child Spacing and Fertility Planning Behavior among Women in Mana District, Jimma Zone, South West Ethiopia. *Ethiopian journal of health sciences* 2010; 20. <http://www.ajol.info/index.php/ejhs/article/view/69433> (accessed Feb 14, 2014).

- 18 Kozuki N, Walker N. Exploring the association between short/long preceding birth intervals and child mortality: using reference birth interval children of the same mother as comparison. *BMC Public Health* 2013; 13: S6.
- 19 Saha UR, van Soest A. Contraceptive Use, Birth Spacing, and Child Survival in Matlab, Bangladesh. *Studies in family planning* 2013; 44: 45–66.
- 20 Ekpo G, Asy J, Sarmiento C, et al. Report Of The Rapid Assessment Of Family Planning Services For The Integration Of Child Spacing Into Maternal And Child Health Programs In Oecusse District, East Timor December. 2008.
- 21 Carinne D Brody, Julie Freccero, Claire D Brindis, Ben Bellows. Redeeming qualities: exploring factors that affect women’s use of reproductive health vouchers in Cambodia. 2013. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3599041/pdf/1472-698X-13-13.pdf> (accessed Feb 14, 2014).
- 22 Pillai VK, Gupta R. Child spacing and contraception among the poor in Zambia. *Open Access Journal of Contraception* 2010; 1: 1–8.
- 23 Marvi K, Howard N. Objects of temporary contraception: an exploratory study of women’s perspectives in Karachi, Pakistan. *BMJ Open* 2013; 3: e003279–e003279.
- 24 Pathak KB, Feeney G, Luther NY. Accelerating India’s fertility decline: the role of temporary contraceptive methods. 1998. <http://scholarspace.manoa.hawaii.edu/handle/10125/3457> (accessed Oct 19, 2014).
- 25 Indongo N. Contraceptive choice and use of methods among young women in Namibia. 2009. <https://tspace.library.utoronto.ca/handle/1807/37846> (accessed Oct 27, 2014).
- 26 Vinitha CT, Singh S, Rajendran AK. Level of reproductive health awareness and factors affecting it in a rural community of South India. *Health and Population* 2007; 30: 24–44.

- 27 Hailemariam A, Haddis F. Factors Affecting Unmet Need for Family Planning in Southern Nations, Nationalities and Peoples Region, Ethiopia. *Ethiop J Health Sci* 2011; 21: 77–89.
- 28 Das KC, Gautam V, Das K, Tripathy PK. Influence of age gap between couples on contraception and fertility. *Journal of Family Welfare* 2011; 57: 30–8.
- 29 Chacko E. Women’s use of contraception in rural India:: a village-level study. *Health & place* 2001; 7: 197–208.
- 30 Gribble JN, Sharma S, Menotti EP. Family planning policies and their impacts on the poor: Peru’s experience. *International family planning perspectives* 2007; : 176–81.
- 31 M C Yadavannavar, Shailaja S Patil. Socio Cultural Factors Affecting Breast Feeding Practices And Decisions In Rural Women. 2011.
- 32 Eyayou Y, Berhane Y, Zerihun L. Socio-cultural factors in decisions related to fertility in remotely located communities: The case of the Suri ethnic group. *Ethiopian Journal of Health Development* 2005; 18: 171–4.
- 33 Van Lith LM, Yahner M, Bakamjian L. Women’s growing desire to limit births in sub-Saharan Africa: meeting the challenge. *Global Health: Science and Practice* 2013; 1: 97–107.
- 34 Patel MG, Mahyavanshi DK, Kartha G, Purani SK, Nagar SS. A cross sectional study on knowledge, attitude and practice regarding spacing methods among married women of the reproductive age group in the field practice area of UHTC in surendranagar district. *Hindu* 2011; 280: 85–1.
- 35 Zavier F, Padmadas SS. Use of a spacing method before sterilization among couples in Kerala, India. *International Family Planning Perspectives* 2000; : 29–35.
- 36 Clusters Awlij, Delhi I. SK Rasania, Suvra Pathi, D. Singh, S. Bhalla & J. Khandekar. *Health and Population Perspectives and Issues* 2004; 27: 211–7.

- 37 Shafei MN. Knowledge and Attitude towards Family Planning Practice and Prevalence of Short Birth Spacing Among Residents of Suburban Area in Terengganu, Malaysia. *Journal of Community Medicine & Health Education* 2012; 02. DOI:10.4172/2161-0711.1000180.
- 38 Khan ME, Sebastian MP, Sharma U, et al. Promoting healthy timing and spacing of births in India through a community-based approach. Population Council New Delhi, India 2008. http://www.popcouncil.info/pdfs/frontiers/FR_FinalReports/India_HTSP.pdf (accessed Feb 14, 2014).
- 39 Begna Z, Assegid S, Kassahun W, Gerbaba M. Determinants of inter birth interval among married women living in rural pastoral communities of southern Ethiopia: a case control study. *BMC Pregnancy Childbirth* 2013; 13: 116.
- 40 Pörtner CC. Sex selective abortions, fertility and birth spacing. University of Washington, Department of Economics, Working Paper 2010. http://www.iussp.org/sites/default/files/event_call_for_papers/ver1-4_0.pdf (accessed Feb 14, 2014).
- 41 Naidu S, Vennam B, PKVS. Knowledge about reproductive health among adolescent high school girls (rural) in Karapa Mandal, East Godavari District. .
- 42 M L, Neetha N, Rai S. Contraceptive practices among reproductive age group of women in Justice K S Hegde Medical College Hospital, Mangalore. *International Journal of Reproduction, Contraception, Obstetrics and Gynecology* 2013; 2: 39.
- 43 Adanu RM, Seffah JD, Hill AG, Darko R, Duda RB, Anarfi JK. Contraceptive use by women in Accra, Ghana: results from the 2003 Accra Women's Health Survey: original research article. *African journal of reproductive health* 2009; 13: 123–33.
- 44 Troske KR, Voicu A. The effect of the timing and spacing of births on the level of labor market involvement of married women. *Empirical Economics* 2012; 45: 483–521.

- 45 Uddin ME, MSS TZH, MSS MSA. Socio-Cultural Factors Affecting Family Size between Muslim and Santal Communities in Rural Bangladesh. *Cultural Anthropology*; 395: 410.
- 46 ade anju, s revathi, Kulkarni A. Reproductive health profile and health seeking behavior among muslim women of urban slums of Raichur ,Karnataka. .
- 47 Saha S, Ravindran TS. Gender Gaps in Research on Health Services in India. *Journal of Health Management* 2002; 4: 185–214.
- 48 Dahal GP, Padmadas SS, Hinde PA. Fertility-limiting behavior and contraceptive choice among men in Nepal. *International Family Planning Perspectives* 2008; : 6–14.
- 49 Male Involvement in Family Planning & Reproductive Health in Rural Central India. *Tampere Univ Pr*, 2011.
- 50 Patro BK, Kant S, Baridalyne N, Goswami AK. Contraceptive practices among married women in a resettlement colony of Delhi. *Health and Population-Perspectives and Issues* 2005; 28: 9–16.
- 51 Khan A, Shaikh BT. An all time low utilization of intrauterine contraceptive device as a birth spacing method-a qualitative descriptive study in district Rawalpindi, Pakistan. *Reproductive health* 2013; 10: 10.
- 52 Rana MS, Thapaliya M, Aryal RP, Sathian B, Rana MS. Health Effects of Modern Temporary Female Hormonal Contraceptives among the Women in the Pokhara Sub-Metropolitan City of Western Nepal. 2012. http://www.jcdr.net/article_fulltext.asp?issn=0973-709x&year=2012&month=February&volume=6&issue=1&page=51&id=1881 (accessed Oct 27, 2014).
- 53 Odumosu OF, Ajala AO, Nelson-Twakor EN, Alonge SK. Unmet need for contraception among married men in urban Nigeria. *Unmet Needs And Poverty* 2005; : 201.

- 54 Valenzuela FR. Contraceptive Discontinuation: A One-Year Follow-Up Study of Female Reversible Method Users in Urban Honduras. <http://www.globalhivmeinfo.org/DigitalLibrary/Digital%20Library/MEASURE-Contraceptive%20Discontinuation%20A%20One-Year%20Follow-Up%20Study%20of%20Female%20Reversible%20Method%20Users%20in%20Urban%20Honduras.pdf> (accessed Oct 20, 2014).
- 55 Lakshmi G, Radha P, naidu S. Knowledge, attitude and practices of emergency contraception among female medical students of Andra Medical College, Vishakapatnam. .
- 56 Singh R, Tripathi V, Kalaivani M, Singh K, Dwivedi SN. Determinants of birth intervals in Tamil Nadu in India: developing Cox hazard models with validations and predictions. *Revista Colombiana de Estadística* 2012; 35: 289–307.
- 57 Singh SN, Singh SN, Narendra RK. Demographic and socio-economic determinants of birth interval dynamics in Manipur: A survival analysis. *Online Journal of Health and Allied Sciences* 2011; 9. <http://cogprints.org/7245/> (accessed Feb 14, 2014).
- 58 Jayaraman A, Mishra V, Arnold F. The relationship of family size and composition to fertility desires, contraceptive adoption and method choice in South Asia. *International perspectives on sexual and reproductive health* 2009; : 29–38.
- 59 UDDIN MI, Bhuyan KC, ISLAM SS. Determinants of desired family size and children ever born in Bangladesh. *Journal of Family Welfare* 2011; 57: 30–8.
- 60 District Level Household and Facility Survey 2007 - 2008 Kerala. 2010.
- 61 Sharma R., Rajalekshmi M, Jeyaraj A. Current status of fertility control methods in India. 2005.
- 62 Barua A, Kruz K. Reproductive health-seeking by married adolescent girls in Maharashtra, India. 2001.

- 63 Rahman MM, Islam AZ, Islam MR. Rural-Urban Differentials of Knowledge and Practice of Contraception in Bangladesh. .
- 64 Kumar A, Bhardwaj P, Srivastava JP, Gupta P. A study on family planning practices and methods among women of urban slums of lucknow city. *Indian Journal of Community Health* 2012; 23: 75–7.
- 65 Olawo AA, Bashir I, Solomon M, Stanback J, Ndugga BM, Malonza I. ‘A cup of tea with our CBD agent...’ community provision of injectable contraceptives in Kenya is safe and feasible. *Global Health: Science and Practice* 2013; 1: 308–15.

ANNEXURES

Annexure – I

Consent Form (English)

Good Morning/Afternoon Madam,

I am Dr. Parvathy Mini Pradeep, doing my Master of Public Health (MPH) at Achutha Menon Centre for Health Science Studies, Sree ChitraThirunal Institute for Medical Sciences and Technology (SCTIMST), Thiruvananthapuram. As a part of my course I am expected to do a study and my topic of study is” Assessment of Factors Influencing the Choice and Use of Temporary Contraceptive Methods for Birth Spacing among Married Women in Rural Trivandrum”. I request you to spend some time & participate in my study.

Purpose of the study

The Spacing of consecutive births is essential for maternal and child health. This can be achieved by various contraceptive methods. This study is to find the extent of awareness and practices of various temporary methods of contraception among married women of 20 to 30 years in Trivandrum.

Participation from your side

If you are willing to participate in study I have a few questions regarding your socio demographic characteristics and your perceptions and practice of birth spacing. There are no direct benefits for you by participating in the study. By participating in the study you will not be risking anything including health. Your participation in the study is voluntary and you can withdraw from the study at any point of time and refusal to participate will not involve any form of penalty.

Privacy and Confidentiality

The Privacy/confidentiality of the information you provide will be maintained. Your personal identity will not be revealed to anyone. Some of the information will be shared

with people who are associated with study. All the copies of filled interview schedules and consent forms will be kept under my custody and will be destroyed when they are deemed no longer needed. The study will be published in scientific journal but your identity will not be revealed.

For any further clarification, you may directly contact me. My name is Dr. Parvathy Mini Pradeep and my contact number is 984652269. You may also contact the Member Secretary of Ethics Committee of SCTIMST at 0471-2520256.

Are you willing to participate in this study?

- Yes
- No

As a part of the requirement, I need your signature/ thumb impression which indicates your willingness to participate. Could you kindly sign/or give thumb impression below?

Signature of the participant: _____

Signature of the investigator: _____

- If the respondent is not willing to sign or give thumb impression (verbal consent)

Signature of witness: _____

Name of witness: _____

Address of witness: _____

If you are not willing to participate in the study then, Thank you for sparing some of your valuable time to engage with me.

Date: _____

Place: _____

Annexure II

Interview Schedule

Name of Block Panchayat: _____	Date: dd/mm/yy
Name of Gram Panchayat: _____	Time: _____
Name of Ward : _____	
Cluster number : <input type="checkbox"/> <input type="checkbox"/>	
House Number /Address: _____ _____	

1. What is your Name : _____
2. What is your Age(yrs) : _____
3. How many individuals (including you) live in this household : _____
4. Are you living with :
 - 1) your husband's family
 - 2) your own family
 - 3) your husband and own child/children only
 - 4) Others , specify : _____
5. Are you currently living with your husband or is he staying elsewhere :
 - 1) Living with husband
 - 2) Husband living elsewhere
6. What is your Educational Qualification :
 - 1) No formal education
 - 2) Primary education (1 – 7yrs)
 - 3) High school education(8 – 10yrs)

- 4) Higher secondary education(11 – 12yrs)
- 5) Diploma (13-14yrs)
- 6) Graduate level (13 – 15yrs)
- 7) Post graduation or more (>16yrs)
7. What is your Occupation : _____
8. Was it your own decision to have an occupation of your own
- 1) Yes 2) No
9. If 8.2 ,then, Who took the decision for your occupation :
- 1) Self
- 2) Husband
- 3) Your family
- 4) Your husband's family
- 5) Others, specify : _____
10. What is the Current status of your Occupation :
- 1) Employed
- 2) Unemployed
- 3) Work from home
- 4) Maternity leave
- 5) Others, Specify : _____
11. If you get a job where you will have to stay away from your house, what will be your decision: _____
12. What is the Monthly Income of the household (Rs) : _____
13. What is your contribution to your Family Income (Rs): _____
14. Does your family have a BPL card :
- 1) Yes 2) No
15. What Religion do you follow :

- 1) Hindu
- 2) Christian
- 3) Muslim
- 4) Buddhism
- 5) Others, specify : _____

16. Do you and your husband follow the same religion:

- 1) Yes
- 2) No

17. How frequently do you watch television

18. How frequently do you listen to a radio

19. How frequently do you read newspaper and its related magazines

Health Seeking Behaviour

20. What is the health care facility that you and your husband usually use

- 1) Government hospital in city
- 2) PHC nearby
- 3) Private Hospitals in city
- 4) Private Clinics nearby
- 5) Others, Specify : _____

21. Is this facility easily accessible from your house:

- 1) Yes
- 2) No

22. If you have certain illnesses like fever, cold, cough, what do you usually do :

-

Marital Status and Pregnancy History

23. How old were you when you got married: _____

24. Now I would like to ask about all the births you have had during your life. Have you ever given birth?

1) Yes 2) No

25. How old were you when you had your first child:-----

26. Are you pregnant now

1) Yes 2) No

27. How many months pregnant are you : _____

28. How many children do you have:-----

29. What is the Age of the child /children (in order) :

1) _____

2) _____

30. What is the Sex of the first child / Children(in order) :

1) _____

2) _____

31. Do any of your children suffer from any long term health problems?

1) Yes 2) No

32. Have you felt that your child/children become ill quite frequently:

1) Yes 2) No

If 31(1) and 32(1), then ask 33, else ask 34

33. Were there any illness that happened in the last 6 months that required hospitalization of the child

34. What should be the ideal gap (age difference) between two children:

1) 0-1 year

2) 1-2 years

3) 2-3 years

- 4) 3-4 years
- 5) 5 years and above
- 6) Others, Specify : _____

35. Sometimes women become pregnant even when they were not planning a pregnancy. Have all your previous pregnancies been planned?

- 1) yes
- 2) No

36. Have you had any pregnancy that terminated in still birth?

- 1) yes
- 2) No

37. Have you had any pregnancy that terminated in an abortion (induced/spontaneous)?

- 1) Yes
- 2) No

38. Have you ever given birth to a boy or girl who was born alive but later died?

- 1) Yes
- 2) No

Personal Perception about Family Planning

39. What is your desired family size :

40. Have you discussed with your husband about the number of children you would like to

- have :
- 1) Yes
 - 2) No

41. According to you, what does the term "family planning" mean?

- 1) Pregnancy prevention
- 2) Birth spacing
- 3) Planning your family's life
- 4) Birth control
- 5) Limiting
- 6) Don't know
- 7) Other, specify : _____

42. Have you ever used anything or tried in any way to delay or avoid getting pregnant?

- 1) Yes 2) No

If 42(2), then go to 57

I would like to ask you some questions on various family planning methods that are available.

43. Awareness and Practice of Family Planning

<u>Method</u>	<u>Heard of the method</u>	<u>Where is it available</u>	<u>Where can you get advice about method</u>	<u>Have you ever used</u>
Pills	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No	1. <input type="checkbox"/> Government hospital 2. <input type="checkbox"/> Private hospital 3. <input type="checkbox"/> Pharmacy/Medical store 4. <input type="checkbox"/> Local health worker visits	1. <input type="checkbox"/> Doctor 2. <input type="checkbox"/> Nurse 3. <input type="checkbox"/> Local health worker	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
Intra uterine devices (IUD, Loop, Copper T)	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No	1. <input type="checkbox"/> Government hospital 2. <input type="checkbox"/> Private hospital 3. <input type="checkbox"/> Pharmacy/Medical store 4. <input type="checkbox"/> Local health worker visits	1. <input type="checkbox"/> Doctor 2. <input type="checkbox"/> Nurse 3. <input type="checkbox"/> Local health worker	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No

Injections	1) <input type="checkbox"/> Yes 2) <input type="checkbox"/> No	1) <input type="checkbox"/> Government hospital 2) <input type="checkbox"/> Private hospital 3) <input type="checkbox"/> Pharmacy/ Medical store 4) <input type="checkbox"/> Local health worker visits	1) <input type="checkbox"/> Doctor 2) <input type="checkbox"/> Nurse 3) <input type="checkbox"/> Local health worker	1) <input type="checkbox"/> Yes 2) <input type="checkbox"/> No
Condom/Nirodh	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No	1. <input type="checkbox"/> Government hospital 2. <input type="checkbox"/> Private hospital 3. <input type="checkbox"/> Pharmacy/ Medical store 4. <input type="checkbox"/> Local health worker visits	1. <input type="checkbox"/> Doctor 2. <input type="checkbox"/> Nurse 3. <input type="checkbox"/> Local health worker	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
Emergency Contraceptives	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No	1. <input type="checkbox"/> Government hospital 2. <input type="checkbox"/> Private hospital 3. <input type="checkbox"/> Pharmacy/ Medical store 4. <input type="checkbox"/> Local health worker visits	1. <input type="checkbox"/> Doctor 2. <input type="checkbox"/> Nurse 3. <input type="checkbox"/> Local health worker	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
Rhythm method	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No	1. <input type="checkbox"/> Government hospital 2. <input type="checkbox"/> Private hospital	1. <input type="checkbox"/> Doctor 2. <input type="checkbox"/> Nurse 3. <input type="checkbox"/> Local	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No

		3. <input type="checkbox"/> Pharmacy/Medical store 4. <input type="checkbox"/> Local health worker visits	health worker	
Withdrawal method	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No	1. <input type="checkbox"/> Government hospital 2. <input type="checkbox"/> Private hospital 3. <input type="checkbox"/> Pharmacy/Medical store 4. <input type="checkbox"/> Local health worker visits	1. <input type="checkbox"/> Doctor 2. <input type="checkbox"/> Nurse 3. <input type="checkbox"/> Local health worker	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
Male sterilization	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No		1. <input type="checkbox"/> Doctor 2. <input type="checkbox"/> Nurse 3. <input type="checkbox"/> Local health worker	
Female sterilization	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No		1. <input type="checkbox"/> Doctor 2. <input type="checkbox"/> Nurse 3. <input type="checkbox"/> Local health worker	

44. Are you currently doing something or using any method to delay or avoid getting pregnant?

- 1) Yes 2) No

45. Which is the method you use currently :

- 1) Pills
- 2) IUD's
- 3) Condom/Nirodh
- 4) Rhythm
- 5) Withdrawal
- 6) Male sterilization
- 7) Female sterilization
- 8) Others, specify : _____

46. Who motivated/advised you to use the method:

- 1) doctor
- 2) nurse
- 3) local health worker
- 4) Husband
- 5) Mother
- 6) Mother in law
- 7) Relatives/Friends
- 8) Others, specify : _____

47. How often does a health worker visit your house:

- 1) Never
- 2) Once a week
- 3) Once in 2 weeks
- 4) Once in a month
- 5) Once in 2 months

6) Others, specify : _____

If 47(1), go to 50 else go to 48

48. When a local health worker visits your house, are you provided information on family planning?

1) Yes 2) No

If yes go to 49, else go to 50

49. When the health worker explains on family planning, does she try to make sure that you understood the information that is provided?

1) Yes 2) No

After referring to the 43 table, ask 50

50. Are the people who provided the service or information about the service responsive to your problems and needs?

1) Yes 2) No

51. Do the people who provide family planning services respect your need for privacy if you needed it?

1) Yes 2) No

52. Have you been advised about the side effects of the method of choice :

- 1) Yes
- 2) Yes, when I asked for
- 3) No

If 52 (2) go to 53, else go to 54

53. How did you know to ask for side effects : _____

54. Have you had any health problems after adopting the method :

1) Yes 2) No

55. If 37.1, What is the health problem you faced by using the method

: _____

56. Were you told what to do if you experienced side effects or problems?

1) Yes 2) No

57. Why are you not using any birth spacing methods :

- 1) Not having sex/infrequent sex
- 2) Husband away
- 3) Hysterectomy
- 4) Breast feeding
- 5) Post partum amenorrhea
- 6) Husband opposition
- 7) Religious prohibition
- 8) Health concerns/fear of side effects
- 9) Inconvenient to use
- 10) Affects body's normal practices
- 11) Others, specify : _____

58. Do you intend to use any method of birth spacing in future :

- 1) Yes
- 2) No
- 3) Not yet decided

59. If yes, What will be Your Method of choice:

Annexure III

വിവരങ്ങൾ ധരിപ്പിച്ചുകൊണ്ടുള്ള സമ്മതപത്രം

“നമസ്കാരം” ഞാൻ ഡോ.പാർവ്വതി മിനി പ്രദീപാണ്. ഞാൻ തിരുവനന്തപുരം ശ്രീ ചിത്തിരതിരുനാൾ ഇൻസ്റ്റിറ്റ്യൂട്ട് ഫോർ മെഡിക്കൽ സയൻസ് ആന്റ് ടെക്നോളജി യുടെ അച്യുതമേനോൻ സെന്റർ ഫോർ ഫെൽത്ത് സയൻസ് സ്റ്റഡീസ് പൊതുജനാരോഗ്യ സംരക്ഷണത്തിൽ മാസ്റ്റേസിന് പഠിക്കുന്നു. ഈ കോഴ്സിന്റെ ഭാഗമായി ഞാൻ ഏറ്റെടുത്തിരിക്കുന്നത് ഉൾനാടൻ തിരുവനന്തപുരത്തിലെ വിവാഹിതരായ സ്ത്രീകൾ പ്രസവങ്ങൾ തമ്മിലുള്ള അകലം നിലനിർത്താൻ വേണ്ടി ഉപയോഗിക്കുന്ന താൽക്കാലിക ഗർഭ നിരോധന ഉപാധികളുടെ തിരഞ്ഞെടുക്കലിനേയും അവയുടെ ഉപയോഗത്തിനേയും ബാധിക്കുന്ന ഘടകങ്ങളുടെ മൂല്യനിർണ്ണയം എന്ന വിഷയത്തിന്റെ പഠനമാണ്. മേൽപ്പറഞ്ഞിരിക്കുന്ന പഠനത്തിനായി താങ്കളുടെ കുറച്ചു സമയം ചിലവഴിക്കണമെന്നും ഇതിൽ ചേരണമെന്നും താഴ്മയായി അഭ്യർത്ഥിക്കുന്നു.

പഠനോദ്ദേശ്യം

അടുത്തടുത്തുള്ള പ്രസവങ്ങളുടെ ഇടയിൽ അന്തരം പാലിക്കുകയെന്നത് മാതൃശിശു ആരോഗ്യത്തിന് അത്യന്താപേക്ഷിതമാണ്. വിവിധയിനം ഗർഭനിരോധന ഉപാധികൾ വഴി ഇത് സാധ്യമാക്കാവുന്നതാണ്. തിരുവനന്തപുരത്തിൽ താമസിക്കുന്ന 20-നും 30-നും ഇടയിൽ പ്രായമുള്ള വിവാഹിതരായ സ്ത്രീകൾക്ക് താൽക്കാലിക ഗർഭനിരോധന ഉപാധികളെക്കുറിച്ചുള്ള അവബോധത്തിന്റെ നിലവാരം കണ്ടെത്തുന്നതിനാണ് ഈ പഠനം ഏറ്റെടുത്തിരിക്കുന്നത്.

താങ്കളുടെ പങ്ക്

ഈ പഠനത്തിൽ പങ്കെടുക്കാൻ താൽപര്യമുള്ള പക്ഷം താങ്കളോട് കുറച്ചു ചോദ്യങ്ങൾ ചോദിക്കുന്നതാണ്. പ്രസവങ്ങൾ തമ്മിലുള്ള അകലം പാലിക്കുന്നതിന് വേണ്ടിയുള്ള താങ്കളുടെ മനോഭാവം, താങ്കളുടെ സാമൂഹികവും ജനസംഖ്യാപരവുമായിട്ടുള്ള എന്നിവയായിരിക്കും ഈ ചോദ്യങ്ങളിൽ അടങ്ങിയിരിക്കുന്നത്.

ഈ പഠനത്തിൽ പങ്കെടുക്കുന്നതിലൂടെ താങ്കൾക്ക് ആനുകൂല്യങ്ങൾ ഉണ്ടായിരിക്കുന്നതല്ല. ഇതിൽ പങ്കെടുക്കുന്നതിലൂടെ താങ്കൾക്ക് യാതൊരുവിധ അപകടവും ഉണ്ടാകുന്നതല്ല. ഇതിലുള്ള പങ്കെടുക്കൽ താങ്കളുടെ സ്വമേധയാലുള്ള തീരുമാനമാണ്. പഠനത്തിന്റെ ഇടയിൽ ഏതൊരു സമയത്തും താങ്കൾക്ക് പിൻവാങ്ങാൻ കഴിയുന്നതാണ്. അതിൻമൂലം താങ്കളിൽ നിന്ന് യാതൊരു വിധ പിഴയും ഏർപ്പെടുത്തുന്നതല്ല.

പഠനത്തിന്റെ സ്വകാര്യത

താങ്കൾ നൽകുന്ന വിവരങ്ങളും അതിന്റെ വിശദാംശങ്ങളും തികച്ചും സ്വകാര്യമായിരിക്കും. താങ്കളുടെ സ്വകാര്യതയും സ്വത്വവും വെളിപ്പെടുത്തുന്നതല്ല. ചില പ്രത്യേക വിവരങ്ങൾ മാത്രം പഠനത്തിന്റെ ആവശ്യത്തിനുവേണ്ടി ഇതുമായി ബന്ധപ്പെട്ട ചില ആൾക്കാരുമായി മാത്രം പങ്കുവയ്ക്കുന്നതായിരിക്കും. പൂരിപ്പിക്കപ്പെട്ട ഫോമുകളുടെ എല്ലാ പകർപ്പുകളും സമ്മതപത്രങ്ങളും തികച്ചും എന്റെ സുരക്ഷിതത്വത്തിൽ മാത്രം ആയിരിക്കുകയും ആവശ്യം കഴിയുന്ന പക്ഷം അവ നശിപ്പിച്ചുകളയുകയും ചെയ്യുന്നതായിരിക്കും. ശാസ്ത്രജ്ഞലുകളിൽ ഈ പഠനം പ്രസിദ്ധീകരിക്കപ്പെടുമെങ്കിലും താങ്കളുടെ സ്വത്വവും വെളിപ്പെടുത്തപ്പെടുകയില്ല.

ഇതുമായി ബന്ധപ്പെട്ടേതു സംശയത്തിനും താങ്കൾക്ക് ഞാനുമായി നേരിട്ട് ബന്ധപ്പെടാവുന്നതാണ്. എന്റെ പേര് ഡോ. പാർവ്വതി മിനി പ്രദീപ് എന്നാണ്. എന്റെ ബന്ധപ്പെടുന്നതിനുള്ള നമ്പർ : 984652269. എസ്.സി.ഐ.എം.എസ്.റ്റിയിൽ കാര്യോലോചന സഭയുടെ മെമ്പർ സെക്രട്ടറിയുമായി താങ്കൾക്ക് 0471-2520256 എന്ന നമ്പരിലും ബന്ധപ്പെടാവുന്നതാണ്.

താങ്കൾക്ക് ഈ പഠനത്തിൽ പങ്കെടുക്കാൻ താൽപര്യമുണ്ടോ ?

- ഉണ്ട്
- ഇല്ല

ആവശ്യകോപാധിയായി പഠനത്തിൽ പങ്കെടുക്കാനുള്ള താങ്കളുടെ സന്നദ്ധത പ്രകടിപ്പിച്ചുകൊണ്ടുള്ള താങ്കളുടെ ഒപ്പ്/വിരലടയാളം ആവശ്യമാണ്. താഴെ കൊടുത്തിരിക്കുന്ന സ്ഥലത്ത് താങ്കൾക്ക് ഒപ്പ് ഇടാവുന്നതോ വിരലടയാളം പതിക്കാവുന്നതുമാണ്.

പങ്കെടുക്കുന്നയാളുടെ ഒപ്പ് :

ഇൻവെസ്റ്റിഗേറ്ററുടെ ഒപ്പ് :

പങ്കെടുക്കുന്നയാൾ ഒപ്പിടാനോ വിരലടയാളം പതിക്കാനോ സന്നദ്ധതപ്രകടിപ്പിക്കാത്ത പക്ഷം (വാക്കാലുള്ള സമ്മതം)

ദൃക്സാക്ഷിയുടെ ഒപ്പ് :

ദൃക്സാക്ഷിയുടെ മേൽവിലാസം :

പഠനത്തിൽ പങ്കെടുക്കാൻ താങ്കൾക്ക് താൽപര്യമില്ലാത്ത പക്ഷവും ഇത്രയും സമയവും ഞാനുമായി ചിലവഴിക്കാൻ മനസ്സുകാണിച്ചതിന് നന്ദി പ്രകടിപ്പിക്കുന്നു.

Annexure IV

അഭിമുഖത്തിനായുള്ള ചോദ്യാവലി

ബ്ലോക്ക് പഞ്ചായത്തിന്റെ പേര്: തീയതി :

ഗ്രാമ പഞ്ചായത്തിന്റെ പേര് :സമയം :

വാർഡിന്റെ പേര് :

ക്ലസ്റ്റർ നമ്പർ :□□

വീട്ട് നമ്പർ/വിലാസം:

1. പേര് :
2. വയസ്സ് :
3. താങ്കളുടെ വീട്ടിൽ താങ്കൾ ഉൾപ്പെടെ എത്ര അംഗങ്ങൾ ഉണ്ട് :
4. താങ്കൾ ആരുടെ കൂടെയാണ് താമസിക്കുന്നത് :
 1. ഭർത്താവിന്റെ കുടുംബം
 2. താങ്കളുടെ സ്വന്തം കുടുംബം
 3. താങ്കളുടെ ഭർത്താവും സ്വന്തം കുട്ടി/കുട്ടികളും മാത്രം
 4. മറ്റുള്ളവ വ്യക്തമാക്കുക :
5. താങ്കൾ ഇപ്പോൾ താങ്കളുടെ ഭർത്താവിന്റെ കൂടെയാണോ താമസിക്കുന്നത് അതോ അദ്ദേഹം മറ്റെവിടെയെങ്കിലുമാണോ താമസിക്കുന്നത് ?
 1. ഭർത്താവിന്റെ കൂടെ
 2. ഭർത്താവ് വേറെ താമസിക്കുന്നു

6. താങ്കളുടെ വിദ്യാഭ്യാസനിലവാരം എന്ത് ?

1. വിദ്യാഭ്യാസമില്ല
2. പ്രാഥമിക വിദ്യാഭ്യാസം (1-7 വർഷം)
3. ഹൈസ്കൂൾ വിദ്യാഭ്യാസം (8-10 വർഷം)
4. ഹൈയർ സെക്കൻഡറി വിദ്യാഭ്യാസം (11-12 വർഷം)
5. ഡിപ്ലോമ(13-14 വർഷം)
6. ബിരുദം (13-15 വർഷം)
7. ബിരുദാനന്തര ബിരുദം (> 16 വർഷം)

7. താങ്കളുടെ തൊഴിൽ എന്താണ് :

8. തൊഴിൽ ചെയ്യുക എന്നത് താങ്കളുടെ സ്വന്തം തീരുമാനം ആയിരുന്നോ?

1. അതെ
2. അല്ല

9. 8.2 ആണെങ്കിൽ, ആരാണ് താങ്കളുടെ തൊഴിലിന്റെ തീരുമാനം എടുത്തത് ?

1. സ്വന്തം
2. ഭർത്താവ്
3. താങ്കളുടെ കുടുംബം
4. താങ്കളുടെ ഭർത്താവിന്റെ കുടുംബം
5. മറ്റുള്ളവർ, വ്യക്തമാക്കുക :

10. താങ്കളുടെ തൊഴിലിന്റെ ഇപ്പോഴത്തെ നിലവാരം

1. ഉദ്യോഗം ഉണ്ട്
2. ഉദ്യോഗം ഇല്ല
3. വീട്ടിൽ നിന്നും തൊഴിൽ
4. മറ്റേണിറ്റി അവധി
5. മറ്റുള്ളവ, വ്യക്തമാക്കുക :

11. വീട്ടിൽ നിന്ന് മാറി നിൽക്കേണ്ടി വരുന്ന തൊഴിൽ ലഭിക്കുകയാണെങ്കിൽ താങ്കളുടെ തീരുമാനം എന്തായിരിക്കും :
12. താങ്കളുടെ കുടുംബത്തിന്റെ മാസ വരുമാനം എത്ര :
13. താങ്കളുടെ കുടുംബ വരുമാനത്തിൽ, താങ്കളുടെ സംഭാവന എന്ത് :
14. താങ്കളുടെ കുടുംബത്തിന് ബി.പി.എൽ കാർഡ് ഉണ്ടോ ?
 1. ഉണ്ട്
 2. ഇല്ല
15. താങ്കളുടെ മതം ഏത് ?
 1. ഹിന്ദു
 2. ക്രിസ്ത്യൻ
 3. ഇസ്ലാം
 4. ബുദ്ധമതം
 5. മറ്റുള്ളവ, വ്യക്തമാക്കുക :
16. താങ്കളും താങ്കളുടെ ഭർത്താവും ഒരേ മതത്തിൽ ആണോ വിശ്വസിക്കുന്നത്
 1. അതെ
 2. അല്ല
17. താങ്കൾ എത്ര സമയം ടെലിവിഷൻ കാണും (ഒരു ദിവസം) :
18. താങ്കൾ എത്ര സമയം റേഡിയോ കേൾക്കാറുണ്ട് (ഒരു ദിവസം):
19. താങ്കൾ മാസത്തിൽ എത്ര മാസികകൾ/പത്രം വായിക്കാറുണ്ട് (ദിവസവും എത്ര നേരം)

ആരോഗ്യവുമായി ബന്ധപ്പെട്ട വ്യവഹാരം

20. താങ്കളും താങ്കളുടെ ഭർത്താവും ആരോഗ്യ പരിപാലനത്തിനും ചികിത്സയ്ക്കുമായി എവിടെയാണ് പോകാറുള്ളത്
 1. നഗരത്തിലെ സർക്കാർ ആശുപത്രി
 2. അടുത്തുള്ള പൊതു ആരോഗ്യ പരിപാലന കേന്ദ്രം

- 3. നഗരത്തിലെ സ്വകാര്യ ആശുപത്രി
- 4. സമീപത്തുള്ള സ്വകാര്യ ക്ലിനിക്കുകൾ

21. ഈ സ്ഥാപനങ്ങൾ താങ്കളുടെ വീട്ടിൽ നിന്നും അടുത്താണോ

- 1. അതെ
- 2. അല്ല

22. താങ്കൾക്ക് ജലദോഷം, പനി, ചുമ തുടങ്ങിയ അസുഖങ്ങൾ വന്നാൽ എന്താണ് സാധാരണയായി ചെയ്യാറുള്ളത് :

വൈവാഹിക നിലവാരവും, ഗർഭധാരണത്തിന്റെ വിവരങ്ങളും

23. താങ്കൾ വിവാഹിതയായപ്പോൾ താങ്കൾക്ക് എത്ര വയസ്സായിരുന്നു :

ഇനി നിങ്ങളുടെ ഇതുവരെയുള്ള ഗർഭധാരണത്തിന്റെ വിവരങ്ങളാണ് ചോദിച്ചറിയാൻ ആഗ്രഹിക്കുന്നത്.

24. താങ്കൾ ഇതുവരെ എപ്പോഴെങ്കിലും ഒരു കുഞ്ഞിന് ജന്മം നൽകിയിട്ടുണ്ടോ

- 1. ഉണ്ട്
- 2. ഇല്ല

25. താങ്കളുടെ ആദ്യ ശിശു ജനിച്ചപ്പോൾ താങ്കൾക്ക് എത്ര വയസ്സായിരുന്നു :

26. താങ്കൾ ഇപ്പോൾ ഗർഭിണി ആണോ

- 1. ആണ്
- 2. അല്ല

27. താങ്കൾക്ക് എത്ര കുട്ടികളുണ്ട് :

29. താങ്കളുടെ കുട്ടി/കുട്ടികൾക്ക് എത്ര വയസ്സ് ഉണ്ട് (ക്രമത്തിൽ)

- 1.
- 2.

30. കുട്ടികൾ ആണോ പെണ്ണോ (ക്രമത്തിൽ)

1.

2.

31. താങ്കളുടെ കുട്ടി/കുട്ടികൾ ദീർഘകാലമായി ഏതെങ്കിലും ആരോഗ്യപ്രശ്നങ്ങൾ തോന്നിയിട്ടുണ്ടോ ?

1. ഉണ്ട്

2. ഇല്ല

32. താങ്കളുടെ കുട്ടിക്ക്/കുട്ടികൾക്ക് അടിക്കടി അസുഖം ബാധിക്കുന്നതായി താങ്കൾക്ക് അനുഭവപ്പെട്ടിട്ടുണ്ടോ ?

1. ഉണ്ട്

2. ഇല്ല

31(1) & 32(1) ആണെങ്കിൽ 33-ാം ചോദ്യം അല്ലെങ്കിൽ 34-ാം ചോദ്യം

33. കഴിഞ്ഞ 6 മാസത്തിനിടയിൽ, നിങ്ങളുടെ കുട്ടിയെ ആശുപത്രിയിൽ അഡ്മിറ്റ് ചെയ്യാൻ തക്കവണ്ണമുള്ള ഏതെങ്കിലും അസുഖം ഉണ്ടായിട്ടുണ്ടോ :

34. രണ്ടു കുട്ടികൾ തമ്മിലുള്ള ഏറ്റവും അനുയോജ്യപരമായ പ്രായ വ്യത്യാസം എത്രയാണ് ?

1. 0-1 വയസ്സ്

2. 1-2 വയസ്സ്

3. 2-3 വയസ്സ്

4. 3-4 വയസ്സ്

5. 5 വയസ്സോ അതിനു മുകളിലോ

6. മറ്റുള്ളവ, വ്യക്തമാക്കുക :

35. ചിലപ്പോൾ സ്ത്രീകൾ ഉദ്ദേശിക്കാതെ തന്നെ ഗർഭിണി ആകാറുണ്ട്. താങ്കളുടെ മുൻ പ്രസവങ്ങൾ എല്ലാം ആസൂത്രണം ചെയ്യപ്പെട്ടതായിരുന്നോ ?

1. അതെ

2. അല്ല

36. താങ്കൾക്ക് ഏതെങ്കിലും പ്രസവത്തിൽ ചാപിള്ള ഉണ്ടായിട്ടുണ്ടോ ?

- 1. ഉണ്ട്
- 2. ഇല്ല

37. താങ്കളുടെ ഏതെങ്കിലും ഗർഭം, ഗർഭച്ഛിദ്രം നടത്തേണ്ടതായി വന്നിട്ടുണ്ടോ ?
(പ്രേരിതമായോ, യാദൃശ്ചികമായോ)

- 1. ഉണ്ട്
- 2. ഇല്ല

38. താങ്കളുടെ ഏതെങ്കിലും കുട്ടി (ആണോ/പെണ്ണോ) ജനിച്ചതിനു ശേഷം മരിച്ചു പോയിട്ടുണ്ടോ ?

- 1. ഉണ്ട്
- 2. ഇല്ല

കുടുംബാസൂത്രണത്തിനെ കുറിച്ചുള്ള വ്യക്തിപരമായ ധാരണ

39. താങ്കൾ ആഗ്രഹിക്കുന്ന കുട്ടികളുടെ എണ്ണം :

40. താങ്കൾ എപ്പോഴെങ്കിലും എത്രകുട്ടികൾ വേണമെന്ന് നിങ്ങളുടെ ആഗ്രഹം ഭർത്താവുമായി ചർച്ച ചെയ്തിട്ടുണ്ടോ ?

- 1. ഉണ്ട്
- 2. ഇല്ല

41. താങ്കളുടെ അഭിപ്രായത്തിൽ കുടുംബാസൂത്രണം എന്നാൽ എന്ത് ?

- 1. ഗർഭധാരണ നിരോധനം
- 2. ഗർഭങ്ങൾക്കിടയിലുള്ള കാലാന്തരം
- 3. താങ്കളുടെ കുടുംബ ജീവിതത്തിന്റെ ആസൂത്രണം
- 4. ജനന നിയന്ത്രണം

- 5. പരിമിതപ്പെടുത്തൽ
- 6. അറിയില്ല
- 7. മറ്റുള്ളവ വ്യക്തമാക്കുക :

42. താങ്കൾ ഗർഭധാരണം താമസപ്പെടുത്താനോ ഒഴിവാക്കാനോ ഇതുവരെ ശ്രമിക്കുകയോ എന്തെങ്കിലും ഉപയോഗിക്കുകയോ ചെയ്തിട്ടുണ്ടോ ?

- 1. ഉണ്ട്
- 2. ഇല്ല

42(2) ആണെങ്കിൽ, 57-ാം ചോദ്യത്തിലേക്ക്

ഇനി ഞാൻ താങ്കളോട് വിവിധതരം കുടുംബാസൂത്രണ മാർഗ്ഗങ്ങളെ പറ്റി ചോദ്യങ്ങൾ ചോദിക്കാനാഗ്രഹിക്കുന്നു.

43. കുടുംബാസൂത്രണത്തെ കുറിച്ചുള്ള അവബോധവും വ്യവഹാരവും

ഉപാധി	ഉപാധിയെ പറ്റി കേട്ടിട്ടുണ്ടോ	എവിടെയാണ് ലഭിക്കുക	ഉപാധിയെക്കുറിച്ച് എവിടുന്ന് ഉപദേശം ലഭിക്കും	എപ്പോഴെങ്കിലും നിങ്ങൾ ഉപയോഗിച്ചിട്ടുണ്ടോ
ഗുളികകൾ (പിൽസ്)	1. <input type="checkbox"/> ഉണ്ട് 2. <input type="checkbox"/> ഇല്ല	1. <input type="checkbox"/> സർക്കാർ ആശുപത്രി 2. <input type="checkbox"/> സ്വകാര്യ ആശുപത്രി 3. <input type="checkbox"/> ഫാർമസി 4. <input type="checkbox"/> തദ്ദേശ ആരോഗ്യ പ്രവർത്തകരുടെ സന്ദർശനങ്ങൾ	1. <input type="checkbox"/> ഡോക്ടർ 2. <input type="checkbox"/> നഴ്സ് 3. <input type="checkbox"/> തദ്ദേശ ആരോഗ്യ പ്രവർത്തകർ	1. <input type="checkbox"/> ഉണ്ട് 2. <input type="checkbox"/> ഇല്ല
ഇൻട്ര യൂറൈൻ ഉപകരണങ്ങൾ	1. <input type="checkbox"/> ഉണ്ട്	1. <input type="checkbox"/> സർക്കാർ ആശുപത്രി	1. <input type="checkbox"/> ഡോക്ടർ	1. <input type="checkbox"/> ഉണ്ട്

(ഐ.യു. ഡി./കോപ്പർടി /ലൂപ്പ്)	2. <input type="checkbox"/> ഇല്ല	2. <input type="checkbox"/> സ്വകാര്യ ആശുപത്രി 3. <input type="checkbox"/> ഫാർമസി 4. <input type="checkbox"/> തദ്ദേശ ആരോഗ്യ പ്രവർത്തകരുടെ സന്ദർശനങ്ങൾ	2. <input type="checkbox"/> നഴ്സ് 3. <input type="checkbox"/> തദ്ദേശ ആരോഗ്യ പ്രവർത്തകർ	2. <input type="checkbox"/> ഇല്ല
ഇൻജക്ഷനുകൾ	1. <input type="checkbox"/> ഉണ്ട് 2. <input type="checkbox"/> ഇല്ല	1. <input type="checkbox"/> സർക്കാർ ആശുപത്രി 2. <input type="checkbox"/> സ്വകാര്യ ആശുപത്രി 3. <input type="checkbox"/> ഫാർമസി 4. <input type="checkbox"/> തദ്ദേശ ആരോഗ്യ പ്രവർത്തകരുടെ സന്ദർശനങ്ങൾ	1. <input type="checkbox"/> ഡോക്ടർ 2. <input type="checkbox"/> നഴ്സ് 3. <input type="checkbox"/> തദ്ദേശ ആരോഗ്യ പ്രവർത്തകർ	1. <input type="checkbox"/> ഉണ്ട് 2. <input type="checkbox"/> ഇല്ല
കോൺടാക്ട്/നിരോധ്	1. <input type="checkbox"/> ഉണ്ട് 2. <input type="checkbox"/> ഇല്ല	1. <input type="checkbox"/> സർക്കാർ ആശുപത്രി 2. <input type="checkbox"/> സ്വകാര്യ ആശുപത്രി 3. <input type="checkbox"/> ഫാർമസി 4. <input type="checkbox"/> തദ്ദേശ ആരോഗ്യ പ്രവർത്തകരുടെ സന്ദർശനങ്ങൾ	1. <input type="checkbox"/> ഡോക്ടർ 2. <input type="checkbox"/> നഴ്സ് 3. <input type="checkbox"/> തദ്ദേശ ആരോഗ്യ പ്രവർത്തകർ	1. <input type="checkbox"/> ഉണ്ട് 2. <input type="checkbox"/> ഇല്ല
എമർജൻസി ഗർഭനിരോധന ഉപാധികൾ	1. <input type="checkbox"/> ഉണ്ട് 2. <input type="checkbox"/> ഇല്ല	1. <input type="checkbox"/> സർക്കാർ ആശുപത്രി 2. <input type="checkbox"/> സ്വകാര്യ ആശുപത്രി 3. <input type="checkbox"/> ഫാർമസി 4. <input type="checkbox"/> തദ്ദേശ ആരോഗ്യ പ്രവർത്തകരുടെ സന്ദർശനങ്ങൾ	1. <input type="checkbox"/> ഡോക്ടർ 2. <input type="checkbox"/> നഴ്സ് 3. <input type="checkbox"/> തദ്ദേശ ആരോഗ്യ പ്രവർത്തകർ	1. <input type="checkbox"/> ഉണ്ട് 2. <input type="checkbox"/> ഇല്ല

<p>റിതം രീതി</p>	<p>1. <input type="checkbox"/> ഉണ്ട് 2. <input type="checkbox"/> ഇല്ല</p>	<p>1. <input type="checkbox"/> സർക്കാർ ആശുപത്രി 2. <input type="checkbox"/> സ്വകാര്യ ആശുപത്രി 3. <input type="checkbox"/> ഫാർമസി 4. <input type="checkbox"/> തദ്ദേശ ആരോഗ്യ പ്രവർത്തകരുടെ സന്ദർശനങ്ങൾ</p>	<p>1. <input type="checkbox"/> ഡോക്ടർ 2. <input type="checkbox"/> നഴ്സ് 3. <input type="checkbox"/> തദ്ദേശ ആരോഗ്യ പ്രവർത്തകർ</p>	<p>1. <input type="checkbox"/> ഉണ്ട് 2. <input type="checkbox"/> ഇല്ല</p>
<p>പിന്മാറ്റ മാർഗ്ഗം</p>	<p>1. <input type="checkbox"/> ഉണ്ട് 2. <input type="checkbox"/> ഇല്ല</p>	<p>1. <input type="checkbox"/> സർക്കാർ ആശുപത്രി 2. <input type="checkbox"/> സ്വകാര്യ ആശുപത്രി 3. <input type="checkbox"/> ഫാർമസി 4. <input type="checkbox"/> തദ്ദേശ ആരോഗ്യ പ്രവർത്തകരുടെ സന്ദർശനങ്ങൾ</p>	<p>1. <input type="checkbox"/> ഡോക്ടർ 2. <input type="checkbox"/> നഴ്സ് 3. <input type="checkbox"/> തദ്ദേശ ആരോഗ്യ പ്രവർത്തകർ</p>	<p>1. <input type="checkbox"/> ഉണ്ട് 2. <input type="checkbox"/> ഇല്ല</p>
<p>പുരുഷവന്ധ്യം കരണം</p>	<p>1. <input type="checkbox"/> ഉണ്ട് 2. <input type="checkbox"/> ഇല്ല</p>	<p>1. <input type="checkbox"/> സർക്കാർ ആശുപത്രി 2. <input type="checkbox"/> സ്വകാര്യ ആശുപത്രി 3. <input type="checkbox"/> ഫാർമസി 4. <input type="checkbox"/> തദ്ദേശ ആരോഗ്യ പ്രവർത്തകരുടെ സന്ദർശനങ്ങൾ</p>	<p>1. <input type="checkbox"/> ഡോക്ടർ 2. <input type="checkbox"/> നഴ്സ് 3. <input type="checkbox"/> തദ്ദേശ ആരോഗ്യ പ്രവർത്തകർ</p>	<p>1. <input type="checkbox"/> ഉണ്ട് 2. <input type="checkbox"/> ഇല്ല</p>
<p>സ്ത്രീ വന്ധ്യം കരണം</p>	<p>1. <input type="checkbox"/> ഉണ്ട് 2. <input type="checkbox"/> ഇല്ല</p>	<p>1. <input type="checkbox"/> സർക്കാർ ആശുപത്രി 2. <input type="checkbox"/> സ്വകാര്യ ആശുപത്രി 3. <input type="checkbox"/> ഫാർമസി 4. <input type="checkbox"/> തദ്ദേശ ആരോഗ്യ പ്രവർത്തകരുടെ സന്ദർശനങ്ങൾ</p>	<p>1. <input type="checkbox"/> ഡോക്ടർ 2. <input type="checkbox"/> നഴ്സ് 3. <input type="checkbox"/> തദ്ദേശ ആരോഗ്യ പ്രവർത്തകർ</p>	<p>1. <input type="checkbox"/> ഉണ്ട് 2. <input type="checkbox"/> ഇല്ല</p>

44. താങ്കൾ നിലവിൽ ഗർഭധാരണം താമസിപ്പിക്കാനായോ ഒഴിവാക്കാനായോ ശ്രമിക്കുകയോ, എന്തെങ്കിലും ഉപയോഗിക്കുകയോ ചെയ്യുന്നുണ്ടോ ?

- 1. ഉണ്ട്
- 2. ഇല്ല

45. താങ്കൾ നിലവിൽ ഉപയോഗിക്കുന്ന ഉപാധി ഏത് ?

- 1. ഗുളികകൾ (പിൽസ്)
- 2. ഐ.യു.സി.കൾ
- 3. കോണ്ടം/നിരോധ്
- 4. റിതം
- 5. പിന്മാറ്റം
- 6. പുരുഷവന്ധ്യംകരണം
- 7. സ്ത്രീ വന്ധ്യംകരണം

46. താങ്കളെ ഈ മാർഗ്ഗം ഉപയോഗിക്കാൻ ആരാണ് പ്രോത്സാഹിപ്പിച്ചത്/ഉപദേശിച്ചത്

- 1. ഡോക്ടർ
- 2. നഴ്സ്
- 3. തദ്ദേശ ആരോഗ്യ പ്രവർത്തകർ
- 4. ഭർത്താവ്
- 5. അമ്മ
- 6. അമ്മായിഅമ്മ
- 7. ബന്ധുക്കൾ/സുഹൃത്തുക്കൾ
- 8. മറ്റുള്ളവ, വ്യക്തമാക്കുക :

47. ആരോഗ്യ പ്രവർത്തകർ താങ്കളുടെ വീട് എത്ര പ്രാവശ്യം സന്ദർശിക്കാറുണ്ട്

- 1. ഒരിക്കലും ഇല്ല
- 2. ആഴ്ചയിൽ ഒരിക്കൽ

- 3. രണ്ടാഴ്ചയിൽ ഒരിക്കൽ
- 4. മാസത്തിൽ ഒരിക്കൽ
- 5. രണ്ടു മാസത്തിലൊരിക്കൽ
- 6. മറ്റുള്ളവ, വ്യക്തമാക്കുക

47 (1) ആണെങ്കിൽ, 50-ാമത്തെ ചോദ്യത്തിലേക്ക് പോകുക, അല്ലെങ്കിൽ 48-ാമത്തേത് ചോദിക്കുക

48. തദ്ദേശ ആരോഗ്യ പ്രവർത്തകർ താങ്കളുടെ വീട് സന്ദർശിക്കുമ്പോൾ കുടുംബാംഗസുത്രണത്തെക്കുറിച്ചുള്ള വിവരങ്ങൾ താങ്കൾക്ക് നൽകാറുണ്ടോ ?

- 1. ഉണ്ട്
- 2. ഇല്ല

49. ആരോഗ്യ പ്രവർത്തകർ കുടുംബാംഗസുത്രണത്തെക്കുറിച്ച് വിശദീകരിച്ചു തരുമ്പോൾ ആ വിവരങ്ങൾ താങ്കൾക്ക് മനസ്സിലാക്കാൻ കഴിയുന്നുണ്ടോ എന്നത് അവർ ഉറപ്പ് വരുത്താറുണ്ടോ ?

- 1. ഉണ്ട്
- 2. ഇല്ല

43-ാം ടേബിൾ സന്ദർശിച്ചതിനു ശേഷം 50-ാമത്തേത് ചോദിക്കുക

50. കുടുംബാംഗസുത്രണത്തെക്കുറിച്ച് അറിവ് പ്രദാനം ചെയ്യുകയും സേവനങ്ങൾ നൽകിയാക്കുകയും ചെയ്ത പ്രവർത്തകർ താങ്കളുടെ ആവശ്യങ്ങൾ/ബുദ്ധിമുട്ടുകൾ അഭിസംബോധന ചെയ്യാറുണ്ടോ ?

- 1. ഉണ്ട്
- 2. ഇല്ല

51. കുടുംബാസൂത്രണത്തെക്കുറിച്ചുള്ള സേവനങ്ങൾ നൽകുന്ന പ്രവർത്തകർ താങ്കളുടെ സ്വകാര്യത കാത്തു സൂക്ഷിക്കാറുണ്ടോ ?

- 1. ഉണ്ട്
- 2. ഇല്ല

52. താങ്കൾ ഉപയോഗിക്കാൻ തീരുമാനിച്ച മാർഗ്ഗത്തിന്റെ പാർശ്വഫലങ്ങളെപ്പറ്റി അവർ താങ്കൾക്ക് പറഞ്ഞു തരാറുണ്ടോ ?

- 1. ഉണ്ട്
- 2. ചോദിച്ചപ്പോൾ പറഞ്ഞു
- 3. ഇല്ല

52 (2) ആണെങ്കിൽ, 53-ാമത്തെ ചോദ്യത്തിലേക്ക് പോകുക, അല്ലെങ്കിൽ 54-ാമത്തേത് ചോദിക്കുക

53. പാർശ്വഫലങ്ങളെപ്പറ്റി ചോദിക്കണം എന്ന് താങ്കൾക്ക് എങ്ങനെ അറിയാം :

54. താങ്കൾ തിരഞ്ഞെടുത്ത ഉപാധി/മാർഗ്ഗം ഉപയോഗിച്ചതിനു ശേഷം എന്നെങ്കിലും ആരോഗ്യ പ്രശ്നങ്ങൾ ഉണ്ടായിട്ടുണ്ടോ

- 1. ഉണ്ട്
- 2. ഇല്ല

55. 54(1) ആണെങ്കിൽ, താങ്കൾ അനുഭവിച്ച ആരോഗ്യ പ്രശ്നം എന്താണ് :

56. താങ്കൾക്ക് പാർശ്വഫലങ്ങൾ അഥവാ പ്രശ്നങ്ങൾ ഉണ്ടായാൽ എന്തു ചെയ്യണം എന്ന് പറഞ്ഞ് തന്നിട്ടുണ്ടോ ?

- 1. ഉണ്ട്
- 2. ഇല്ല

57. താങ്കൾ എന്തുകൊണ്ട് ഗർഭധാരണ ക്രമീകരണ മാർഗ്ഗങ്ങൾ ഉപയോഗിക്കുന്നില്ല ?

1. ലൈംഗികബന്ധം പുലർത്തുന്നില്ല/ലൈംഗികബന്ധം അടിക്കടി ഇല്ല
2. ഭർത്താവ് അകലെയാണ്
3. ഹിസ്റ്ററോക്ടമി (ഗർഭപാത്രം മാറ്റൽ)
4. മുലയൂട്ടൽ
5. പ്രസവശേഷമുള്ള അമിനോറിയ
6. ഭർത്താവിന്റെ വിരോധം
7. മതപരമായ വിലക്കുകൾ
8. പാർശ്വഫലത്തെക്കുറിച്ചുള്ള ഭയങ്ങൾ
9. ഉപയോഗിക്കുന്നതിലുള്ള അസൗകര്യം (വ്യക്തമാക്കുക)
10. ശരീരത്തിന്റെ സാധാരണയുള്ള പ്രവർത്തനങ്ങൾ ബാധിക്കുന്നത്
11. മറ്റുള്ളവ, വ്യക്തമാക്കുക :

58. താങ്കൾ ഭാവിയിൽ ഗർഭധാരണം ക്രമീകരിക്കാൻ ഏതെങ്കിലും മാർഗ്ഗം ഉപയോഗിക്കാൻ ഉദ്ദേശിക്കുന്നുണ്ടോ

1. ഉണ്ട്
2. ഇല്ല
3. ഇതുവരെ തീരുമാനിച്ചിട്ടില്ല

59. ഉണ്ട് എങ്കിൽ ഏതൊക്കെയായിരിക്കും :

Annexure V

श्री चित्रा तिरुनाल आयुर्विज्ञान और प्रौद्योगिकी संस्थान
तिरुवनन्तपुरम - 695 011, केरल, भारत
SREE CHITRA TIRUNAL INSTITUTE FOR MEDICAL SCIENCES AND TECHNOLOGY
THIRUVANANTHAPURAM - 695 011, INDIA
(An Institute of National importance under Govt. of India)



Institutional Ethics Committee
(IEC Regn No. ECR/189/Inst/KL/2013)

SCT/IEC/616/JUNE -2014

11-06-2014

Ms. Parvathi Mini Pradeep
MPH Student
AMCHSS, SCTIMST.

Dear Ms. Parvathi Mini Pradeep,

The Institutional Ethics Committee reviewed and discussed your application to conduct the study entitled "ASSESSMENT OF FACTORS INFLUENCING THE CHOICE AND USE OF TEMPORARY CONTRACEPTIVE METHODS FOR BIRTH SPACING AMONG MARRIED WOMEN IN RURAL TRIVANDRUM" (IEC/616) on 7th June, 2014.

The following documents were reviewed:

- 1) *Cover page.*
- 2) *Principal investigator's short curriculum vitae.*
- 3) *Project Proposal.*
- 4) *Consent Form – English.*
- 5) *Consent Form – Malayalam.*
- 6) *Interview schedule – English.*
- 7) *Interview schedule – Malayalam.*

Page 1 of 2

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The following members of the Ethics Committee were present at the meeting held on 7th June, 2014 at G. Parthasarathi Board Room, AMCHSS, SCTIMST.

SL. No.	Member Name	Highest Degree	Gender	Scientific /Non Scientific	Affiliation with Institution(s)
1.	Justice Gopinathan. P.S	BSc. LLB	Male	Legal Expert (Chairperson)	No
2.	Dr. Meenu Hariharan	DM	Female	Clinician (Gastro Enterologist)	No
3.	Dr. M.D. Gupte	MD, DPH	Male	Public Health	No
4.	Dr. R.V.G. Menon	PhD	Male	Lay Person	No
5.	Dr. Mala Ramanathan	MSc, PhD, MA	Female	Ethicist/Social Scientist (Member Secretary)	Yes

IEC Decision

The IEC approved the conduct of the study in the present form.

Remarks:

The Institutional Ethics Committee expects to be informed about the progress of the study, any SAE occurring in the course of the study, any changes in the protocol and patient information/informed consent and asks to be provided a copy of the final report.

There was no member of the study team /guide who participated in voting / decision making process. The ethics committee is organized and operated according to the requirements of Good Clinical Practice and the requirements of the Indian Council of Medical Research (ICMR).

Sincerely,



Mala Ramanathan
Member Secretary, IEC

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