

Knowledge, Attitude and Practice (KAP) of Birth Control Measures Among the Mao Nagas of Senapati District, Manipur

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ABSTRACT It is presently attempted to assess the knowledge, attitude and practice status of birth control measures among the Mao Nagas of Manipur. Different modern birth control measures though widely propagated yet few persons adopted them. Indigeneous birth control methods are not prevalent. There are various factors which influence the acceptance of birth control methods. Educational status of the mother and the economic status are presently found to significantly influence the acceptance of birth control measures among the Maos.

INTRODUCTION

India has been the ever first country in the world to launch a nationwide Family Planning Programme with government support. The programme was start right from the first Five Year Plan (1951-56) with a modest outlay of Rs. 5 million which was increased to a sizeable outlay of Rs. 5160 million in the Fifth Plan Period (1974-79) and subsequently has increased substantially over the years. According to Barnabas (1977), the Indian Family Planning Programme has been a major government undertaking. He has emphasized the role of socio-economic factors and has asserted that research is required not only in bio-medical areas of fertility but also in the inter-relationship of demographic, social and economic fields. Although the first nationwide Family Planning Programme was launched in 1952, the result has been very disappointing. Till today the population planners have not reached their proposed target. Only two states - Kerala and Goa, have respectively reached the target in this regard i.e. two children per couple norm to a satisfying degree. But these two states represent only 4% of the total Indian population.

Social values, which are part of our customs and traditions, have a grip over the people. Any innovation intended to initiate changes will have to take into account the range of cultural or so-

cial values and how strongly these are rooted, for the acceptance or rejection of a new thing. Hence, the present study intends to assess the status of KAP of birth control measures in the Mao community which is basically an agriculturist group so that necessary steps to be taken could be identified. Further, a decadal assessment too has been made so that the policy planners can take note of the specific age cohort which might require specific attention.

MATERIAL AND METHODS

The present study is based on data from 536 ever married Mao women from the three villages viz. Chowainu, Punanamei and Makhel which were selected randomly from 21 Western Mao villages. Informations were collected through personal interview with the help of the pre-tested interview schedule. The interview schedule contained questions pertaining to the knowledge, attitude and practice of birth control measures besides those on educational status and economic status. The data was analysed using the statistical techniques.

RESULTS AND DISCUSSION

Knowledge about contraception - Nearly two-third of the Mao Community (66%) were aware of the modern birth control measures (BCM). A decadal age cohortwise trend is observable with regard to the knowledge of BCM with the youngest (15-24 years) age cohort having the highest percentage of women (93.9%) having knowledge about birth control measures while the oldest age cohort i.e. 65 yrs. and above had the lowest percentage of women (8.6%), having knowledge of BCM. 87 to 94% women below 45 years of age were aware of the birth control measures.

On grouping the women into two major divisions i.e. women who have not completed their reproductive period (those ≤ 49 yrs) and those who would have completed their reproductive period (i.e. > 49 yrs) it is found that the percentage of awareness about BCM in the reproductive age group is three times more than that of the women who had already completed the reproductive period. This is a positive sign indicating that the chances to adopt BCM may be much higher in the age cohort of the women that are presently responsible for reproduction.

Table 1: Decadal age cohort wise distribution of women's knowledge of birth control measures (BCM)

Age group (yrs)	Knowledge of any method of contraception				Total
	Yes		No		
	N	%	N	%	
15-24	31	93.9	2	6.1	33
25-34	114	92.7	9	7.3	123
35-44	127	87.6	18	12.4	145
45-54	55	49.1	57	50.9	112
55-64	22	33.8	43	66.2	65
65 +	5	8.6	53	91.4	58
Total	354	66.0	182	34.0	536
≤ 49 yrs	312	84.1	59	15.9	371
> 49 yrs	42	25.5	123	74.5	165

Awareness of contraception through sterilization is found to be the highest (37.3%) (see table 2). 14.4% of the respondents were aware of the natural birth control measures besides other contraceptive methods. Among the women who were ≤ 49 yrs, maximum (38.5%) had the

Table 2: Reproductive and post-reproductive age wise distribution of women's knowledge of specific birth control methods

Age Group	*C	**IUD	***S	C+IUD+S	Natural	Total
≤ 49 yrs	11	27	104	120	50	312
% age	3.5	8.7	33.3	38.5	16.0	100
> 49 yrs	2	7	29	4	1	42
% age	4.8	16.7	66.6	9.5	2.4	100
Total	13	34	132	124	51	354
% age	3.7	9.6	37.3	35.0	14.4	100.0

* C - Condom

** IUD - Intra Uterine Devices

*** S - Sterilization

* 182 mothers had no knowledge about BCM hence excluded from analysis

knowledge of at least three methods, namely, Condom, Intra-uterine devices and Sterilization (C+IUD+S). But of the women who were > 49 yrs, majority (66.6%) had the knowledge about sterilization.

From table 3 it is seen that peer group and neighbours (Category II) were the chief source of information about birth control measures in all the decadal age cohorts of the women. Information received solely from Qualified Medical Practitioners (QMED) i.e. Category III, was only 10.7%. Category III (QMED) and Category IV (QMED + Neighbours) together could account for about one-fourth (23.7%) of knowledge imparted, implying that the major role played in bringing about awareness of BCM in the Maos was not of the QMED but of the respondents' peer group and neighbours. The BCM information obtained from media was only 11.6% which is quite understandable because T.V. which is an important agent or source for propagating BCM awareness was not common in the area under study. Approximately 1% household (7/528 households) had a T.V. Much knowledge about BCM through radio (AIR) could also not be obtained as majority of the people did not properly understand Manipuri Language (Meiteilon) in which most of the radio programmes are aired. As for the Mao dialect only 20 minutes were allotted by the AIR Imphal. Hence, no regular information on BCM could be obtained by the people through radio except for the occasional talks given by the QMED. Only the educated Maos were exposed to other media like books or pamphlets or newspapers.

Table 3: Decadal age cohort wise distribution of women's source of information about BCM

Age Group (yrs)	Category I Spouse	Category II *PG + N	Category III **QMED	Category IV PG+N + QMED	Category V Media	Total
15-24	-	2-	3	3	5	31
25-34	7	64	9	19	15	114
35-44	17	55	19	19	17	127
45-54	6	37	3	5	4	55
55-64	1	18	3	-	-	22
65+	-	4	1	-	-	5
Total	31	198	38	46	41	354
% age	8.8	55.9	10.7	13.0	11.6	100.0

* PG + N = Peer groups + neighbours

** QMED = Qualified Medical Practitioners

Acceptance or non-acceptance and successes or failure of programmes not only rests on the mental attitude of the individual but may also depend upon the duration of exposure to the concerned information. This is found to be particularly true in the case of family planning programmes. The distribution of duration of exposure to the information about BCM among the Mao women is listed in table 4. 22.9% of the respondents knew about BCM for more than 10 yrs while 7.6% came to know of it rather recently i.e. for less than three years. Among the persons knowledgeable about birth control, 36.4% had known it for a period of 6-10 years, while 33.1% had known it for 3-5 years.

Table 4: Distribution of EGO's duration of exposure to the information about BCM

All age cohorts	Duration of BCM information				Total
	< 3 yrs	3-5 yrs	6-10 yrs	> 10 yrs	
No. of women	27	117	129	81	354
% age	7.6	33.1	36.4	22.9	100
≤ 49 yrs	22	98	116	78	314
% age	7.0	31.2	36.9	24.9	100
> 49 yrs	5	19	13	3	40
% age	12.5	47.5	32.5	7.5	100

From the above observation it is evident that most of the Maso have been rather recently exposed to the knowledge of BCM and they may require more duration of exposure to knowledge of BCM for the effective acceptance of it by them.

The situation is, however, encouraging as much higher percentage of women in reproductive age group (i.e. ≤ 49 yrs) are found to have exposure to knowledge about BCM for more

than 5 years, than the women in post reproductive (>49 yrs) age group.

Attitude towards BCM

The attitude of the Mao women towards adoption of BCM has been assessed and the results are set out in tables 5, 6a, and 6b. 30% of the women credited adoption of BCM as good while 33.6% as bad; 36.4% of the women remained either indifferent towards it or gave no response. Further, it is observed that the younger mothers had more positive attitude towards BCM adoption compared to the mothers in respectively higher age cohorts. This decadal change, as is observable from table 5, is an indication that the adoption of BCM should have a better prospect in this population especially in the younger mothers provided proper attention is given to propagate the use of the BCM.

Table 6a lists the reasons for positive attitude towards BCM. 52.8% of the mothers considered adoption of BCM good as it reduced the burden of rearing many children especially when there was very less gap between the successive conceptions. 24.8% of the mothers opined that adoption of BCM ensures good health for the mothers as well as for the infant. 13.1% of the mothers were of the opinion that adoption of BCM would make them economically better while 9.3% could not specify any specific reasons for the positive attitude. Although the mothers having a positive attitude were only 30% (as shown in Table 5), it is observed that these mothers have understood the value of BCM and there were good chances for them to adopt BCM in the near future if they had already not resorted to it.

Table 5: Decadal age cohort wise distribution of EGO's attitude towards BCM adoption

Age group	Attitude towards BCM adoption						Total
(yrs)	Positive (Good)		Negative (Bad)		Natural or no response		
	N	%	N	%	N	%	
15-24	19	57.6	4	12.1	10	30.3	33
25-34	57	46.3	26	21.1	40	32.5	123
35-44	59	40.7	38	26.1	48	33.1	145
45-54	18	16.1	48	42.9	46	41.1	112
55-64	5	7.7	38	58.5	22	33.8	65
65 +	3	5.2	26	44.8	29	50.0	58
Total	161	30.0	180	33.6	195	36.4	536
≤ 49 yrs	148	39.9	94	25.3	129	34.8	371
> 49 yrs	13	7.9	86	52.1	66	40.0	165

Table 6a: Decadal age cohort wise distribution of EGO's reason for positive attitude towards BCM

Age group	Reasons								Total
(yrs)	Rearing burden reduced		Ensures good health		Economically better		Cannot specify		
	N	%	N	%	N	%	N	%	
15-24	8	42.1	6	31.6	5	26.3	-	-	19
25-34	36	63.2	11	19.3	4	7.0	6	10.5	57
35-44	30	50.8	16	27.1	8	13.6	5	8.5	59
45-54	7	38.9	6	33.3	2	11.1	3	16.7	18
55-64	2	40.0	1	20.0	2	40.0	-	-	5
65 +	2	66.7	-	-	-	-	1	33.3	3
Total	85	52.8	40	24.9	21	13.0	15	9.3	161

In short, the general belief of those respondents with positive attitude towards BCM was that by the use of birth control measures unwanted pregnancies could be easily avoided and improved health status for both mother and child was ensured, ultimately leading to sound economic conditions. However, a large proportion of the respondents were not in favour of adopting BCM. They were not convinced of the merits of BCM. This is obvious from table 6b.

8 yrs ago) reinforced their fear and as a result the people continued to have a negative attitude towards the acceptance of BCM. 17.2% of the mothers felt that more Mao population is needed as the overall Mao population is comparatively smaller compared to the other Naga tribes such as the Tangkhuls, Kukis, etc. This attitude (of 17.2% of the mothers) is to some extent politically motivated, since they felt that other neighbouring communities like Maram, Poumei

Table 6b: Decadal age cohort wise distribution of EGO's reason for negative attitude towards BCM

Age group	Reasons								Total
(yrs)	Against nature		Affect mother's health		More people required		Not specific		
	N	%	N	%	N	%	N	%	
15-24	1	25.0	-	-	1	25.0	2	50.0	4
25-34	10	38.5	5	19.2	3	11.5	8	30.8	26
35-44	19	50.0	9	23.7	4	10.5	6	17.8	38
45-54	32	66.7	7	14.6	3	6.3	6	12.5	48
55-64	20	52.6	6	15.8	9	23.7	3	7.9	38
65 +	14	53.8	1	3.9	11	42.3	-	-	26
Total	96	53.3	28	15.6	31	17.2	25	13.9	180

One of the main reasons for the negative attitude as well as adhorrence towards adopting BCM was the value attached to children in the community. Children are considered by these women as gifts of God, a sign of God's blessing. To be barren is adjusted to be a curse. 53.3% of the respondents with negative attitude were of the opinion that adoption of BCM is not only a sin against God but also against nature. 15.6% of the respondents were steadfast in their conviction that adoption of BCM definitely weakened the health of the mother sooner or later. The death of a women who died of womb cancer subsequent to sterilization in the past (about

might outnumber them and get majority during election. Further, because of adherence to old culture they still took pride in belonging to a large family, clan, village or for that matter even the tribe as a whole irrespective of the quality or the standard of living. Hence increased efforts have to be made by population planners to erase these negative and preconceived notions about BCM among the Mao.

The Maos in general are deeply rooted in their traditional concepts. Hence an opinion seeking question on the importance of BCM adoption was asked (see Table 7). Depending on their attitude towards the importance of BCM, steps

Table 7: Decadal age cohort wise distribution of EGO's opinion about importance of BCM

Age	Importance of BCM						Total
group (yrs)	Yes		No		Indifferent or no response		
	N	%	N	%	N	%	
15-24	15	45.4	2	6.1	16	48.5	33
25-34	54	43.9	10	8.1	59	48.0	123
35-44	49	33.8	18	12.4	78	53.8	145
45-54	19	17.0	44	39.3	49	43.7	112
55-64	5	7.7	28	43.1	32	49.1	65
65 +	7	12.1	34	58.6	17	29.3	58
Total	149	27.8	136	25.4	251	46.8	536

could be taken and measures formulated in order to bring about faster progress in adoption of BCM by the community.

It is observed from table 7 that only 27.8% of the respondents realized the importance of adoption BCM. Almost half of the mothers (46.8%) were either indifferent towards the question pertaining to the importance of BCM, while 25.4% did not feel any need for adoption of BCM nor its importance. However, a decadal change is observed in this regard i.e. the percentage of younger mothers who felt the need/importance of BCM was much more in comparison to that of the mothers of higher age cohorts, which is itself is a positive sign for adoption of BCM in future.

No two individuals are exactly alike. One's liking could be another's dislike. Table 8 shows women's opinion about the best or preferred advisor for adoption of BCM.

Although half of the respondents did not state their specific preferences as to who was/is or would be their best advisor vis-a-vis BCM, yet

of the remaining half - i.e. one fourth (24.8%) of the total respondents preferred QMED and 5.6% preferred religious and public workers as BCM advisors. 14.9% wanted both i.e. QMED and religious workers together with public/social workers. Interestingly, a few of the respondents (2.8%) considered early adopters as their best advisor for they felt that it is they (early adopters) who would be able to tell and advise them about the real truth regarding adopting BCM.

From the responses collected it is seen that every responsible individual, be it a QMED, religious, public or social worker or leader or any other responsible individual in the society has to play an important role in motivating the Mao people at large about safe motherhood in particular and the community's progress through family planning and population control in general, particularly when the majority of the mothers were illiterate and deeply rooted in their traditional ideas. Therefore, it would require longer time for them to give up their already preconceived ideas. It is also observed from table 8 that the older age groups resorted to seeking advice from QMED + leaders more while the younger mothers had more faith in QMED only. This indicates that the QMED could accomplish a lot more through these younger mothers.

Use of BCM

Table 9 shows the decadal age-cohort wise BCM adoption status of the Mao couples.

In India, particularly in rural and tribal regions where ignorance, tradition, superstitions and a lot of cultural repression of sex feeling

Table 8: Decadal age cohort wise distribution of women's opinion about best/preferred advisor vis-a-vis BCM

Age group (yrs)	Advisor										Total
	QMED		* Leader		**Both		Early adopter		No response		
	N	%	N	%	N	%	N	%	N	%	
15-24	15	45.5	1	3.0	6	18.2	1	3.0	10	30.3	33
25-34	53	43.1	3	2.4	13	10.6	9	7.3	45	36.6	123
35-44	41	28.3	4	2.8	28	18.3	1	0.7	71	48.9	145
45-54	15	13.4	8	7.1	18	13.1	3	2.7	68	60.7	112
55-64	6	9.2	8	12.3	10	15.3	1	1.5	40	61.5	65
65 +	3	5.1	6	10.3	5	8.6	-	-	44	75.8	58
Total	133	24.8	30	5.6	80	14.9	15	2.8	278	51.9	536

* Leader - religious, public, social worker

** Both - QMED + leader

Table 9: Decadal age cohort wise distribution of BCM users and non-users

Age group (yrs)	BCM use				Total
	Yes		No		
	N	%	N	%	
15-24	4	1.2	29	87.8	33
25-34	23	18.7	100	81.3	123
35-44	34	23.4	111	76.6	145
45-54	6	5.4	106	94.6	112
55-64	-	-	65	100.0	65
65 +	-	-	58	100.0	58
Total	67	12.5	469	87.5	536

exist, a scheme of family planning is indeed difficult to put through. The result obtained among the Mao is a clear indication to it. In spite of their high awareness of BCM, (see table 9) the percentage of couples opting for BCM was very low (i.e. 12.5%). More than 7/8th (87.5%) of the couples had not resorted to any birth control devices. Further, it is observed that the highest percentage of BCM adopters is found in the 34-44 yrs age cohort (23.4%) while mothers beyond 55 yrs of age had not adopted BCM at any point of time during their fertile period. This clearly indicates that adoption of BCM started rather late in the presently studied community.

Reasons for not Adopting BCM

Various reasons have been given by the Mao women for not adopting BCM (see table 10). 38.8% of the respondents stated that they had no knowledge about BCM. Fear of side effects, accounted for 12.8%. Religion, particularly the Roman Catholic, prohibited the adoption of any form of contraception excepting the Natural method. In the presently studied group 13% of the respondents did not use any BCM as they

were aware of the religious prohibition. Other reasons such as "too early to adopt", "not required", and "no specific reasons" comprised 8.5%, 9.8% and 17.1% respectively.

From table 10 it is evident that a good number of respondents had been misinformed or under informed about the use of BCM. Misinformed were particularly those who stated fear of side effect as the reason for not using BCM; the fear mostly emerged from hearsay. Underinformed were those who had no knowledge of BCM at all or who had been very little informed. In view of the above empirical facts the population planners, particularly those in the Family Welfare Department, need to formulate at micro level strategies so as to have mass acceptance of family planning or birth control in this tribal group.

Adoption of Specific Birth Control Measures with Reasons

The distribution of specific birth control measures adopted by these (12.5%) couples with reasons are presented in table 11a and 11b respectively; the most common method of contraception used was condom (34.3%); use of Natural method, Intra Uterine devices (IUD) and Tubectomy is found to be 29.9%, 23.9% and 10.4% respectively. Oral pill is found to be adopted by only 1.5% respondents. No definite trend with respect to the use of contraceptive method is discernible through different decadal age cohorts. The women who had completed 49 years did not report having used any contraceptive.

From table 11 it is observed that more than half of the couples (53.7%) adopted BCM for child spacing and 19.4% for termination i.e. for

Table 10: Decadal age cohort wise distribution of BCM non-users' reasons for not adopting it

Age group (yrs)	Reasons						Total
	Lack of knowledge	Religion	Lack of faith	Too early to adopt	Do not required	Not specific	
15-24	2	4	3	8	3	9	29
25-34	9	20	14	28	10	19	100
35-44	18	25	26	4	14	24	111
45-54	57	9	14	-	11	15	106
55-64	43	3	3	-	8	8	65
65 +	53	-	-	-	-	5	58
Total	182	61	60	40	46	80	469
% age	38.8	13.0	12.8	8.5	9.8	17.1	100

Table 11a: Decadal age cohort wise distribution of specific BCM type used/adopted

Age group (yrs)	BCM type used/adopted										Total
	Condom		Pill		IUD		Sterilization		Natural		
	N	%	N	%	N	%	N	%	N	%	
15-24	3	75.0	-	-	1	25.0	-	-	-	-	4
25-34	6	26.0	-	-	8	34.7	1	4.3	8	34.0	23
35-44	11	32.0	1	2.9	6	17.6	5	14.7	11	32.3	34
45-54	3	50.0	-	-	1	16.6	1	16.6	1	16.6	6
Total	23	34.3	1	1.5	16	23.9	7	10.4	20	29.9	67

Table 11b: Decadal age cohort wise distribution of reasons for adopting the specific method

Age group (yrs)	Reasons						Total
	Mother's health		Spacing		Termination for no more children		
	N	%	N	%	N	%	
15-24	-	-	4	100.0	-	-	4
25-34	5	21.7	18	78.3	-	-	23
35-44	10	29.4	14	41.2	10	29.4	34
45-54	3	50.0	-	-	3	50.0	6
Total	18	26.9	36	53.7	13	19.4	67

no more children. 26.9% of the couple who used BCM used it to avoid risk to health particularly of the mother.

Education of Mothers and Use of BCM

Education has no doubt a great impact on several aspects of life. In the present community it is seen (from table 12) that the percentage of birth control users is slightly more in mothers who had some level of education in all the age cohorts excepting those in 35-44 age cohort in whom illiterates outnumbered the literate in adopting birth control measures.

In spite of the small percentage of BCM users, it may be concluded from the above table that education in general and the duration/level

of education has had some positive influence on the acceptance of BCM among the Mao. This is further confirmed if we take into account the percentage of literates (*23.7%) and illiterates (*76.3%) vis-a-vis the acceptance of BCM. The percentage of BCM acceptance is much higher among the literates (i.e. 27.6%) than that among the illiterates (i.e. only 7.8%) indicating that the rate of BCM adoption is more among the literates in comparison to the illiterate mothers.

Economic Status and Use of BCM

Annual per capita income distribution among the BCM users is shown in table 13.

It is evident from the table that the people with lowest per capita income practised BCM

Table 12: Distribution of BCM users vis-a-vis educational status

Age cohorts	Total	Illiterate		Literate			
				≤ 10 yrs of schooling		> 10 yrs schooling	
		N	%	N	%	N	%
15-24	4	1	25.0	3	75.0	-	-
25-34	23	9	39.1	4	17.4	10	43.5
35-44	34	20	58.8	5	14.7	9	26.5
45-54	6	2	33.3	4	66.7	-	-
Total	67	32	46.8	16	23.9	19	28.3

* Out of 536 women, 409 = illiterate; 127 = literate

Table 13: Percentage distribution of BCM users vis-a-vis economic status

All age cohorts	Total	Annual per capita income (Rs.)				
		≤ 3000	3001-6000	6001-9000	9001-12000	> 12000
No. of women	67	7	16	12	13	19
% age	100.0	10.4	23.9	17.9	19.4	28.4

the least and the people with the highest per capita income practised BCM the most. However, at the P.C.I. level of Rs. 3000-6000/- there was a sudden increase (to about 24%) in the use of BCM which declined by about 6% at the P.C.I. level of Rs. 6001-9000, but gradually increased with subsequent increased in P.C.I.

Average Fertility and Use of BCM

The average number of live birth for BCM users in the different age cohorts varied from a minimum of 1.5 (in the 15-24 yrs mothers' age cohort) to the maximum of 6.0 (in the 45-54 yrs mothers' age cohort), while the average live birth for BCM non-users varied from a minimum of 1.34 to a maximum of 6.86. In all the age cohorts, BCM non-users showed a higher average fertility compared to that of the (age wise) respective users except for the 15-24 yrs age cohort where the non-users showed a lower average fertility. This lower average fertility may be attributed to those who got married recently and had not produced any child so far. But from both the table (14 and 15) it is seen

that the overall average live birth is lower by 1.56 in BCM users compared to that of the non users (For BCM users = 3.31 and for BCM Non-users = 4.88).

Factors Influencing Use of BCM - A Multivariate Analysis

Acceptance of birth control measures may depend on several socio-economic and demographic factors. To determine the factors which significantly affected BCM acceptance in this population - a step wise multivariate regression analysis is carried out by taking into account the following variables.

1. Current age of the mother
2. Age at marriage
3. Age at first conception
4. Educational level of the mother
5. Experience of infant mortality (Yes/No)
6. Annual per capita income
7. Ideal family size
8. Desired number of sons

The results of step wise regression analysis are shown in table 16.

Upto 17% of the variance in acceptance of BCM is found to be explained by educational status and it is found to be a statistically significant contribution (see table 16). 5% of the variance is explainable by the annual per capita income which is again found to be a significant contribution. 1% of the variance is explained by current age of mother but it is not found to make a significant contribution. The other factors namely, experience of infant mortality, desired number of sons, ideal family size, age at effective marriage and age at first conception put together explained 1% of variance and have not emerged as significant factor/factors in influencing use of BCM among the Maos.

To sum up, it maybe said that although the percentage of awareness of BCM is high (66%) among the Maos yet the acceptance i.e. the actual practice of BCM is rather low (12.5%).

Table 14: Age fertility vis-a-vis BCM users

Age cohort (yrs)	Total no. of women	Total no. of live birth	Average live birth
15-24	4	6	1.5
25-34	23	45	1.96
35-44	34	135	3.97
45-54	6	36	6.0
Total	67	222	3.31

Table 15: Age fertility vis-a-vis BCM non-users

Age cohort (yrs)	Total no. of women	Total no. of live birth	Average
15-24	29	39	1.34
25-34	100	237	2.37
35-44	111	529	4.76
45-54	106	658	6.20
55-64	65	433	6.66
65 +	58	398	6.86
Total	469	2293	4.88

Table 16: Step wise regression analysis for factors influencing acceptance of BCM

<i>Step no.</i>	<i>Variable selected (as per order of importance)</i>	<i>R² (% of variance explained)</i>	<i>Significance of contribution of the factor (P value)</i>
1.	Educational level of the mother	17%	< .0000
2.	Annual per capita income	22%	< .0000
3.	Current age of the mother	23%	< .1012
4.	Experience of infant mortality	24%	< .1688
5.	Desired number of sons	24%	< .2734
6.	Ideal family size	24%	< .3265
7.	Age at marriage	24%	< .3999
8.	Age at first conception	24%	< .4043

Response regarding the knowledge of the different methods of birth control indicated that sterilization was the single most commonly known birth control method. The chief source of information about BCM is found to be the peer groups and neighbours which may be due to the constant interaction amongst them. News or information is generally spread by word of mouth in almost all the villages. Hence, it is not surprising that friends/neighbours are found to be the most effective means of spreading information about family planning as there was/is not much media coverage of BCM owing to little AIR time allotted to it in the lingua franca. Information about BCM received by the Mao from QMED too was rather low. Acceptance of BCM is also found to depend upon the duration of exposure to the information. Various reasons have been stated by the Mao for non-acceptance of BCM, such as lack of BCM's knowledge, fear of side effects (due to hearsay), desire for more children, religion etc. Of those who practiced BCM, more than half (53.7%) adopted for child spacing. Economic dependence on agricultural products for their livelihood which required more people to carry out the manual work could be one of the contribution factors for non-acceptance of BCM besides high level of illiteracy.

It is observed that maternal education and economic status had significant impact on the acceptance of BCM. Similar conclusion was drawn by Piplai et al. (1990) among the Bengali couples of West Bengal. Further, a difference in the average fertility of BCM users and non-users too is seen, with the former having lower fertility.

From the present study it appears that family planning programmes are miles away from

bringing about population control in this tribal community. However, it is not to be ignored that the younger mothers who had just begun their reproductive period were more willing to accept BCM compared to the older mothers. Hence, proper attention/intervention by the population planners and executors is likely to make a real difference in the near future. However, this population is poised for a significant increase in the use of BCMs if the population planners drew and implemented plans for raising the educational status of the Mao women, and the per capita income of the population. The education and the economic planners need to put their heads together to draw out an effective strategy in this regard.

Seal (1967) has rightly pointed out that Family Planning is a field where implementation of the scheme is directly in the hands of the people, whose personal philosophies and instincts determine the fate of the scheme. He further asserts that a democratic society cannot perforce make the individual believe that the problem of over-population is developing because of his actions. Neither law can help in this, nor the wisdom of the planners and politicians. What he emphasised is the continuous use of educative methods based on the fuller understanding of the individual and his sociological situations.

Thus keeping the peoples' religious background in mind and also all the "negative" aspects of the "after-effects" of the various contraceptive methods - it appears that in the presently studied community one of the ways to propagate family planning may be through motivating Natural Family Planning Programme as it counters the religious prohibition. Family Welfare workers need to emphasize on the

Natural family planning methods besides the artificial family planning methods. One of the Natural methods which could be widely mobilised is the MMM (Modified Mucus Method) or Prajanan Jagrooti as propagated by Dr. Dorairaj who asserts that other than the advantage of being acceptable to poor women this method required no existing infrastructure and has a simple delivery system. (Dorairaj, 1987). This method is presently used in Sierra Leone, Ethiopia, Zambia, Liberia, Ghana, Gambia and Uganda. Mann (1968) pointed out that in tribal society, woman occupies a high position and she has a say in all family matters, though the society is patriarchal. He further pointed out that the tribal leaders command high influence and unless they are motivated others will not follow. However, if the Mao women leaders can be harnessed or motivated they can easily influence others and thus much progress can be achieved in this regard.

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