

Socio-economic profile of laproscopic sterilization acceptors of rural community in Rajasthan

SM Mathur^{1,*}, Brajesh Kumar², Sumit Ahluwalia³, Rekha Mathur⁴

^{1,2,3}Assistant Professor, Dept. of Community Medicine, National Institute of Medical Sciences, Medical College, Jaipur, Rajasthan, ⁴Retired Senior Medical Officer, Medical Health & Family Welfare Dept., Rajasthan

***Corresponding Author:**

Email: drsmmathur@gmail.com

Abstract

Background and Introduction: Among the various health problems like Population explosion, Infections, Malnutrition, Environmental sanitation, LBW, etc. Population explosion is one of the most serious problems encountered by a developing country like India. About three fourths of the world's population lives in the developing countries. Although, in terms of population USA ranks third in the world after India, there is yawning gap of 978 million between the populations of these two countries. The United Nations has estimated that world's population grew at an annual rate of 1.23 percent during 2000-2010. China registered a much lower annual growth rate of population (0.6 percent) during 2002-2012, as compared to India (1.4 percent). Three countries of SEAR, i.e., India (17.5 percent), Indonesia (3.49 percent) and Bangladesh (2.19 percent) are among the most populous ten countries of the world. At present India's population is second to that of China. According to UN projections India's population will reach 1.53 billion by the year 2050, and will be the highest population in the world.

Aims and Objectives: To study the socio-economic profile of acceptors of Laparoscopic sterilization in rural area.

Method and Material: Present study is retrospective cross - sectional study. It was conducted on health record of 283 Laparoscopic sterilized women, operated from 1st April 2015 to 31st March 2016, in PHC Achrol, District Jaipur, Rajasthan.

Results: In the present study most of the females who undergone laparoscopic sterilization were from 24-30 years(90.10%) of age group. 93.63% females belonged to Hindu religion and only 5.65% to Muslim community, and only 0.70% were from Sikhs. In the present study 43.47% belonged to Gen and OBC, 28.97% belonged to SC and remaining 27.56% were from ST caste. 80.91% got themselves operated when the youngest child was less than 3 yrs of age. Ladies from socio-economic class I represented 3.89%, II represented 6.71%, III represented 14.49%, IV represented 32.15% and V represented 42.76%. Only 15.19% Husbands of laparoscopic acceptors were uneducated and among the acceptor ladies 17.66% were uneducated. With one male child survived 49.11%, two male child survived 40.28% and with three male child survived 10.60%, got themselves operated.

Conclusion: Three major deterrents to development are illiteracy, poverty and social inequality and injustice. Out of these, illiteracy is probably most important from the point of view of family planning. Two major strategies to contain population growth are family planning and education. About one- third of Indian women use female sterilization as a method for regulating fertility, analysis reveals that people from different socio-economic, religious and demographic strata do not generally opt for sterilization in equal proportion. In this respect existing agencies like VHGs, SHGs groups, AWWs, Sahali, and other paid grass root level workers, requires more motivation and dedication to work, which is normally not seen. Some NGOs can also make a change in situation if they are properly guided and monitored.

Keywords: Laparoscopic, Sterilization, Socio-economic

Access this article online

Website:

www.innovativepublication.com

DOI:

10.5958/2394-6776.2016.00041.2

Introduction

Among the various health problems like Population explosion, Infections, Malnutrition, Environmental sanitation, LBW etc. Population explosion is one of the most serious problems encountered by a developing country like India. About three fourths of the world's population lives in the developing countries. Although, in terms of population USA ranks third in the world after India, there is yawning gap of 978 million between the populations of these two countries. The United

Nations has estimated that world's population grew at an annual rate of 1.23 percent during 2000-2010. China registered a much lower annual growth rate of population (0.6 percent) during 2002-2012, as compared to India (1.4 percent). Three countries of SEAR, i.e., India (17.5 percent), Indonesia (3.49 percent) and Bangladesh (2.19 percent) are among the most populous ten countries of the world. At present India's population is second to that of China. According to UN projections India's population will reach 1.53 billion by the year 2050, and will be the highest population in the world.

India is the first country to launch a National Family Planning Program during the year 1952, with the objective of, reducing the birth rate of the extent necessary to stabilize the population at a level consistent with requirement of National economy,¹ initially with establishment of few clinics and material

on education, training and research. During Third Five year Plan (1961-65), Family Planning was declared as, the very center of planned development. Emphasis was shifted from clinic approach to the more vigorous 'Extension Education Approach' for motivating people for acceptance of the 'Small family norm'. During Fourth five year plan (1969-74), giving priority program was integrated with MCH services in PHC's and SC. During 1970 All India Hospital Postpartum Program and in 1972 MTP act was introduced. During Fifth Five Year Plan (1975-80) major changes took place in the program. During 1976, country framed its first 'National Population Policy'. Ruling party then introduced target oriented sterilization campaign during 1976, during emergency. Though a good achievement was achieved in numbers but, it was a disaster, many misappropriation took place. In June 1977, new government ruled out compulsion, and coercion for all times to come. The pace of the program was accelerated by the involvement of the local people at the grass root level with the launching of Rural Health Scheme during 1977. To achieve demographic goals of 'Health for all' in 1978 Family Welfare Program was accorded a central place in health development during 6th and 7th five year plans. Since the beginning of the program fertility levels had declined throughout the country. The contraceptive prevalence increased from 10 percent (1971) to 46 percent by mid-1990². The extent of acceptance of contraceptive methods still varies within societies and also among different castes and religious groups. The factors responsible for such varied picture operate at the individual, family and community level

Observations

with their roots in the socio-economic and cultural milieu of Indian society.³

Aims and Objective

To study the socio-economic profile of acceptors of Laparoscopic sterilization in rural area.

Method and Material

Present study is retrospective cross - sectional study. It was conducted on health record of 283 Laparoscopic sterilized women, operated from 1st April 2015 to 31st March 2016, in PHC Achrol, District Jaipur (Rajasthan). Population of Achrol village is 15077 (7861 Male, 7216 Females) as per censuses 2011. Ethical clearance was obtained from hospital ethical committee to conduct the study. As is the trend in rural areas, because of so many myths in the community about the sterilization only 8 male opted NSV, during above mentioned period, so looking to very small sample size their profile was not studied. Results were finally subjected to statistical analysis with MS excel.

Inclusion Criteria

All successfully operated for laparoscopic sterilization from 1st April 2015 to 31st March 2016, at PHC Achrol, District Jaipur,(Raj) were included in this study.

Exclusion Criteria

Cases who were not successfully operated due to adhesions or due to some other pathology inside abdomen were not included in present study.

Table 1: Socio- demographic distribution of acceptors of laproscopic sterlization

S. No.	Characteristics	Number	Percentage	Chi-square	p- value
1.	Age Group.				
	24-30 years	255	90.10. %	182.08	<0.0001 H.S.
	Above 30 years.	28	9.90%		
	Total	283	100%		
2.	Religion.				
	Hindu	265	93.63%	462.38.	<0.0001 H.S.
	Muslim	16	5.65%		
	Others	2	0.70%		
	Total	283	100%		
3.	Caste.				
	SC	82	28.97%	32.02	<0.001. H.S.
	ST	78	27.56%		
	OBC	93	32.86%		
	GEN	30	10.61%		
	Total	283	100%		
4	Age of youngest child				
	Less than 3 yrs	229	80.91%	153.58	<0.001. H.S.
	Above 3 yrs	54	19.09%		
	Total	283	100%		

Table 2: Distribution of laproscopic sterilization accepters according to socio-economic status

Socioeconomic Status	Numbers	Percentage
Grade I	11	3.89%
Grade II	19	6.71%
Grade III	41	14.49%
Grade IV	91	32.15%
Grade V	121	42.76%
Total	283	100%

$X^2 = 160.19$ with 4 d.f. $p < 0.0001$. H.S.

Table 3: Distribution of husband of acceptors of laproscopic sterilization according to education level

	Numbers	Percentage
Uneducated	43	15.19%
Primary	62	21.90%
Middle	79	27.93%
Secondary and above	99	34.98%
Total	283	100%

$X^2 = 24.22$. with 3 d.f. $p < 0.0001$. H.S.

Table 4: Distribution of acceptors of laproscopic sterilization according to education level

	Numbers	Percentage
Uneducated	50	17.66%
Primary	69	24.38%
Middle	76	26.87%
Secondary and above	88	31.09%
Total	283	100%

$X^2 = 10.73$. with 3 d.f. $p < 0.013$. S.

Table 5: Distribution of laproscopically sterilized mothers according to number of servival of male or female children at the time of sterilization

	Male children	Female children	Total	Chi square	p-value
One child	139(49.11%)	125(44.16%)	264	0.74	0.388(N.S.)
Two children	114(40.28%)	106 (37.45%)	220	0.29	0.58(N.S.)
Three and more children	30(10.60%)	52(18.37%)	82	5.90	0.015 (S)
Total	283	283			

Discussion

Laparoscopic sterilization have become very popular in India. Nearly 41.4% of all female sterilization during 2010-11 were through laparoscopic method.⁴ As depicted in Table 1. In the present study most of the females who undergone laparoscopic sterilization were from 24 to 30 years (90.10%) of age group, on the other side above 30 years age group was represented by only few females(9.90%). In the study of Ketan B Parmar et al⁵ in urban slums of Surat city the mean age of females was 27.42±4.10 yrs. Similar were the observations of Khan et al⁶ at Agra, their mean age of females was 30.44±8.8 yrs. Abdul Salam Malik et al⁷ in their study observed that 99.34% were from 21 to 40 years of age and 0.65% were above 40 years Being rural study present study is with little less age group. Looking to the observation in this study 93.63% females belonged to Hindu religion and only 5.65% to Muslim community, showing disinterest in family planning, reflecting their various religious reasons, only

0.70% were from Sikhs (there are few families Sikhs in the village.) Ketan B Parmar et al, in their observation came out with the finding that 66.91% were from Hindu religion and 33.09% were from Muslim religion. While comparing this data with NFHS-3 survey it shows that 81.7% were Hindus and 12.5% Muslims and rest were from other religion. In the present study 43.47% belonged to Gen and OBC, 28.97% belonged to SC and remaining 27.56% were from ST caste. In study of Abdul Salam Malik et al had 92.65% were from lower class. Whereas data of NFHS-3 shows, 39.6% of families from SEBC, 19.2% from SC, 8.4% from ST and 31.9% from other castes. It was interesting to know in this study most of the ladies, 80.91% got themselves operated when the youngest child was less than 3 yrs of age not much relying on temporary methods. Only 19.09% delayed their operation when their youngest child was more than 3 yrs of age.

As depicted in Table 2. Ladies from socio-economic class I represented 3.89%, II represented

6.71%, III represented 14.49%. IV represented 32.15% and V represented 42.76%. So realizing high living cost besides poor rural community. Katen B Parmar et al also found maximum numbers of female sterilization (490) were in social class IV and V. Achrol is mainly inhabited by low socio-economic class. The World Population Conference at Bucharest in fact stressed that economic development is the best contraceptive, it will take care of population growth and bring about reductions in fertility.

As shown in Table 3. It was found that among the husbands of laparoscopic acceptors 15.19% were uneducated, 21.90% were primary educated, 27.93% were up to middle educated and 34.98% were secondary and above studied, showing education as positive effect on sterilization acceptance. In Abdul Salam Malik et al study 74.06% Husbands were illiterate.

As shown in Table 4, among the operated ladies 17.66% were uneducated, 24.38% were primary educated, 26.87 % middle educated and 31.09% were secondary and above studied. In Ketan B Parmar study 43.36% females were illiterate. In the study of Abdul Salam Malik et al 88.09% were illiterate and more than three children, otherwise education favored small family norm. The National Family Health Survey-3 shows that the total fertility rate is 1.7 children higher for illiterate women than for women with at least a high school education.

As shown in Table 5 with one male child survived 49.11%, two male child survived 40.28% and with three male child survived 10.60%, got themselves operated. On the other hand with one female child survived 44.16%, with two female survived 37.45% and with three female children only 18,37% of laparoscopic acceptors got sterilized. Looking to figures it seems survival of male or female child does not have much impact upon the decision of laparoscopic sterilization.

Conclusion

Population of India has been growing at a very rapid rate. Family planning was accepted as the best way to control the rapidly and massively growing population.⁸ In the present study statistically highly significant observations were found as regard age 24-30 yrs of age, as regard acceptability by Hindu religion, as regard caste OBC were main acceptors, and female went for sterilization when the youngest child was less than 3 yrs of age. Main acceptors of Laparoscopic acceptors were from socio-economic status 4th and 5th Grade. It was also proved statistically that education improved the acceptance of Laparoscopic sterilization. In present study three and more children was a great motive for sterilization. It has been rightly said that development is the best contraceptive, meaning thereby that fertility rates come down as development proceeds. Three major deterrents to development are illiteracy, poverty and social inequality and injustice. Out of

these, illiteracy is probably most important from the point of view of family planning. Two major strategies to contain population growth are family planning and education. Female literacy is of crucial importance. In the context of family planning. According to the 1984 World Development Report, "More education for women is one of the strongest factors in reducing fertility."⁹ The Family Planning Program is beset by bureaucracy employs a large workforce of 11million and spends millions of rupees on stale and ineffectual propaganda. Moreover, the political will to implement the family planning program lacks on the part of politicians who have their eyes on vote banks. Manas Ranjan Pradhan et al¹⁰ discussing The Indian experience and ethical issues, states that about one-third of Indian women use female sterilization as a method for regulating fertility, analysis reveals that people from different socio-economic, religious and demographic strata do not generally opt for sterilization in equal proportion. Informed choice has found to be very poor among women and so also the quality of available services. Besides sensitizing the providers about the importance of ethical issues, govt. need to think over spacing methods. In this respect existing agencies like VHGs, SHGs groups, AWWs, Sahali etc. requires more motivation and dedication to work, which is normally not seen. Some NGOs can also make a change in situation if they are properly guided and monitored.

Bibliography

1. National population policy 2000. Department of family welfare, Ministry of Health and Family Welfare, Govt. of India, New Delhi.
2. Family Welfare Program in India year back, 1995-1996. New Delhi, Govt. of India. Ministry of Health and Family Welfare. Department of family Welfare, 1997, 124.
3. A Kansal, R Chandra, S.D. Kandpal, K S Negi, factors responsible for family planning acceptance with single child- finding from a study in Karnataka, demography India, 1998,28(1);65-73.
4. Govt of India (2011). Family Welfare Statistics in India, 2011. Ministry of Health and Family Welfare, New Delhi.
5. Ketan B Parmar, et al. A cross- sectional study to understand socio-demographic profile of couples who adopted permanent sterilization in urban slums of Surat city, National Journal of community Medicine, Volume 4, Issue 3, July-Sept 2013, Page 443-448.
6. Khan M E et al. Male involvement in family planning. A KABP study of Agra District. The Population Council, India. 1997.
7. Abdul Salam Malik, et al from Education pmhson.line.com.
8. Hemla Agrawal, et al. Comparison at the level of awareness of family planning measure in the urban and urban-slum women. Ghandhinagar College for women. Jammu, J%K, India (2005),35-40.
9. Mahajan & Gupta, Text book of preventive and social medicine. Fourth edition, 2013. Page 631.
10. Manas Ranjan Pradhan et al, The Indian Experience and ethical issues. Sch.sage pub.com/content/39/3/365. Refs.