AWARENESS AND ATTITUDE OF MIZO WOMEN TOWARDS FAMILYPLANNING IN RELATION TO THEIR EDUCATION AND DEMOGRAPHIC VARIABLES

by

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EDUCATION DEPARTMENT

Submitted in partial fulfilment for the requirement of the Degree of Doctor of Philosophy in Education of Mizoram University, Aizawl

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CERTIFICATE

Certified that the thesis, 'Awareness and Attitude of Mizo Women towards Family Planning in Relation to their Education and Demographic Variables', submitted for the degree of Doctor of Philosophy in Education in Mizoram University is the result of bonafide research carried out by Ms. Vanlaltanpuii under my supervision and guidance. This thesis or any part there to has not been submitted for any degree in this or any other University.

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Month : May **Year : 2019**

DECLARATION

I Vanlaltanpuii hereby declare that the subject matter of this thesis is the record of work done by me, that the contents of this thesis did not form basis of the award of any previous degree to me or to the best of my knowledge to anybody else, and that the thesis has not been submitted by me for any research degree in any other University/Institute.

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ACKNOWLEDGEMENT

I offer my heartfelt gratitude to my advisor Prof.R.P.Vadhera, Department of Education, Mizoram University for the sincere guidance and invaluable advice rendered to me all through the process of this study. He has been a constant source of direction and encouragement without which this study would not have been completed.

Grateful thanks are also due to Prof. Lalbiakdiki Hnamte, Professor, Department of Education, Mizoram University, for her continuous encouragement and support provided during the course of this study.

Sincere thanks are extended to all the Mizo women of the eight districts of Mizoram for their valuable co-operation during my data collection and to all the DIET faculty members of Champhai, Kolasib, Serchhip, Mamit, Lunglei, Lawngtlai and Siaha Districts for ensuring that my data collection went smoothly at their respective districts.

I wish to take this opportunity of sincerely and gratefully acknowledging my indebtedness to Dr. Vanlalhruaii, Jt. Director, Family Planning Wing, Health Department for her generous help in the section on Family Planning history of Mizoram.

I also owe sincere thanks to my Principal, Prof. Vanlalhruaii for her immense support at the final stages of this work. Her interest, help and especially support have provided a constant encouragement and has made every effort worthwhile.

Last but not the least, I would like to dedicate this study in memory of my father Mr.V.L.Rema(L), C.E. P&E Dept.(Rtd) who never got to see me complete it and very special thanks go to my mother Dr. Darchhingpuii, Asso. Prof., IASE. (Rtd) who has always been the constant driving force to ensure that I complete this study.

(VANLALTANPUII)

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CHAPTER – I : INTRODUCTION :

1.1 Population Growth: World Scenario

Historically, the world population grew only very slowly from about 2.5 million at the beginning of urbanization to some 50 million around the time of the Black Plague of the middle ages. It is only with the industrial, scientific and medical revolution and the colonial expansion of Western Powers, that the world population has climbed to the dizzy heights. During the 20th century, the world's population increased almost four fold, from 1.6 billion to 6 billion. Until very recently, there were fears that in the next century, world population would explode to some 12 billion people, leaving little room for wilderness areas to preserve wild life and putting extreme pressure on food production, water and non-renewable resources.

Globally, the growth rate of the human population has been steadily declining since peaking in 1962 and 1963 at 2.20 percent per annum. In 2007, the growth rate was 1.19 percent per annum. The last one hundred years have seen a rapid increase in population due to medical advances and massive increase in agricultural productivity made possible by the Green Revolution.

In 1901 the world population was 1.6 billion. Currently, one billion people are added every 12 - 13 years. During the last decade there has been substantial decline in birth rate. The reasons for decline vary from society to society; urbanization, rising educational attainment, increasing employment among women, lower infant mortality are some major factors responsible for growing desire for smaller families; increasing awareness and improved access to contraception have made it possible for the majority of the couples to achieve the desired family size. As a result of all these, the decline in the global population growth during the nineties is steeper than the earlier predictions. Currently, the annual increment is about 80 million. It is expected to decrease to about 64 million by 2020 - 25 and to 33 million by 2045 - 50; 95 percent of the growth of population occurs in developing countries. Most demographers

believe that the current accelerated decline in population growth will continue for the next few decades and the medium projections of Population Division of United Nations, that the global population will grow to 8.9 billion by 2050, is likely to be achieved.

1.1.a Demographic Transition:

The population explosion began in the West, around the middle of the 17th century. Until then, the numbers of people in the world had grown, but slowly, from about 150 million at the time of Christ to somewhere around 500 million. Births and deaths had more or less cancelled each other out, but then, the rate of increase quickened dramatically. By 1850 there were some 1200 million people on earth and the growth rate continued to rise. Birth rates stayed much the same as before, but death rates fell, causing population to grow. People had no more babies but they lived longer, as food supplies increased, public health improved and eventually proper sanitation spread.

As people in industrialized countries became more prosperous, birth rates fell until once again, they virtually matched the number of deaths, slowing the population growth again in the developed world. Population in Europe and North America have all but stabilized. In almost every country they are growing by less than 1 percent. Sweden, Denmark, West Germany, Austria and Hungary actually have a declining population. Industrialized countries have thus completed the 'demographic transition'. Third World Nations are only beginning to do so, and it is this that is fueling the world's current prodigious growth. Since the Second World War, death rates in developing countries have fallen dramatically, partly as a result of the reductions in killer diseases like small pox and malaria, much faster than they had done during Europe's population explosion. But the fall in death rates has not been preceded by an equivalent agricultural revolution nor accompanied by similar economic development. Migration is not an answer as it may have appeared in colonial times. Birth rates have declined somewhat, but they remain high, and may not fall enough to complete the

demographic transition before other constraints such as malnutrition and the costs of environmental damage become limiting factors.

1.1.b Human Population Growth Rate:

The actual annual growth in the number of humans fell from its peak of 87.5 million per annum in 1989, to a low of 76.4 million per annum in 2002 at which it stabilized and has started to slowly rise again to 79.4 million per annum in 2007 and 80.2 million per annum in 2009. Growth remains high in the Middle East, South Asia, South East Asia, Latin America and primarily in Sub - Saharan Africa. According to projections by the US Census Bureau, the annual world population growth will peak in 2011 at 80.9 million. Some countries experience negative population growth, especially in Eastern Europe. In Southern America, growth is slow due to high number of HIV related deaths. Some Western Europe countries might also encounter negative population growth. Japan's population began decreasing in 2005.

The world's population is now about 5.9 billion and it is expanding very rapidly, despite a marginal slowing over the last couple of years. Every day we share the Earth and its resources with 250,000 more people than the day before. Every year, there are about another 90 million mouths to feed. It is the equivalent of adding a Philadelphia to the world population every week, a Los Angeles every two weeks, a Mexico every year, and a US and Canada every three years. Though fertility rates are dropping, the sheer momentum of population growth ensures that at least another 3 billion people will be added to the planet between now and the year 2025. It could be as high as 4 billion taking it close to 10 billion total. At present growth rates, 1 billion people are added to the human ark every 11 years. If current trends are not reversed, or at least slowed down, we could be facing a global population of close to 14 billion by the year 2100. But the problem is not population growth percent. It is that over 90 percent of births now take place in the countries least able

to cope with the resource and environmental consequences of burgeoning population.

World population is a very significant factor in both poverty and hunger and in habitat destruction and loss of biodiversity. There is urgent need to realize an abatement of population growth before we all suffer the consequences severely next century. However, the population problem is complicated by severe economic andenergy consumption inequities. While population growth in much of the developed world has declined or even reversed as a result of the 'demographic transition' accompanying higher living standards and better education, the developing world is caught in a vicious cycle of exploitation which results in poverty, hunger, lack of education, population growth and habitat destruction which cannot be addressed without addressing educational , gender and economic inequity between the developed and developing world.

1.2 Population Growth in India :-

India has a total land area of 3,287,263 Sq.km i.e. 2.4 percent of the world's land area and it is the most populated country in the world. India is the home of 17 percent of world's population. India's population as on 1st March,2011 stood at 1,21,01,93,422 out of which 62,37,24,248 are males and 58,64,69,174 are females. The population of India according to the recorded decennial census from 1901 has grown steady except for a decrease during 1911-1921. We know the year 1921 as Great Divide year in the demographic history of India. India is in a critical position today as regards the problems of her growing number. India's population has always grown from decade to decade but its growth was not so menacing as it is today.

The country's population was 236 million in 1901, by 1951 it had increased to 361 million representing 52 percent raise in 50years. In the next decades i.e. between 1951 and 1971 from 360 million it rose to 548 million

representing another increase of 52 percent in just 20years. As per the 1981 census the population of India has gone up to 683 million. In 1991 census the population rose to 846 million and in the 2001 census the population crossed the billion mark at 1.02 billion. Finally, in the 2011 census the population of India stood at 1.21 billion. The future projections of India's population reveal that its population base may reach 1.4 billion by 2025 and may stabilize around 1.8 billion by 2075. India's annual growth rate was still as high as 1.7 percent in 2004. This is the fact that more than 40 percent of the population is under 15 years of age. And this group will enter the child bearing age in the next decades.

The density of population implies the average number of persons living per Sq.km. From a small figure of 77 persons living per Sq.km in 1901, the density of the population of India rose to 90 per Sq.km in 1931. But during 1961-81, density jumped to 216 per Sq.km in 1981 indicating an unprecedented increase of 52 percent during the last 20 years. In 1991 the density of population rose to 267 per Sq.km and further shot up to 324 per Sq.km in 2001.

A disturbing revelation of the 1991 census was the decline in the ratio of females per 1,000 males. The sex ratio declined from 934 in 1981 to 929 in 1991. However, the overall trend of sex ratio in the country since 1901 also shows a continuous trend towards a decline in sex ratio, barring marginal improvement in 1981. In 2001, there was a slight improvement in the proportion of females to 933. It is growing with an average annual growth rate of 2.13 percent per annum.

India, currently with 1,220,200,000 (1.22 billion) people, is the second most populous country in the world, while China is on the top with over 1,350,044,605 (1.35 billion) people. India represents almost 17.31 percent of the world's population, which means one out of six people on this planet live in India. Although, the crown of the world's most populous country is on China's head for decades, India is all set to take the number one position. With the population growth rate at 1.58 percent, India is predicted to have more than 1.53 billion people by the end of 2050. Thus, as widely believed and expected, India became the second country in the world after China to officially cross the one

billion mark. India accounts for a meager 2.4 percent of the world surface area of 135.79 million square kms yet it supports and sustains a whopping 17.31 percent of the world population.

India has had a very checkered demographic history, more so during the 20th century. The Indian demographic history of the 20th century can be divided into three distinct periods of stagnant population, steadily increasing population and rapidly growing population. The years 1901 to 1921 have often been recognized as the period of stagnant population. During this period, India's population increased from 236 million to only 248 million. This was a period when the mortality rate was very high and often out-matched the fertility rate. During this period, both fertility and mortality were well above 40 per thousand.

During 1921 to 1951, the population of India increased from 248 million to 360 million. The Indian demographic scene witnessed significant changes during this period due to the increasing control over abnormal deaths caused by epidemics, famines, etc. The distributional network was strengthened to meet the emergency calls of food shortage in different parts of the country. The economy was developed, particularly the agricultural sector, with a view to improving the food situation. General conditions of sanitation and medical facilities were improved significantly with a view to bringing down the mortality rates.Table I shows that estimated mortality rate, which stood at 47 per thousand for the country in 1921, was brought down significantly to 27 per thousand in 1951.

TABLE – 1.1
India : Natural Rates of Increase, 1911-2011

YEAR	Birth Rate/Thousand	Death Rate/Thousand	Natural Rate of Increase
1911	49	43	6
1921	48	47	1
1931	46	36	10
1941	45	31	14
1951	40	27	13
1961	42	23	19
1971	37	15	23
1981	34	12	22
1991	31	11	20
2001	25	08	17
2011	46	20	26

Source : (1) Selected Socio- Economic Statistics 1998 Ministry of Planning and program Implementation, Government of India New Delhi.
(2) Provisional Population Total : Census of India, 2001 & 2011.

Thus, the steady increase in population in India during 1921-1951 was the result of a sharp decline in the mortality rate of the country, whereas the fertility rate still remained high, around 40 per thousand. The year 1951 offers another significant demographic divide in Indian demographic history, because the post 1951 period has recorded an unprecedented growth in the country's population.

The population of India has more than doubled itself since 1951. It has increased from 360 million in 1951 to 1028 million in 2001. On an average, it has been increasing at a growth rate of 2 percent per annum. Such an unprecedented increase in the country's population in the last 50 years maybe attributed to large scale developmental activities in different parts of the country, improving conditions of food supply, and improving medical services, all of which have been responsible for bringing further fall in the mortality rate. The estimated mortality rate declined significantly from 27 per thousand in 1951 to 8 per

thousand in 2001 (Table I). Since the fall in the fertility rate still continued to be gradual, the sharper fall in mortality rate yielded still greater natural increments.

The preceding discussion reveals that the decline in mortality rate, in case of India, has been the chief contributing factor towards the rapid increase in the country's population. The rapid growth which results from widening gap between the births and deaths carries with it its own consequences. The percentage of young population in India's total population has been increasing. About 36 per cent of the country's population was below 15 years of age (2004) which meant a very high dependency ratio. The percentage of population in the reproductive age group has also been increasing as a consequence of high birth rate and increasing life expectancy at birth.

During 1971-81, the areas that recorded a high growth rate of 30 percent included the entire North Eastern region, the arid and semi-arid parts of Western Rajasthan, the Terrai zone of Uttar Pradesh and the Bombay-Poona industrial belt. Gosal (1982,p.31) attributes this rapid increase in these areas to large scale in-migration into these areas associated with :

(i) Development of industries, mining,commercial activities and miscellaneous services all leading to acceleration in the urbanization process

(ii) Extension of irrigation facilities to the arid and semi-arid parts of Western Rajasthan making it possible to bring new areas under cultivation

(iii) Reclamation of waste lands and intensification of agriculture in the lands already under plough as in the Terrai tract of Uttar Pradesh.;

(iv) Extension of farming into the upland areas and marginal hill-lands; and

(v) Infiltration from neighboring countries, particularly from Bangladesh.

By contrast, the slow growth rate of less than 20 percent was experienced by large parts of Kerala, Southern Maharashtra, and Tamil Nadu. These were the areas which experienced out-migration due to severe population pressure and paucity of resources.

TABLE – 1.2

Census of India, 1901-2011

Census Years	Population	Change in Population Between Censuses	Percent Change Between Censuses	Annual Growth Rate (percent)
1901	238,396,327	—	—	—
1911	252,093,390	13,697,063	5.8	0.6
1921	251,321,213	-772,177	-0.03	0
1931	278,977,238	27,656,025	11.0	1.0
1941	318,660,580	39,683,342	14.2	1.3
1951	361,088,090	42,427,510	13.3	1.3
1961	439,234,771	78,146,681	21.6	2.0
1971	548,159,652	108,924,881	24.8	2.2
1981	683,329,097	135,169,445	24.7	2.2
1991	846,421,039	163,091,942	23.9	2.2
2001	1,028,737,436	182,316,397	21.5	2.0
2011	1,210,193,422	181,455,986	17.6	1.6

Source: Registrar General of India, Census 2011, Provisional Population Totals.

1.2.a Population Growth during 1981-91

The Census of March 1991 had revealed a perceptible change in the country's demographic scene, especially in its growth rate. Although the last inter-censal decade added over 160 million, which was about 25 million more than the addition during the previous decade of 1971-81, yetin terms of percentage increase the decade 1981-91 recorded a growth of 23.79 as against 24.99 during the previous decade. Thus, for the first time during the post-independence period there was a fall in the growth rate of the country's population to the tune of 1.20 per cent. It signals the beginning of a new era in the country's demographic history.

Growth of population in any area has to be seen in the context of its vital rates. The projected vital statistics released by the census revealed that the average fertility and mortality rates for the period 1986-1991 were likely to be 30.9

and 10.8 per thousand respectively. Further, it was hoped that by the turn of the century, the country's fertility rate would decline to 24.9 and mortality to 8.4, yielding a growth rate of 16.5 percent.

Another notable feature has been the increase in life expectancy at the time of birth. The projected life expectancy at birth was 58.1 years in case of males and 59.1 years in cases of females for the years 1986 – 1991.

1.2.b Population Growth during 1991-2001

Maintaining its decline, the growth rate of population during 1991-2001 declined further. The decade recorded a growth rate of 21.54 percent. It was down by 2.31 percent in comparison to the preceding decade. It established that the decline in India's population growth that began during 1981-91 had got further consolidated during 1991-2001. It was largely because of the fact that the country's mortality rate had been brought down to a level which was fairly low and was less than that of even some of the developed countries. Presently, India has a mortality rate of only 8 per thousand. Not only that, most of Indian states and Union Territories have already attained this feat with a few exceptions, of course. From among the various states,Kerala had maintained its distinction of having the lowest growth rate of only 9.43 percent during 1991-2001, recording a significant fall from its growth rate (14.3 percent) during the preceding decade (1981-91). Other states that recorded less than 15 percent growth in their population during 1991-2001 included Tamil Nadu (11.72 percent), and Andhra Pradesh (14.59 percent). All states also recorded a further decline in their growth rates in comparison to their growth during the preceding decade. However, Tripura recorded the sharpest decline in its growth rate from 34.3 percent in 1981-91 to 16.03 percent in 1991-2001, a huge decline of 18.27 percent in 10 years. A commendable achievement indeed.Other states which recorded a growth rate lower than the National average of 21.54 percent included Goa (15.21 percent), Orissa (16.25 percent), Karnataka (17.51 percent), Himachal Pradesh (17.54 percent) West Bengal (17.77 percent), Chhattisgarh (18.27 percent), Assam (18.92 percent), Uttaranchal (19.41 percent) and Punjab

(20.10 percent). Thus, out of 28 states, 13 states displayed a growth rate of less than 20 percent as against the National average of 21.54 percent during 1991-2001.

However, one disturbing fact that has emerged during 1991-2001 is that abortion, especially of unwanted child, is emerging as an important method of putting a check on the family size among educated, illiterate or semi-literate people in the country. It has been revealed by a sharp fall in sex ratio in the zero to six age group in the case of most of the states, particularly Northern states of India. The increasing incidence of female feticide may, on the one hand, help the country in putting a check on its growth of population, but on the other hand, if allowed to continue, may emerge as a surrogate for female infanticide of the yesteryears with equally far reaching implications. During 1991-2001, child sex ratio (in 0-6 age group) of India declined from 945 to 927.

Now the2011 census has shown a clear fall, to a decadal growth of 17.6 percent and annual rate of 1.62 percent. In fact, not just the growth rate but the absolute increase has also shown a decline, from 182million during 1991-2001 to 181 million during 2001-11. Clearly, India's trajectory of growth has turned downward though the population trajectory continues to be upward.

1.2.c Population Policies:

India justifiably claims to be the first country to adopt an official policy to slow population growth, beginning with the country's first Five Year Plans in 1952. In the 1950s, the country was experiencing accelerated population growth created by declining death rates and high birth rates, a situation shared by many developing countries in that period. Death rates had fallen as these countries gained better public sanitation, widespread immunization of children, and expanded medical care. But birth rates remained high, pushing population growth to unprecedented heights.

Initial efforts to implement a family planning program were rather limited, with a budget of US$1.35 million. The program began by setting up family Planning Clinics with the expectation that people would seek out the clinics on

their own. But the goal of reducing birth rates through family planning was hampered both by deep-seated traditions that favored larger families and by the enormous challenge of bringing services to a vast, largely rural population.

In the second Five Year Plans (1956-1961), expenditures for family planning were increased and the idea of incorporating family planning into community - based development programs were introduced . Home visits byfamilyplanning workers was expanded in the 1960s to reach even more people. The populationprogram gained status when it was brought under the new Ministry of Health and family Planning in 1966. The government's concern about the country's population growth was heightened in the 1970s when successive censuses had shown that the rate was rising, despite the policies and investments in family planning. This concern set the stage for the family planningprogram's most controversial period. This took place during the National Emergency declared by Prime Minister Indira Gandhi in 1975, partly to thwart her political opposition. With financial support from the Central Government and the political backing of Mrs. Gandhi's popular son Sanjay, many states adopted coercive measures along with quota systems that resulted in the establishment of the infamous sterilization camps.

In the 1976–1977 program year, 8.3 million sterilizations, primarily vasectomies, were performed, up from 2.7 million the year before. The abuses and negative publicity generated by the emergency compromised the reputation of the government family planning program, and family planning services were suspended. By the 1977–1978 program year, the number of sterilizations had plummeted to 0.9 million. The slow decline in India's fertility rate of the previous decade stopped. To distance itself from the negative image of the emergency, the name of the ministry responsible for family Planning was changed to the Ministry of Health and family Welfare, and remains so to this day. The backlash against the involuntary sterilizations was partly responsible for the defeat of Mrs. Gandhi's party in the next elections. Successive governments—including Mrs. Gandhi herself, who returned to power in 1980 and served until her

assassination in 1984—have been careful to emphasize the voluntary nature of the program.

Following the 1994 International Conference on Population and Development in Cairo, India announced that it was adopting a "target-free" approach in its population policy. This change reflected the spirit of the Cairo conference, which called for greater emphasis on a full program of reproductive health that would be less concerned with specific demographic goals. In reality, this new approach has been applied differently in different areas of the country. In some cases, local clinics found it hard to operate without specific quotas, such as the number of women accepting family planning or for condoms distributed. Some states, such as Andhra Pradesh, continued to offer incentives such as cash (about US$11), or goods such as transistor radios, for women to agree to sterilization. In the 1998 – 1999 period, 67 percent of women aged 25 to 29 years in Andhra Pradesh had been sterilized, a remarkably high percentage for women under 30 years of age.

The failure of some states to lower their birth rates also has undermined their political clout in the national legislature. Seats in India's parliament are apportioned among the states according to population size. But giving the rapidly growing northern states more seats was viewed as rewarding them for poor performance in lowering birth rates and contradicting the government's policy to reduce population growth. Accordingly, the Indian Supreme Court has repeatedly frozen the allocation of seats to the population distribution as of 1971.

In 2000, the year population reached 1 billion, the government promulgated its first National Population Policy, (NPP 2000). This policy contained a comprehensive socio-demographic program covering 14 topics such as reducing infant and maternal mortality, promoting later marriage, universal immunization of children, and preventing the spread of HIV. The policy maintains a commitment to couples' "voluntary and informed choice" of reproductive health services so that replacement level fertility of

two children per woman could be achieved by 2010. The need for a separate national population policy had been identified as early as 1983, but was not realized for 17 years. This long delay atleast partly reflected fears of a political backlash against family planning, as there had been after the emergency.

More recently, a debate has been underway regarding elected officials leading by example, willingly or unwillingly, in the practice of family planning. In a number of states, including Maharashtra, people with more than two children are banned from any elective office from state assemblies to five – member village councils (panchayats). There has been an outcry against this policy as inequitable and too strict, and charges that it will increase, not reduce, female feticide. In the wake of the controversy, Himachal Pradesh state withdrew its two child limit for elected officials in 2005.

1.3 Population Growth in Mizoram

Mizoram has a low population concentration in contrast to the other Indian states. Nevertheless, it has been witnessing an ever-increasing growth of population consequent upon the increasing pressure on physical and economic progress and unemployment. The analysis of population growth therefore holds significance for an underdeveloped state like Mizoram where rapid increase in population may act as the main drawback in achieving the desired degree of economic and social progress.

TABLE – 1.3
Growth of Population in Mizoram, 1901 – 2011

Sl.No.	Year	Male	Female	Total
1	1901	39,004	43,430	82,434
2	1911	43,028	48,176	91,204
3	1921	46,652	51,754	98,406
4	1931	59,186	65,218	1,24,404
5	1941	73,855	78,931	1,52,786
6	1951	96,136	1,00,066	1,96,202
7	1961	1,32,465	1,33,598	2,66,063
8	1971	1,70,824	1,61,566	3,32,390
9	1981	2,57,239	2,36,518	4,93,757
10	1991	3,58,978	3,30,778	6,89,756
11	2001	4,59,109	4,29,464	8,88,573
12	2011	5,52,339	5,38,675	10,91,014

Source : Census, Provisional Population Totals, Mizoram, 2011.

1.3.a Mizoram Population Growth Rate:

The total population growth in this decade was 22.78 percent while in the previous decade it was 29.18 percent. The population of Mizoram formed 0.09 percent of India in 2011.

1.3.b Mizoram Population 2011:

As per details from Census 2011, Mizoram has a population of 10.91 Lacs, an increase from the figure of 8.89 Lacs in 2001 Census. Total population of Mizoram as per 2011 Census is 1,091,014 out of which males and females are 552,339 and 538,675 respectively. In 2001, total population was 888,573 in which males were 459,109 while females were 429,464.

TABLE – 1.4
Decadal growth rate and its variation of Mizoram, 1901-2011

Census year	Persons	Variation since the Precedingcensus		Males	Females
		Absolute	Percentage		
1901	82434	-----	-----	39004	43430
1911	91204	8770	10.64	43028	48176
1921	98406	7202	7.9	46652	51754
1931	124404	25998	26.42	59186	65218
1941	152786	28382	22.81	73855	78931
1951	196202	43416	28.42	96136	100066
1961	266063	69861	35.61	132465	133598
1971	332390	66327	24.93	170824	161566
1981	493757	161367	48.55	257239	236518
1991	689756	195999	39.7	358978	330778
2001	888573	198817	28.82	459109	429464
2011	1091014	202441	22.78	552339	538675

Source : Census, Provisional Population Totals, Mizoram, 2011.

1.3.c Mizoram Population Density 2011:

Total area of Mizoram is 21,081 sq. km. Density of population of Mizoram is 52 per sq. km which is lower than the National average which is 382 per sq. km. In 2001, the density of population of Mizoram was 42 per sq.km, while the National average in 2001 was 324 per sq. km.

Although a sharp fall in rate of growth has been registered during the last decade in Mizoram with 39.69 percent, the figure is, no doubt, distinctive if compared with the all India growth rate of 23.50 percent. It is not only during the decade that growth rate of Mizoram population is higher than National level, but throughout the centuries that Mizoram has maintained a higher decadal growth rate than the all India growth rate.

1.3.d Mizoram Urban Population 2011:

Out of total population of Mizoram, 51.51percent people live in urban regions. The total figure of population living in urban areas is 561,977, wherein

281,020 are males and the remaining 280,957 are females. The urban population in the last 10 years has increased by 27.43 percent.

Sex Ratio in urban regions of Mizoram was 1000 females per 1000 males. For child (0-6) sex ratio the figure for urban region stood at 978 girls per 1000 boys. Total children (0-6 age) living in urban areas of Mizoram were 73,781. Of the total population in urban region, 13.13 percent were children (0-6).

Average Literacy rate in Mizoram for Urban regions was 98.10 percent in which 98.67percent were literate males while female literacy stood at 97.54percent. Total literates in urban region of Mizoram were 478,920.

1.3.e Mizoram Rural Population 2011:

Of the total population of Mizoram state, around 48.49 percent live in the villages of rural areas. In actual numbers, males and females were 271,319 and 257,718 respectively. The total population of rural areas of Mizoram state was 529,037. The population growth rate recorded for this decade (2001-2011) was 18.20percent.

In rural regions of Mizoram state, female sex ratio per 1000 males was 950 while for the child (0-6 age) it was 966 girls per 1000 boys. In Mizoram, 91,755 children (0-6) live in rural areas. Child population forms 17.34 percent of the total rural population.

The literacy rate for males and females stood at 88.35 percent and 80.04percent . Average literacy rate in Mizoram for rural areas was 84.31 percent. Total literates in rural areas were 368,672.

TABLE – 1.5

District - wise distribution of rural and urban population and percentage to total population in Mizoram - 2011

Name of the District	Distribution of Rural and Urban Population		Percentage to total population	
	Rural	Urban	Rural	Urban
Mamit	70,948	14,809	82.73	17.27
Kolasib	36,358	46,696	43.78	56.22
Aizawl	91,217	312,837	22.58	77.42
Champhai	77,153	48,217	61.54	38.46
Serchhip	32,894	31,981	50.70	49.30
Lunglei	92,611	61,483	60.10	39.90
Lawngtlai	96,555	20,889	82.21	17.79
Saiha	31,301	25,065	55.53	44.47

Source : Census, Provisional Population Totals, Mizoram , 2011.

Description	Rural%	Urban%
Population (%)	48.49	51.51
Total Population	529,037	561,977
Male Population	271,319	281,020
Female Population	257,718	280,957
Population Growth	18.20 %	27.43 %

Source : Census, Provisional Population Totals, Mizoram, 2011.

1.3.f Migration:

Migration is an important aspect in population studies because it is a major factor in changing the size, structure and quality of the population.The migration process affects the areas to which migrants have moved and area which they left; and is considered as a symptom of basic social change.There are various causes of the human movement.One of these is population pressure, which often forces people to go out of the area in search of land, employment or any other means of subsistence. On the other hand,better job opportunities in relatively

more industrially or economically developed areas attract people from economically backward areas.Understandably, for many migrants, the prospect of a better job is one of the most important reasons for migrating. Moreover, studies of internal migration have shown that the volume of migration to a nation naturally tends to be highest when it is near the peak of business cycle and from it in times of business depression or famine.

According to 1991 census 11,495 persons constituting 1.67 percent of the total population were internal migrants from other states of India classified by place of birth, of which 62.54 percent are males and 37.45 percent are females. Internal migration within the state by the same classification accounted for 12.27 percent. Population of Mizoram who were born outside India are 6,353 constituting 0.92 percent. Of these international migrants, 48.15 percent are males and 51.84 percent are females.This means that 17,848 persons comprising of 2.58 percent of the total population were born outside Mizoram, and are therefore to be treated as migrants by place of birth.

Migration is not significant in this region due to political restrictions, as such the figure constituted only a small percent of the total population. Of the total migrants, 64.40 percent are national migrants, i.e. migrants from other states and union territories of India, and international migrants comprised of only 35.59 percent of the total migrant population of Mizoram.

1.4 Rationale:

The family planning program in Mizoram was launched in the mid-nineties under the auspices of the Health Department, Govt. of Mizoram. Initially, the Mizo people were not appreciative of the family planningprogram and were more or less against it. The reason for this was that the Mizo people believed that their population was very small when compared with the population of the other inhabitants of various states of India. Besides this, the Mizo people had a misconception about the meaning of family planning. They thought that acceptance of family planning meant giving birth to only two (2) children. With the strong belief that the Mizo population

was very small as compared to the other states, the idea of giving birth to no more than two(2) children was totally unacceptable.

Majority of Mizo people are Christians. The Christian view about birth control stems from the teachings of the church rather than scripture (since little is said about contraception in the Bible). So, beliefs about birth control and its methods tend to be based on different interpretations of marriage, sex, and family. Contraception was condemned by Christianity as a barrier to God's procreative purpose of marriage until the start of the 20th century. Protestant theologians have now become more willing to accept that morality should come from the conscience of each person rather than from outside teachings with regards to family planning.

The Roman Catholic Church absolutely prohibits abortion and does not encourage its members to follow any family planning programs. Natural family planning method such as periodic abstinence is the only contraceptive method sanctioned by the Catholic Church. However, Stacy, D. (May 21, 2019), in her article "What Do Religions Say About Birth Control and Family Planning?" noted that 90 percent of Catholic women, from the United States, who are of child bearing age use a form of birth control method not sanctioned by the Catholic Church.

Similarly, the Presbyterian Church issued pamphlets in 2007 which were to be read compulsorily in all its Churches. The gist of the pamphlets were simply discouragingfamily planning programs. The Baptist Church also propagated, more or less, the same amongst its members in a similar fashion. However, now many Protestant denominations are of the view that members use birth control as dictated by their consciences. Many considered having children a positive force that could strengthen marriage and family, if couples did not feel threatened by the possibility of having children they could not support which could lead to poverty and its related issues in the family.

Hinduism encourages procreation within marriage, yet there is no opposition against contraception either. However, the Hindus firmly believe that it is one's duty to procreate and have a family within the fertility span of one's life. So, they are unlikely to use birth control or any other methods of family planning during that

time. That being said, The Dharma (doctrine of moral and religious codes) emphasizes the need to act for the sake of the good of the world; hence, it is also believed by some Hindus that producing more children than the environment could support is against this code.

Islam considers procreation as one's religious duty. So, there is unanimous rejection of sterilization and abortion. It is their belief that if family planning method is put to use, the un-born children would confront the parents in their life after death. Most Islamic traditions will permit the use of birth control only if maternal health or the well-being of the family is going to be compromised. The Islamic faith prioritizes human life, so being able to space out births allows a mother ample time to care for each child. Birth control is supported for economic reasons; it helps protect the mother's life and provide for her children; which in turn means, family planning can keep poverty at bay as it regulates the number of members consuming the family wealth.

The Mizo people are not aware of the fact that family planning services have the potential to improve the quality of their lives and also their economic welfare. They tend to ignore the fact that by not accepting family planning services they are denying the Mizo women to have healthy children and become healthy mothers. They are unaware of the fact that knowledge of family planning also increases and limits the interval between births and that delaying the birth of a child until the mother turns 20 years is beneficial to both the mother and the infant.

Increasing population growth is a world-wide problem today and Mizoram is no exception. Mizoram possesses about 0.64 percent of the country's area but its inhabitants form 0.081 percent of the total population of India. The density of population of Mizoram (52 per sq.km) is far below than the All India level (382 per sq. km). If we look at these figures we feel quite comfortable but it should be noticed in the light of the fact that only about 1/3 of the total area of this state is suitable for inhabitation.

The state's development policy concern was that between 1961 and 1991, population increased two and a half times to 689,756 in 1991 and rose up to 8,88,573

in 2001. Within the last 90 years its population has multiplied 10 times (Table-1.3, pg. 15). Its growth rate was always significantly higher than the All India Average.Census data provided the level and pattern of fertility and the determinants of fertility i.e. proportion of women married, contraceptive usage, prevalence of abortion, and post-partum infecundability. Other factors could include socio-economic measures, urbanization, female literacy, marriage age, infant and child mortality, and female participation in the labour force. The proportion of women of reproductive age and post-partum in fecundity were the two main proximate determinants of the maintained fertility. The impact of major socio-economic factors such as female literacy, female age at marriage, infant and child mortality, and women's participation in the work force have not reduced fertility thus far.

Mizoram cultural practices have always favoured higher age at marriage. Factors which may have strong impacts on Mizoram fertility like religion, ethnicity, and family structurehave not been examined. Contraceptive use was considered key to reducing future fertility, but the familyplanningprogram had been late in starting in the state. Government priority areas should be concentrated on a vigorous implementation of the family welfare program, involvement of religious leaders and voluntary agencies in the familyplanningprograms, initiation of an awareness program about population growth by the Education Department, effective implementation of Child Care Programs, advocacy of breast feeding, and encouraging research studies on population after the creation of a reliable database.

Total Fertility Rate (TFR) was 4.0 in 1981 and the Total Marital Fertility Rate (TMFR) was 6.3. A comparison by religion showed a TFR of 7.9 for Christians, 4.2 for Hindus, and 3.4 for Buddhists. Regarding TMFR, Christians had 6.7 children, Hindus 5.3, and Buddhists 4.3. Children ever born among the cohort aged 45-49 years was 5.7 and over 50 years was about 6.0. Completed marital fertility according to patterns in 1981 were 9.2, which is the highest in all of India.

The high growth rate of population may be because of various factors like migration from neighboring countries like Myanmar and Bangladesh and increased flow rate of Indian citizens seeking jobs. Illegal immigration from neighboring

countries such as Bangladesh, Nepal and Myanmar, which is a time bomb that will explode eventually, has shot up drastically in Mizoram. Latest reports put the illegal migrants at 10,000, but looking at sheer settlements of aliens, one can say the demographics of the land has been changed by Bangladeshis, as also those from other states who come here to find work.

The close border connection with Myanmar makes Mizoram one of the largest migrant population in the country. The state has a population of about 10 lakh or one million. Of that figure, some 70,000 to 80,000 are migrants from Myanmar, largely Chins from the neighboring Chin State and SahGing Division. Most of these have fled the unsettled economic conditions in their country in a desperate search for work over the past two decades and more. There are a handful of political refugees, refugee leaders in Mizoram and Delhi say that this figure is unlikely to be more than 70 i.e. political figures who cannot return home because of threats they face. Mizoram has felt the direct impact of the economic disaster and humanitarian crisis that is sweeping across Myanmar, and its border regions. There has been a sharp change in attitudes here towards the Chins - ranging from welcoming in the mid-1990s to outright condemnation and hostility more recently - but one cannot move away from the reality that the state has hosted a migrant population which is nearly one-eighth of its own size for nearly 20 years. The impact of militarization, lack of peace and under-development in Myanmar are the reasons for this flight across borders. If conditions at home were as attractive as conditions here, people would not move. This is one of the cardinal principles of out-migration, especially of refugees - people move away from unstable situations where they feel under threat, from harsh political, environmental and economic situations.

But in addition to these, there are other reasons which are directly related to the Mizo people such as religious and social beliefs, family planning, early marriages etc. Hence the investigator decided to study the awareness of and attitude towards family planning programs among Mizo women in relation to their education , occupation , socio- economic status and rural-urban background.

It is noteworthy that the Northeast Indian ethnic studies on population and its related issues are very less and not many in number; especially in the state of Mizoram as there have been no studies regarding knowledge, attitude and practices of family planning in Mizoram; the current study is the pioneer and pilot study in relation to the KAP of family planning in Mizoram. Majority of the existing information regarding population and its related areas in Mizoram came from the Government of India through the Censuses conducted over the past decades. The present study is also undertaken with the objective of assessing the level of awareness of different family planning methods, the attitudes of Mizo women towards family planning and also seeks to find out the current practice of family planning methods followed by Mizo women of reproductive age group.

More specific knowledge can be acquired from this study about the factors that determine the non-acceptance of familyplanningprograms which will enlighten the Health Department to develop suitable programs for awareness of the benefits of family planning and enable them to create a positive attitude towards the family planning programs among the Mizo women.

1.5 Statement of the Problem:

"Awareness and Attitude of Mizo Women towards family planning in Relation to their Education and Demographic Variables.**"**

1.6 Research questions :

1) Does education have any influence on the awareness level of Mizo women in relation to family planning programs?
2) Does occupation have any influence on the awareness level of Mizo women in relation to family planning programs?
3) Does socio-economic status have any influence on the awareness level of Mizo women in relation to family planning programs?
4) Does the locale have any influence on the awareness level of Mizo women in relation to family planning programs?

5) Does education have any influence on the attitude of Mizo women in relation to family planning?

6) Does occupation have any influence on the attitude of Mizo women in relation to family planning?

7) Does socio-economic status have any influence on the attitude of Mizo women in relation to family planning?

8) Does the locale have any influence on the attitude of Mizo women in relation to family planning?

9) Does education have any influence on the family planning practices of Mizo women?

10) Does occupationhave any influence on the family planning practices of Mizo women?

11) Does socio-economic statushave any influence on the family planning practices of Mizo women?

12) Does the localehave any influence on the family planning practices of Mizo women?

1.7 Objectives of the Study :

1) To examine the status of awareness of Mizo women about various family planning methods in relation to their education.

2) To examine the status of awareness of Mizo women about various family planning methods in relation to their occupation.

3) To examine the status of awareness of Mizo women about various family planning methods in relation to their socio-economic status.

4) To examine the status of awareness of Mizo women about various family planning methods in relation to their rural – urban background.

5) To study the attitude of Mizo women towards family planning in relation to their education.

6) To study the attitude of Mizo women towards family planning in relation to their occupation.

7) To study the attitude of Mizo women towards family planning in relation to their socio- economic status.

8) To study the attitude of Mizo women towards family planning in relation to their rural – urban background.

9) To study the family planning practices among Mizo women in relation to their education.

10) To study the family planning practices among Mizo women in relation to their occupation.

11) To study the family planning practices among Mizo women in relation to their socio-economic status.

12) To study the family planning practices among Mizo women in relation their rural – urban background.

13) To study opinion on certain issues related to family planning.

1.8 Research Hypotheses :

1) There is a significant difference among Mizo women with different educational backgrounds in relation to their awareness about various family planning methods.

2) There is a significant difference among Mizo women engaged in different occupations in relation to their awareness about various family planning methods.

3) There is a significant difference among Mizo women having different socio-economic status in relation to their awareness about various family planning methods.

4) There is a significant difference among Mizo women from rural and urban backgrounds in relation to their awareness about various family planning methods.

5) There is a significant difference among Mizo women with different educational backgrounds in relation to their attitude towards family planning.

6) There is a significant difference among Mizo women engaged in different occupations in relation to their attitude towards family planning.

7) There is a significant difference among Mizo women having different socio-economic status in relation to their attitude towards family planning.

8) There is a significant difference among Mizo women from rural and urban backgrounds in relation to their attitude towards family planning.

9) There is a significant difference among Mizo women with different educational backgrounds in relation to their family planning practices.

10) There is a significant difference among Mizo women engaged in different occupations in relation to their family planning practices.

11) There is a significant difference among Mizo women having different socio-economic status in relation to their family planning practices.

12) There is a significant difference among Mizo women from rural and urban backgrounds in relation to their family planning practices.

1.9 Null Hypotheses :

For the purpose of testing, the aforesaid research hypotheses were transformed into the following null-hypotheses:

1) There is no significant difference among Mizo women with different educational backgrounds in relation to their awareness about various family planning methods.

2) There is no significant difference among Mizo women engaged in different occupations in relation to their awareness about various family planning methods.

3) There is no significant difference among Mizo women having different socio-economic status in relation to their awareness about various family planning methods.

4) There is no significant difference among Mizo women from rural and urban backgrounds in relation to their awareness about various family planning methods.

5) There is no significant difference among Mizo women with different educational backgrounds in relation to their attitude towards family planning.

6) There is no significant difference among Mizo women engaged in different occupations in relation to their attitude towards family planning.

7) There is no significant difference among Mizo women having different socio-economic status in relation to their attitude towards family planning.

8) There is no significant difference among Mizo women from rural and urban backgrounds in relation to their attitude towards family planning.

9) There is no significant difference among Mizo women with different educational backgrounds in relation to their family planning practices.

10) There is no significant difference among Mizo women engaged in different occupations in relation to their family planning practices.

11) There is no significant difference among Mizo women having different socio-economic status in relation to their family planning practices.

12) There is no significant difference among Mizo women from rural and urban backgrounds in relation to their family planning practices.

1.10 Operational Definitions :

(i) Awareness:

The term ***'Awareness'*** in the present study, refers to the existence of idea, on the part of thepeople, that there are certain methods by means of which a couple can postpone or even completely stop a pregnancy while following, at the same time, a normal conjugal life.

(ii) Family Planning Practices:

The term ***'Family Planning Practices'*** in the present study, means family planning methods actually being followed by people to control their family size.

(iii) Attitude :

The predisposition of the individual to evaluate some symbol or object or aspect of his world in a favourable and unfavourable manner.

1.11 Delimitation of the Study :

The present study shall be confined only to those Mizo women who are living within the state of Mizoram.

1.12 Organizationof the Report :

The report of the present study has been divided into five (5) chapters to facilitate a systematic presentation.

Chapter – II : REVIEW OF RELATED LITERATURE :

The present study is designed with a view to analyse the awareness of, attitude towards and practices of family planning programs among Mizo women in relation to their education, occupation, socio-economic status and urban-rural locale. A survey of the studies conducted in the related areas is undertaken in this chapter. The review of related research has been presented under the following three sections:

2.1 Review of Research related to Awareness of family planning programs.

2.2 Review of Research related to Attitude towards family planning programs.

2.3 Review of Research related to family planning Practices.

2.1 Review of Research related to Awareness of family planningprograms:-

Over the years, there have been many reports published on researches related to awareness of family planning programs. Awareness of family planning programs have been studied analysing its relation to variables like education, locale, socio-economic status, occupation and age. The studies vary in methods, techniques and mode of analysis. Most of the studies which have been conducted in India are KAP studies on family planning which include knowledge of, attitude towards and practice of family planning. The research related to awareness of family planning programs both in India and abroad has been reviewed in this section.

In general terms, 'Awareness' refers to the knowledge that something exists. However, in this study, the term ' Awareness' refers to the existence of idea, on the part of the people, that there are certain methods by means of which a couple can postpone or even completely stop a pregnancy while following, at the same time, a normal conjugal life. It has been indicated that certain variables such as education, occupation, socio-economic status and locale play an important part in determining the awareness level of family planning programs amongst the Mizo women. A synoptic view of the researches will enable the researcher to explore greater depths in this important area of study.

Researchers have conducted numerous studies on the awareness level of family planning programs amongst women all across the world using a number of variables like age, education, socio-economic status, occupation, locale, husband's opposition, fear of side effects, religion etc.

Dandekar, Kumudni (1951-52) conducted the first of the studies on the attitudes towards the adoption of family planning in India in the District of Poona. The investigation regarding the ***"Attitudes towards family planning and Limitations"*** was done by means of two questionnaires, one for the males and the other for the females. In this study, widespread ignorance regarding the contraceptives was noticed and it was observed that if the subject was introduced without creating appropriate background, it was liable to failure because of misconception about family planning.

Dandekar,V.M and Dandekar,K (1953) conducted a ***"Survey of Fertility and Mortality in Poona District"*** to investigate attitudes toward family planning. However, the results, besides showing the attitudes, also showed that out of 1,767 males and 752 females, 509 males had no knowledge of family planning methods whereas only 40 females were aware of family planning methods.

Sovani, N.V and Dandekar,K (1955) conducted ***"Fertility Surveys of Nasik, Kolaba and Satara (North) District, Poona*** with the objective of assessing attitudes toward family planning and family limitation. They found that 49 percent were unaware of family planning methods, 48 percent felt that it was not necessary to know about family planning methods and 43 percent were interested in knowing more about family planning methods.

Morrison, William A (1957) conducted a study on the ***"Attitudes of Males and Females towards family planning in a Western Indian Village"*** and found that most of the respondents were aware of family planning methods and programs.

Agarwala, SN (1961) conducted a study on ***"Family planning in four Delhi Villages"*** and found that out of the 298 women interviewed, 50 percent were aware of family planning, 19 percent had knowledge of a method and 3 percent used birth control.

Rao, H. Krishna, Satyanarayanacher, R.A., and Begam, Ameena (1971) conducted ***"A study on the Attitudes of Muslim women towards family planning in Bangalore City"*** and found that out of 500 women, 446 women had knowledge of family planning methods.

Vora, U.D., and Khatri, T.D. (1971) conducted ***"A study on knowledge, attitude and practice of eligible couples of Banaskantha district towards family planning"*** and found that only 22 percent of 396 couples had not heard of family planning. Of the remaining 310 who were aware of family planning, 64 percent reported the family planning staff as the source of information.

Zaheer, Mohammad, Sinha, S.N., and Khan, Aziz (1971) conducted a study on the ***"Knowledge and practice of family planning among Grade IV employees of Aligarh Muslim University"*** and found that, of the 316 respondents, over 90 percent of the respondents were aware of family planning through mass media while 17 percent were aware through family planning clinics.

Taneja, R.N. (1972) carried out a study on the ***"Fertility, Knowledge, Attitude and Practice (KAP) in relation to family planning in a selected population of Armed Forces"*** which included a sample of 251 civil women and 230 women of service personnel. All respondents were aware of family planning and 50 percent of civilian and 66 percent of service women knew of the use of one and more methods of birth control.

Das, Narayan (1972) conducted a study on the ***"Factors related to Knowledge, family size preference and Practice of family planning in India"*** and found that nearly 77 percent of urban males and 64 percent of urban females had heard of family planning methods as compared to 72 percent rural males and 69 percent rural females.

Akhtar, H.S.M.Q., Sueha, Anjali Kumar, and Islam, Faizul (1972) conducted a study on the ***"Attitude and practices of Graduate School Teachers towards family planning"*** among 207 Higher Secondary School teachers in Patna and found that 30 percent of the unmarried males and 35 percent of the unmarried females could mention some methods of contraception in contrast with 8.12 percent of the married males and 90 percent of the married females.

Mukherjee,B.N.(1974) carried out a study on ***"Family planning in Haryana and Tamil Nadu"*** and found that Haryana couples showed a slightly better knowledge of family planning methods as compared to Tamil Nadu couples probably due to differences in the thrust of the program in the two states.

Kee, W. F. and Swee Hock, S. (1975) in their study ***"Knowledge, Attitudes, and Practice of family planning in Singapore"*** found thatthey have good knowledge about methods of contraception and reported a high level of its usage.

Khan, M.E. (1979) conducted a study on "***Family planning among Muslims in India"***. The study revealed that a majority of both male and female respondents were aware of modern family planning methods. However, they lacked clear and adequate knowledge about them. It was observed that majority of Muslims have blind belief that family planning is against religion although family planning programs were very popular among them.

Thapa, S. (1989) in his study ***"A decade of Nepal's family planning program: achievements and prospects"*** found that there existed awareness among the

population but the strategies employed to promote family planning should be modified and critically reviewed.

Bhuyan, K. C. (1991) on the basis of a study on ***" Social Mobility and family planning Practices in Rural Bangladesh – A Case Study "*** concluded that every couple in the rural area is aware of family planning but very few practice it.

Pandey, R. N.(2002) in his study ***"Changing Knowledge, Attitude and Practice of family planning Methods in an Economy under Transition"*** reveals an increase in the awareness level of Mongolian women towards family planning and its practices about the use of modern contraceptive methods is also recorded by the study.

Thalji, N.N , (2002) conducted a study on the ***" Knowledge, Attitude and Practice of Women Towards family planning Methods in Tafila-Jordan "*** and found that 93 percent women showed considerable knowledge about different methods of contraception. She concluded that women in Tafila city have considerable knowledge about contraception methods.

Srivastava, Reena; Srivastava, Dhirendra Kumar; Jina, Radha; Srivastava, Kumkum;Sharma, Neela and Saha, Sushmita(2005) conducted a "***Contraceptive knowledge attitude and practice (KAP) survey"*** in Gorakhpur, Eastern UP and found that although 82.2 percent women were aware of the existence of a contraceptive method, only 44.2 percent ever used one. The study highlights that awareness does not always lead to the use of contraceptives.

Mao, J. (2007) conducted a study on the "***Knowledge, Attitude and Practice of family planning: A Study of Tezu Village, Manipur (India)"*** and found that 48 percent of the respondents had the knowledge of tubectomy and 44 percent of the respondents reported that it is through friends they come to know about the different contraceptive methods.

Singh, V.K and Singh,M.B (2007) conducted a study on ***"Social Dynamic Status and its Reflection on use of family planning Methods in an Indian Village: The Case of 'Gaura' Village (UP)"*** and found that majority of the respondents had knowledge and awareness about various aspects of family planning but its adoption is of low magnitude.

Kazi, Kalsoom (2008) conducted **"*A study of Knowledge, Attitude and Practice (KAP) of family planning among the women of rural Karachi"***. Seven hypotheses were tested which yielded the following results: 1) Literacy among rural women is related with their knowledge about family planning. 2) Empowerment of rural women in their personal matters is related to their knowledge about family planning . 3) Availability of electronic media facility (TV and Radio) at home is related with their knowledge about family planning. The present study confirms that, for the success of family planning program, awareness is very necessary especially in rural areas where, though many women are reported as being aware of family planning but contraceptive rate is still very low.

Deb, Roumi (2010) undertook a study on ***" Knowledge, Attitude and Practices Related to family planning Methods among the Khasi Tribes of East Khasi Hills, Meghalaya"*** and found that the knowledge of family planning methods is not much widespread but more than fifty percent of the women were adopting at least one kind of family planning method. However, there is a gap between the knowledge and the practice of contraception among these women.

Dhingra, R., Manhas, S., Kohli, N. & Mushtaq, A. (2010) conducted a study entitled***'Attitude of Couples towards family-Planning'*** with an aim to assess knowledge, understanding and attitude of couples towards family planning across the two ecological settings of Jammu district. The results witnessed a high prevalence of illiteracy and associated ignorance among rural masses (35 percent) especially regarding the concepts and measures of family planning. Majority of rural respondents especially women folk (51 percent) were unaware of concepts related to

family planning. Education was found to be significantly associated with the respective attitude of respondents towards family planning.

Mohamadein, Dr. Adam Salih, Hamad, Sister. HassanatElnour, Hamid, Mohamed Osman and Elbanani, Hikma Idris (April 2010) conducted a study, ***"RH Situation Analysis & Small KAP Study North Darfur "*** and concluded that 77.2 percent of respondent said that use of family planning reduce the risk of women by spacing the pregnancy and 10.1 percent of respondents believe that family planning methods causes problems and complications for women.11.4 percent of respondents have no ideas about family planning.

Kaushal, S K; Saxena,S C; Srivastava,V K; Gupta,S C and Nigam,S (2009-2010) conducted a ***"KAP Study on Contraceptive Methods in Kanpur District of UP"*** and found that awareness about family planning methods was more than 90 percent for all available methods except vasectomy and injections which were 31.5 percent and 8.6 percent respectively.

Sajid. A. and Malik. S. (2010) in their study ***"Knowledge, Attitude and Practice of Contraception Among Multiparous Women at Lady Aitchison Hospital, Lahore"*** concluded that 60 percent of the women have awareness of the contraceptive methods. 40 percent of the population still have no awareness and need our attention; by improving the awareness and the practice of using contraception we can reduce the population growth rate.

Mahawar, Priyanka; Anand, Shweta; Raghunath, Deepa and Dixit, Sanjay(2011) carried out a study on ***"Contraceptive Knowledge, Attitude and Practices in Mothers of infants: A Cross-sectional Study"*** at Bhopal (MP). They found that 98 percent of the subjects hadheard about oral contraceptive pills and 88 percent of the subjects had heard about Cu-T but none of them had complete knowledge about any family planning method. 88 percent women had television as their source of knowledge and less than 50 percent women said that their Doctor

provided them knowledge. 62 percent women thought that family planning methods should be used only by women having children less than 1 year of age.

Patel, Mitali G; Mahyavanshi, Darshan K; Kartha, Girija; Purani, Shyamal K and Nagar, Sunita S (2011) carried out "***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"*** and found that almost half of the study subjects showed a lack of awareness and inadequate knowledge of the importance of contraception.

J. Lwelamira, G. Mnyamagola and M.M. Msaki (2012) studied ***'Knowledge, Attitude and Practice (KAP) Towards Modern Contraceptives among Married Women of Reproductive Age in Mpwapwa District, Central Tanzania'.*** Results showed that half (50 percent) of total respondents that were aware of modern contraceptives thought that benefits of modern contraceptives outweigh negative effects and nearly two- third (65.2 percent) were interested to know more (learn more) on modern contraceptives. Furthermore, 42 percent of them that is four in every ten of respondents that were aware of modern contraceptives admitted that they could recommend use of modern contraceptives to a friend.

Makade, K.G., Padhyegurjar, M., Padhyegurjar, S.B. and Kulkarni, R.N. (2012) carried out a ***" Study of Contraceptive Use Among Married Women in a Slum in Mumbai "*** and found that 87 percent of women were aware of at least one method of contraception. 14 percent women were unaware of any health care facility providing contraceptives in the vicinity. In conclusion, although there is a high level of awareness, contraceptive use is not very high.

Koranne. S.P. and Wahane. R. A. (Oct – Dec 2014) carried out a study on ***"An Analysis of Awareness and Utilization of Contraceptives amongst Married Women Attending a Tertiary Care Hospital in Maharashtra"*** and the study reveals that the women respondents have awareness of contraception. However, only by proper

motivation, counselling and improving the facilities at both Government & Private sectors, can the unmet need of contraception can be achieved.

Pandey. D., Garg. D. And Salhan. S. (2014) in their work ***"Study of knowledge and contraception practices in low socio-economic women of Delhi"*** found that lack of education, knowledge and awareness led to inadequate usage of contraception in women who are in the reproductive age group from a low socio-economic status. Awareness for emergency contraception is more as compared to awareness of regular methods of contraception. It mandated the need to educate the women that emergency contraception should not be used as a replacement for regular family planning methods.

Sarella, Lavanya Kumari and Prasanna, NSL (2014) had conducted **"*A study on contraceptive knowledge, attitude and practice among reproductive age group women in a tertiary institute"*** which revealed that out of 500 women interviewed 484 (96.8 percent) had heard of or are aware of family planning methods (permanent/temporary).

Juma. P. A., Mutombo. N. And Mukiira. C. (2015) in their study ***"Women's attitudes towards receiving family planning services from community health workers in rural Western Kenya"*** found that the need to invest a substantial amount of effort into educating women on the relevance of community health workers' in providing family planning services is quite low. Various methods and campaigns for awareness creation on family planning services provided by community health workers should be used to facilitate a higher acceptance by the target population.

Machiyama, K. et al. (May 2018) in their study ***titled "Women's attitudes and beliefs towards specific contraceptive methods in Bangladesh and Kenya"*** found that majority of the women were aware and that though there was a high level of contraceptive usage, it can co-exist with widespread misgivings about the methods, even for those contraceptives that are widely used. however, this pointer provides useful guidance for counselling and informational campaigns for the future.

2.2 Review of Research related to Attitude towards family planning programs

In preceding years, there have been many reports published on researches related to Attitudes towards family planning programs. Attitudes towards family planning programs have been studied analysing its relation to variables like education, locale, socio-economic status, occupation and age. The studies vary in methods, techniques and mode of analysis. Most of the studies which have been conducted in India are KAP studies on family planning which include Knowledge of, Attitude towards and Practice of family planning. The research related to Attitudes towards family planning programs both in India and abroad has been reviewed in this section.

In this study, the term 'Attitude' refers to the predisposition of the individual to evaluate some symbol or object or aspect of his world in a favourable and unfavourable manner. It has been indicated that certain variables such as education, occupation, socio-economic status and locale play an important part in determining the attitude towards family planning programs amongst the Mizo women. A synoptic view of the researches will enable the researcher to explore greater depths in this important area of study.

Researchers have conducted numerous studies on the attitudes towards family planning programs amongst women all across the world using a number of variables like age, education, socio-economic status, occupation, locale, husband's opposition, fear of side effects, religion etc.

Dandekar, Kumudni (1951-52) conducted the first of the studies on the attitudes towards the adoption of family planning in India in the District of Poona. The investigation regarding the ***"Attitudes towards family planning and Limitations"*** was done by means of two questionnaires, one for the males and the other for the females. In this study, widespread ignorance regarding the contraceptives was noticed and it was observed that if the subject was introduced without creating appropriate background, it was liable to failure because of misconception about family planning.

Dandekar, V.M and Dandekar,K (1953) conducted a ***"Survey of Fertility and Mortality in Poona District"*** to investigate attitudes toward family planning. The results showed that out of 1,767 males and 752 females, 206 males and 121 females were totally opposed to family planning whereas 542 males and 190 females wanted more information on family planning and the remaining respondents either did not reply or left the questions unanswered.

Sovani, NV and Dandekar, K (1955) conducted ***"Fertility Surveys of Nasik, Kolaba and Satara (North) District, Poona"*** and found that 52 percent had a positive attitude towards family planning and 48 percent felt that it was not necessary to know about family planning methods.

Morrison, W.A (1957) conducted a study on the ***"Attitudes of Males and Females towards family planning in a Western Indian Village"*** and found that although most of the respondents were aware of family planning, level of education played a significant role in determining whether a respondent had a negative or positive attitude towards family planning. 93 percent of uneducated males had a negative attitude whereas 53 percent of males with an 8^{th} grade or higher education were favourably inclined. 73 percent of uneducated females had a negative attitude whereas 74 percent who had higher education were also favourably inclined.

Dandekar, K(1959) carried out a study on the ***"Attitudes Towards family planning – Demographic Survey of Six Rural Communities"*** and found that out of 647 women respondents aged 25 – 40 years, although more than 90 percent were aware of family planning, 453 women had a favourable attitude towards family planning and 194 women had a negative attitude towards family planning.

Chandrasekhar, S (1959) conducted a study on ***"Family planning in an Indian Village : Motivation and Methods"*** at village Mangadu, Chingleput District, Madras and found that 55 percent of husbands and 58.11 percent of wives were strongly in

favour of family planning whereas 44.65 percent males and 41.6 percent females were against family planning.

Rao, H.Krishna, Satyanarayanacher, R.A., and Begam, Ameena (1971) conducted ***"A study on the Attitudes of Muslim women towards family planning in Bangalore City"*** and found that out of 500 women, 402 women had a favourable attitude towards family planning and approved of the use of family planning methods.

Vora, U.D., and Khatri, T.D. (1971) conducted ***"A study on knowledge, attitude and practice of eligible couples of Banaskantha district towards family planning"*** and found that 56.44 percent had favourable attitude towards family planning and 106 of the respondents opposed family planning due to religious objection (25.47 percent), objection by husband (18.87 percent) and objection by elders (18.87 percent).

Akhtar, H.S.M.Q., Sueha, Anjali Kumar, and Islam, Faizul (1972) conducted a study on the ***"Attitude and practices of Graduate School Teachers towards familyplanning"*** among 207 graduate teachers of Higher Secondary Schools in Patna (180 males and 27 females). The study revealed that 80 percent males and 85 percent females have a positive attitude towards family planning.

Mukherjee, B.N.(1974) carried out a study on ***"Family planning in Haryana and Tamil Nadu"*** and found that more eligible couples of Tamil Nadu were favourably disposed to the family planning program than their counterparts in Haryana (difference significant at .001 level).

Kee, W. F. and Swee-Hock, S. (1975) in their study ***"Knowledge, Attitudes, and Practice of family planning in Singapore"*** found that, by and large, the attitudes of the married women in Singapore towards family planning are favourable.

Belcher, DW; Neumann,AK; Ofosu-Amaah,S; Nicholas,DD and Blumenfeld, SN (1978) conducted a survey in Ghana on the ***'Attitudes Towards family Size and***

family planning in Rural Ghana-Danfa Project: 1972 Survey Findings'. Most respondents (70.1 percent) reported approval, including 67.4 percent of males and 72.1 percent of females; 26.7 percent of the sample disapproved and 3.7 percent were uncertain.

Thapa, S. (1989) in his study ***"A decade of Nepal's family planning program: achievements and prospects"*** found that the strategies employed to promote family planning should be modified and critically reviewed. The motivation to use family planning for fertility regulation seems to be promising in Nepal. Between 1976 and 1986, the desired number of children in a family set-up decreased by 14 percent among women ageing between 15 years old - 24 years old; by 12 present among the women whose age are between 40 - 49. The overall mean for desired number of children declined from 4.0 to 3.5 per woman during the decade.

Odimegwu, C.O. (1999) in his study ***"Family planning Attitudes and Use in Nigeria: A Factor Analysis"*** found that the respondents' perceptions or attitudes towards family planning were associated with contraceptive usage: Those who approved of family planning were twice as likely to use contraceptives as compared against the respondents who disapproved; respondents who have good communication with their spouse regarding family planning were also three times more likely to use contraceptives than those who did not. Women who agreed with statements regarding supporting girls' education and discouraging early marriage were three times more likely to use contraceptives than their counterpart who disagreed. Using Contraceptive was also more common in men who has been exposed to family planning and its methods through the media than among those who were not.

Hennink, Monique; Stephenson, Rob and Clements, Steve(**2001**) studied ***'Demand for family planning in Urban Pakistan'.*** They found out that the level of approval of contraception is an indicator of the potential willingness of a population to accept the use of family planning methods. Although it is important to note that an individual may indicate approval of contraception in general but not be personally

able or willing to adopt a method. With the exception of Larkana, more than three-quarters of women stated that they approved of contraception, women in Gujrat showed the highest level of approval (91.1 percent). Almost one third of women in Larkana disapproved of contraception. However, the majority of women in all sites stated that if the decision was entirely their own, they would be willing to use a method of contraception. The majority of women in all study sites (78 percent) stated that it was mainly the husband's idea to adopt a method of family planning; only 18 percent reported that contraceptive use was the woman's own idea. Although some men stated that it is a woman's decision to use contraception, all agreed that a woman is unable to use family planning without the husband's consent.

Thomas, M.D., Thomas. P. and Garland, F.C.(2001) in their study ***"Contraceptive Use and Attitudes Toward family planning in Navy Enlisted Women and Men"*** found that enlisted women and men had favourable attitudes towards contraception. It was also found that contraceptive use was related to attitude towards family planning. Women and men who used birth control have a more favourable attitude towards family planning than those who did not use birth controls; women have a more positive attitude towards family planning as compared to the men.

Korra, Antenane (2002) in her book ***"Attitudes toward family planning, and Reasons for Non use among Women with Unmet Need for family planning in Ethiopia"*** stated education as one of the factors that significantly contributes to the quality of women's lives. Improving women's access to education and encouraging continuous and constant exposure would significantly increase the use of family planning and reduce unmet need. family planning services needs to be expanded and strengthened in rural Ethiopia so as to let the people gain knowledge, education, and counselling on family planning and provide services to the needy, especially to the unreached and underserved populations.

Pandey, R. N.(2002) in his study ***"Changing Knowledge, Attitude and Practice of family planning Methods in an Economy under Transition"*** reveals that 60

percent of the Mongolian women in the age-group of 15-49 years expressed their desire to use any contraceptive method in the future, the analysis revealed. Though Mongolia has transition to a market economy, contraceptive use is still very low; between the years 1994 – 1996 there was almost no change in the figure observed for contraceptive usage. However, an increase in the awareness level of Mongolian women towards family planning and its practices about the use of modern contraceptive methods is also recorded by the study.

Thalji, N.N (2003) conducted a study on *the* ***" Knowledge, Attitude and Practice of Women Towards family planning Methods in Tafila-Jordan "*** and found that 67 percent showed positive attitude towards using a contraceptive method that was approved by the husband. In contrast, 23 percent showed negative attitudes towards using a contraceptive. She concluded that women in Tafila city have considerable knowledge and positive attitudes towards contraception methods.

Dabral, Shweta and Malik, S.L. (2004) in their study ***'Demographic Study of Gujjars of Delhi: IV. KAP of family planning'*** found out that the analysis of attitude of every married women towards acceptability of family planning messages on radio or television reflects that media messages are acceptable to four-fifth of the women. Relatively larger proportion of older women (over 44 years), and women who are illiterate, don't consider broadcasting of family planning messages acceptable. On the other hand attitudes towards the acceptability of media messages, are highly favourable among women who have completed primary school and above, as well as those below 30 years of age. Thus, education is one of the significant parameter that influences the attitude and abilities of the women. Also, family planning is more acceptable to younger women. Majority of women have a favourable attitude towards family planning. Over ninety percent of currently married non-sterilized women approve of family planning use. Similar proportion of women are of the opinion that parents can take proper care of their children, only when the children are few in number i.e., family size is limited. Information on whether women talk about family planning at all, and with whom, reflects their

interest in family planning and other sources of information. More than half of the women reported that they have not discussed about family planning methods with their husbands reflecting lack of spousal communication regarding family planning. Spousal communication increases the likelihood of contraceptive use and thus, with regards to family planning it is an important parameter for determining the family size

Kumar, S; Priyadarshini, A; Kant, S; Anand, K and Yadav BK (2005) in their study ***'Attitude of women towards family planning methods and its use – Study from a slum of Delhi'*** found that more than 90 percent had an unfavourable attitude towards family planning. Almost 2/3rd women did not adopt family planning method because they want more children or a son. Many of them did not prefer any of the family planning methods due to its side effects (50 percent) and other health problems (50 percent).

Dhingra, Rajni; Manhas, Sarika; Kohli, Nidhi and Mushtaq, Asiya (2010) studied ***'Attitude of Couples towards family planning'*** and while assessing the attitude of respondents towards family planning, a marked difference was observed in the two ecological settings under consideration. Majority of the male (55 percent) and female (61 percent) respondents in urban areas were having positive attitude towards family planning. Only 1/4th (approx.) of both male (27 percent) and female (25 percent) respondents had negative attitude. As compared to urban areas, majority of respondents, females (50percent) and male (72 percent) in rural areas showed negative attitude towards family planning. Just 21 percent of females and 25 percent males had positive attitude, indicating that family planning measures are not widely accepted by rural respondents especially by males.

Sajid, A. and Malik, S. (2010) in their study ***"Knowledge, Attitude and Practice of Contraception Among Multiparous Women at Lady Aitchison Hospital, Lahore"***found that 60 percent of the women have positive attitude towards contraception. 45 percent of the women use contraceptive methods on a regular basis; 33 percent uses it irregularly; the reasons for not using contraception was fear

of side effects, lack of knowledge and the desire to produce a male child. 40 percent of the population still have no awareness and need our attention; by improving the awareness and the practice of using contraception we can reduce the population growth rate.

Dr.Abedin, Asma (2011) conducted a study on ***'Knowledge, attitudes and practice survey of family planning among South Asian immigrant women in Oslo, Norway'*** and found that 59.5 percent of the respondents, aged 31-45 years, have a positive attitude whereas 53 percent, aged 20-30 years show negative attitudes towards family planning.

Mahawar, Priyanka; Anand, Shweta; Raghunath, Deepa and Dixit, Sanjay(2011) carried out a study on ***"Contraceptive Knowledge, Attitude and Practices in Mothers of infants: A Cross-sectional Study"*** at Bhopal (MP) found out that 98 percent women felt that exclusive breast-feeding should be done for 6 months. 46 percentwomen thought that OCPs should be used within 6 months after child birth. 58 percent women felt that Cu-T should be inserted in post delivery period. 96 percent women thought that there should be a difference of minimum 3 years between two children. 86 percent women agreed that permanent sterilization should be done after two children. 46 percent women think they can use i-pill as a regular family planning method.

Olugbenga-Bello, A.I; Abodunrin, O.L and Adeomi, A.A (2011) studied ***"Contraceptive Practices Among Women in Rural Communities in South-Western Nigeria"***. On the attitude of the respondents towards contraception, most of them strongly agreed to the national policy of 4 children per family 487 (79.6 percent) and the involvement of husbands in family planning decisions 476 (77.7 percent). Most of the respondents strongly disagreed with the fact that contraception was against culture and religion 382 (62.4 percent), and that only females should use contraceptives 411 (67.1 percent). Furthermore, they strongly disagree that contraceptives are ineffective 376 (61.4 percent) and that it is only for the literates 489 (79.9 percent). Appreciable number however felt contraceptives would encourage promiscuity 186 (30.4 percent) and would diminish sexual pleasure 162

(26.4 percent). Though 329 (53.7 percent) and 368 (60.2 percent) respectively felt otherwise.

Yoder, P. Stanley; Guèye ,Mouhamadouand Konaté, Mamadou (2011) studied ***'The Use of family planning Methods in Mali: The How and Why of Taking Action'.***Two respondents said their husbands did not agree to the use of family planning. Other reasons infrequently cited were the inefficiency of the method, miscarriage, and menopause. Several of the women who had never used family planning were nevertheless open to using it in the future, as in the comments by a woman from Wakoro.

J. Lwelamira, G. Mnyamagola and M.M. Msaki (2012) studied ***'Knowledge, Attitude and Practice (KAP) Towards Modern Contraceptives Among Married Women of Reproductive Age in Mpwapwa District, Central Tanzania'.*** Despite positive attitude towards modern contraceptives by a considerable proportion of women, its use can be limited by negative attitude of husband towards modern contraceptives as it has been observed in other studies in other parts of Africa (Tuloro et al., 2006; Nwankwo and Ogueri, 2006; Igwegbe et al., 2009; Burke and Ambasa- Shisanya, 2011; Mathe et al., 2011). The study shows two- thirds (65.8 percent) of study participants indicated their husbands don't approve modern contraceptives and very few (20 percent) frequently talk/discuss with husbands on modern contraceptives/family planning, a situation which may hinder uptake of modern contraceptives by married women in a study population.

Juma, P.A; Mutombo, N and Mukiira, C. (2015) in their study ***"Women's attitudes towards receiving family planning services from community health workers in rural Western Kenya"*** found that approval of family planning services delivered by community health workers in rural Kenya is quite low. The need to invest a substantial amount of effort into educating women on the relevance of community health workers' in providing family planning services is quite low. Various methods and campaigns for awareness creation on family planning services

provided by community health workers should be used to facilitate a higher acceptance by the target population. Also, the same study noted that enhancing the capacity of the community health workers to deploy family planning services would help reduce the unmet need for family planning in the area and further impact on overall fertility rate reduction in the country.

Machiyama, K. et al. (May 2018) in their study titled ***"Women's attitudes and beliefs towards specific contraceptive methods in Bangladesh and Kenya"*** found that though there might be a high level of contraceptive usage, it can co-exist with widespread misgivings about the methods, even for those contraceptives that are widely used. The study also noted that concerns about damage to health, long term fertility impairment, and dangers of prolonged use without taking a break were particularly common; these beliefs may explain the high levels of discontinuation of contraceptive use which was observed in Kenya and elsewhere in Africa; however, this pointer provides useful guidance for counselling and informational campaigns for the future.

2.3 Review of Research related to Family Planning Practices.

Sovani, NV and Dandekar, K (1955) conducted ***"Fertility Surveys of Nasik, Kolaba and Satara (North) District, Poona".*** They found that although 52 percent had a positive attitude towards family planning only 1.7 percent in urban and 2.1 percent of the women in rural areas were actually practicing or adopting family planning methods.

Morrison, William. A (1957) conducted a study on the ***"Attitudes of Males and Females towards family planning in a Western Indian Village"*** and found that although most of the respondents were aware of family planning, there was a significant association between number of years married and useof contraceptives with regard to the females. 53 percent of women married less than 15 years were practicing / willing to practice family planning while only 25 percent of women married 15 years or more had the same attitude.

Rao, H. Krishna, Satyanarayanacher, R.A., and Begam, Ameena (1971) conducted ***"A study on the Attitudes of Muslim women towards family planning in Bangalore City"*** and found that out of 500 women, only 17 percent (82 women) were current users of contraception. Of these, 24 women used 'Nirodh' and the rest had undergone tubectomy.

Vora, U.D., and Khatri, T.D. (1971) conducted ***"A study on knowledge, attitude and practice of eligible couples of Banaskantha district towards family planning"*** and found that about 62 percent of the sample couples had never used a method of birth control. Further, there was a noticeable gap between knowledge and practice of birth control.

Zaheer, Mohammad, Sinha, S.N., and Khan, Aziz (1971) conducted a study on the ***"Knowledge and practice of family planning among Grade IV employees of Aligarh Muslim University"*** and found that out of the 316 respondents, only 49 were practicing family planning. Sterilization and condom were the most preferred methods accepted by 14 respondents each.

Akhtar, H.S.M.Q., Sueha, Anjali Kumar, and Islam, Faizul (1972) conducted a study on the ***"Attitude and practices of Graduate School Teachers towards family planning"*** among 207 Higher Secondary School teachers in Patna and found that 38 married males and 5 married females reported practicing birth control at one time or the other.

Das, Narayan (1972) conducted a study on the ***"Factors related to Knowledge, family size preference and Practice of family planning in India"*** and found that 44 percent urban males and 31 percent rural males had ever practiced family planning while 48 percent urban females and 51 percent rural females reported practice of natural methods.

Kee, W. F. and Swee-Hock, S. (1975) in their study ***"Knowledge, Attitudes, and Practice of family planning in Singapore"*** found a high level of contraceptive usage; conditions that led to sterilization and abortion are found to exist as well.

Espenshade, T. J. (1978) in his ***study "Zero Population Growth and the Economies of Developed Nations"*** noted that population trends shape the context in which economic policy decisions are made and may help to determine which policies are required. As revealed in the study, population trends of a given country also influence the labour force, consumptions, savings and investments, education, social security and other government programs and the spatial re-distribution of the population. Lower fertility may be economically more advantageous to society than an average family size of three children.

Thapa, S. (1989) in his study ***"A decade of Nepal's family planning program: achievements and prospects"*** found that the strategies employed to promote family planning should be modified and critically reviewed. The motivation to use family planning for fertility regulation seems to be promising in Nepal. Between 1976 and 1986, the desired number of children in a family set-up decreased by 14 percent among women ageing between 15 - 24 years old; by 12 percent among the women whose age are between 40 - 49. The overall mean for desired number of children declined from 4.0 to 3.5 per woman during the decade.

McGinn, Therese; Sebgo, Pascaline; Fenn, Thomas and Bamba, Azara (1989) conducted a survey entitled ***'Family planning in Burkina Faso: Results of a Survey'.*** The survey revealed that use of traditional methods was more prevalent, as might be expected in this largely traditional society. Forty-eight percent of women reported that they were currently practicing abstinence; this included 41 percent who were postpartum and 7 percent who were not. Of the 41 percent who were postpartum, 97 percent had a child aged three years or younger. It is interesting to note, however, that not all of these postpartum abstainers view their behaviour as "contraceptive": 39 percent of current abstainers (16 percent of the total simple) responded negatively when asked whether they had ever "abstained for several

months or longer in order to avoid having a baby." The interviewers were instructed to prompt on this point in order to clarify the apparent contradiction between the abstainers' behavior and their negative responses. Most responses affirmed the observation that postpartum abstinence is practiced by many for reasons of custom, and is not directly or overtly associated with family planning.

Rao, G.Rama; Moulasha, K. and Sureender,S. (1993) conducted a study on the *'Knowledge, attitude and practice of family planning among fishermen in Tamil Nadu',* which reveals that almost two-fifths (37.8 percent) of the respondents had ever used some type of contraception during their married life. Among the methods, sterilisation was the most accepted method. Nearly a fifth (19 percent) of all the respondents and 52 percent of all ever users reported to have adopted sterilisation. It may be noted that though vasectomy is well known, not a single vasectomy had been performed in the study area. This clearly indicates that only women were active in the adoption of permanent methods. Next to tubectomy, abstinence was the most popular method and around 42 percent of the ever users reported to have practiced it. Such a high percentage of couples practicing natural methods is not found among other societies. Only 6.2 percent of the ever users had accepted temporary methods like the IUD and/or l pills.

The above findings reveal that among the respondents who had accepted family planning, tubectomy ranked first; there was not even a single case of male sterilisation. The reason for this is probably the type of occupation that the men folk are engaged in-since fishing is hard work, the fishermen do not want to take any risk which would affect their livelihood by accepting vasectomy, which they fear will affect their health and strength.

Odimegwu, C. O. (1999) in his study ***"Family planning Attitudes and Use in Nigeria: A Factor Analysis"*** found that the respondents' perceptions or attitudes towards family planning were associated with contraceptive usage: Those who approved of family planning were twice as likely to use contraceptives as compared against the respondents who disapproved; respondents who have good communication with their spouse regarding family planning were also three times

more likely to use contraceptives than those who did not. Women who agreed with statements regarding supporting girls' education and discouraging early marriage were three times more likely to use contraceptives than their counterpart who disagreed. Using Contraceptive was also more common in men who has been exposed to family planning and its methods through the media than among those who were not.

House, William J (2000) studied and published ***'Demographic Behaviour in the Cook Islands: Results From a Recent Survey'.*** He found out that 53.7 percent of all adult women of childbearing age, and 63.2 percent of married women or those in a de facto relationship, are currently using contraception of one form or another. Meanwhile, 50.4 percent of all women and 60.4 percent of currently married women or those in a de facto relationship are using an "effective" method. Another 5.4 percent of all women, and 6.1 percent of women in some form of union, are using an "ineffective" method. Of those women using any contraceptive method, one-third are dependent on the pill while an additional 29 percent use Depo Provera. Almost 14 percent have been sterilized. Therefore, the family planning programme in the Cook Islands is heavily dependent on just two methods of contraception – the pill and Depo Provera – with tubal ligation being used by many older women who have completed their family formation. Only 38 percent of male respondents claimed that they or their spouse had ever used a method of family planning in the past. And only 17 percent admitted to ever having used a condom; no-one had undergone vasectomy. Only 9 percent of the 15-19 year olds and 14 percent of the 20-29 year olds had ever used a condom. The highest ever use of condoms was in the 30 to 39 year olds at 28 percent.

Thomas, M.D.; Thomas, P. and Garland, F.C.(2001) in their study ***"Contraceptive Use and Attitudes Toward family planning in Navy Enlisted Women and Men"*** found that contraceptive use does not depend on gender, age, marital status, pay grade, race, or education. In the study, it was found that contraceptive use was related to attitude towards family planning. Women and men

who used birth control have a more favorable attitude towards family planning than those who did not use birth control.

Hennink, Monique; Stephenson, Rob; Clements, Steve studied ***'Demand for family planning in Urban Pakistan'*** **(2001).** They found out that Seventy-eight percent of women approve of contraceptive use. Approval for contraceptive use is lowest in Larkana (68 percent) and highest in Gujrat (91 percent). It is often the husband's approval of contraception that may lead to actual method uptake. Women reported that 68 percent of husbands approved of contraceptive use. In Larkana only 54 percent of husbands approved the use of contraception.The contraceptive prevalence rate (CPR) refers to the proportion of married women of reproductive age who are currently using (or whose husband is using) a method of contraception. The CPR ranged from 10.8 percent in Larkana to 28.8 percent in Hyderabad. Ever use of contraception was higher in each of the study sites. The majority of users adopted modern methods of contraception. The use of natural methods (rhythm, withdrawal, abstinence and breastfeeding), although low, was highest in Gujrat (7.8 percent). The proportion of women currently using contraception increases with the standard of living (SL); 16 percent of women at a 'basic' SL were users, this increases to 28 percent at 'low' SL, 32percent at 'medium' SL and 35 percent at 'higher' SL. The contraceptive method mix indicates the distribution of contraceptive use across different methods of contraception. Method mix is variable by study site , however the condom, female sterilisation and the IUD are the most commonly used methods of modern contraception. Periodic abstinence and withdrawal are the most prevalent natural methods of contraception.

Korra, Antenane. (2002) in her book ***"Attitudes toward family planning, and Reasons for Non use among Women with Unmet Need for family planning in Ethiopia"*** stated education as one of the factors that significantly contributes to the quality of women's lives. Improving women's access to education and encouraging continuous and constant exposure would significantly increase the use of family planning and reduce unmet need.

Pandey, R. N.(2002) in his study ***"Changing Knowledge, Attitude and Practice of family planning Methods in an Economy under Transition"*** reveals that 60 percent of the Mongolian women in the age-group of 15-49 years expressed their desire to use any contraceptive method in the future, the analysis revealed. Though Mongolia has transition to a market economy, contraceptive use is still very low; between the years 1994 – 1996 there was almost no change in the figure observed for contraceptive usage.

Dabral, Shweta and Malik, S.L. (2004), in their study ***'Demographic Study of Gujjars of Delhi: IV. KAP of family planning'*** found out that maximum proportion of women in the age group 30-34 years, have used a method at any time of their life. Ever use of any method increases with woman's age up to 30-34 years reflecting that, as with age, their fertility goals are fulfilled, the women increasingly adopt contraception. Decline in ever use of contraceptive methods at older ages indicates lower contraceptive prevalence in the past. The most commonly ever-used methods are Intra Uterine Devices (about one-sixth), condom (nearly one-eighth) and female sterilization (two- third). No male sterilization is reported. Current contraceptive prevalence, like that of ever use, is high among Gujjars. Three out of every five currently married women are using some or the other method of contraception. Most of the currently married women (80 percent), who have ever used a contraceptive, are presently using a method. Female sterilization dominates all the contraceptive methods, with four-fifth women being sterilized. The number of living children and the number of sons are the most crucial factors influencing the acceptance of sterilization.

Tuladhar, H and Marahatta, R (2008) studied the ***'Awareness and practice of family planning methods in women attending Gynealogical OPD at Nepal Medical College Teaching Hospital'*** and found that irregular bleeding per vaginum was the most commonly experienced adverse effect as stated by 16 percent followed by weight gain/loss and nausea, headache, weakness, dizziness, loss of appetite etc.Majority (26 percent) of the women had discontinued family planning methods due to side effects, only 12 percent stopped them to conceive next baby, 5.5 percent

gave some other reasons for discontinuation e.g. husband staying away, inconvenience in getting the methods etc.

The study showed a very low use of family planningmethods in contrast to the high level of awareness. 65 percent of the women had never used any methods, whereas only 33.5 percent were currently using one of the family planning methods, among which Depo Provera was the most commonly used one and female sterilization was more common than male. The practice was highest among the age group 20-34 years, urban women, business occupation, Lama/ Sherpa Tamang, women educated more than secondary level and in women with living issue more than two.

Mustafa, Rozina; Afreen, Uzma and Hashmi, Haleema A. (2008) studied ***'Contraceptive Knowledge, Attitude and Practice Among Rural Women'.*** Regarding the usage of contraceptive methods, only 53 (53 percent) of the respondents were using some sort of contraception. Barrier method (condoms) was in practice by 18 (33.9 percent) and 12 (22.6 percent) of women had already undergone tubal ligation. The women using injectables and intrauterine contraceptive devices were 10 (18.8 percent) and 7 (13.2 percent) respectively. Six were using oral contraceptive pills (11.3percent). Positive attitude towards contraception was shown by 76 (76 percent) of them, while 41 (41 percent) stated their husbands' positive attitude towards contraception.

Velankar, Deepa. H (2009) studied ***'Knowledge, Attitude and Practices Regarding Contraceptive Methods of family planning in an Urban Slum Community of Mumbai'*** and found out that 78.6 percent of the women do not use any family planning methods, while 21.4 percent have adopted some family planning methods. It is observed that, among the acceptors, oral contraceptive pills were used, most commonly, followed by IUCD and condoms and as expected it is evident that responsibility of family planning is entrusted. The main reason for discontinuation of family planning among acceptors was desire for male child i.e. 61.1 percent, followed by desire for female child i.e. 22.2 percent, 16.7 percent gave failure of contraceptives as the reason for their conception. Among the 198 non- acceptors of

family planning i.e. 78.6 percent, desire for male child was the main reason followed by religion, no guidance, opposition from home, no female child, superstition, harmful to health, 1-2 children breast feeding and husband away etc. Among the 198 women 85 women did not answer this question.

Kumar Arjit, Bhardwaj,P., Srivastava,J.P. and Gupta, P (July 2009 to July 2011) which revealed the acceptance of family planning methods, both temporary and permanent, increased with level of literacy of women. More number of illiterate and primary educated accepted permanent method after 3 or more children than higher educated who accepted it after 1 or 2 children. Among acceptors of permanent methods, total 70.27 percent were experiencing side effects and among temporary method users, it accounted 23.30percent.

In conclusion, acceptance in family planning is associated with increasing age, nuclear family and level of literacy. IUD is the most accepted one among all temporary methods. Vasectomy and newer contraceptives were not used at all.

Deb, Roumi (2010) undertook a study on ***" Knowledge, Attitude and Practices Related to family planning Methods among the Khasi Tribes of East Khasi Hills, Meghalaya "*** to know the extent of awareness, attitude and practices of family planning methods among the Khasi women. She found that the knowledge of family planning methods is not much widespread but more than fifty percent of the women were adopting at least one kind of family planning method. The majority of the women who adopted family planning methods belonged to the age group 25-35 years. However, there is a gap between the knowledge and the practice of contraception among these women.

Sajid, A. and Malik. S. (2010) in their study ***"Knowledge, Attitude and Practice of Contraception Among Multiparous Women at Lady Aitchison Hospital, Lahore"***. 45 percent of the women use contraceptive methods on a regular basis; 33 percent uses it irregularly; the reasons for not using contraception was fear of side effects, lack of knowledge and the desire to produce a male child.

Abdel Aziem A Ali, Duria A Rayis, Mona Mamoun and Ishag Adam (2011) studied ***'Use of family planning methods in Kassala, Eastern Sudan'*** and concluded that Oral combined contraceptive pills was the predominant method used by the enrolled women (46.7 percent) followed by progesterone injection (17.8 percent), progesterone only pills (15.2 percent), intrauterine contraceptive device (7.4 percent), safe period (6.7 percent), male condom (4percent) and abstinence (2.2 percent). Husband objection (47.5 percent), religious belief (28.2 percent), desire for more babies (14.3 percent), fear of side effects (6.14 percent), non- availability (2.7 percent) and medical diseases (1.2 percent) were common reason for non use of family planning given by the respondents. While age and residence were not associated with the use of family planning services, high parity (> five), educational levels (secondary level) of the couples were the significant predictors of family planning services use in this setting.

Mahawar, Priyanka; Anand, Shweta; Raghunath,Deepa and Dixit,Sanjay (**2011**) in their study ***"Contraceptive Knowledge, Attitude and Practices in Mothers of Infant: A Cross-Sectional Study"*** found out that 40 percent women had used family planning method in past, 26 percent were using family planning method at present out of which only 1 women was using Condom, 10 were using Cu-T and 2 had adopted permanent method i.e. tubectomy. Only 1 woman in this study, had used I-pill in past on the advice of her mother.

P. Stanley Yoder, Guèye, Mouhamadou and Konaté, Mamadou (2011) studied ***'The Use of family planning Methods in Mali: The How and Why of Taking Action'.*** The research into the reasoning of women who had previously used contraceptives but were not currently using them focused on why they had discontinued use. Out of a total of 72 respondents, 17 had previously used contraception but were not current users. Two respondents said their husbands did not agree to the use of family planning. Other reasons infrequently cited were the inefficiency of the method, miscarriage, and menopause.

In the group of former users, two major reasons for discontinuing family planning were given: 1) the desire to have another child; 2) the side effects experienced in

using pills or injectables. Seven women said they had ceased using a modern method because they wanted to have another child. Six said they stopped because of side effects.

The side effects cited primarily concerned injectables, though a few women also had problems with the pill. Some women said they had fallen seriously ill after the injection. Women complained of abdominal pains, the absence of periods, or, on the contrary, excessive bleeding. Women using contraceptive methods gave other reasons besides spacing births. Six said they did not want more children any time soon because of financial reasons, and that they thought the household could not afford the expenses of a larger family. Four had suffered from difficult pregnancies and wished to avoid more. Three had had caesarean. Only two declared categorically that they did not want any more children.

In sum, nearly all women interviewed understood that family planning can be used to space births, including those who have never used family planning. They recognized the positive effects of proper birth spacing. Several of the women who had never used family planning were nevertheless open to using it in the future, as in the comments by a woman from Wakoro.

Patel, Mitali G; Mahyavanshi, Darshan K; Kartha, Girija; Purani, Shyamal K and Nagar, Sunita S. (2011) conducted ***"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"*** which revealed that the most common reason for not using OC pills in spite of awareness was fear of side effects(80.4 percent) followed by "forget to take" (7.6 percent) and "do not like" (5.2 percent), while the "failure of contraception" was answered by only 3 women . Most common reasons for not using IUDs are fear of wearing (22.5 percent) & increased menstrual bleeding (15.5 percent). In the present study, the couple protection rate was 51 percent, which is less as compared to NFHS-III data for Gujarat which is 66.6 percent. Availability of spacing methods is better in the area under supervision of UHTC. Cu T (14 percent) was most popular spacing method being used followed by OC pills & condom. The possible explanation for popularity of Copper T could be that it is a one time procedure &

gives protection for longer time. The most important reason for not using spacing methods was that those who were not using any contraceptive methods perceived risk of pregnancy more.

Peyman, Nooshin and Oakley, Deborah (2011) studied ***'Married Iranian Women's Knowledge, Attitude and Sense of Self- efficacy about Oral Contraceptives: Focus Group Discussion'*** and found that almost half (n=6) of the users thought that pill side-effects were the reason people thought it should be used for a short time. Commonly, users mentioned side-effects of the pill as weight gain, headache, nervousness, dizziness and menstrual irregularities. Four mentioned other complaints such as gastric tenderness, an increase in body hair and changes in mood. Menstrual irregularities were defined as shortened bleeding time, lengthened cycle or amenorrhea. More than two-thirds (n=9) of the users stated that unwanted side-effects of pill use could be eliminated if the user instructions were well- understood and followed. In addition, it was recognized that health checks were required before starting the pill. These participants understood the pill's effect on menstrual cycle regulation. Users talked about the effectiveness of OCs and stated that they had not experienced an increase in body hair or nervousness.

Olugbenga-Bello AI, Abodunrin, O.L and Adeomi,A.A(2011) studied ***Contraceptive Practices Among Women in Rural Communities in South-Western Nigeria***. They found that more than half 406 (66.3 percent) were currently using a modern contraceptive method, 41 (6.7 percent) and 4 (0.7 percent) were using natural and traditional methods respectively, however, 161 (26.3 percent) were not using any method, main reasons being affordability and availability 184 (41.2 percent), and reliability (20.1 percent). Rings 359 (58.7 percent), abstinence 527 (86.1 percent), male condom 571 (93.3 percent) and injectables 491(80.2 percent) were the most well-known traditional, natural, barrier and hormonal methods respectively. Majority of the respondents 406 (66.3 percent) were currently using a modern contraceptive method, 41 (6.7 percent) were using natural methods, 4 (0.7 percent) were using traditional methods and 161 (26.3 percent) were not using any method. The main reason given for choice of contraceptive methods was

affordability and availability, 184 (41.2 percent), followed by reliability by 20.1 percent of the respondents. Most of the non-users 142 (86.4 percent) did not have any reason for not using any method. Most of the users had used the method of choice between 1- 5 Years (44 percent), followed by 6-10 years by 26.6 percent of the respondents.

Dr. Asma Abedin (2011) conducted a study on ***'Knowledge, attitudes and practice survey of family planning among South Asian immigrant women in Oslo, Norway'***and found that majority of the (83.3 percent) of the South Asian immigrant women married in the age of 18-24 years. Two third of the (66.7 percent) respondents had not used any contraceptives after marriage and half of the (56.6 percent) respondents have at least one child. Among the South Asian immigrant respondents, 68.9 percent of women were using contraceptives either modern or traditional contraceptive methods. Over forty percent (40.1 percent) of South Asian immigrant married respondents take oral contraceptive pills followed by 31.2 percent of women who use intrauterine device, 12.1 percent who use condoms and 13.4 percent of women who practised traditional methods. More than two third (80.2 percent) of the women 31-45 years were using contraceptives. The majority (76.7 percent) of the women using contraceptive were Sri-Lankan in origin using contraceptive. Only 57.1 percent women of Pakistani origin were using contraceptives compared to other ethnic group. Women who had less than 12 years of education 84.3 percentwere using contraceptives. There is a significant association between use of contraceptives and age (p-value <0.001*) and education (p-value <0.001). Women who had positive attitude towards family planning (78.1 percent) and women who have 2 or more children (85.9 percent) were using contraceptives and there was significant association between positive attitude (p-value 0.001*Fisher's exact test), number of children (p-value-<0.001* Fisher's exact test) and contraceptive use.

J. Lwelamira, G. Mnyamagola and M.M. Msaki (2012) studied ***'Knowledge, Attitude and Practice (KAP) Towards Modern Contraceptives Among Married Women of Reproductive Age in Mpwapwa District, Central Tanzania'.*** They found that nearly one- third (31.6 percent) of sampled women indicated to have ever used

modern contraceptives with most ever used method being injection (72 percent) followed by pills (60 percent) mainly obtained from public health facilities. Criteria for the choice of the method were mainly safety and convenience indicated by 38 percent and 30 percent of the respondents, respectively. Studies have indicated women prefer injection method as it is long term acting and it is not easy to be detected by a husband (secrecy) in case he doesn't approve modern contraceptives. Although a noticeable proportion of respondents ever used modern contraceptives, however, there was a substantial drop-out and shifting from one method to another. As a result, by the time this study was carried out a proportion of current users of modern contraceptives for the married women of reproductive age (i.e., contraceptive prevalence rate) stood at 25.3 percent . This figure indicates there is some improvement when compared to the value of 20 percent reported for the national averages on the year 2004/2005 (TDHS, 2005). However, the current figure is far away (too low) from the national target of 60percent (URT, 2010), indicating more effort is needed to increase contraceptive use in a study population. Furthermore, results indicate that more than half (56 percent) of the respondents reported that they had ever experienced side effects and 22 percent, that is two in every ten respondents had ever shifted from one method to another. Irregular bleeding and abdominal pain were the main side effects ever experienced mentioned 64.3 percent and 32.1 percent of the respondents, respectively. Studies have indicated experiencing of side effects are among the major factors for non use of modern contraceptive, drop-out and shifting from one method to another among women (Marchant et al., 2004; Khan et al., 2008; Igwegbe et al., 2009).

Makade, Kiran.G et. al. (2012) conducted "***A Study of Contraceptive Use Among Married Women in a Slum in Mumbai"*** whoseobjectivesinclude studying the practices and preferred method of contraception. 342 married women were interviewed out of which 68.4 percent women were using a contraceptive at the time. It was concluded that although there is a high level of awareness, contraceptive use is not very high. New methods of motivating people to adopt and sustain family planning methods should be considered.

Koranne. S.P. and Wahane. R. A. (Oct – Dec 2014) carried out a study on ***"An Analysis of Awareness and Utilizaion of Contraceptives amongst Married Women Attending a Tertiary Care Hospital in Maharashtra"*** and the study reveals that the women respondents have awareness and favorable attitude towards contraception. However, some of the reasons for the non acceptance of contraceptives include worries about side effects, misconceptions, desire to have a male child, and poor FP services. Therefore, by proper motivation, counselling and improving the facilities at both Government & Private sector, the unmet need of contraception can be achieved.

Pandey, D; Garg, D and Salhan, S (2014) in their work "Study of knowledge and contraception practices in low socio-economic women of Delhi" found that lack of education, knowledge and awareness led to inadequate usage of contraception in women who are in the reproductive age group from a low socio-economic status. The study established that availability is not sufficient to reach optimum female health; accessibility to family planning methods need to be increased by means of educating the females and motivating couples to make use of the existing family planning methods and resources.

Juma, P.A; Mutombo, N and Mukiira, C (2015) in their study "***Women's attitudes towards receiving family planning services from community health workers in rural Western Kenya"*** found that approval of family planning services delivered by community health workers in rural Kenya is quite low. The need to invest a substantial amount of effort into educating women on the relevance of community health workers' in providing family planning services is quite low. Various methods and campaigns for awareness creation on family planning services provided by community health workers should be used to facilitate a higher acceptance by the target population. Also, the same study noted that Enhancing the capacity of the community health workers to deploy family planning services would help reduce the unmet need for family planning in the area and further impact on overall fertility rate reduction in the country.

Machiyama, K. et al. (May 2018) in their study ***titled "Women's attitudes and beliefs towards specific contraceptive methods in Bangladesh and Kenya"*** found that though there might be a high level of contraceptive usage, it can co-exist with widespread misgivings about the methods, even for those contraceptives that are widely used. The study also noted that concerns about damage to health, long term fertility impairment, and dangers of prolonged use without taking a break were particularly common.

2.4 Overview of the Studies Reviewed

This chapter on the review of related literature has been summed up under the following three sections –

2.4.a Review of the Studies on Awareness:

In light of the various studies reviewed, it may be noted that education could be one of the key factors in creating awareness among the people. Dandekar and Dandekar (1953) in their study a *"Survey of Fertility and Mortality in Poona District"* found that out of 752 females, only 40 females were aware of family planning methods; this could be due to the fact that during that time, female education was not given much importance especially in a country like India. Kazi (2008) conducted "*A study of Knowledge, Attitude and Practice (KAP) of family planning among the women of rural Karachi"* andfound that education or literacy is one of the major factors in creating awareness among the people. Khan (1979) in the study "*family planning among Muslims in India"* noted that they lacked clear and adequate knowledge about family planning and its methods and it was also observed that majority of the Muslims have blind belief that family planning is against religion although family planning programs were very popular among them. Education could help get rid of these misconceptions. Sovani and Dandekar (1955) in their study *"Fertility Surveys of Nasik, Kolaba and Satara (North) District, Poona"* found that 49 percent were unaware of family planning methods, 48 percent felt it was not necessary to have the knowledge about family planning. Therefore, Education could be one solution to creating proper awareness among the people. In the current study, the researcher tries to determine if education, among other factors,

has an impact on the awareness of family planning and its practices among Mizo Women.

Some of the reviewed literatures also showed that the kind of occupation one holds may also lead to awareness of family planning and its methods. Zaheer, Sinha, and Khan (1971) conducted a study on the *"Knowledge and practice of family planning among Grade IV employees of Aligarh Muslim University"* and found that, out of 316 respondents, over 90 percent were aware of family planning through mass media or other sources. Taneja (1972) carried out a study on the *"Fertility, Knowledge, Attitude and Practice (KAP) in relation to family planning in a selected population of Armed Forces"* which included 251 civil women and 230 women of service personnel respondents. All respondents were aware of family planning and 50 percent of civilian and 66 percent of service women knew of the use of one and more methods of birth control. It can also be noted that the percentage of service women is higher as compared to civilian women in terms of awareness towards family planning and its practices; therefore, the occupation one holds could be one factor affecting awareness of family planning and its methods. Akhtar, Sueha, and Faizul (1972) conducted a study on the *"Attitude and practices of Graduate School Teachers towards family planning"* among 207 teachers in Patna and found that 30 percent of the unmarried males and 35 percent of the unmarried females could mention some methods of contraception in contrast with 8.12 percent of the married males and 90 percent of the married females. In light of these studies, the current study also tries to attempt to find if occupation has an impact on the awareness of family planning and its methods among Mizo Women. It is noteworthy that no studies on the KAP of family planning pertaining to Mizoram or the Mizo people have ever been done before.

In the current study, the researcher also took up locale and socio-economic status as possible factors that could have an impact on the awareness of family planning among Mizo Women.Vora and Khatri (1971) in their study *"A study on knowledge, attitude and practice of eligible couples of Banaskantha district towards family planning"* found that 64 percent of the respondents reported the family planning staff as the source of information. This could be because if one holds an occupation in the areas where the Government constantly organises seminars and

awareness programs, it is likely that the person would be aware as well.Das (1972) conducted a study on*"Factors related to Knowledge, family size preference and Practice of family planning in India"* and found that nearly 77 percent of urban males and 64 percent of urban females had heard of family planning methods as compared to 72 percent rural males and 69 percent rural females. This increases the likelihood that the locale (Rural vs Urban) where one resides could have an impact on the awreness of familyplaning. Kee. W. F. and Swee-Hock. S. (1975) in their study *"Knowledge, Attitudes, and Practice of family planning in Singapore"* found that they have good knowledge about methods of contraception and reported a high level of its usage; Again, this could be attributed to the fact that Singapore is a highly developed country and has good communication systems as well. Bhuyan (1991) on the basis of a study on *" Social Mobility and family planning Practices in Rural Bangladesh – A Case Study "* concluded that every couple in the rural area is aware of family planning but very few practice it. Mao. J. (2007) in the study "*Knowledge, Attitude and Practice of family planning: A Study of Tezu Village, Manipur (India)"* found that 48 percent of the respondents had the knowledge of tubectomy and 44 percent of the respondents reported that it is through friends they come to know about the different contraceptive methods. Deb (2010) undertook a study on *" Knowledge, Attitude and Practices Related to family planning Methods among the Khasi Tribes of East Khasi Hills, Meghalaya"* and found that the knowledge of family planning methods is not much widespread but more than fifty percent of the women were adopting at least one kind of family planning method. However, there is a gap between the knowledge and the practice of contraception among these women. In light of the reviewed literature, the researcher has also set out to determine if education, occupation, socio economic status and locale could have an impact on the awareness of family planning and its methods.

Awareness towards family planning programs and methods is important as family planning can only be applied if one has an awareness of the subject first. Creating appropriate awareness by educating the people could get rid of any misconceptions towards family planning methods and programs that couples might have. Hence, creating awareness or educating the people helps by giving a real-time view about the concept of family planning and tries to get rid of all the negativity

towards the same by actually showing/telling the targeted population what family planning is all actually about and that it has nothing to do with their religious beliefs or cultural values. The researcher also looked into occupation, socio economic status and locale as possible causes that could affect or have an impact on the awareness of family planning and its methods among Mizo Women. High level score on awareness could lead to a high level of application of family planning and it methods. The higher the awareness, the higher the chances of application. As cited previously, It is noteworthy that no studies on the KAP of family planning pertaining to Mizoram or the Mizos have ever been done before; and the current study is the Pilot study pertaining to Mizo Women regarding the subject under discussion i.e. KAP of family planning.

2.4.b Review of the Studies on Attitude:

Attitude towards family planning means the predisposition that a person has regarding family planning.The current study also focuses on the attitude of Mizo women regarding family planning and its practices. In light of the reviewed related literatures, the researcher has also set out to determine if attitude towards family planning is affected by education, occupation, socio economic status or locale. Some of the literatures reviewed showed a trend of how attitude could be impacted by education, occupation, socio economic status or Locale.

Dandekar and Kumudni (1951-52) conducted the first of the studies on the attitudes towards the adoption of family planning in India in the District of Poona. In their study *"Attitudes towards family planning and Limitations"* it was found that there was widespread ignorance regarding the contraceptives and it was observed that if the subject of family planning was introduced without creating appropriate background, it was liable to failure because of misconception about family planning. The study justifies the importance of education or appropriate awareness to have a favourable attitude towards family planning and its methods. Dandekar and Dandekar (1953) in the study *"Survey of Fertility and Mortality in Poona District"* to investigate attitudes towardfamily planning, found that out of 1,767 males and 752 females, 206 males and 121 females were totally opposed to family planning. It is therefore, unlikely that they will ever adopt family planning practices due to their

attitude that could have stemmed from lack of proper knowledge.Sovani and Dandekar (1955) in their study *"Fertility Surveys of Nasik, Kolaba and Satara (North) District, Poona"* and found that 48 percent felt that it was not necessary to know about family planning methods. From the few studies cited above, amongst many, it is evident that practicing family planning depends on whether the person has a favourable attitude towards family planning and its methods through a process of education or creating appropriate awareness regarding the same. For example, the study conducted by Akhtar, Sueha, and Faizul (1972) titled *"Attitude and practices of Graduate School Teachers towards family planning"* found that among 207 graduate teachers of Higher Secondary Schools in Patna (180 males and 27 females). The study revealed that 80 percent males and 85 percent females have a positive attitude towards family planning. Therefore, the high level of percentage on teachers with a favourable attitude could be attributed to education which could foster a positive outlook towards family planning and its methods.

Another noteworthy study that has cited education as an important factor was conducted by Korra (2002) in her book *"Attitudes toward family planning, and Reasons for Non use among Women with Unmet Need for family planning in Ethiopia"* stated education as one of the factors that significantly contributes to the quality of women's lives. Improving women's access to education and encouraging continuous and constant exposure would significantly increase the use of family planning and reduce unmet need. Family planning services needs to be expanded and strengthened in rural Ethiopia so as to let the people gain knowledge, education, and counselling on family planning and provide services to the needy, especially to the unreached and underserved populations.

The current study also focuses on socio economic status (SES) and locale as instrumental in forming an attitude towards family planning. The study conducted by Rao, Krishna, Satyanarayanacher and Ameena (1971) called *"A study on the Attitudes of Muslim women towards family planning in Bangalore City"* found that out of 500 women, 402 women had a favourable attitude towards family planning and approved of the use of family planning methods. However, Chandrasekhar,S (1959) conducted a study on *"family planning in an Indian Village : Motivation and Methods"* at village Mangadu, Chingleput District, Madras and found that 55

percent of husbands and 58.11percent of wives were strongly in favour of family planning whereas 44.65percent males and 41.6percent females were against family planning. The difference could be because the population sampled in the studies are from a city and a village respectively. This makes it likely that the locale (rural and urban) could be one factor that can determine one's attitude towards family planning and its methods. Another study done by Kee and Swee-Hock (1975) on *"Knowledge, Attitudes, and Practice of family planning in Singapore"* found that, by and large, the attitudes of the married women in Singapore towards family planning are favourable. Likewise, Belcher, Neumann, Ofosu-Amaah, Nicholas and Blumenfeld (1978) conducted a survey in Ghana on the *'Attitudes Towards family Size and family planning in Rural Ghana-Danfa Project: 1972 Survey Findings'*. Most respondents (70.1percent) reported approval, including 67.4percent of males and 72.1percent of females; 26.7percent of the sample disapproved and 3.7percent were uncertain. It is noteworthy that the studies done by Kee and Swee-Hock (1975) and Belcher, Neumann, Ofosu-Amaah, Nicholas and Blumenfeld (1978) both showed a high approval percentage for family planning practices in both areas i.e. Singapore and Rural Ghana. This showed that people from a more developed or urban places are likely to have a more favourable attitude towards family planning. It is also likely that people from high socio economic status would have a more favourable attitude towards family planning and its methods as they are more likely to settle in urban areas. Hence, the researcher has also set out in an attempt to determine if socio economic status and locale are one of the factors that could affect the attitude of Mizo women towards family planning and its methods. Also, in the study conducted by Dhingra, Manhas, Kohli and Mushtaq (2010) on *'Attitude of Couples towards family planning'* it was found that Just 21 percent of females and 25 percent males had positive attitude, indicating that family planning measures are not widely accepted by rural respondents especially by males. Occupation also plays an important role as many of us resides where our work is located. Hence, people could migrate to the urban areas because their occupation required them to, which in turn could influence their attitudes on family planning and practices.

The chances of application of the methods of family planning depend a lot on a positive attitude. Negativity towards family planning makes it unlikely that the

various methods of family planning would be applied. Hence, it is due to this that awareness campaigns are done in such a way to facilitate a positive outlook towards family planning. For the same reason, the Government changed the name of the family planning Department to Reproductive & Child Health as the name 'family planning' was viewed with a lot of scepticism and negativity and it was also not in sync with the religious beliefs of the people. Hence, for any family planning programs and methods to be successful, one has to garner a positive and favourable attitude towards the concept of family planning.

2.4.c Review of the Studies on Practices:

There are various practices involved in family planning. Practices simply refers to the means by which couples put a method of family planning to use; it may involve using methods like using contraceptives in the form of condoms, Intravenous Uterine Devices (IUD), Tubectomy etc. to keep spacing between the birth of children or to completely prevent unwanted pregnancies.In the current study, the researcher also tries to find out the practices of family planning prevalent among Mizo women in relation to education, occupation, socio economic status and locale. Some of the studies reported in the reviewed related literature showed that there is a gap in the knowledge and practice of family planning and its methods; not everyone who is aware or has knowledge of family planning practices are practicing family planning and its methods. Hence, there is a gap between the knowledge and application of family planning and its methods.

Vora and Khatri (1971) in their study *"A study on knowledge, attitude and practice of eligible couples of Banaskantha district towards family planning"* found that about 62 percent of the couples had never used a method of birth control. Further, there was a noticeable gap between knowledge and practice of birth control. Morrison (1957) in his study *"Attitudes of Males and Females towards family planning in a Western Indian Village"* found there was a significant association between number of years married and use of contraceptives with regard to the females. 53 percent of women married less than 15 years were practicing / willing to practice family planning while only 25 percent of women married 15 years or more

had the same attitude. Likewise, Zaheer, Mohammad, Sinha and Khan (1971) conducted a study on *"Knowledge and practice of family planning among Grade IV employees of Aligarh Muslim University"* and found that out of the 316 respondents, only 49 were practicing family planning; Akhtar, Sueha and Islam (1972) conducted a study on the *"Attitude and practices of Graduate School Teachers towards familyplanning"* among 207 Higher Secondary School teachers in Patna and found that only 38 married males and only 5 married females reported practicing birth control at one time or the other. From the studies, it is evident that just knowledge of family planning does not lead to its practice.

It is important to apply healthy practice of family planning and its methods as the growing population has created big issues that are environmental, economic, social, etc in nature. From the reviewed related literature, education seems to be one way of dealing with the issues relating to family Practices. In some of the studies (Thapa, 1989; Korra, 2002), it was found that proper and appropriate awareness or education could lead to the application of family planning practices. In light of these studies the researcher has set out to give a real-time view of the current practices followed or applied by Mizo women regarding family planning and its practices. As cited previously, there has been no study conducted in the past that pertains to Mizo Women and family planning. The current study conducted will be the first and Pilot study.

The researcher has also reviewed the trend of family planning practices in different places (Dabral and Malik, 2004; Tuladhar and Marahatta, 2008; Mustafa, Afreen and Hashmi, 2008; Velankar, 2009; Deb,2010; Abdel, Duria, Mona and Ishag, 2011; Yoder, Guèye, and Konaté, 2011; Peyman and Oakley, 2011; Sajid And Malik, 2010; Dr. Abedin, 2011; Koranne and Wahane, Oct – Dec 2014; Pandey, Garg and Salhan, 2014) and it was noted that education, locale, socio-economic status and occupation could be instrumental in the correct or healthy practice of family planning and its methods even in the context of Mizo women.

Putting the practices of family planning to use is mainly the objective or aim of all family planning campaigns. One has to follow the kind of practices that best suited his/her lifestyle. There are some methods that are more expensive than others.

Hence, to practice family planning methods, one needs to have awareness coupled with a positive attitude; only then it is likely that a couple will practice family planning methods. Therefore, the researcher has made an attempt to find out if there is any association between family planning practices and education, occupation, socio-economic status and locale.

CHAPTER – III: METHODOLOGY :

3.0 Introduction

The reliability, validity and generalizations of findings of any research largely depend on the methods and procedures adopted by the researcher in the execution of his/her study. Besides, it helps the readers in understanding the various processes employed in the conduct of the research. Thus, in this chapter the scholar has attempted to explain the methodological issues relating to method of study, population & sample, construction of tools for data collection, collection & tabulation of data, and statistical techniques used for data analysis. A brief description of each is given as under.

3.1 Method of Study

As the study was expected to examine and describe the existing status of awareness, attitude and practices of Mizo women relating to family planning programs, therefore, the investigator decided to use the descriptive method of study.

3.2 Population of the Study

All the married Mizo women residing in the state of Mizoram constituted the sample of this study. The Table 3.1 gives an overall population of women in various districts. However, the classified data on the number of married women was not available. Perusal of data vide the same table reveals Mizoram population as per 2011 census consists of 49.4 percent of females and 50.6 percent males. A district wise comparison of gender composition of population reveals that other than Aizawl district, the population of males is higher than females in all other districts.

TABLE -3.1

District-wise Details of Population of Women

District	Population of Women					
	Male		Female		Total	
	N	%	N	%	N	%
Aizawl	201072	49.8	202982	50.2	404054	37.0
Lunglei	79252	51.4	74842	48.6	154094	14.1
Saiha	28490	50.5	27876	49.5	56366	05.2
Lawngtlai	60379	51.4	57065	48.6	117444	10.8
Champhai	63299	50.4	62071	49.6	125370	11.5
Serchhip	32824	50.5	32051	49.5	64875	05.9
Mamit	44567	51.9	41190	48.1	85757	07.8
Kolasib	42456	51.1	40598	48.9	83054	07.6
Total	5,52,339	50.6	5,38,675	49.4	10,91,014	

Source : Census, Provisional Population Totals, Mizoram, 2011.

3.3 Sample and Sampling Design

A sample consisting of 1164 married Mizo women was selected from all 8 districts of Mizoram through stratified proportionate random sampling design. Aizawl, Lunglei, Champhai and Lawngtlai districts being the four biggest districts, having 37 percent, 14 percent and 11 percent of the state population of women, respectively; the scholar took almost the same proportion of sample from these districts. The remaining 27 percent of the sample was drawn from the remaining four districts, keeping in view the proportion of their population (For details see Table 3.2)**.**

The variable wise distribution of the sample has been explained as following-

3.4 Composition of Sample in Terms of Independent Variables

a) Composition of Sample in Terms of Level of Education

In terms of level of educational background, 412 women (35 percent) were from Elementary Education background, 544 women (47 percent) from Secondary & Higher Secondary Education background and 208 (18 percent) from Higher Education backgrounds.

b) Composition of Sample in Terms of Occupation

In terms of occupational structure, the sample of this study comprised of 202 (17 percent) women from different professions, 147 (12 percent) from clerical background, 229 (19 percent) business women, 155 (13 percent) farmers, 123 (10 percent) daily labourers, and 308 (27 percent) housewives.

c) Composition of Sample in Terms of Socio-Economic Status

In terms of socio-economic status, the sample of this study comprised of 358 (31 percent) women from Low Socio-Economic Status (LSES), 709 women (61 percent) from Middle Socio-Economic Status (MSES) and 97 women (8 percent) from High Socio-Economic status (HSES).

TABLE – 3.2

Composition of Sample in terms of Level of Education, Occupational background, Socio-Economic Status and Locale

District	Locale		Level of Education			Socio-Economic Status			Occupation					
	Rural	Urban	El. Edn	High & Hr. Sec	Higher Edn	LSES	MSES	HSES	Professional	Clerical	Business	Farmers	Daily Laborers	Housewives
Aizawl	176	267	187	163	93	127	276	40	75	44	90	56	49	129
Lunglei	55	100	48	70	37	28	103	24	42	27	19	36	5	26
Saiha	30	51	34	45	2	46	31	4	7	12	17	1	2	42
Lawngtlai	38	58	23	59	14	15	70	11	20	25	6	4	7	24
Champhai	57	87	24	80	40	41	97	6	37	16	36	7	27	21
Serchhip	30	50	33	43	4	34	42	4	12	1	16	11	11	29
Mamit	30	50	34	39	7	38	40	2	9	2	12	34	11	12
Kolasib	35	50	29	45	11	28	51	6	13	2	34	16	5	15
TOTAL	**451 (39%)**	**713 (61%)**	**412 (35%)**	**544 (47%)**	**208 (18%)**	**357 (31%)**	**710 (61%)**	**97 (8 %)**	**215 (18%)**	**129(11%)**	**23(20%)**	**165 (14%)**	**117 (10%)**	**308 (27%)**

Source: Computation from Field Wor

d) Composition of Sample in Terms of Location

In terms of rural-urban composition, the sample of the study consisted of 451 women (39 percent) from urban areas and 713 women (61 percent) from rural areas. A perusal of data vide Table - 3.2, further reveals that the percentage of sample of

urban women in all eight districts varied from 35.4 percent from Lunglei district to 41.4 percent from Kolasib district. For more specific details on district wise composition of rural and urban sample one can look into the Table 3.2.

3.5 Tools and Techniques of Data Collection

The required data for this study was collected by using the following tools:

1. Socio-economic Status Scale developed by Lallianzuali Fanai and R.P.Vadhera (2005).
2. Attitude Scale towards family planning, developed by the investigator.
3. Awareness Scale about family planning Methods and programs, developed by the investigator.
4. Questionnaire on family planning Practices, developed by the investigator.
5. The data relating to the status of family planning programs run by the state government and NGOs were collected through personal interviews with the concerned state level officers**.**

3.6 Description of Tools

A. Socio-Economic Status Scale:

To find out the Socio-Economic Status of the respondents, Socio-Economic Status Scale developed by LallianzualiFanai and R.P.Vadhera was adopted and administered to the respondents. The scoring key developed by the authors was used for scoring of the SES Scale. A copy of this scale along with the scoring key has been given in (Appendix – No.1)

B. Questionnaire on Awareness about family planning programs and Methods :

To find out the status of awareness among Mizo women about various family planning methods and programs, an awarenessscale was constructed by the investigator as there was no readymade scale that could be used. The steps and procedures adopted for its construction have been explained as follows:

(i) Collection of Statements

For construction of statements to measure the awareness, the investigator consulted available literature related to awareness of family planning methods and programs. A total of 40 statements were framed for the first draft. A thorough study of the statements was made by the investigator's guide, and the statements were reduced to 35 statements. These 35 statements were set in the form of multiple choice questions and distributed to experts in the field of family planning for content analysis. After the editing by 5 experts and try out on a sample of 10 women, these 35 items were reduced to 29. Thus, the final draft of this questionnaire has only 29 statements.

(ii) Establishment of Reliability

To ensure that the awareness scale has the desired reliability to generalize the findings to the target population, the scholar split her awareness scales into two halves on the basis of odd and even items, and worked out the coefficient correlation between two halves with Product Moment Method which came out to be 0.59. The reliability of the half-test was then converted into the self-correlation of the whole test by using Spearman-Brown Prophecy formula (Garrett, page no. 339) which came out to be 0.74. The procedures adopted and the relevant computations for reliability coefficient of Awareness Scale have been given in Table – 3.3.

(iii) Establishment of Validity

The content validity of the scale was established on the basis of opinion of experts in the field of education and family planning.

TABLE – 3.3

Split-Half Scores on Awareness Scale of 100 Respondents

Sl. No	1st Half	2nd Half	Sl. No.	1st Half	2nd Half	Sl. No.	1st Half	2nd Half	Sl. No.	1st Half	2nd Half
1	10	3	26	10	4	51	12	6	76	5	6
2	5	2	27	11	6	52	10	8	77	10	9
3	5	1	28	13	7	53	7	3	78	3	4
4	12	5	29	9	6	54	13	5	79	14	8
5	10	8	30	10	7	55	18	9	80	5	2
6	13	5	31	16	9	56	7	2	81	11	5
7	4	8	32	7	7	57	10	9	82	7	3
8	10	6	33	10	7	58	9	6	83	5	7
9	16	9	34	16	9	59	15	7	84	6	5
10	9	7	35	16	7	60	14	8	85	8	7
11	17	7	36	8	7	61	9	7	86	11	6
12	18	11	37	16	6	62	16	8	87	7	6
13	16	8	38	14	8	63	13	5	88	10	7
14	18	10	39	14	6	64	17	8	89	15	6
15	15	6	40	16	9	65	14	6	90	15	8
16	10	5	41	14	7	66	15	5	91	16	7
17	6	5	42	11	7	67	12	4	92	10	6
18	17	8	43	16	6	68	10	6	93	3	5
19	14	4	44	9	6	69	10	6	94	7	7
20	15	5	45	14	10	70	18	10	95	3	7
21	15	7	46	9	5	71	17	9	96	9	6
22	12	7	47	10	8	72	16	7	97	15	5
23	5	0	48	7	3	73	5	6	98	10	6
24	12	7	49	12	6	74	6	6	99	17	9
25	10	9	50	10	8	75	9	6	100	3	8

Scoring : Computation from Field Work

(iv) Scoring of the Awareness Scale

A scoring key, wherein all the correct answers of each multiple choice question were provided, was developed by the researcher. Each correct answer was given a score of one (1) and a wrong answer yielded a score of zero (0). Thus, the highest score a respondent could get was twenty nine (29) and the lowest score obtainable was zero (0). The scores of all the 1164 respondents were classified and arranged into tables according to the independent variables as well as the objectives of the study.

C. Attitude Scale towards family planning

There was no readymade scale available that could be readily used to study the attitude of Mizo women towards family planning, therefore, an attitude scale towards family planning was constructed by the investigator following Likert's method. The steps and procedures adopted for its construction and standardization have been explained as follows:

(i) Collection and Editing of Statements

For construction of statements to measure the attitude, the investigator consulted available literature related to attitude towards family planning. A total of 92 statements were framed for the first draft. A thorough study of the statements was made by the investigator's guide, and the statements were reduced to 69 statements. These 69 statements were distributed to experts in the field of education and family planning for content analysis. After the editing, 60 statements were selected for the second draft of the attitude scale.

(ii) Try Out

The draft attitude scale consisting of 60 statements was administered to 30 married women in order to find out whether the scale would be good enough for the population for whom it was intended. For this purpose, the 30 respondents were asked their understanding of the statements as well as their degree of acceptance or rejection of the statements. After analysing their responses, 7 statements were rejected on the basis that it could not be fully comprehended by the 'try-out group'. This resulted in 53 statements being retained for the third draft.

(iii) Item Discrimination

To find out the discriminating value of each item, the third draft was administered to 150 married women in Aizawl. After scoring, the top 27 percent and the bottom 27 percent of respondents were set aside. For determining discrimination value of each statement, 't-test' was applied. The items having insignificant t-value at 0.05 level of confidence were rejected. The final Attitude Scale that was used for data collection comprised of 50 statements out of which 29 were positive statements and 21 were negative statements. **(Table No.3.4)**

TABLE – 3.4

Item Discrimination Values of Statements in Attitude Scale

Item No	Mean and SD top 27%		Mean and SD bottom 27%		t - value	Item No	Mean and SD top 27%		Mean and SD bottom 27%		t - value
	Mean	SD	Mean	SD			Mean	SD	Mean	SD	
1	4.09	0.73	1.97	0.85	14.13	28	3.26	1.00	1.95	0.84	7.28
2	3.13	1.07	1.94	0.95	6.26	29	3.07	0.88	1.89	0.63	8.43
3	4.11	0.83	2.94	1.11	6.16	30	3.80	0.82	2.32	0.82	9.87
4	3.09	1.26	2.17	1.05	4.16	31	3.63	0.75	2.13	0.81	10.00
5	3.98	0.87	2.11	0.85	11.40	32	3.39	0.99	1.83	0.62	9.75
6	2.80	1.06	1.59	0.84	6.72	33	3.96	0.64	2.67	0.98	8.06
7	3.74	0.84	1.94	0.62	12.86	34	3.81	0.64	2.06	0.48	17.5
8	4.04	0.71	1.96	0.71	16.00	35	3.81	0.67	1.98	0.56	15.25
9	3.70	0.88	1.85	0.73	12.33	36	2.93	0.95	1.82	0.68	6.94
10	3.39	1.02	1.67	0.58	10.75	37	2.87	0.96	1.69	0.57	7.87
11	3.59	0.93	2.11	0.87	8.70	38	2.74	0.86	1.59	0.52	8.21
12	3.44	0.99	1.83	0.89	8.94	39	3.18	1.02	1.80	0.56	8.62
13	4.13	0.54	2.52	0.96	10.73	40	2.50	0.88	1.67	0.52	5.93
14	3.33	0.96	2.13	0.94	6.67	41	2.59	1.00	1.52	0.50	7.13
15	3.20	1.04	1.82	0.62	8.62	42	3.37	0.77	1.78	1.05	8.83
16	3.55	0.92	2.30	0.94	6.94	43	3.54	0.89	1.83	0.45	12.21
17	4.09	0.52	2.37	0.85	13.23	44	2.13	0.69	1.56	0.70	4.38
18	2.52	0.88	2.41	1.21	0.55*	45	2.98	0.89	2.08	0.91	5.29
19	3.50	0.81	1.83	0.53	12.85	46	3.61	0.68	2.09	0.72	11.69
20	4.09	0.73	2.06	0.85	13.53	47	3.35	0.80	2.22	0.85	7.06
21	3.37	1.06	2.09	1.00	6.40	48	3.61	0.78	2.69	0.94	5.75
22	4.02	0.62	3.07	1.18	5.28	49	3.37	0.87	1.65	0.62	12.28
23	3.67	0.96	2.52	0.96	6.39	50	3.31	0.90	2.22	0.71	7.27
24	3.42	0.98	3.59	0.73	-1.00*	51	3.54	0.89	1.98	0.56	11.14
25	3.09	1.08	3.00	0.92	0.47*	52	3.70	0.76	2.09	0.55	12.38
26	3.92	0.67	2.15	0.56	14.75	53	3.48	0.85	1.87	0.77	10.73
27	3.18	1.00	1.83	0.70	7.94	-	-	-	-	-	-

Item number 18, 24 and 25 were not included in the final scale due to their low discrimination value

(iv) Scoring of the Attitude Scale

The items on attitude scale were scored following the scoring procedure suggested by Likert. Positive statements were scored as 5,4,3,2 and 1 for strongly agree, agree, undecided, disagree and strongly disagree responses, respectively. On the other hand, negative statements were scored as 1,2,3,4 and 5 for strongly agree, agree, undecided, disagree and strongly disagree responses, respectively. The scores of all the 1164 respondents were classified into tables according to the independent variables as well as the objectives of the study.

(v) Establishment of Reliability

For establishing the reliability of the test, the 'Split-Half Method' was employed by theinvestigator. The whole scale was split into two halves by taking equal number of Positive and Negative statements. The co-efficient of reliability was computed using 'Spearman – Brown Prophecy Formula'. The co-efficient of reliability of the whole scale came out to be 0.80. The data relating to the scores on two halves of the test has been given in Table No. 3.5.

(vi) Establishment of Validity

The content validity of the scale was established on the basis of opinion of experts in the field of Education and Family Planning.

TABLE – 3.5

Split-Half Scores on Attitude Scale of 100 Respondents

Sl. No	1st Half	2nd Half	Sl.No.	1st Half	2nd Half	Sl. No	1st Half	2nd Half	Sl. No.	1st Half	2nd Half
1	92	89	**26**	89	69	**51**	56	42	**76**	71	58
2	66	57	**27**	41	43	**52**	64	42	**77**	99	96
3	71	67	**28**	73	65	**53**	74	63	**78**	69	56
4	79	72	**29**	78	71	**54**	52	40	**79**	61	48
5	91	84	**30**	71	64	**55**	92	71	**80**	42	44
6	72	66	**31**	72	59	**56**	71	65	**81**	41	44
7	96	91	**32**	71	66	**57**	76	60	**82**	72	59
8	74	69	**33**	74	65	**58**	77	68	**83**	84	67
9	66	55	**34**	71	58	**59**	99	91	**84**	87	82
10	66	53	**35**	76	65	**60**	69	63	**85**	66	57
11	100	97	**36**	66	57	**61**	66	66	**86**	49	64
12	49	65	**37**	74	65	**62**	68	54	**87**	48	62
13	82	65	**38**	69	58	**63**	65	53	**88**	47	59
14	71	64	**39**	59	42	**64**	66	57	**89**	95	80
15	84	66	**40**	51	66	**65**	45	46	**90**	72	59
16	86	80	**41**	94	82	**66**	48	61	**91**	68	54
17	102	101	**42**	67	53	**67**	91	84	**92**	70	58
18	84	79	**43**	48	63	**68**	76	66	**93**	68	58
19	73	69	**44**	93	80	**69**	33	35	**94**	96	89
20	84	79	**45**	56	43	**70**	49	65	**95**	76	63
21	72	68	**46**	87	68	**71**	86	66	**96**	55	40
22	79	61	**47**	93	80	**72**	78	71	**97**	69	57
23	73	64	**48**	74	59	**73**	96	82	**98**	86	66
24	47	61	**49**	91	70	**74**	84	68	**99**	53	42
25	95	82	**50**	71	63	**75**	88	80	**100**	65	53

Scoring : Computation from Field Work

D. Questionnaire on Family Planning Practices

To find out the actual family planning Practices, a questionnaire was developed by the investigator after going through the related literature on family planning methods and practices. A total of 10 questions were set concerning issues such as the age at marriage, number of children, age at birth of first child, age at birth of last child, whether spacing is followed or not, whether methods of family planning were adopted and size of ideal family.

(i) Establishment of Reliability

The establishment of reliability of a questionnaire is not quite the same as that of a test for which scores are obtained. As this questionnaire was designed to find out the status of family planning practices among the Mizo women, the responses to the various items of the questionnaire do not necessarily reflect the intensities of the various family planning practices. The responses to the different items of the questionnaire were not scores in the usual sense of the term. Moreover, every item in this questionnaire was independent and measures a different dimension. Therefore, responses to the various items could not be added like scores. So, the well-knownmethods of establishing reliability like Split-half, Alternate or Parallel form andRational Equivalence methods were not applicable. However, to ensure the reliability of the said questionnaire, the investigator applied 'test-retest' method by administering it twice on a sample of 20 women with a gap of two weeks and found it to be reliable.

(Ii) Establishment of Validity

The content validity of the scale was established on the basis of opinion of experts in the field of Education and Family Planning.

E. Interview Schedule for family planning programs run by Government

To find out the status of family planning programs run by the state government, the investigator personally interviewed the officer in charge of the Reproductive and Child Health program. The investigator had also conducted telephonic interview with the Jt. Director, family planning, Department of Health

&family Welfare, Govt. of Mizoram. The investigator gathered a lot of useful information regarding the family planning programs run by the Government.

As no NGOs in Mizoram was ever involved in the propagation and implementation of family planning programs, therefore, the investigator did not develop any questionnaires in this regard.

3.7 Administration of Tools and Collection of Data

All the four tools of data collection namely, Socio-Economic Status Scale, Awareness Scale on family planning Methods & programs, Attitude Scale towards family planning, and Questionnaire for family planning Practices were personally administered to 1200 women selected proportionately from all the eight (8) districts of Mizoram. Before administering these tools the investigator introduced herself and explained the purpose and importance of the study. Besides, they were also ensured that information supplied by them will be kept strictly confidential and used for the research purpose only. After establishing the necessary rapport, all the aforesaid four tools were administered. The respondents were given enough time to ponder over all the statements in each of the three tools so as to ensure a truthful response from them. However, after scoring of all four tools it was discovered that 36 respondents had not completed one tool or another. Thus, these 36 women were not included for the analysis of data because of incompleteness of their responses and the scholar was left with only 1164 women respondents for data analysis.

3.8 Tabulation of Data

The data collected for the study was examined carefully. After screening the incomplete responses, 1164 complete responses out of 1200 were available for final analysis. The classified materials were recorded accurately in mathematical terms, that is, marking and counting frequency tallies for different items on which information was gathered. Each respondent was assigned a serial number and their details regarding age, level of education, occupation, locale and the scores obtained on Socio-economic status, awareness about family planning methods and programs and attitude towards family planning was entered in a tabulation sheet. Keeping in view the different nature of data gathered through the questionnaire on family

planning practices, a separate master table was prepared for data entry on various issues related to family planning practices such as age at marriage, number of children, age at birth of first child, age at birth of last child, size of ideal family, adoption of spacing and adoption of family planning method.

3.9 Statistical Techniques for Analysis of Data

The analysis of data was done by using both descriptive and inferential statistical techniques described as follows :

a) Frequency, percentage, cumulative percentage, mean , median, mode, standard deviation and skewness were used to study the nature of distribution of scores with regard to the age at marriage, number of children, age at birth of first child, age at birth of last child, size of ideal family and spacing.

b) Product-Moment Correlation followed by Spearman-Brown Prophecy Formula to establish reliability of the Awareness Scale and Attitude Scale.

c) 't' test for item discrimination as well as to find out the significance of difference in attitude towards family planning, and awareness about family planning methods & programs in relation to education, occupation, socio-economic status and rural/urban background of Mizo women.

d) Chi-square test to test the hypothesis of independence in relation to the association between family planning practices and education, occupation, socio-economic status and rural/urban background of Mizo women.

CHAPTER-IV: DATA ANALYSIS AND INTERPRETATION

4.0 Introduction:

Awareness towards family planning programs and methods, attitude towards family planning and practices of family planning are all very important concepts in today's world. The current study looks into these issues in the context of Mizo women; the current chapter deals with the analysis and interpretation of the findings on awareness of Mizo women about family planning programs and methods, their attitude towards family planning and family planning practices that are actually carried out among Mizo women. The chapter has beenorganized under the following three (3) sections :-

4.1 Awareness of Family Planning Programs and Methods

4.2 Attitude towards Family Planning Programs and

4.3 Family Planning Practices

4.1 AWARENESS OF FAMILY PLANNING PROGRAMS AND METHODS–

The current study looks into the issue of awareness of family planning programs and methods among Mizo women with regard to their level of education, occupation, socio-economic status and locale. The educational levels of the Mizo women in question were classified under elementary, secondary and higher secondary. The occupations held by the Mizo women were classified under the groups - professional women, business women, farmers, clerical, labourers and housewives. The socio-economic status of the Mizo women was also divided into high, middle and low socio-economic status for the purpose of the study and the locale of the Mizo women was grouped under rural and urban locales respectively.

The present study focuses on the level of awareness of family planning programs and methods for the aforementioned groups of Mizo women. Family

planning and its methods can be applied only if there is an awareness of the concept among the target population. It is due to the same reason that Non-Government Organisations (N.G.Os) along with the Government creates awareness programs and campaigns to be in a position to deploy the practices of family planning and its methods so that the concept would filter down to the target population prior to the actual application of family planning and its methods. India being one of the most populated countries of the world, awareness campaigns and programs are carried out as an attempt to curb the ever-growing population of India. Over-population is a menace especially for a developing country like India as it has the potential to destroy the bio-diversity of a given place; it slows down economic growth and is one major cause of pollution as well.

Family planning awareness is an important tool to steer the country away from becoming more and more populated; at the same time, through the awareness campaigns and programs, one can instil a positive and favourable outlook towards family planning programs and its methods among Mizo women. The importance of awareness of family planning practices is that it is the first step towards population control. Hence, the present study looks into the awareness of family planning methods among different groups of Mizo women from diverse background.

A. Impact of Education of Women with regard to their Awareness of family planning rograms:

TABLE No: 4.1.a
Significance of Difference among Women with Different Levels of Education in Relation to their Awareness about family planning

Groups of Comparison		Mean	SD	t-value
Elementary Education Vs Secondary Education	Elementary Education (N = 412)	15.85	5.55	**6.02****
	Secondary Education (N =544)	17.9	5.45	
Elementary Education Vs Higher Education	Elementary Education (N = 412)	15.85	5.55	**9.66****
	Higher Education (N = 208)	20.2	5.45	
Secondary Education Vs Higher Education	Secondary Education (N = 544)	17.9	5.45	**5.34****
	Higher Education (N =208)	20.2	5.45	

*Source: Field Work, ** Significant at .01 level*

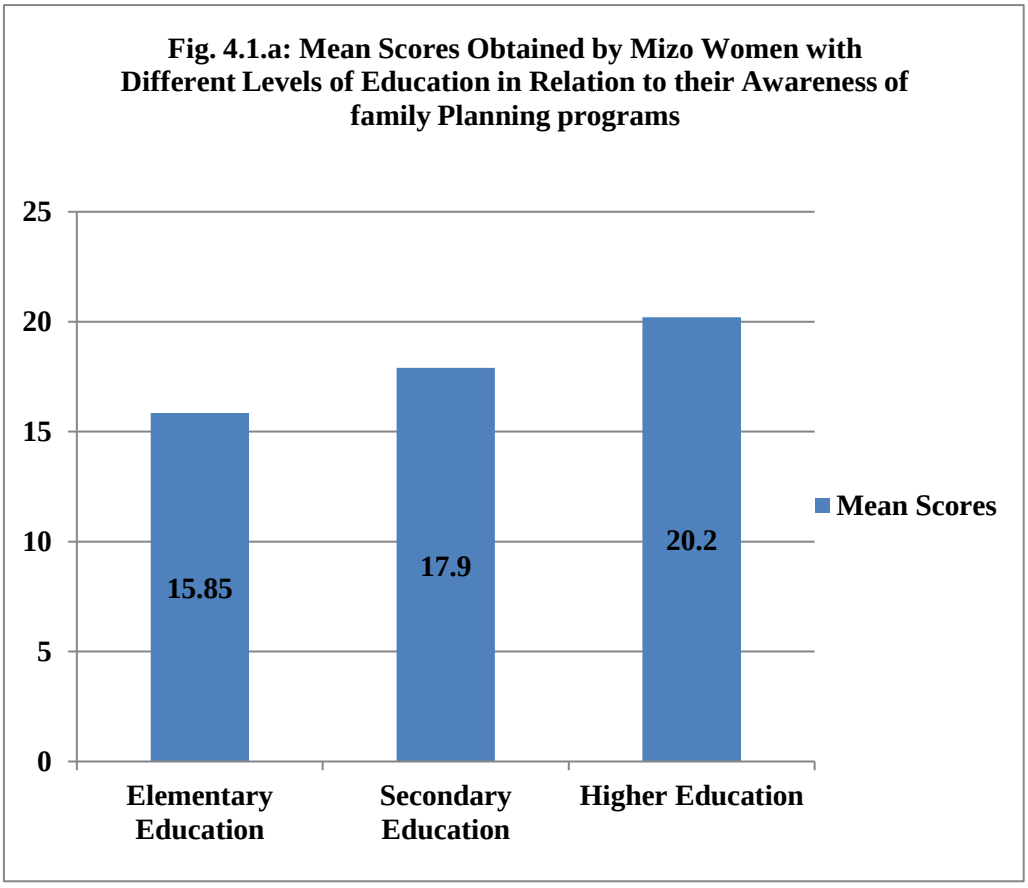
A quick glance at Table 4.1.a reveals that the t-value for the significance of difference between the means of Elementary vs. Secondary educational level groups of women with regard to their awareness of family planning programs is 6.02, whereas the required t-values to declare the said difference as significant are 1.97 and 2.59 at .05 and .01 level respectively. Since the observed t-value of 6.02 is more than the required t-value at .01 level, therefore, there exists a significant difference between the means of elementary and secondary educational level groups of women with regard to their awareness of family planning programs at .01 level. In view of the aforesaid significant difference, the Null Hypothesis, that there exists no significant difference between the Elementary and Secondary educational level groups of women in relation to their awareness of family planning programs is **rejected**. An analysis of the mean scores of both the groups of women reveals that the said significant difference is in favour of the secondary educational level group of women as their mean score is higher than their counterparts from the elementary educational level group.

Similarly, Table 4.1.a also reveals that the t-value for the significance of difference between the means of elementary vs. higher educational level groups of women with regard to their awareness of family planning programs is 9.66, whereas the required t-values to declare the said difference as significant are 1.97 and 2.59 at .05 and .01 level respectively. Since the observed t-value of 9.66 is more than the required t-value at .01 level, therefore, there exists a significant difference between the means of elementary and higher educational level groups of women with regard to their awareness of family planning programs at .01 level. In view of the aforesaid significant difference, the Null Hypothesis, that there exists no significant difference between the elementary and higher educational level groups of women in relation to their awareness of family planning programs is **rejected**. An analysis of the mean scores of both the groups of women reveals that the said significant difference is in favour of the higher educational level group of women as their mean score is higher than their counterparts from the elementary educational level group.

Likewise, Table 4.1.a further reveals that the t-value for the significance of difference between the means of secondary vs. higher educational level groups of women with regard to their awareness of family planning programs is 5.34, whereas

the required t-values to declare the said difference as significant are 1.97 and 2.59 at .05 and .01 level respectively. Since the observed t-value of 5.34 is more than the required t-value at .01 level, therefore, there exists a significant difference between the means of secondary and higher educational level groups of women with regard to their awareness of family planning programs at .01 level. In view of the aforesaid significant difference, the Null Hypothesis, that there exists no significant difference between the secondary and higher educational level groups of women in relation to their awareness of family planning programs is **rejected**. An analysis of the mean scores of both the groups of women reveals that the said significant difference is in favour of the higher educational level group of women as their mean score is higher than their counterparts from the secondary educational level group.

Fig. 4.1.a: Mean Scores Obtained by Mizo Women with Different Levels of Education in Relation to their Awareness of family Planning programs



B. Impact of Occupation of Women with regard to their Awareness of family planning programs:

TABLE No: 4.1.b(i)

Significance of Difference between Professional and Other Occupational Groups of Mizo Women in Relation to their Awareness about family planning programs

Groups of Comparison		Mean	SD	t-value
Professional Vs Business Women	Professional Women (N = 215)	20.64	5.81	**8.18****
	Business Women (N = 230)	16.30	5.3	
Professional Vs Clerical Women	Professional Women (N = 215)	20.64	5.81	**4.12****
	Clerical Women (N = 129)	18.00	5.70	
Professional Vs Women Farmers	Professional Women (N =215)	20.64	5.81	**6.34****
	Women Farmers (N = 165)	17.15	4.70	
Professional Vs Housewives	Professional Women (N =215)	20.64	5.81	**6.77****
	Housewives (N = 308)	16.98	6.44	
Professional Vs Women Labourers	Professional Women (N =215)	20.64	5.81	**8.08****
	Women Labourers (N = 117)	15.95	4.70	

*Source: Field Work , ** significant at .01 level*

A quick glance at Table 4.1.b(i) reveals that the t-value for the significance of difference between the means of professional vs. business women with regard to their awareness of family planning programs is 8.18, whereas the required t-values to declare the said difference as significant are 1.97 and 2.59 at .05 and .01 level respectively. Since the observed t-value of 8.18 is more than the required t-value at .01 level, therefore, there exists a significant difference between the means of

professional and business women with regard to their awareness of family planning programs. In view of the aforesaid significant difference, the Null Hypothesis, that there exists no significant difference between Professional and Business women in relation to their awareness of family planning programs is **rejected**. An analysis of the mean scores of both the groups of women reveals that the said significant difference is in favour of professional group of women as their mean score is higher than their counterparts from Business group.

A quick glance at Table 4.1.b(i) reveals that the t-value for the significance of difference between the means of women from professionals vs. clerical occupation with regard to their awareness of family planning programs is 4.12, whereas the required t-values to declare the said difference as significant are 1.97 and 2.59 at .05 and .01 level respectively. Since the observed t-value of 4.12 is more than the required t-value at .01 level, therefore, there exists a significant difference between the means of Professional and Clerical women with regard to their awareness of family planning programs. In view of the aforesaid significant difference, the Null Hypothesis, that there exists no significant difference between Professional and Clerical women in relation to their awareness of family planning programs is **rejected**. An analysis of the mean scores of both the groups of women reveals that the said significant difference is in favour of professional group of women as their mean score is higher than their counterparts from clerical group.

A quick glance at Table 4.1.b(i) reveals that the t-value for the significance of difference between the means of women from Professionals vs. Farmers occupation with regard to their awareness of family planning programs is 6.34, whereas the required t-values to declare the said difference as significant are 1.97 and 2.59 at .05 and .01 level respectively. Since the observed t-value of 6.34 is more than the required t-value at .01 level, therefore, there exists a significant difference between the means of professional and farmers group of women with regard to their awareness of family planning programs. In view of the aforesaid significant difference, the Null Hypothesis, that there exists no significant difference between professional and farmers group of women in relation to their awareness of family planning programs is **rejected**. An analysis of the mean scores of both the groups of

women reveals that the said significant difference is in favour of professional group of women as their mean score is higher than their counterparts from Farmers group.

A quick glance at Table 4.1.b(i) reveals that the t-value for the significance of difference between the means of women from professionals vs. housewives with regard to their awareness of family planning programs is 6.77, whereas the required t-values to declare the said difference as significant are 1.97 and 2.59 at .05 and .01 level respectively. Since the observed t-value of 6.77 is more than the required t-value at .01 level, therefore, there exists a significant difference between the means of professional and housewives group of women with regard to their awareness of family planning programs. In view of the aforesaid significant difference, the Null Hypothesis, that there exists no significant difference between professional and housewives group of women in relation to their awareness of family planning programs is **rejected**. An analysis of the mean scores of both the groups of women reveals that the said significant difference is in favour of professional group of women as their mean score is higher than their counterparts from housewives group.

A quick glance at Table4.1.b(i) reveals that the t-value for the significance of difference between the means of women from professionals vs laborers occupation with regard to their awareness of family planning programs is 8.08, whereas the required t-values to declare the said difference as significant are 1.97 and 2.59 at .05 and .01 level respectively. Since the observed t-value of 8.08 is more than the required t-value at .01 level, therefore, there exists a significant difference between the means of professional and labourers group of women with regard to their awareness of family planning programs. In view of the aforesaid significant difference, the Null Hypothesis, that there exists no significant difference between professional and labourers group of women in relation to their awareness of family planning programs is **rejected**. An analysis of the mean scores of both the groups of women reveals that the said significant difference is in favour of professional group of women as their mean score is higher than their counterparts from labourers group.

Fig 4.1.b(i): Mean Scores Obtained by Mizo Professional Women Compared to other Occupational Groups in Relation to their Awareness of family Planning programs

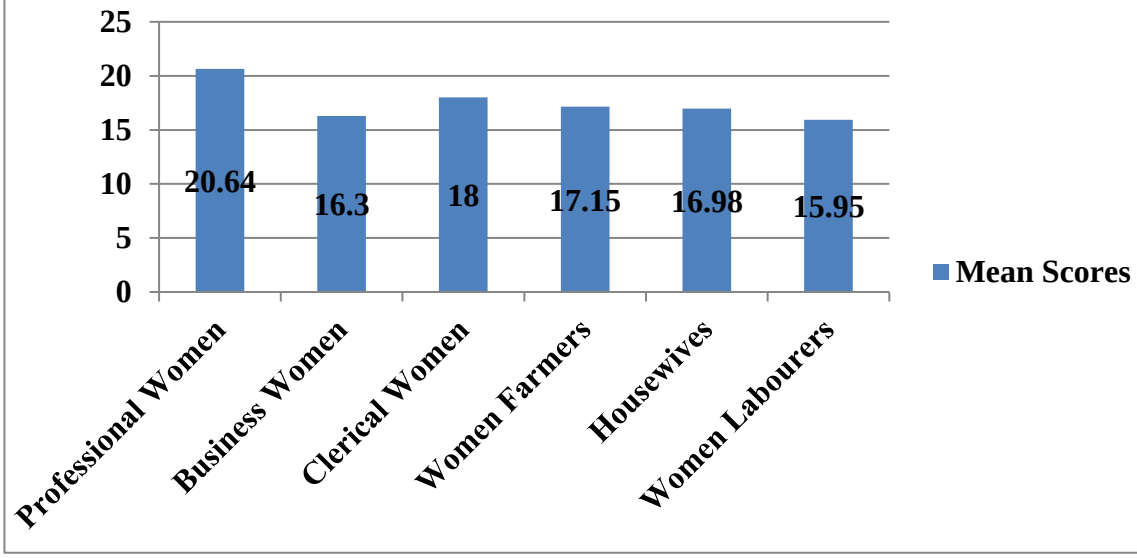


TABLE No : 4.1.b(ii)

Significance of Difference between Business and Other Occupational Groups of Mizo Women in Relation to their Awareness about family planning programs

Groups of Comparison		Mean	SD	t-value
Business Vs Clerical Women	Business Women (N =230)	16.30	5.3	**2.83****
	Clerical Women (N =129)	18.00	5.70	
Business Vs Women Farmers	Business Women (N =230)	16.30	5.3	**1.7 n.s**
	Women Farmers (N =165)	17.15	4.7	
Business women Vs House wives	Business Women (N =230)	16.30	5.3	**1.36 n.s**
	House wives (N =308)	16.98	6.44	
Business Vs WomenLabourers	Business Women (N =230)	16.30	5.3	**0.66 n.s**
	Women Labourers (N =117)	15.95	4.70	

*Source: Field Work; n.s=Not Significant, ** Significant at .01 level*

A quick glance at Table 4.1.b(ii) reveals that the t-value for the significance of difference between the means of business women v/s clerical women with regard to their awareness of family planning programs is 2.83, whereas the required t-values to declare the said difference as significant are 1.97 and 2.59 at .05 and .01 level respectively. Since the observed t-value of 2.83 is more than the required t-value at .01 level, therefore, there exists a significant difference between the means of business women and clerical women with regard to their awareness of family planning programs. In view of the aforesaid significant difference, the Null Hypothesis, that there exists no significant difference between business women and clerical women in relation to their awareness of family planning programs is **rejected**. An analysis of the mean scores of both the groups of women reveals that the said significant difference is in favour of clerical group of women as their mean score is higher than their counterparts from business group of women.

A perusal of data vide Table 4.1.b(ii) shows that the t-value for the significance of difference between the means of business women vs farmers group of women is 1.7, whereas the required t-value to declare the said difference as significant at .05 level is 1.97. Since the observed t-value is less than the required t-value at .05 level, therefore, it can be concluded that there exists no significant difference between the means of the business women and farmers group of women in relation to their awareness of family planning programs. In view of this finding, the Null Hypothesis, that there exists no significant difference between the means of the business women and farmers group of women is **accepted**.

A perusal of data vide Table 4.1.b(ii) shows that the t-value for the significance of difference between the means of Business vs Housewives group of women is 1.36, whereas the required t-value to declare the said difference as significant at .05 level is 1.97. Since the observed t-value is less than the required t-value at .05 level, therefore, it can be concluded that there exists no significant difference between the means of the business women and housewives group of women in relation to their awareness of family planning programs. In view of this finding, the Null Hypothesis, that there exists no significant difference between the means of the business women and housewives group of women is **accepted**.

A perusal of data vide Table 4.1.b(ii) shows that the t-value for the significance of difference between the means of business women vs labourers group of women is 0.66, whereas the required t-value to declare the said difference as significant at .05 level is 1.97. Since the observed t-value is less than the required t-value at .05 level, therefore, it can be concluded that there exists no significant difference between the means of the business women and labourers group of women in relation to their awareness of family planning programs. In view of this finding, the Null Hypothesis, that there exists no significant difference between the means of the business women and labourers group of women is **accepted**.

Fig 4.1.b(ii):Mean Scores Obtained by Mizo Business Women compared to other Occupational Groups in Relation to their Awareness of Family Planning Programs

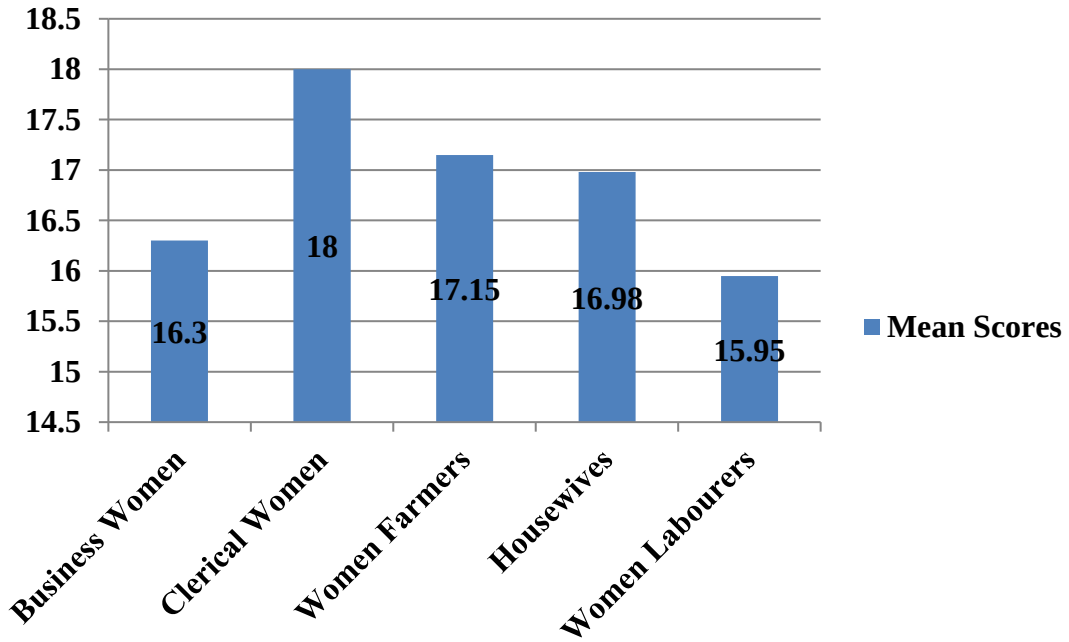


TABLE No: 4.1.b(iii)

Significance of Difference between Clerical and other Occupational Groups of Mizo Women in Relation to their Awareness of family planning programs

Groups of Comparison		Mean	SD	t-value
Clerical Vs Women Farmers	Clerical Women (N =129)	18.00	5.70	**1.39n.s**
	Women Farmers (N =165)	17.15	4.70	
Clerical Vs Housewives	Clerical Women (N =129)	18.00	5.70	**1.70n.s**
	House wives (N =308)	16.98	6.44	
Clerical Vs Women Labourers	Clerical Women (N =129)	18.00	5.70	**3.20****
	Women Labourers (N =117)	15.95	4.70	

*Source: Field Work; n.s. =Not Significant, ** Significant at .01 level*

A perusal of data vide Table 4.1.b(iii)shows that the t-value for the significance of difference between the means of clerical women vs farmers group of women is 1.39, whereas the required t-value to declare the said difference as significant at .05 level is 1.97. Since the observed t-value is less than the required t-value at .05 level, therefore, it can be concluded that there exists no significant difference between the means of the Clerical and Farmers group of women in relation to their awareness of family planning programs. In view of this finding, the Null Hypothesis, that there exists no significant difference between the means of the Clerical and Farmers group of women is **accepted**.

A perusal of data vide Table 4.1.b(iii) shows that the t-value for the significance of difference between the means of Clerical vs Housewives group of women is 1.7, whereas the required t-value to declare the said difference as significant at .05 level is 1.97. Since the observed t-value is less than the required t-value at .05 level, therefore, it can be concluded that there exists no significant difference between the means of the clerical women and housewives group of women in relation to their awareness of family planning programs. In view of this finding, the Null Hypothesis, that there exists no significant difference between the means of the clerical women and housewives group of women is **accepted**.

A quick glance at Table 4.1.b(iii) reveals that the t-value for the significance of difference between the means of clerical women vs women labourers with regard to their awareness of family planning programs is 3.20, whereas the required t-values to declare the said difference as Significant are 1.97 and 2.59 at .05 and .01 level respectively. Since the observed t-value of 3.20 is more than the required t-value at .01 level, therefore, there exists a significant difference between the means of clerical women and labourers group of women with regard to their awareness of family planning programs. In view of the aforesaid significant difference, the Null Hypothesis, that there exists no significant difference between clerical women and labourers group of women in relation to their awareness of family planning programs is **rejected**. An analysis of the mean scores of both the groups of women reveals that the said significant difference is in favour of clerical group of women as their mean score is higher than their counterparts from labourers group of women.

Fig 4.1.b(iii):Mean Scores Obtained by Mizo Clerical Women compared to other Occupational Groups in Relation to their Awareness of family Planning Programs

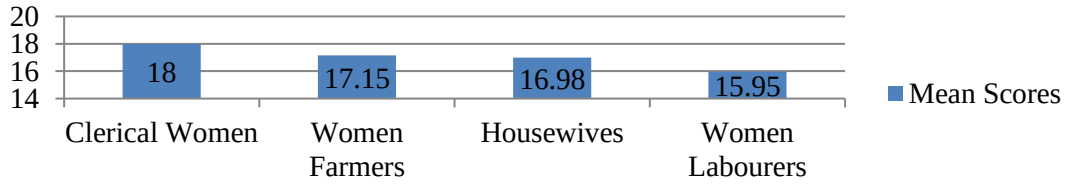


TABLE No : 4.1.b(iv)

Significance of Difference between Farmers and other Occupational Groups of Mizo Women in Relation to their Awareness of family planning programs

Groups of Comparison		Mean	SD	t-value
Women Farmers Vs House Wives	Women Farmers (N =165)	17.15	4.70	**0.33n.s**
	House wives (N =308)	16.98	6.44	
Women Farmers Vs Women Labourers	Women Farmers (N =165)	17.15	4.70	**2.18***
	Women Labourers (N =117)	15.95	4.70	

*Source: Field Work, n.s=Not Significant, * Significant at .05 level*

A perusal of data vide Table 4.1.b(iv)shows that the t-value for the significance of difference between the means of women farmers vs housewives group is 0.33, whereas the required t-value to declare the said difference as significant at .05 level is 1.97. Since the observed t-value is less than the required t-value at .05 level, therefore, it can be concluded that there exists no significant difference between the means of the women farmers and housewives group of women in relation to their awareness of family planning programs. In view of this finding, the Null Hypothesis, that there exists no significant difference between the means of the Farmers and Housewives group of women is **accepted**.

A quick glance at Table 4.1.b(iv) reveals that the t-value for the significanceof difference between the means of women farmers vs women labourers occupation with regard to their awareness of family planning programs is 2.18, whereas the required t-values to declare the said difference as significant are 1.97 and 2.59 at .05 and .01 level respectively. Since the observed t-value of 2.18 is more than the required t-value at .01 level, therefore, there exists a significant difference between the means of women farmers and labourers group of women with regard to their awareness of family planning programs. In view of the aforesaid significant difference, the Null Hypothesis, that there exists no significant difference between women farmers and labourers group of women in relation to their awareness of family planning programs is **rejected**. An analysis of the mean scores of both the groups of women reveals that the said significant difference is in favour of women farmers as their mean score is higher than their counterparts from women labourers group.

Fig 4.1.b(iv):Mean Scores Obtained by Mizo Women Farmers compared to other Occupational Groups in Relation to their Awareness of Family Planning Programs

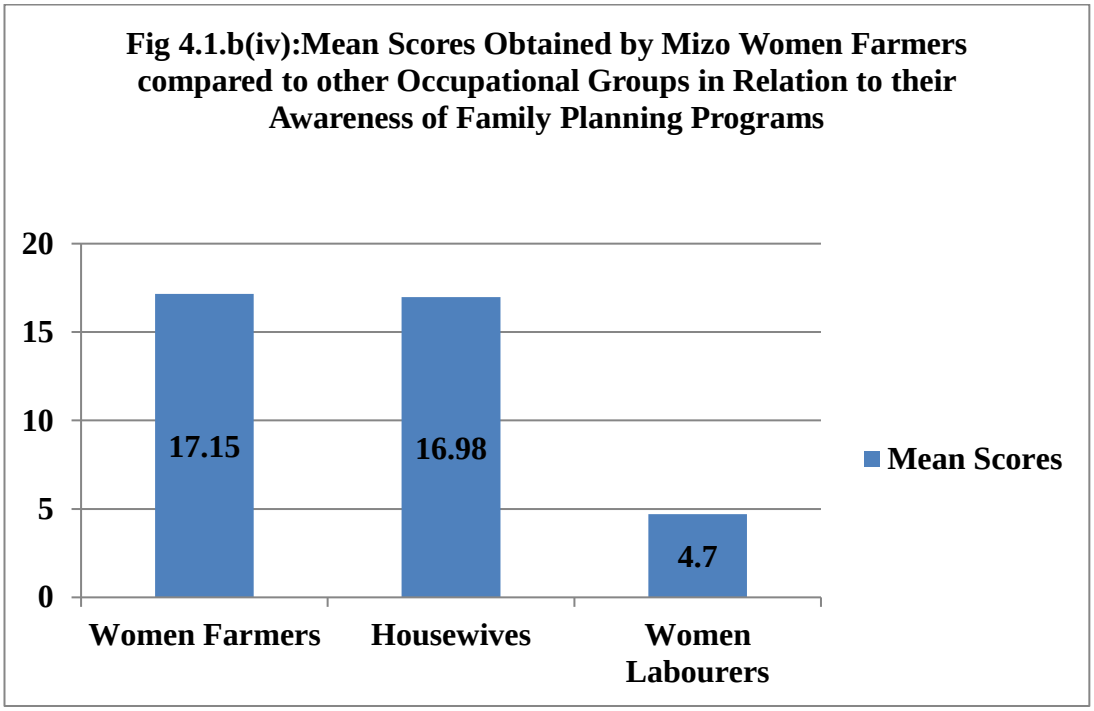


TABLE No: 4.1.b(v)

Significance of Difference between Housewives and Labourer Groups of Mizo Women in Relation to their Awareness of family planning programs

Groups of Comparison		Mean	SD	t-value
House wives Vs Women Labourers	House wives (N =308)	16.98	6.44	**1.90n.s**
	Labourer Women (N =117)	15.95	4.70	

Source: Field Work, n.s=Not Significant

A perusal of data vide Table 4.1.b(v) shows that the t-value for the significance of difference between the means of Housewives vs Labourers group of women is 1.90, whereas the required t-value to declare the said difference as significant at .05 level is 1.97. Since the observed t-value is less than the required t-value at .05 level, therefore, it can be concluded that there exists no significant difference between the means of the Housewives and Labourers group of women in relation to their awareness of family planning programs. In view of this finding, the Null Hypothesis, that there exists no significant difference between the means of the Housewives and Labourers group of women is **accepted**.

Fig 4.1.b(v): Mean Scores Obtained by Mizo Housewives compared to Mizo Women Labourer Group in Relation to their Awareness of family planning programs

C. Impact of Socio-Economic Status of Women with regard to their Awareness of family planning programs:

TABLE 4.1.c

Significance of Difference between Low SES, Middle SES and High SES Groups of Women with regard to their Awareness of family planning programs

Groups of Comparison		Mean	SD	t-value
Low SES Vs Middle SES	Low SES (N = 357)	15.85	5.4	**4.43****
	Middle SES (N = 710)	17.49	5.6	
Low SES Vs High SES	Low SES (N =357)	15.85	5.4	**8.31****
	High SES (N = 97)	19.59	6.02	
Middle SES Vs High SES	Middle SES (N =710)	17.49	5.6	**5.12****
	High SES (N =97)	19.59	6.02	

*Source: Field Work , ** significant at .01 level*

A quick glance at Table 4.1.c reveals that the t-value for the significance of difference between the means of low SES vs middle SES groups of women with regard to their awareness of family planning programs is 4.43, whereas the required t-values to declare the said difference as significant are 1.97 and 2.59 at .05 and .01

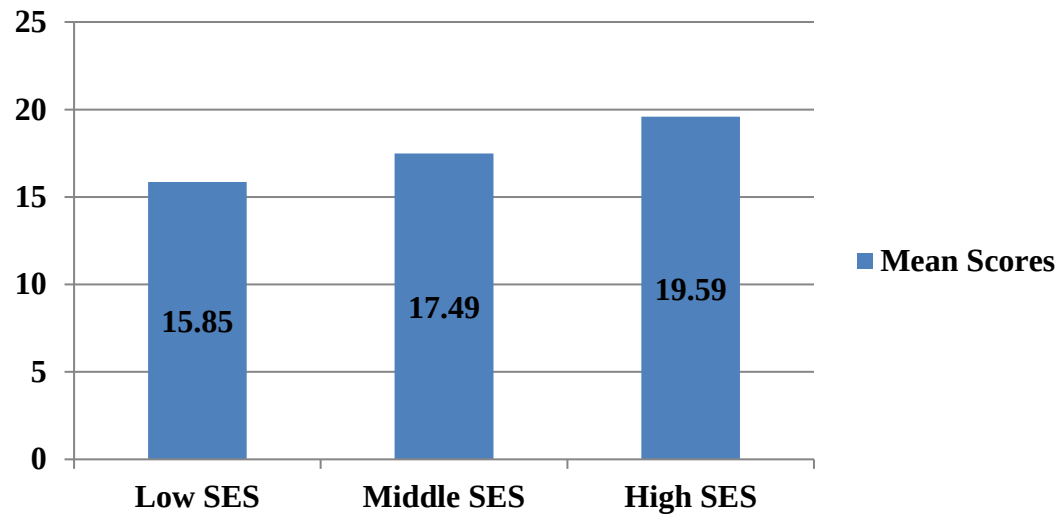
level respectively. Since the observed t-value of 4.43 is more than the required t-value at .01 level, therefore, there exists a significant difference between the means of low SES and middle SES groups of women with regard to their awareness of family planning programs at .01 level. In view of the aforesaid significant difference, the Null Hypothesis, that there exists no significant difference between the low SES and middle SES groups of women in relation to their awareness of family planning programs is **rejected**. An analysis of the mean scores of both the groups of women reveals that the said significant difference is in favour of the Middle SES group of women as their mean score is higher than their counterparts from the Low SES group.

A quick glance at Table 4.1.c reveals that the t-value for the significance of difference between the means of Low SES vs High SES groups of women with regard to their awareness of family planning programs is 8.31, whereas the required t-values to declare the said difference as significant are 1.97 and 2.59 at .05 and .01 level respectively. Since the observed t-value of 8.31 is more than the required t-value at .01 level, therefore, there exists a significant difference between the means of low SES and high SES groups of women with regard to their awareness of family planning programs at .01level. In view of the aforesaid significant difference, the Null Hypothesis, that there exists no significant difference between the low SES and high SES groups of women in relation to their awareness of family planning programs is **rejected**. An analysis of the mean scores of both the groups of women reveals that the said significant difference is in favour of the high SES group of women as their mean score is higher than their counterparts from the low SES group of women.

A quick glance at Table 4.1.c reveals that the t-value for the significance of difference between the means of middle SES vs high SES groups of women with regard to their awareness of family planning programs is 5.12, whereas the required t-values to declare the said difference as significant are 1.97 and 2.59 at .05 and .01 level respectively. Since the observed t-value of 5.12 is more than the required t-value at .01 level, therefore, there exists a significant difference between the means of middle SES and high SES groups of women with regard to their awareness of family planning programs at .01level. In view of the aforesaid significant difference,

the Null Hypothesis, that there exists no significant difference between the middle SES and high SES groups of women in relation to their awareness of family planning programs is **rejected**. An analysis of the mean scores of both the groups of women reveals that the said significant difference is in favour of the high SES group of women as their mean score is higher than their counterparts from the middle SES group.

Fig 4.1.c: Mean Scores Obtained by Low SES, Middle SES and High SES Groups of Mizo Women with regard to their Awareness of family planning programs



D. Impact of Locale of Women with regard to their Awareness of family planning programs:

TABLE 4.1.d
Significance of Difference between Rural and Urban Women with regard to their Awareness of family planning programs

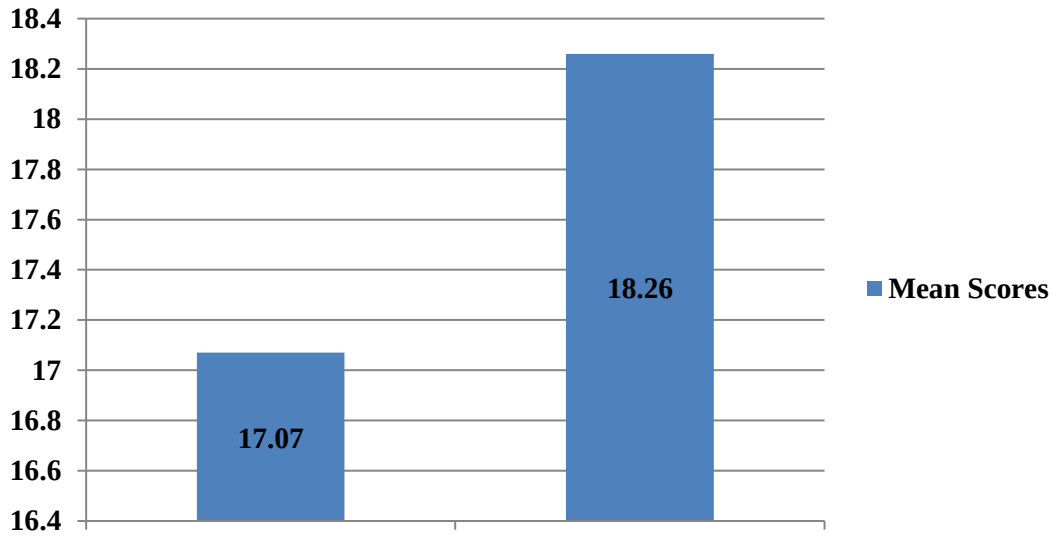
Groups of Comparison		Mean	SD	t-value
Rural and Urban Women	Rural (N = 451)	17.07	5.81	**3.5****
	Urban (N =713)	18.26	6.02	

*Source: Field Work , ** significant at .01 level*

A quick glance at Table 4.1.d reveals that the t-value for the significance of difference between the means of rural vs urban Mizo women with regard to their

awareness of family planning programs is 3.50, whereas the required t-values to declare the said difference as significant are 1.97 and 2.59 at .05 and .01 level respectively. Since the observed t-value of 3.50 is more than the required t-value at .01 level, therefore, there exists a significant difference between the means of rural and urban Mizo women with regard to their awareness of family planning programs at .01 level. In view of the aforesaid significant difference, the Null Hypothesis, that there exists no significant difference between the rural and urban Mizo women in relation to their awareness of family planning programs is **rejected**. An analysis of the mean scores of both the groups of women reveals that the said significant difference is in favour of the urban Mizo women as their mean score is higher than their counterparts from the rural group of Mizo women.

Fig 4.1.d: Mean Scores obtained by Rural and Urban Mizo Women with regard to of Awareness of Family Planning Programs



4.2 ATTITUDE TOWARDS FAMILY PLANNING

The current study attempts to find out the attitude of Mizo women towards family planning. Attitude towards family planning simply means the predisposition that the Mizo women in question have towards family planning and it can either be positive or negative. The attitude towards family planning is what determines whether these Mizo women would actually utilize the family planning methods - the

more positive the attitude towards family planning, the more likely the family planning practices would be put to use. Hence, attitude is an important factor that determines the application of family planning methods.

Initially, family planning was viewed as a very negative concept by Mizo women as it does not conform to their beliefs and ideas. However, with repeated awareness campaigns undertaken by the Government, many Mizo women now have a shift in their attitude towards family planning. The current study is an attempt to study the attitude of Mizo women towards family planning with regards to their level of education, occupation, socio-economic status and locale. The educational levels of the Mizo women in question were classified under elementary, secondary and higher secondary educated. The occupations held by the Mizo women were classified under the groups - Professional women, Business women, Women Farmers, Clerical, Women Laborers and Housewives. The socio-economic status of the Mizo women was also divided into high, middle and low for the purpose of the study; and with regards to the locale of the Mizo women, they were grouped under rural and urban locales.

A. Impact of Education of Women with regard to their Attitude towards family planning:

TABLE No: 4.2.a

Significance of Difference between Women with Different Levels of Education in Relation to their Attitude towards family planning

Groups of Comparison		**Mean**	**SD**	**t-value**
Elementary Vs Secondary	Elementary Education (N = 412)	129.4	24.8	**0.42 n.s**
	Secondary Education (N = 544)	130.3	30.4	
Elementary Vs Higher	Elementary Education (N = 412)	129.4	24.8	**2.78****
	Higher Education (N = 208)	136.3	30.3	
Secondary Vs Higher	Secondary Education (N =544)	130.3	30.4	**2.42****
	Higher Education (N = 208)	136.3	30.3	

*Source: Field Work, n.s=Not Significant, ** Significant at .01 level*

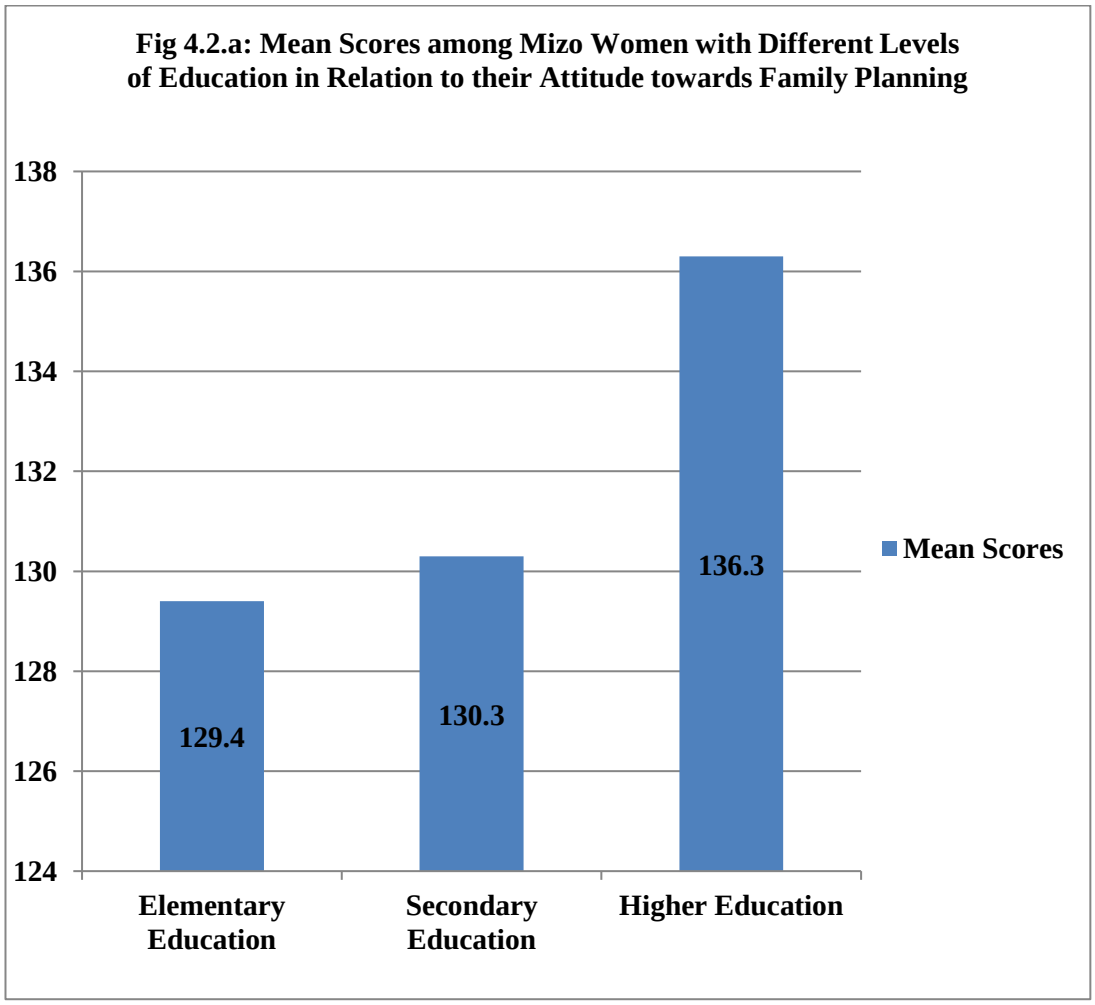
A perusal of data vide Table 4.2.a shows that the t-value for the significance of difference between the means of elementary vs secondary educational level groups of Mizo women is 0.42, whereas the required t-value to declare the said difference as significant at .05 level is 1.97. Since the observed t-value is less than the required t-value at .05 level, therefore, it can be concluded that there exists no significant difference between the means of the elementary and secondary educational level groups of women in relation to their attitude towards family planning. In view of this finding, the Null Hypothesis, that there exists no significant difference between the means of the Elementary and Secondary educational level groups of Mizo women is **accepted**.

A quick glance at Table 4.2.a reveals that the t-value for the significance of difference between the means of elementary vs higher educational level groups of Mizo women with regard to their attitude towards family planning is 2.78 whereas the required t-values to declare the said difference as significant are 1.97 and 2.59 at .05 and .01level respectively. Since the observed t-value of 2.78 is more than the required t-value at .01 level, there exists a significant difference between the means of elementary vs higher educational level groups of Mizo women with regard to their attitude towards family planning at .01 level. In view of the aforesaid significant difference, the Null Hypothesis, that there exists no significant difference between elementary vs higher educational level groups of Mizo women in relation to their attitude towards family planning is **rejected**. An analysis of the mean scores of both the groups of women reveals that the said significant difference is in favour of the Higher educational Level group of Mizo women as their mean score is higher than their counterparts from elementary educational level group of Mizo women.

A quick glance at Table 4.2.a reveals that the t-value for the significance of difference between the means of secondary v/s higher educational level groups of Mizo women with regard to their attitude towards family planning is 2.42 whereas the required t-values to declare the said difference as significant are 1.97 and 2.59 at .05 and .01level respectively. Since the observed t-value of 2.42 is more than the required t-value at .01 level, there exists a significant difference between the means of secondary vs higher educational level groups of Mizo women with regard to their attitude towards family planning at .01 level. In view of the aforesaid significant

difference, the Null Hypothesis, that there exists no significant difference between secondary vs higher educational level groups of Mizo women in relation to their attitude towards family planning is **rejected**. An analysis of the mean scores of both the groups of women reveals that the said significant difference is in favour of the higher educationallevel group of women as their mean score is higher than their counterparts from secondary educational level group of Mizo women.

Fig 4.2.a: Mean Scores among Mizo Women with Different Levels of Education in Relation to their Attitude towards Family Planning



B. Impact of Occupation of Women with regard to their Attitude towards family planning:

TABLE No : 4.2.b(i)

Significance of Difference between Professional and Other Occupational Groups of women in Relation to their Attitude towards family planning

Groups of Comparison		Mean	SD	t-value
Professional Vs Business Women	Professional Women (N =215)	133.5	29.1	**0.59 n.s**
	Business Women (N =230)	135.4	36.9	
Professional Vs Clerical Women	Professional Women (N =215)	133.5	29.1	**0.00 n.s**
	Clerical Women (N =129)	133.5	33.3	
Professional Vs Women Farmers	Professional Women (N =215)	133.5	29.1	**1.87 n.s**
	Women Farmers (N =165)	128.3	22.8	
Professional Vs House wives	Professional Women (N =215)	133.5	29.1	**0.74 n.s**
	House wives (N =308)	131.5	29.1	
Professional Vs Women Labourers	Professional Women (N =215)	133.5	29.1	**2.40***
	Women Labourers (N =117)	125.9	26.2	

*Source: Field Work ,n.s=Not Significant, * Significant at .05 level*

A perusal of data vide Table 4.2.b(i) shows that the t-value for the significance of difference between the means of professionals vs business group of Mizo women is 0.59, whereas the required t-value to declare the said difference as significant at .05 level is 1.97**.** Since the observed t-value is less than the required t-value at .05 level, therefore it can be concluded that there exists no significant difference between the means of the Mizo women who hold a professional occupation and business Mizo women in relation to their attitude towards family planning. In view of this finding, the Null Hypothesis, that there exists no significant difference between the means of the Professionals and Business group of women is **accepted**.

A perusal of data vide Table 4.2.b(i) shows that the t-value for the significance of difference between the means of professionals vs clerical group of Mizo women is 0, whereas the required t-value to declare the said difference as significant at .05 level is 1.97. Since the observed t-value is less than the required t-value at .05 level, therefore it can be concluded that there exists no significant difference between the means of the professionals and clerical group of Mizo women in relation to their attitude towards family planning. In view of this finding, the Null Hypothesis, that there exists no significant difference between the means of the Mizo women with a professional occupation and clerical group of Mizo women is **accepted**.

A perusal of data vide Table 4.2.b(i) shows that the t-value for the significance of difference between the means of professionals vs farmers group of Mizo women is 1.87, whereas the required t-value to declare the said difference as significant at .05 level is 1.97. Since the observed t-value is less than the required t-value at .05 level, therefore it can be concluded that there exists no significant difference between the means of the Mizo women with a professional occupation and farmers group of Mizo women in relation to their attitude towards family planning. In view of this finding, the Null Hypothesis, that there exists no significant difference between the Means of the professionals and farmers group of Mizo women is **accepted**.

A perusal of data vide Table 4.2.b(i) shows that the t-value for the significance of difference between the means of professionals vs housewives group of Mizo women is 0.74, whereas the required t-value to declare the said difference as significant at .05 level is 1.97. Since the observed t-value is less than the required t-value at .05 level, therefore it can be concluded that there exists no significant difference between the means of the Mizo women with professional occupations and housewives group of Mizo women in relation to their attitude towards family planning. In view of this finding, the Null Hypothesis, that there exists no significant difference between the means of the professionals and housewives group of Mizo women is **accepted**.

A quick glance at Table 4.2.b(i) reveals that the t-value for the significance of difference between the means of professionals vs labourers group of women, with

regard to their attitude towards family planning is 2.40, whereas the required t-values to declare the said difference as significant are 1.97 and 2.59 at .05 and .01 level respectively. Since the observed t-value of 2.40 is less than the required t-value at .01 level and more than the required t-value at .05 level, there exists a significant difference between the means of Mizo women with professional occupations and labourers group of Mizo women with regard to their attitude towards family planningat .05 level. In view of the aforesaid significant difference, the Null Hypothesis, that there exists no significant difference between professional and labourers group of women in relation to their attitude towards family planning is **rejected**. An analysis of the mean scores of both the groups of women reveals that the said significant difference is in favour of Mizo women with professional occupation as their mean score is higher than their counterparts from Mizo women labourers group.

Fig 4.2.b(i): Mean Scores Obtained by Mizo Professional Women compared to Other Occupational Groups in Relation to their Attitude towards Family Planning

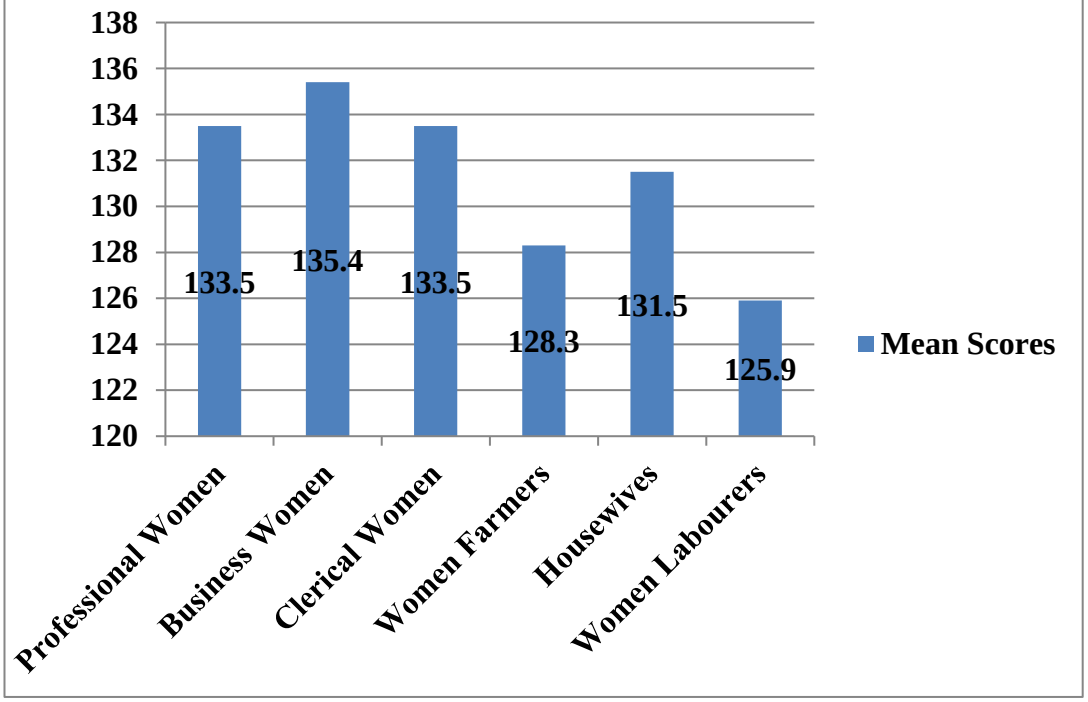


TABLE No: 4.2.b(ii)

Significance of Difference between Business and Other Occupational Groups of Women in Relation to their Attitude towards family planning

Groups of Comparison		Mean	SD	t-value
Business Women Vs Clerical Women	Business Women (N =230)	135.4	36.9	**0.50 n.s**
	Clerical Women (N =129)	133.5	33.3	
Business Women Vs Women Farmers	Business Women (N =230)	135.4	36.9	**2.33***
	Women Farmers (N =165)	128.3	22.8	
Business women Vs House wives	Business Women (N =230)	135.4	36.9	**1.32 n.s**
	House wives (N =308)	131.5	29.1	
Business Women Vs Women Labourers	Business Women (N =230)	135.4	36.9	**2.80****
	Women Labourers (N =117)	125.9	26.2	

*Source: Field Work; n.s=Not Significant, * Significant at .05 level **Significant at .01 level*

A perusal of data vide Table 4.2.b(ii) shows that the t-value for the significance of difference between the means of Mizo Business women vs Mizo Clerical group of women is 0.50, whereas the required t-value to declare the said difference as significant at .05 level is 1.97. Since the observed t-value is less than the required t-value at .05 level, therefore it can be concluded that there exists no significant difference between the means of the Mizo business and Mizo clerical group of women in relation to their attitude towards family planning. In view of this finding, the Null Hypothesis, that there exists no significant difference between the means of the business and clerical group of Mizo women is **accepted**.

A quick glance at Table 4.2.b(ii) reveals that the t-value for the significance of difference between the means of Mizo business women vs farmers group of Mizo women, with regard to their attitude towards family planning is 2.33, whereas the required t-values to declare the said difference as significant are 1.97 and 2.59 at .05 and .01level respectively. Since the observed t-value of 2.33 is less than the required t-value at .01level and more than the required t-value at .05 level, there exists a

significant difference between the means of business and farmers group of Mizowomen with regard to their attitude towards family planning at .05 level. In view of the aforesaid significant difference, the Null Hypothesis, that there exists no significant difference between business and farmers group of women in relation to their attitude towards family planning is **rejected**. An analysis of the mean scores of both the groups of women reveals that the said significant difference is in favour of business group of Mizo women as their mean score is higher than their counterparts from farmers group of Mizo women.

A perusal of data vide Table 4.2.b(ii) shows that the t-value for the significance of difference between the means of Mizo business women vs housewives group of Mizo women is 1.32, whereas the required t-value to declare the said difference as significant at .05 level is 1.97. Since the observed t-value is less than the required t-value at .05 level, therefore it can be concluded that there exists no significant difference between the means of the Mizo business women and housewives group of Mizo women in relation to their attitude towards family planning. In view of this finding, the Null Hypothesis, that there exists no significant difference between the means of the Mizo business women and housewives group of Mizo women is **accepted**.

A quick glance at Table 4.2.b(ii) reveals that the t-value for the significance of difference between the means of Mizo business women vs labourers group of Mizo women, with regard to their attitude towards family planning is 2.80, whereas the required t-values to declare the said difference as significant are 1.97 and 2.59 at .05 and .01 level respectively. Since the observed t-value of 2.80 is less than the required t-value at .01 level and more than the required t-value at .05 level, there exists a significant difference between the means of Mizo business women and labourers group of Mizo women with regard to their attitude towards family planning at .05 level. In view of the aforesaid significant difference, the Null Hypothesis, that there exists no significant difference between Mizo business women and labourers group of Mizo women in relation to their attitude towards family planning is **rejected**. An analysis of the mean scores of both the groups of women reveals that the said significant difference is in favour of Mizo business group of

women as their mean score is higher than their counterparts from labourers group of Mizo women.

Fig 4.2.b(ii): Mean Scores Obtained by Mizo Business Women compared to other Occupational Groups in Relation to their Attitude towards Family Planning

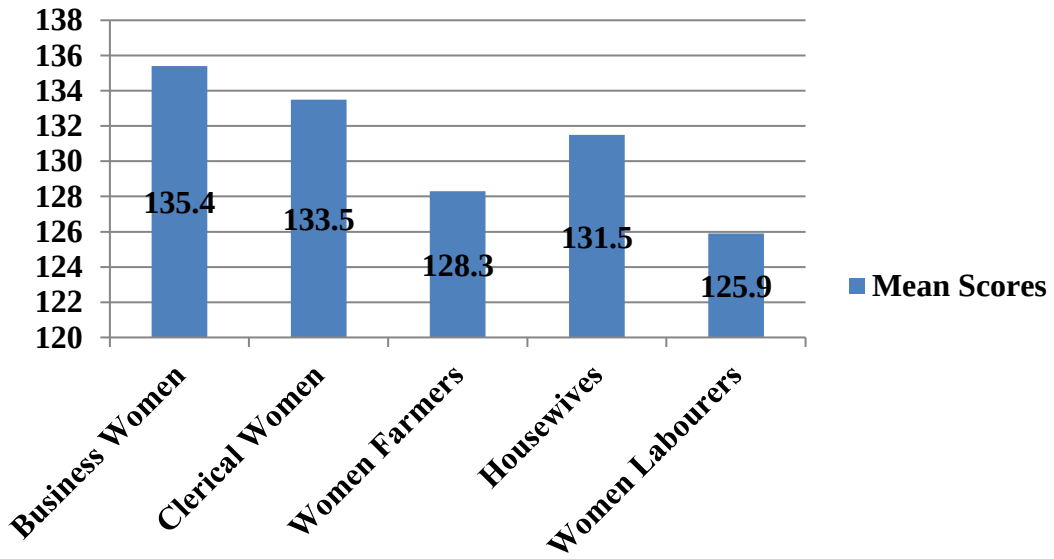


TABLE No: 4.2.b(iii)

Significance of Difference between Clerical and other Occupational Groups of Women in Relation to their Attitude towards family planning

Groups of Comparison		Mean	SD	t-value
Clerical Women Vs Women Farmers	Clerical Women (N =129)	133.5	33.3	**1.52 n.s**
	Women Farmers (N =165)	128.3	22.8	
Clerical Women Vs Housewives	Clerical Women (N =129)	133.5	33.3	**0.60 n.s**
	House wives (N =308)	131.5	29.1	
Clerical Women Vs Women Labourers	Clerical Women (N =129)	133.5	33.3	**2.04***
	Women Labourers (N =117)	125.9	26.2	

*Source: Field Work; n.s=Not Significant, * Significant at .05 level*

A perusal of data vide Table 4.2.b(iii) shows that the t-value for the significance of difference between the means of Mizo women in clerical occupations

vs Mizo farmers group of women is 1.52, whereas the required t-value to declare the said difference as significant at .05 level is 1.97. Since the observed t-value is less than the required t-value at .05 level, therefore it can be concluded that there exists no significant difference between the means of the Mizo women in clerical occupations and Mizo farmers group of women in relation to their attitude towards family planning. In view of this finding, the Null Hypothesis, that there exists no significant difference between the means of the Mizo women in clerical occupations and Mizo farmers group of women is **accepted**

A perusal of data vide Table 4.2.b(iii) shows that the t-value for the significance of difference between the means of Mizo women in clerical with clericaloccupations vs housewives group of Mizo women is 0.60, whereas the required t-value to declare the said difference as significant at .05 level is 1.97. Since the observed t-value is less than the required t-value at .05 level, therefore it can be concluded that there exists no significant difference between the means of the Mizo women with clerical occupations and housewives group of Mizo women in relation to their attitude towards family planning. In view of this finding, the Null Hypothesis, that there exists no significant difference between the means of the Clerical and Housewives group of women is **accepted**.

A quick glance at Table 4.2.b(iii) reveals that the t-value for the significance of difference between the means of Mizo women in clerical occupations vs Mizo womenlabourers, with regard to their attitude towards family planning is 2.04, whereas the required t-values to declare the said difference as significant are 1.97 and 2.59at .05and .01level respectively. Since the observed t-value of 2.04 is less than the required t-value at .01 level and more than the required t-value at .05 level, there exists a significant difference between the means of Mizo women in clerical occupations and Mizo women labourers with regard to their attitude towards family planning at .05 level. In view of the aforesaid significant difference, the Null Hypothesis, that there exists no significant difference between Mizo women in clerical occupations and Mizo women labourers in relation to their attitude towards family planning is **rejected**. An analysis of the mean scores of both the groups of women reveals that the said significant difference is in favour of Mizo women in

clerical occupations as their mean score is higher than their counterparts from the Mizo women labourers group.

Fig 4.2.b(iii): Mean Scores Obtained by Mizo Clerical Women compared to other Occupational Groups in Relation to their Attitude towards Family Planning

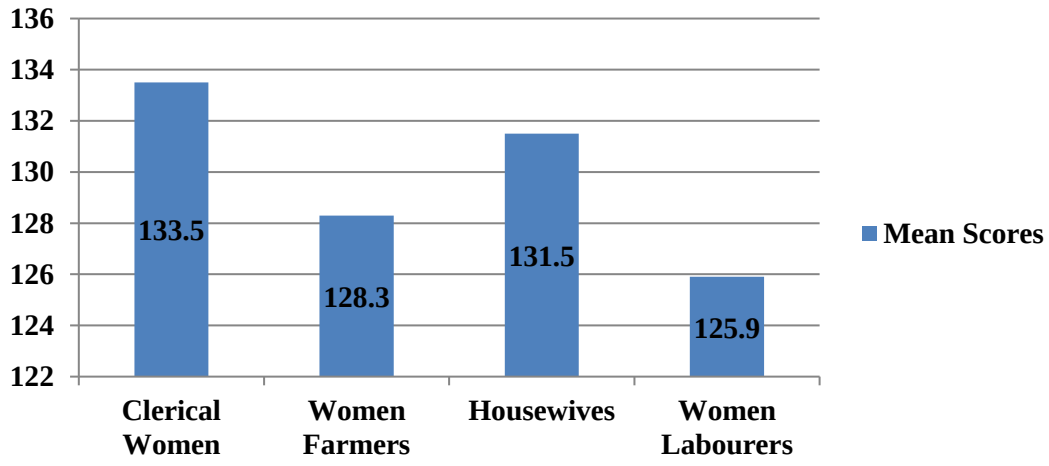


TABLE No : 4.2.b(iv)

Significance of Difference between Farmers and other Occupational Groups of Women in Relation to their Attitude towards family planning

Groups of Comparison		Mean	SD	t-value
Women Farmers Vs House Wives	Women Farmers (N =165)	128.3	22.8	**1.30 n.s**
	House wives (N =308)	131.5	29.1	
Farmer Vs Women Labourers	Women Farmers (N =165)	128.3	22.8	**0.70 n.s**
	Labourer Women (N =117)	125.9	26.2	

Source: Field Work, n.s=Not Significant

A perusal of data vide Table 4.2.b(iv) shows that the t-value for the significance of difference between the means of Mizo women farmers vs Mizo housewives is 1.30, whereas the required t-value to declare the said difference as significant at .05 level is 1.97. Since the observed t-value is less than the required t-value at .05 level, therefore it can be concluded that there exists no significant difference between the means of the Mizo women farmers and Mizo housewives

group in relation to their attitude towards family planning. In view of this finding, the Null Hypothesis, that there exists no significant difference between the means of the Mizo women Farmers and Mizo housewives group of women is **accepted**.

A perusal of data vide Table 4.2.b(iv) shows that the t-value for the significance of difference between the means of Mizo women farmers vs Mizo women labourers is 0.70, whereas the required t-value to declare the said difference as significant at .05 level is 1.97. Since the observed t-value is less than the required t-value at .05 level, therefore it can be concluded that there exists no significant difference between the means of the Mizo women farmers vs Mizo women labourers in relation to their attitude towards family planning. In view of this finding, the Null Hypothesis, that there exists no significant difference between the means of the Mizo women farmers vs Mizo women labourers is **accepted**.

Fig 4.2.b(iv): Mean Scores Obtained by Mizo Women Farmers compared to other Occupational Groups in Relation to their Attitude towards Family Planning

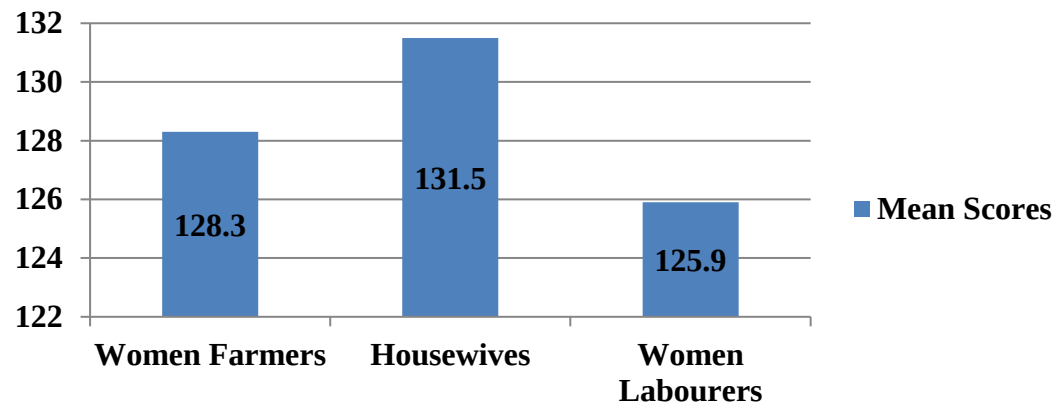


TABLE No: 4.2.b(v)

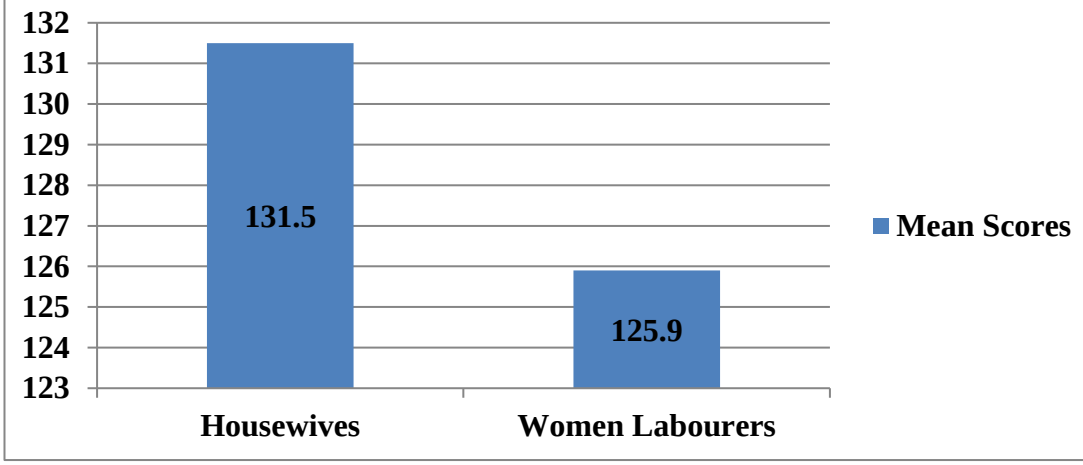
Significance of Difference between Housewives and Labourer Groups of Women in Relation to their Attitude towards family planning

Groups of Comparison		Mean	SD	t-value
Housewives Vs Women Labourers	House wives (N =308)	131.5	29.1	**1.68 n.s**
	Women Labourers (N =117)	125.9	26.2	

Source: Field Work;n.s=Not Significant

A perusal of data vide Table 4.2.b(v) shows that the t-value for the significance of difference between the means of Mizo housewives vs Mizo women labourers is 1.68, whereas the required t-value to declare the said difference as significant at .05 level is 1.97. Since the observed t-value is less than the required t-value at .05 level, therefore it can be concluded that there exists no significant difference between the means of the Mizo housewives vs Mizo women labourers in relation to their attitude towards family planning. In view of this finding, the Null Hypothesis, that there exists no significant difference between the means of the Mizo housewives vs Mizo women labourers is **accepted**.

Fig 4.2.b(v): Mean Scores Obtained by Mizo Housewives and Mizo Women Labourers in Relation to their Attitude towards Family Planning



C. Impact of Socio-Economic Status of Women with regard to their Attitude towards family planning:

TABLE No : 4.2.c

Significance of Difference among Women with Different Levels of SES in Relation to their Attitude towards family planning

Groups of Comparison		Mean	SD	t-value
Low SES Vs Middle SES	Low SES (N = 357)	131.1	26.6	**0.74 n.s**
	Middle SES (N = 710)	132.5	26.6	
Low SES Vs High SES	Low SES (N =357)	131.1	26.6	**0.04 n.s**
	High SES (N = 97)	131.2	29.7	
Middle SES Vs High SES	Middle SES (N =710)	132.5	26.6	**0.63 n.s**
	High SES (N = 97)	131.2	29.7	

Source: Field Work, n.s=Not Significant

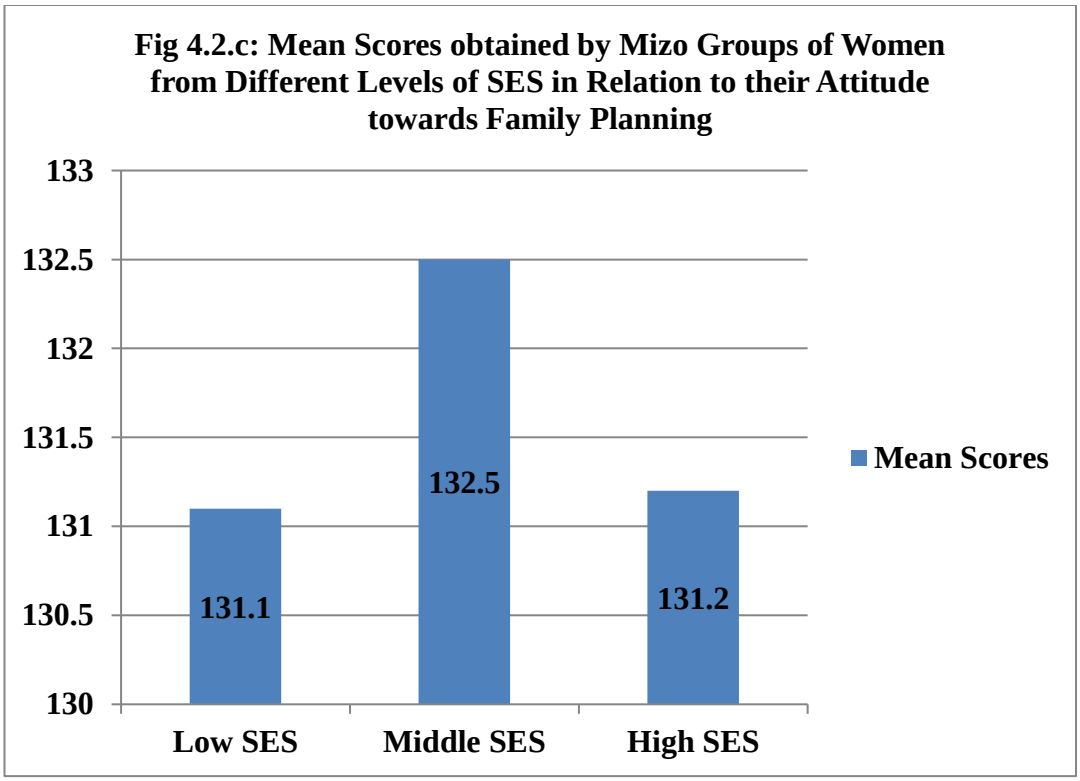
A perusal of data vide Table 4.2.c shows that the t-value for the significance of difference between the means of Mizo women from low SES vs middle SES groups of Mizo women is 0.74, whereas the required t-value to declare the said difference as significant at .05 level is 1.97. Since the observed t-value is less than the required t-value at .05 level, therefore, it can be concluded that there exists no significant difference between the means of the Mizo women from low SES and Mizo women from middle SES in relation to their attitude towards family planning. In view of this finding, the Null Hypothesis, that there exists no significant difference between the means of the Mizo women from low SES and Mizo women from middle SES is **accepted**.

A perusal of data vide Table 4.2.c shows that the t-value for the significance of difference between the means of Mizo women from low SES and Mizo women from high SES is 0.04, whereas the required t-value to declare the said difference as significant at .05 level is 1.97. Since the observed t-value is less than the required t-value at .05 level, therefore, it can be concluded that there exists no significant difference between the means of the Mizo women from low SES and Mizo women from high SES in relation to their attitude towards family planning. In view of this

finding, the Null Hypothesis, that there exists no significant difference between the means of the Mizo women from low SES and Mizo women from high SES is **accepted**.

A perusal of data vide Table 4.2.c shows that the t-value for the significance of difference between the means of Mizo women from middle SES vs Mizo women from high SES is 0.63, whereas the required t-value to declare the said difference as significant at .05 level is 1.97. Since the observed t-value is less than the required t-value at .05 level, therefore, it can be concluded that there exists no significant difference between the means of Mizo women from middle SES vs Mizo women from high SES in relation to their attitude towards family planning. In view of this finding, the Null Hypothesis, that there exists no significant difference between the means of Mizo women from middle SES vs Mizo women from high SES is **accepted**.

Fig 4.2.c: Mean Scores obtained by Mizo Groups of Women from Different Levels of SES in Relation to their Attitude towards Family Planning



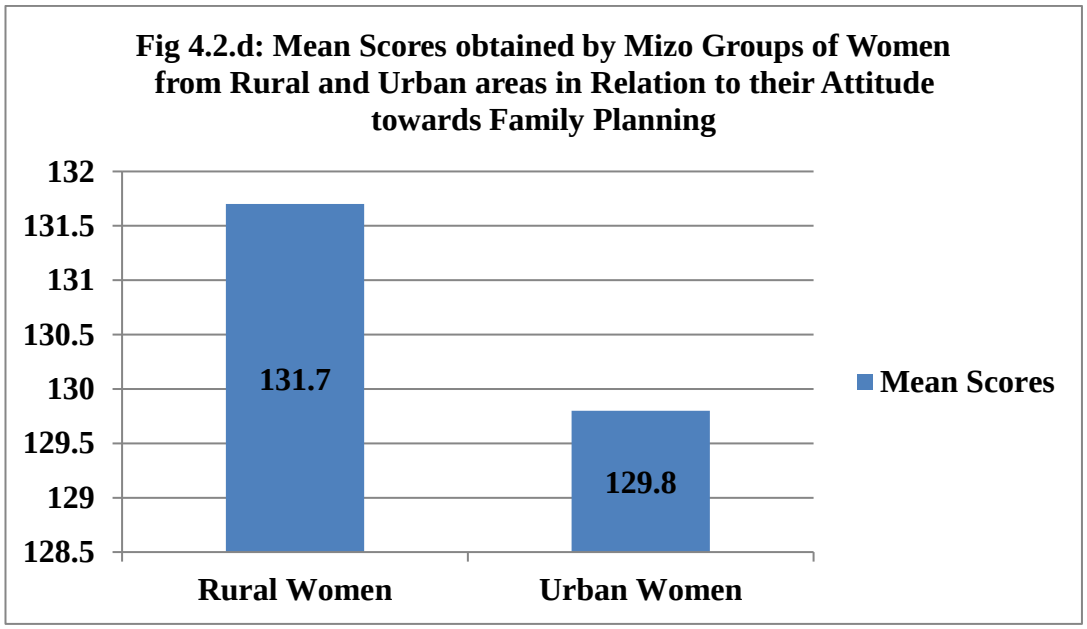
D. Impact of Locale of Women with regard to their Attitude towards family planning:

TABLE No : 4.2.d
Significance of Difference between Rural and Urban Women in Relation to their Attitude towards family planning

Groups of Comparison		Mean	SD	t-value
Rural and Urban Women	Rural (N = 451)	131.7	33.2	**1.01 n.s**
	Urban (N = 713)	129.8	27.6	

Source: Field Work, n.s=Not Significant

A perusal of data vide Table 4.2.d shows that the t-value for the significance of difference between the means of Mizo women from rural areas vs Mizo women from urban areas is 1.01, whereas the required t-value to declare the said difference as significant at .05 level is 1.97. Since the observed t-value is less than the required t-value at .05 level, therefore, it can be concluded that there exists no significant difference between the means of Mizo women from rural areas vs Mizo women from urban areas in relation to their attitude towards family planning. In view of this finding, the Null Hypothesis, that there exists no significant difference between the means of the Rural and Urban women is **accepted**.



4.3 FAMILY PLANNING PRACTICES

The current study on family planning practices among Mizo women utilizes the method of Measures of Central Tendency (Descriptive Statistics) like Mean, Median and Mode; and Standard Deviation for Measures of Variability. The family planning Practices of Mizo women with regards to their age at marriage, number of children, age at birth of first child, age at birth of last child, size of ideal family and spacing are taken into consideration for the current study. The mean, median, mode, Standard Deviation and skewness are calculated and conclusion was drawn. Hence, the hypotheses regarding the family planning practices of Mizo women are either rejected or accepted/retained depending on the scores obtained.

TABLE No: 4.3.a

Descriptive Statistics Relating to Age at Marriage, Age at Birth of First Child, Age at Birth of Last child, Size of Ideal family, Spacing and Number of Children of Women Included in the Sample

Sl. No	Variable	No. of Women	Mean	Median	Mode	SD	Skewness
1	**Age at Marriage**	1164	21.37	20.71	19.33	3.06	+0.64
2	**Number of Children**	1164	3.67	3.85	4.21	1.18	-0.45
3	**Age at Birth of First Child**	1164	22.27	21.88	21.1	3.03	+0.38
4	**Age at Birth of Last Child (50 + age group only)**	182	33.35	33.00	32.3	3.85	+0.27
5	**Size of Ideal family**	1164	4.59	4.31	3.75	1.08	+0.77
6	**Spacing**	1114	2.39	1.76	0.50	0.68	+2.78

Source: Field Work

The Table No. 4.3.a, being the master table, shows the descriptive statistics such as mean, median, mode, standard deviation and skewness value relating to the age at marriage, age at birth of first child, age at birth of last child, size of ideal family, adoption of spacing for birth control and the number of children born to the Mizo women respondents. A detailed interpretation of the descriptive statistics can be seen as follows:

Fig 4.3.a: Mean Scores obtained by Mizo Women in relation to Age at Marriage, Number of Children, Age at Birth of First Child, Age at Birth of Last Child (only 50+ age group only), Size of Ideal Family and Spacing

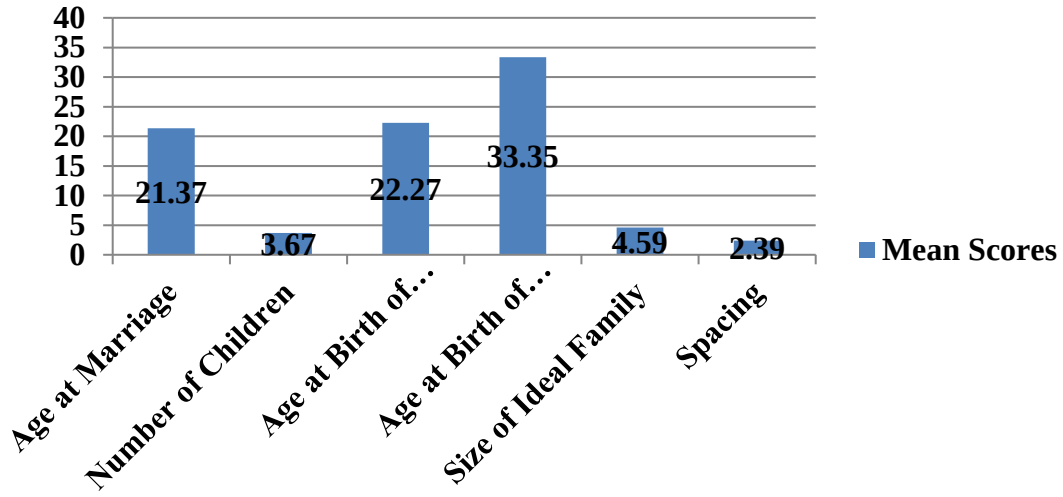


TABLE No. 4.3.b(i)

Number, Percentage and Cumulative Frequencies Relating to Age at Marriage of Women Respondents

Age Range	Frequency	Percentage	Cumulative %
30 &Above	31	2.67	100
27 – 29	50	4.29	97.33
24 – 26	147	12.63	93.04
21 – 23	381	32.73	80.41
18 – 20	526	45.19	47.68
Below 18	29	2.49	2.49
Total	1164	-	-

Source: Field Work

Fig 4.3.b(i): Frequency Polygon showing the number of Mizo Women in Relation to their Age at Marriage

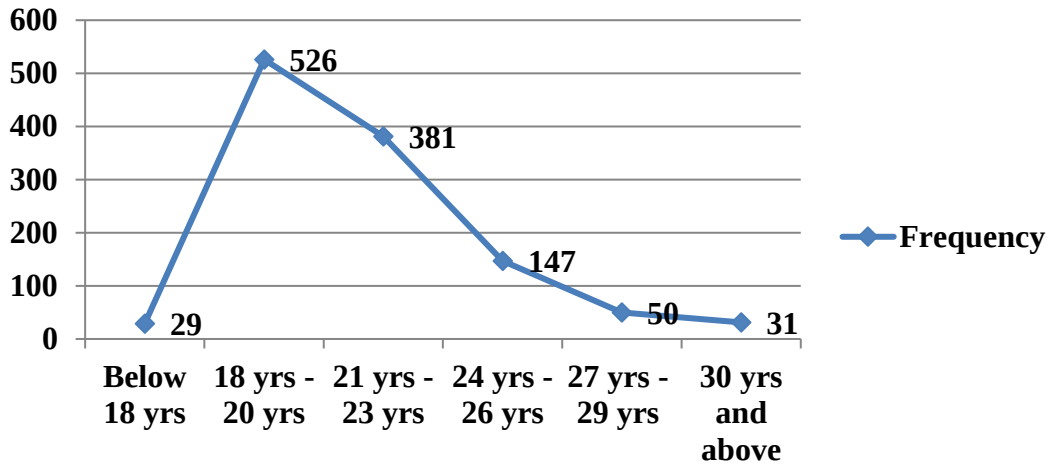


TABLE No. 4.3.b(ii)

Descriptive Statistics Relating to Age at Marriage

Variable	Mean	Median	Mode	SD	Skewness
Age at Marriage	21.37	20.71	19.33	3.06	+0.64

The table 4.3.b(ii) reveals that the average age of Mizo women at the time of marriage is 21.37 years. The median value is 20.71, which indicates that fifty (50) percent of the women get married before attaining the age of 20.71 years, and the remaining fifty (50) percent get married after attaining the age of 20.71 years. Further, the mode value being 19.33 indicates that majority of the respondents get married at the age of 19.33 years. The statistics relating to age at marriage is positively skewed, which indicates a large concentration of scores near the lower end of the distribution. This means that the number of Mizo women getting married at younger age is relatively larger than those who get married late. The positive skewness in the present context suggests that fertility span of majority of women is much longer, and gives them a scope to give birth to more children.

TABLE No. 4.3.c(i)

Number, Percentage and Cumulative Frequencies Relating to Number of Children Born to the Women Respondents

No. of Children	Frequency	Percentage	Cumulative Percentage
5 and Above	349	29.98	100
4	364	31.28	70.02
3	214	18.38	38.74
2	187	16.07	20.36
1	50	4.29	4.29
Total	1164	-	-

Source: Field Work

Fig 4.3.c(i): Frequency Polygon showing the distribution of Mizo Women in Relation to Number of Children

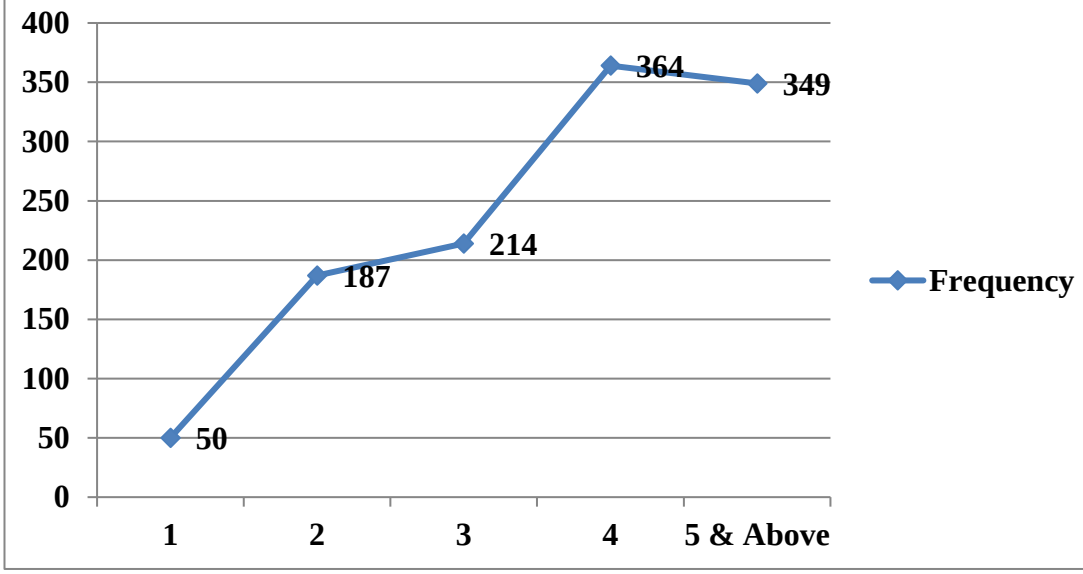


TABLE No. 4.3.c(ii)

Descriptive Statistics Relating to Number of Children born to Women Respondent

Variable	Number	Mean	Median	Mode	SD	Skewness
Number of Children	1164	3.67	3.85	4.21	1.18	-0.45

A perusal of table 4.3.c(ii) shows that among the 1164 respondents, the average number of children that a Mizo woman gives birth to is 3.67 children. The median value is 3.85, which indicates that fifty (50) percent of the Mizo women gave

birth to 3.85 children and the remaining fifty (50) percent gave birth to more than 3.85 children. Further, the mode value being 4.21 indicates that the majority of the respondents gave birth to 4.21 children. The statistics relating to number of children is negatively skewed which indicates a large concentration of scores near the higher end of the distribution. The negative skewness in the present context suggests that the number of Mizo women giving birth to more than 3.67 (Mean) children is much larger than those who gave birth to less than 3.67 children (Mean). From the aforesaid statistics one can easily understand why the population growth in the state is always higher in relation to the growth at all India level

TABLE.No.4.3.d(i)

Number, Percentage and Cumulative Frequencies Relating to Age of Women Respondents at the Time of Birth of First Child

Age(in Yrs)	Frequency	Percentage	Cumulative %
30 and Above	36	3.09	100
29	23	1.98	96.91
28	24	2.06	94.93
27	28	2.41	92.87
26	61	5.24	90.46
25	61	5.24	85.22
24	90	7.73	79.98
23	123	10.57	72.25
22	157	13.49	61.68
21	203	17.44	48.19
20	267	22.94	30.75
19	68	5.84	7.81
18	16	1.37	1.97
17 & Below	7	0.60	0.60
Total	**1164**	-	-

Source: Field Work

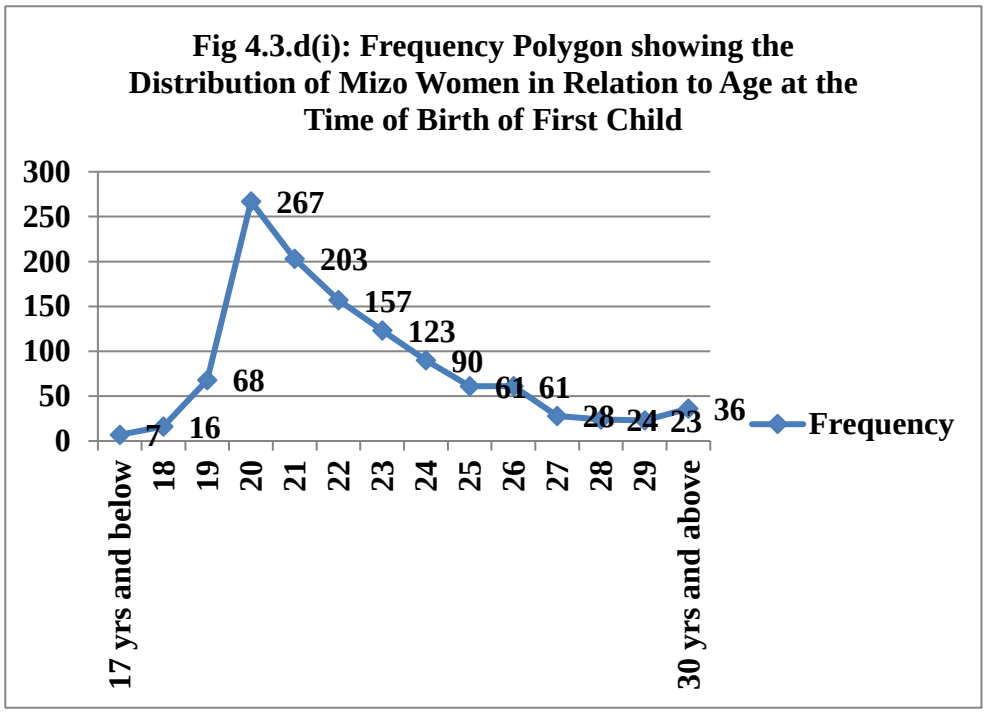


TABLE No. 4.3.d(ii)

Descriptive Statistics Relating to Age of Women Respondents at Birth of First Child

Variable	Mean	Median	Mode	SD	Skewness
Age at Birth of First Child	22.27	21.88	21.1	3.03	+0.38

A quick glance at table 4.3.d(ii) shows us that the average age at which the respondents gave birth to their first child is 22.27 years. The median value is 21.88, which indicates that fifty (50) percent of the Mizo women gave birth to their first child before attaining the age of 21.88 years, and the remaining fifty (50) percent gave birth to their first child after attaining the age of 21.88 years. Further, the mode value being 21.1 indicates that most of the respondents gave birth to their first child at the age of 21.1 years. The statistics relating to the age at the time of birth of the first child is positively skewed which indicates a large concentration of scores near the lower end of the distribution. The positive skewness in the present context suggests that number of Mizo women giving birth to their first child before 22.27 years (Mean) is much larger than those who gave birth to their first child after 22.27 years (Mean).The aforesaid statistics relating to the age of Mizo women respondents

at the time of birth of their first child, like age at marriage, suggests that they have relatively longer span for expansion of their family. Further, giving birth to the child at a young age, as is indicated by the statistics in table 4.3.d(i), is not healthy for both the mother and the child

TABLE No. 4.3.e(i)

Number, Percentage and Cumulative Frequencies Relating to Age of Women at the Time of Birth of Last Child

Age	Frequency	Percentage	Cumulative %
40 and Above	11	6.04	100
39	4	2.2	93.96
38	7	3.85	91.76
37	13	7.14	87.91
36	14	7.69	80.77
35	13	7.14	73.08
34	17	9.34	65.94
33	14	7.69	56.6
32	26	14.29	48.91
31	17	9.34	34.62
30	14	13.19	25.28
29	5	2.75	12.09
28	5	2.75	9.34
27	5	2.75	6.59
26	3	1.64	3.84
25	2	1.10	2.2
24	1	0.55	1.1
23	0	0	0.55
22	1	0.55	0.55
TOTAL	**182***	-	-

*Source: Field Work: * Only 50 years and plus women have been included for analysis under this variable*

Fig 4.3.e(i): Frequency Distribution of Mizo Women in Relation to their Age at the Time of Birth of Last Child

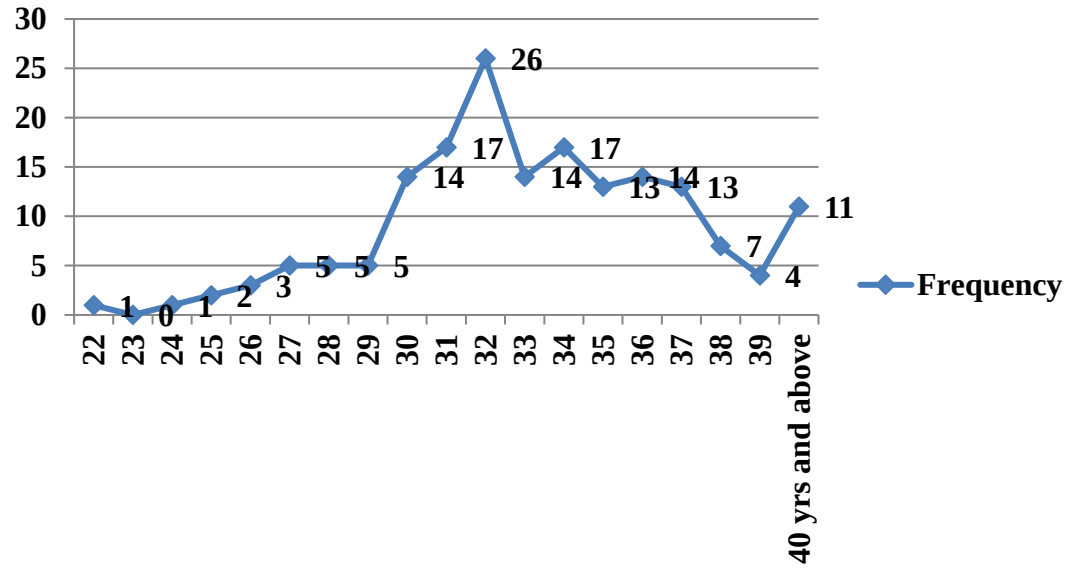


TABLE No. 4.3.e(ii)

Descriptive Statistics Relating to Age of Women at Birth of Last child

Variable	Number	Mean	Median	Mode	SD	Skewness
Age at Birth of Last child (50+ age group only)	182	33.35	33	32.3	3.85	+0.27

Before interpretation of descriptive statistics relating to the age of Mizo women at the time of giving birth to their last child, it needs to be mentioned that the 50yrs and plus respondents only were considered for analysis of data under this variable. The table 4.3.e(ii) reveals that the average age of the respondents at the time of birth of the last child is 33.35 years. The median value is 33, which indicates that fifty (50) percent of the Mizo women gave birth to their last child before attaining the age of 33 years and the remaining fifty (50) percent gave birth to their last child after attaining the age of 33 years. Further, the mode value being 32.3 indicates that most of the Mizo women gave birth to their last child at the age of 32.3 years. The statistics relating to the age at the time of giving birth to the last child is also positively skewed which indicates a large concentration of scores near the lower

end of the distribution. The positive skewness in the present context suggests that number of Mizo women giving birth to their last child before 33.35 years (Mean) is much larger than those who gave birth to their last child after 33.35 years (Mean). The positively skewed distribution here should be taken as desirable because most of the Mizo women respondents completed their family at the right age. Further, the mean age of 22.27 years at the time of birth of first child [Vide Table 4.3.d(ii)], and mean age of 33.35 at the time of birth of last child [Vide Table 4.3.e(ii)] suggests that most Mizo women respondents take around 11 years to complete their family to their desired size.

TABLE No. 4.3.f(i)

Number, Percentage and Cumulative Frequencies Relating to Adoption of Spacing Method for Birth Control/family planning

Spacing (In Years)	Frequency	Percentage
5	19	1.71
4	55	4.94
3	252	22.62
2	773	69.38
1	15	1.35
Total	**1114**	100

Source: Field WorkNote: Out of 1164 Spacing Method for Birth Control is followed by 1114(95.7%)

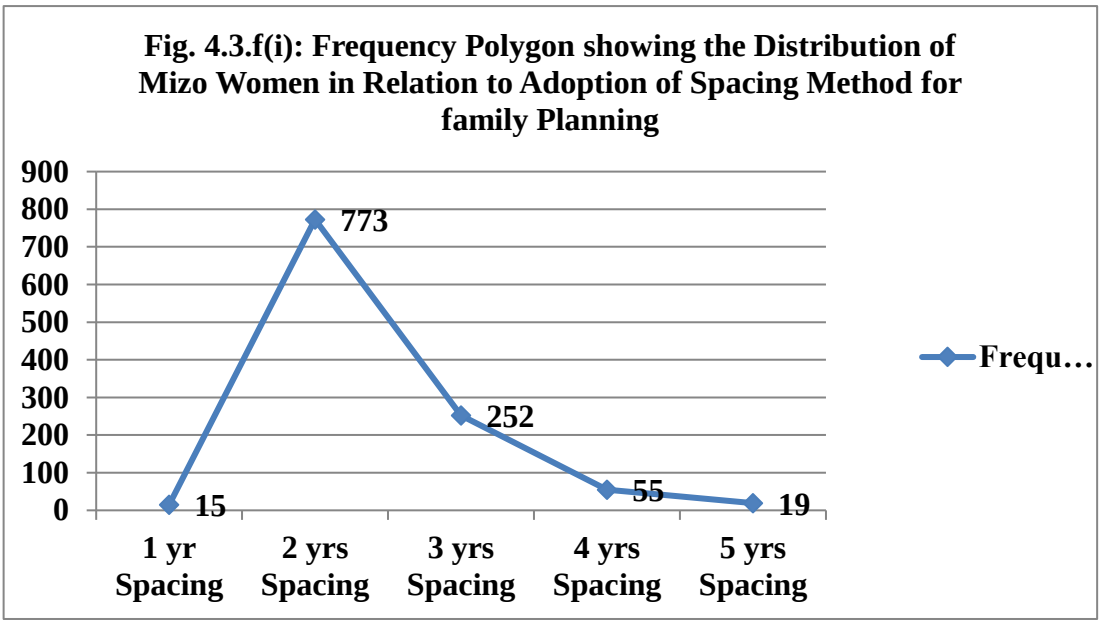


TABLE No. 4.3.f(ii)

Descriptive Statistics Relating to Spacing Method Adopted by the Women Respondents for Birth Control (in Years)

Method of Birth Control	Number	Mean	Median	Mode	SD	Skewness
Spacing Method	1114 (95.7%)	2.39	1.76	0.50	0.68	+2.78

A quick glance at table 4.3.f(ii) shows that out of a total sample of 1164 spacing method for birth control is followed by 1114(95.7 percent) respondents.While practicing spacing method for birth control/family planning, the Mizo women, on an average, leave a gap of 2.39 years in between their children. The median value is 1.76, which indicates that fifty percent of the respondents leave a gap of less than 1.76 years in between the births of their children, and the remaining fifty (50) percent leave a gap of more than 1.76 years in between the births of their children. Further, the mode value being 0.50 indicates that most of the Mizo women practice spacing only for a period of 0.50 years duration which is significantly less than the period of 3 years recommended by family planning programmes under spacing method. Further, the statistics relating to the spacing method for birth control is positively skewed which indicates a large concentration of scores near the lower end of the distribution. The positive skewness in the present context suggests that number of Mizo women keeping a space of less than 2.39 years (Mean) between the births of their children is much larger than those who keep a space of more than 2.39 years.

TABLE No. 4.3.g(i)

Number, Percentage and Cumulative Frequencies Relating to Perception of Women regarding the Size of an Ideal family Size

Size of an Ideal family (C.I)	Frequency	Percentage	Cumulative%
7 and Above	48	4.12	100.00
6	249	21.39	95.88
5	175	15.03	74.49
4	581	49.91	59.46
3	97	8.33	9.55
2	13	1.12	1.22
1	1	0.10	0.10
Total	**1164**	-	-

Source: Field WorkNote

Fig. 4.3.g(i): Frequency Polygon showing the Distribution of Mizo Women in Relation to the Size of Ideal Family

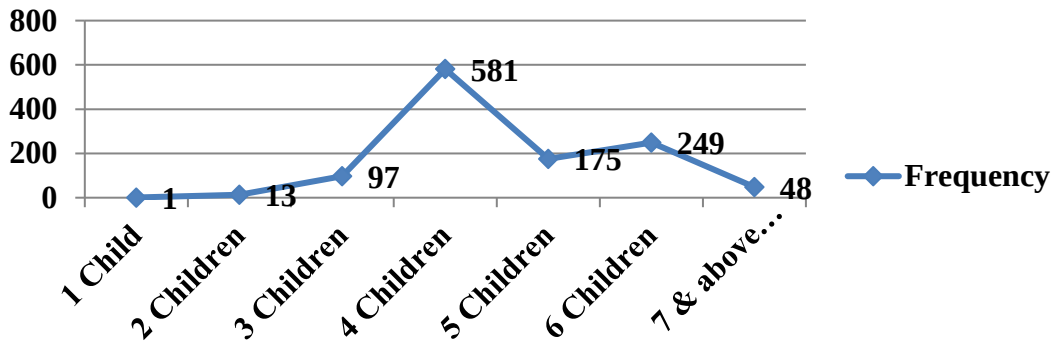


TABLE No. 4.3.g(ii)

Descriptive Statistics Relating to Size of Ideal family

Variable	Mean	Median	Mode	SD	Skewness
Size of Ideal family	4.59	4.31	3.75	1.08	+0.77

A perusal of data vide table 4.3.g(ii) shows that the ideal family size, as perceived by the Mizo women respondents, should on an average consist of 4.59 children. The median value for the same is 4.31 children, which indicates that fifty (50) percent of the Mizo women agree that an ideal family size should include 4.31 children, whereas the remaining fifty (50) percent opine that an ideal family size should include more than 4.31 children. Further, the mode value being 3.75 indicates that most of the respondents believed that an ideal family size should include 3.75 children. The statistics relating to perception of Mizo women regarding the size of an ideal family size is positively skewed which indicates a large concentration of scores near the lower end of the distribution. The positive skewness in the present context suggests that number of Mizo women who perceive ideal family size to be less than 4.59 children (Mean) is much less than those who wish it to be more than 4.59 children (Mean). Although it is relieving to have a positively skewed distribution in relation to the ideal family size, the average size of ideal family i.e. 4.59 children (Mean) suggested by the respondents in itself is much beyond the ideal family size norm suggested by the family planning programmes.

CHAPTER – V: MAJOR FINDINGS, CONCLUSIONS, RECOMMENDATIONS AND SUGGESTIONS

5.0 Introduction

Chapter V has been organized under the following three (3) sections :-

5.1 Deals with the major findings on Awareness of family planning programs and methods

5.2 Deals with the major findings on Attitude towards family planning programs

5.3 Deals with the major findings on family planning Practices

5.1 Major findings in Relation to the Awareness of family planning programs and methods

A. Awareness of family planning programs and methods in relation to educational level-

There exists a significant difference between the means of elementary vs. secondary and higher education level groups of Mizo women with regard to their awareness of family planning programs and methods. (Table 4.1.a)

B. Awareness of family planning programs and methods in relation to occupational background-

i) There exists a significant difference between the means of professional vs. business, clerical, farmers, housewives and laborers groups of Mizo women with regard to their awareness of family planning programs and methods. [Table 4.1.b(i)]

ii) There exists a significant difference between the means of business vs. clerical groups of Mizo women with regard to their awareness of family planning programs and methods [Table 4.1.b(ii)].

iii) There exists no significant difference between the means of business vs. farmers, housewives and laborers groups of Mizo women with

regard to their awareness of family planning programs and methods [Table 4.1.b(ii)].

iv) There exists no significant difference between the means of clerical vs. farmers and housewives groups of Mizo women with regard to their awareness of family planning programs and methods [Table 4.1.b(iii)].

v) There exists a significant difference between the means of clerical vs. laborers groups of Mizo women with regard to their awareness of family planning programs and methods [Table 4.1.b(iii)].

vi) There exists no significant difference between the means of farmers vs. housewives groups of Mizo women with regard to their awareness of family planning programs and methods [Table 4.1.b(iv)].

vii) There exists a significant difference between the means of farmers vs. laborers groups of Mizo women with regard to their awareness of family planning programs and methods [Table 4.1.b(iv)].

viii) There exists no significant difference between the means of housewives vs. laborers groups of Mizo women with regard to their awareness of family planning programs and methods [Table 4.1.b(v)].

C. Awareness of family planning programs and methods in relation to socio-economic status-

There exists a significant difference between the means of low SES vs. middle SES, Low SES vs. high SES and middle SES vs. high SES groups of Mizo women with regard to their awareness of family planning programs and methods. (Table 4.1.c)

D. Awareness of family planning programs and methods in relation to their locale-

There exists a significant difference between the means of rural vs. urban groups of Mizo women with regard to their awareness of family planning programs. (Table 4.1.d)

5.2 Major Findings Relating to the Attitude towards family planning programs:

A. Attitude towards family planning programs and methods in relation to educational level-

i) There exists no significant difference between the elementary vs. secondary education level groups of Mizo women with regard to their attitude towards family planning programs and methods. (Table 4.2.a)

ii) There exists a significant difference between the means of elementary vs. higher and secondary vs higher education level groups of Mizo women with regard to their attitude towards family planning programs and methods. (Table 4.2.a)

B. Attitude towards family planning programs and methods in relation to occupational background-

i) There exists no significant difference between the means of professional vs. business, clerical, farmers and housewives groups of Mizo womenwith regard to their attitude towards family planning programs [Table 4.2.b(i)].

ii) There exists a significant difference between the means of professional vs. laborers groups of Mizo women with regard to their attitude towards family planning programs [Table 4.2.b(i)].

iii)There exists no significant difference between the means of business vs. clerical and housewives groups of Mizo women with regard to their attitude towards family planning programs [Table 4.2.b(ii)].

iv) There exists a significant difference between the means of business vs. farmers and laborers groups of Mizo women with regard to their attitude towards family planning programs [Table 4.2.b(ii)].

v) There exists no significant difference between the means of clerical vs. farmers and housewives groups of Mizo women with regard to their attitude towards family planning programs [Table 4.2.b(iii)].

vi) There exists a significant difference between the means of clerical vs. laborers groups of Mizo women with regard to their attitude towards family planning programs [Table 4.2.b(iii)].

vii) There exists no significant difference between the means of farmers vs. housewives and laborers groups of Mizo women with regard to their attitude towards family planning programs [Table 4.2.b(iv)]

viii) There exists no significant difference between the means of housewives vs. laborers groups of Mizo women with regard to their attitude towards family planning programs [Table 4.2.b(v)]

C. Attitude towards family planning programs and methods in relation to socio-economic status-

There exists no significant difference between the means of low SES vs. middle SES, low SES vs. high SES and middle SES vs. high SES groups of Mizo women with regard to their attitude towards family planning programs (Table 4.2.c).

D. Attitude towards family planning programs and methods in relation to locale-

There exists no significant difference between the means of rural vs. urban women with regard to their attitude towards family planning programs (Table 4.2.d)

5.3 Major Findings Relating to Family Planning Practices

A. Age at marriage:

i) The average age of Mizo women at the time of marriage is 21.37 years. The median value is 20.71, which indicates that fifty (50) percent of the Mizo women get married before attaining the age of 20.71 years, and the remaining fifty (50) percent get married after attaining the age of 20.71 years. Further, the mode value being 19.33 indicates that majority of the respondents get married at the age of 19.33 years. [Table 4.3.b(i)]

ii) The statistics relating to age at marriage is positively skewed, which indicates a large concentration of scores near the lower end of the distribution. This means that the number of Mizo women getting married at younger age is relatively larger than those who get married late. The positive skewness in the present context suggests that fertility span of majority of Mizo women is much longer, and gives them a scope to give birth to more children [Table 4.3.b(ii)].

B. Average number of children born to a Mizo woman:

i) The average number of children that a Mizo woman gives birth to is 3.67 children. The median value is 3.85, which indicates that fifty (50) percent of the women gave birth to less than 3.85 children, and the remaining fifty (50) percent gave birth to more than 3.85 children. Further, the mode value being 4.21 indicates that the majority of the respondents gave birth to 4.21 children. [Table 4.3.c(i)]

ii) The statistics relating to number of children is negatively skewed which indicates a large concentration of scores near the higher end of the distribution. The negative skewness in the present context suggests that the number of Mizo women giving birth to more than 3.67 (Mean) children is much larger than those who gave birth to less than 3.67 children (Mean). From the aforesaid statistics one can easily understand why the population growth in the state is always higher in relation to the growth at all India level. [Table 4.3.c(ii)]

C. Average age of Mizo women respondents at the time of birth of first child:

i) The average age at which the respondents gave birth to their first child is 22.27 years. The median value is 21.88, which indicates that fifty (50) percent of the Mizo women gave birth to their first child before attaining the age of 21.88 years, and the remaining fifty (50) percent gave birth to their first child after attaining the age of 21.88 years. Further, the mode value being 21.1

indicates that most of the respondents gave birth to their first child at the age of 21.1 years. [Table 4.3.d(i)]

ii) The statistics relating to the age at the time of birth of the first child is positively skewed which indicates a large concentration of scores near the lower end of the distribution. The positive skewness in the present context suggests that number of Mizo women giving birth to their first child before 22.27 years (Mean) is much larger than those who gave birth to their first child after 22.27 years (Mean).The aforesaid statistics relating to the age of Mizo women respondents at the time of birth of their first child, like age at marriage, suggests that they have relatively longer span for expansion of their family. Further, giving birth to the child at a young age, as is indicated by the statistics in, is not healthy for both the mother and the child. [Table 4.3.d(ii)]

D. Average age of Mizo women respondents at the time of birth of last child

i) The average age of a Mizo woman at the time of birth of the last child is 33.35 years. The median value is 33, which indicates that fifty (50) percent of the women gave birth to their last child before attaining the age of 33 years and the remaining fifty (50) percent gave birth to their last child after attaining the age of 33 years. Further, the mode value being 32.3 indicates that most of the women gave birth to their last child at the age of 32.3 years. [Table 4.3.e(i)]

ii) The statistics relating to the age of a Mizo woman at the time of giving birth to the last child is also positively skewed which indicates a large concentration of scores near the lower end of the distribution. The positive skewness in the present context suggests that number of Mizo women giving birth to their last child before 33.35 years (Mean) is much larger than those who gave birth to their last child after 33.35 years (Mean). The positively skewed distribution here should be taken as desirable because most of the

Mizo women respondents completed their family at the right age [Table 4.3.e(ii)]

iii) Further, the mean age of 22.27 years at the time of birth of first child[Vide Table 4.3.d(ii)] and mean age of 33.35 at the time of birth of last child [Vide Table 4.3.e(ii)] suggests that most Mizo women respondents take around 11 years to complete their family to their desired size.

E. Perception of women regarding the size of an ideal family size-

i) The ideal family size, as perceived by the Mizo women respondents, should on an average consist of 4.59 children. The median value for the same is 4.31 children, which indicates that fifty (50) percent of the Mizo women agreed that an ideal family size should include 4.31 children, whereas the remaining fifty (50) percent opine that an ideal family size should include more than 4.31 children. Further, the mode value being 3.75 indicates that most of the respondents believed that an ideal family size should include 3.75 children. [Table 4.3.g(i)]

ii) The statistics relating to perception of Mizo women regarding the size of an ideal family size is positively skewed which indicates a large concentration of scores near the lower end of the distribution. The positive skewness in the present context suggests that number of Mizo women who perceive ideal family size to be less than 4.59 children (Mean) is much less than those who wish it to be more than 4.59 children (Mean). Although it is relieving to have a positively skewed distribution in relation to the ideal family size, the average size of ideal family i.e. 4.59 children (Mean) suggested by the respondents in itself is much beyond the ideal family size norm suggested by the family planningprograms**.**[Table 4.3.g(ii)]

F. Association between level of education of women and their family planning practices-

i) There is an association between the level of education of a Mizo woman and her adoption of family planning method for spacing.

ii) Adoption of family planning method for limiting of family size is also associated with the level of education of a Mizo women.

G. Association between occupation of Mizo women and their family planning practices:

i) There is an association between the occupation of Mizo women and their adoption of family planning methods for spacing.

ii) Adoption of family planning methods for limiting the family size is not associated with the occupation of Mizo women.

H. Association between the level of socio-economic status (SES) of Mizo women and their family planning practices:

i) There is no association between the level of SES of Mizo women and their adoption of family planning method for spacing.

ii) Adoption of family planning method for limiting of family size is associated with level of SES of Mizo women.

I. Association between rural and urban background of Mizo women and their family planning practices -

i) There is no association between the rural-urban background of Mizo women and their adoption of family planning method for spacing.

ii) There is no association between the rural-urban background of Mizo women and their adoption of family planning method for limiting of family size.

5.4 Conclusion

From the present study, it is evident that the Mizo group of women with higher level of education has more awareness towards family planning methods and programs as compared to elementary and secondary education level groups of Mizo women. However, there is no significant difference between elementary vs secondary education level of Mizo women regarding awareness of family planning. Therefore, from the study, it is evident that higher level education is needed for awareness of family planning and its methods. This is also evident in the fact that, before higher education was initiated in Mizoram or prior to 1958 (before the initiation of the first Higher Education Institution – Pachhunga University Collecge), family planning was viewed by the people from a negative perspective. This justified that, for people to have a positive outlook or awareness on family planning and its methods, higher education is needed among Mizo women.

With regards to the occupations held by the Mizo women, the analysis done reveals a difference in the level of awareness of family planning programs between the Mizo women with professional occupations vs. Mizo business-women, clerical Mizo women, Mizo women farmers, Mizo housewives and Mizo women labourer groups. The Mizo women from the professional group are most aware about family planning programs and methods as compared to any of their counterparts i.e. Mizo business-women, clerical Mizo women, Mizo women farmers, Mizo housewives and Mizo women labourer groups. The study shows that there exists a difference in the means of awareness of family planning methods and programs between Mizo business women vs. clerical groups of Mizo women; the clerical group of Mizo women have more awareness. It is also noteworthy that there is no significant difference in the awareness of family planning methods between Mizo business women vs. Mizo women farmers, Mizo housewives and Mizo womenlabourers groups. However, there exists a difference in awareness of family planning methods between the Mizo clerical women vs. Mizo women farmers and Mizo women labourers groups; Mizo clerical women group has more awareness in both cases. However, there exists no difference in the awareness level of family planning methods between Mizo clerical women and Mizo housewives group. Likewise, there

exists no difference in the awareness of family planning methods between Mizo women farmers vs. Mizo housewives group. However, there exists a difference in the awareness of family planning methods between Mizo women farmers vs. Mizo women labourers group; the Mizo women farmers group has more awareness.

As far as the findings on occupation are concerned, there could be a relationship between the educational level and Mizo Women with Professional occupations. Mizo women holding professional occupations are more aware as compared to any other occupational groups among Mizo women. This, once again, justifies the importance of education in relation to awareness of family planning and its methods. The study also highlighted that Mizo women with clerical jobs have more awareness than Mizo business women and it could be because majority of the Mizo women clerks are from Government Offices and the Governement has tried inculcating awareness of family planning among their staffs through campaigns and seminars. The study noted that, though, there exists no significance of difference on the awareness between Mizo women clerks and Mizo women labourers, the mean awareness score for Mizo women clerks is higher and this could be attributed to their job environment where the Government organises campaigns and awareness on family planning and its methods

From the study, it is evident that the higher the socio-economic status, the higher the level of awareness of family planning programs and methods. The mean score for awareness of family planning programs and methods of Mizo women from the high SES is higher as compared to that of middle SES and low SES groups of Mizo women. Also, the mean score for awareness of family planning programs and methods in Mizo women from middle SES is higher than the Mizo women from low SES of the society. It is evident from this study, the higher the socio economic status (SES) the higher the level of awareness. This may be because people from high SES are usually exposed to higher level of education and wider outlook is formed; also, people from high SES have access to good and ,maybe, even expensive education and may even study outside the state of Mizoram or even India. This could in-turn lead to forming a broader outlook in relation to famiy planning and its methods resulting in awareness about the same.

The study also established the fact that there exists a difference in the level of awareness of family planning methods between Mizo women from rural vs. Mizo women from urban areas. The study showed that the group of Mizo women from the urban areas have a higher mean score for awareness about family planning and its methods as compared to the Mizo women from rural areas. This could be because of the modernized environmental influence on the Mizo women from urban areas. There could also be a relationship between high SES and Mizo women living in the urban areas. The current study justifies that the mean awareness of family planning and its methods of urban Mizo women is higher as compared to Mizo women from the rural areas. This could be because Mizo women from urban areas have a higher income as compared to Mizo women from rural areas; which could be utilised for higher education to gain knowledge. Also, urbanisation could be one reason why the mean awareness of Mizo women from urban areas are higher than that of the rural areas. In the urban areas, cultural inter-mingling and exchange of ideas take place through a process of socialisation or through social media and technology which might not be the case in rural areas. This could greatly affect the awareness of the Mizo women from urban areas.

The study also justifies that higher educational level groups of Mizo women have a more favourable attitude towards family planning as compared to elementary education level. The study also shows a significant difference between secondary vs. higher Educational level groups of women with regard to their attitude towards family planning. The higher educational level group of Mizo women have a more positive attitude towards family planning. This could be because higher level education could be the key factor in creating, as cited previously, awareness of family planning and its methods; the same goes for forming a positive attitude. The higher the educational level of Mizo women, the more favourable the attitude towards family planning and its methods.

From the study, we get to know that there exists no significant difference in the attitude towards family planning between professionals vs. business, clerical, farmers and housewives groups of Mizo women in relation to their attitude. However, there is a significant difference between Mizo women with professional

occupations and Mizo women labourers group with regard to their attitude towards family planning; Mizo women from the professional occupational group tends to have a more positive or favourable attitude towards family planning.The current studyalsoshows that there exists no significant difference, regarding the attitude towards family planning, between Mizo business women vs. Mizo clerical women group and Mizo housewives group in relation to their attitude. But, there exists a significant difference between the mean scores obtained by the Mizo business women vs. Mizo women farmers groups with regard to their attitude. The business group of Mizo women have a more favourable and positive attitude towards family planning than their counterparts from Mizo women farmers group. Likewise, there is a difference in the attitude towards family planning between the Mizo business women vs. Mizo Women labourer group; the said difference is in favour of the Mizo business women.The study also reveals that there exists no significant difference, in the attitude towards family planning, between Mizo women with clerical jobs vs Mizo women farmers and Mizo housewives groups in relation to their attitude towards family planning. However, there exists a difference, in the attitude towards family planning, between clerical and labourers group of Mizo women. The group of Mizo women with clerical jobs has a more positive attitude towards family planning. The study also determines that there is no difference in attitude towards family planning between Mizo women farmersvs. Mizo housewives and Mizo women labourers group in relation to their attitude towards family planning**.** Likewise, there exists no significant difference between Mizo housewives vs. Mizo women labourers group with regards to their attitude towards family planning.

The study finds no significant difference, with regards to attitude towards family planning, between Mizo women from low SES vs. middle SES; low SES vs. high SES; and middle SES vs.high SES groups of Mizo women. Hence, attitude towards family planning is not influenced by the socio-economic status of the Mizo women

There also exists no significant difference between the mean scores obtained by Mizo women from rural areas vs Mizo women from urban areas with regards to

attitude towards family planning. Therefore, the attitude of Mizo women is not influenced by the locale.

The current study reveals that the average age of Mizo women at the time of marriage is 21.37 years. Fifty percent get married after attaining the age of 20.71 years. The study also indicates that majority of the Mizo women get married at the age of 19.33 years. It is also noteworthy that the number of women getting married at a younger age is relatively larger than those who get married late. This finding also meant that the fertility span of majority of women is much longer, and gives them a scope to give birth to more children as they get married at a younger age.

The study further shows that the average number of children that a Mizo woman gives birth to is 3.67 children; fifty percentof the women gave birth to 3.85 children and the remaining fifty percent gave birth to more than 3.85 children. It is also noteworthy that majority of the Mizo women gave birth to 4.21 children.Also, the number of women giving birth to more than 3.67 children is much larger than those who gave birth to less than 3.67 children. From the aforesaid statistics one can easily understand why the population growth in the state is always higher in relation to the growth at all India level.

The current analysis also reveals that fifty percent of the Mizo women gave birth to their first child before attaining the age of 21.88 years; and the remaining fifty percent gave birth to their first child after attaining the age of 21.88 years. Further, it also indicates that most of the respondents gave birth to their first child at the age of 21.1 years. The number of women giving birth to their first child before 22.27 years is much larger than those who gave birth to their first child after 22.27 years. The aforesaid findings relating to the age of women respondents at the time of birth of their first child, like age at marriage, suggests that they have relatively longer span for expansion of their family. Further, giving birth to a child at a young age is not healthy for both the mother and the child

The analysis also determines the average age of Mizo women at the time of birth of their last child, which is 33.35 years; fifty percent of the women gave birth to their last child before attaining the age of 33 years and the remaining fiftypercent

gave birth to their last child after attaining the age of 33 years. Most of the women gave birth to their last child at the age of 32.3 years. The study also reveals the number of women giving birth to their last child before 33.35 years is much larger than those who gave birth to their last child after 33.35 years; this also indicated that most of the Mizo women respondents completed their family at the right age.

The study also reveals that the ideal family size, as perceived by the Mizo women respondents, should on an average consist of 4.59 children. At the same time, the study also reveals that fifty percent of the Mizo women agreed that an ideal family size should include 4.31 children, whereas the remaining fifty (50) percent opine that an ideal family size should include more than 4.31 children. Most of the respondents Mizo women believed that an ideal family size should include 3.75 children. The study also shows that the number of women who perceive ideal family size to be less than 4.59 children is much less than those who wish it to be more than 4.59 children. Although it is relieving to have a positively skewed distribution in relation to the ideal family size, the average size of ideal family i.e 4.59 children (Mean) suggested by the respondents in itself is much beyond the ideal family size norm suggested by the family planning programs.

5.5 Recommendations:

5.5(i) Recommentions on Awareness on family planning and its methods:

a) Concerned officers of the Health &family Welfare Department should pay more attention to the rapidly increasing growth rate of the Mizo population and actually carry out remedial measures to prevent further high growth rates in future.

b) Awareness programs can be conducted by the concerned officers of the Health &family Welfare department to inform the young girls about the harmful consequences of giving birth at a young age i.e. 16 to 19 years.

c) Introduction of sex-education at the secondary level of education should be taken in to serious consideration by the concerned authorities.

d) Awareness programs can also be conducted by the concerned officers of the Health &family Welfare department to inform the married women about the advantages of adopting spacing methods and adopting family planning methods to limit the size of their families.

e) More in depth knowledge about the religious & cultural beliefs and social norms related to family planning practices with regard to married Mizo women for further research should be carried out.

f) Information and relevant services related to reproductive health should be continuously delivered to newly married couples through awareness campaigns conducted by the concerned officer.

g) In order to encourage the married women to use modern contraceptives for spacing between the birth of children, the Health and family Welfare Department needs to provide available information about the benefits of modern contraceptives.

h) Last but not the least, the Mizo people, as a whole, need to be given more information on what family planning actually means and the benefits that they can reap by following healthy family planning practices.

5.5(ii) Recommentions on Attitude towards family planning and its methods:

a) Awareness programs can also be conducted by the concerned officers of the Health &family Welfare department to inform the married women about the advantages of adopting spacing methods and adopting family planning methods to limit the size of their families.

b) More in depth knowledge about the religious & cultural beliefs and social norms related to family planning practices with regard to married Mizo women for further research should be carried out.

c) Information and relevant services related to reproductive health should be continuously delivered to newly married couples through awareness campaigns conducted by the concerned officers.

d) In order to encourage the married women to use modern contraceptives for spacing between the birth of children, the Health and family Welfare Department needs to provide available information about the benefits of modern contraceptives.

5.5(iii) Recommentions on Practices of family planning and its methods:

a) Concerned officers of the Health &family Welfare Department should pay more attention to the rapidly increasing growth rate of the Mizo population and actually carry out remedial measures to prevent further high growth rates in future.

b) Introduction of sex-education at the secondary level of education should be taken in to serious consideration by the concerned authorities.

c) The concerned officers of the Health and family Welfare department need to undergo intensive training in order to realize the harmful consequences of a rapid growing population.

d) Awareness programs can be conducted by the concerned officers of the Health &family Welfare department to inform the young girls about the harmful consequences of giving birth at a young age i.e. 16 to 19 years.

e) Awareness programs can also be conducted by the concerned officers of the Health &family Welfare department to inform the married women about the advantages of adopting spacing methods and adopting family planning methods to limit the size of their families.

f) In order to encourage the married women to use modern contraceptives for spacing between the birth of children, the Health and family Welfare

Department needs to provide available information about the benefits of modern contraceptives.

5.6 Suggestions for Further Research

The future researcher may take up research on the following topics :

a) Family planning practices of different ethnic groups like Lai, Mara, Mizo, Chakma, Bru etc. residing within Mizoram.

b) Attitude and family planning practices of Mizo women belonging to different denominations.

c) Socio-political and religious factors responsible for consistently high growth rate of population.

d) Attitude and family planning practices of Mizos, Nagas, Khasis, Garos and Jaintias.

e) Total Fertility Rate (TFR) and Total Marital Fertility Rate among women belonging to different ethnic group in various north eastern states can also be taken up for further research.

f) Awareness, attitude and family planning practices of Mizo males in relation to their education and occupation, socio economic status, and denomination.

g) Role of elderly people in the family, and religious leaders in encouraging young people in different ethnic and religious groups to have more children.

h) Opinions of husbands and wives on various issues relating to the family planning.

i) Size of the family: Relative role of husband and wife in decision making.

APPENDICES

LIST OF APPENDICES

Appendix – 1

SOCIO – ECONOMIC STATUS SCALE (English)

A. PERSONAL INFORMATION

1. Name: _____ Age _____
2. Educational Qualification : _____
3. Address: _____ Rural/Urban
4. Occupation : _____ Monthly Income_____

B. INSTRUCTION

I would like to know about the status of your family based on the following questions. In order to answer them, space has been provided against each of them. As your answers are going to be kept confidential, I would like you to answer each of them honestly. Different answers have been prepared for each question. Please tick mark the answer that best suits your family.

1. Educational Qualification of family Members	**Husband**	**Self**	**Eldest Daughter**	**Eldest Son**
A. Ph.D/D.Litt/D.Sc/M.D	( )	( )	( )	( )

B.	M.A/M.Com/ M.Sc/M.Ed/M.Th	( )	( )	( )	( )
C.	B.A/B.Sc/B.Com/ B.Ed or its Equivalent (including Ll.B)	( )	( )	( )	( )
D.	Class 12/Class 10/Any Diploma after passing Class 10	( )	( )	( )	( )
E.	Class 7 or its equivalent	( )	( )	( )	( )
F.	Class 4 passed	( )	( )	( )	( )
G.	Literate (without attending school)	( )	( )	( )	( )
2.	**Family members' occupation**	Husband	Self	Eldest daughter	Eldest son
A.	Gazetted Officer eg.Director, Principal,Engineer,Lawyer,Bank Manager,Doctor,M.L.A.,M.P., Lecturer,I.A.S., Wealthy Businessman etc.	( )	( )	( )	( )
B.	Section Officer,Superintendent, HSS/HS Teacher, Asst.Research Officer, Accountant, Famous Painter, Shopkeeper, Instructor, J.E. etc.	( )	( )	( )	( )
C.	MS/PS Teacher, Clerk, Stenographer, Technician, Chemist, Electrician	( )	( )	( )	( )
D.	Farmer, Daily Laborer, Vegetable Vendor, Hawkers, Driver, IV Grade etc.	( )	( )	( )	( )

3. Monthly Income

A. Rs.30001/- and above ( )

B. Rs.25001/- to Rs.30000/- ( )

C. Rs.20001/- to Rs.25000/- ( )

D. Rs.15001/- to Rs.20000/- ( )

E. Rs.10001/- to Rs.15000/- ( )

F. Rs.5001/- to Rs.10000/- ( )

G. Rs.3001/- to Rs.5000/- ( )

H. Rs.3000/- and below ( )

4. How does your friend or others perceive your family

A. Wealthy family ( )

B. Average family ( )

C. Poor family ( )

5. Put a 'tick' mark against the following owned by your family

A. (Two Wheeler) Scooter/Motor Cycle ( )

B. 1. Foreign Car ( )

2. Indian car/Jeep/Gypsy/Sumo etc. ( )

3. Bus, Truck, JCB, Bulldozer etc. ( )

C. 1. Personal Computer ( )

2. Washing Machine ( )

3. Black & White T.V/Color T.V ( )

4. Portable T.V & Big T.V ( )

5. Refrigerator ( )

6. VCD/DVD ( )

7. Radio/Tape Recorder ( )

6. A. Does your family possess your own house ? Yes/No

B. If 'Yes', what material is it made from ?

i) R.C.C Building ( )

ii) Tile walls and Aluminum roof ( )

iii) Bamboo walls and Aluminum roof ( )

7. Do either you or your spouse hold a position in the Church ?

	Husband	**Self**
A.	Church Elder	Chairperson
B.	Committee Member	Committee member (Women"s Wing)
C.	Deacon eg.Speaker, Sunday School Teacher etc.	Deacon eg. Speaker, Sunday School Teacher

8. Do either you or your spouse hold a position(YMA,MHIP) in your community ? Yes/No

		Husband	**Self**
A.	State Level	( )	( )
B.	District/Group Level	( )	( )
C.	Local Community Level	( )	( )

9. A. Does your family subscribe to the Daily Newspapers (Mizo) ?

i) Always ( )

ii) Sometimes ( )

iii) Never ( )

B. Does your family subscribe to the National Newspapers (English) ?

iv) Always ( )

v) Sometimes ( )

vi) Never ( )

Appendix – 2

SOCIO – ECONOMIC STATUS SCALE (Mizo)

A. PERSONAL INFORMATION

1. Hming :_____Kum_____Mipa/Hmeichhia
2. Thiamna :_____
3. AwmnaHmun :_____Thingtlang/Khawpui
4. Hnathawh :_____Sum lakluhzat (thlakhatah)_____

B. INSTRUCTION

A hnuaia tehna hrang hrang atang hian in chhungkaw dinhmun zir kan duh a.

Heng zawhnate chhanna atan hian a zawnah hmun awl dah a ni a. I chhanna te chu thup tlat an nih dawn avangin thup nei hauhlovin min chhang ang che. Heng zawhna chhana atan hian chhanna hrang hrang peksa a ni a. Heng zinga i inchhung mil ber ni a i ngaihah i thai dawn nia.

1.	**In chhungkua a zirna dinhmun**	**Pasal**	**Mahni**	**Fanu upa ber**	**Fapa upa ber**
A,	Ph.D/D.Litt/D.Sc/M.D	( )	( )	( )	( )
B.	M.A/M.Com/ M.Sc/M.Ed/M.Th	( )	( )	( )	( )
C.	B.A/B.Sc/B.Com/ B.Ed emaw a tlukpui (Ll.B telin)	( )	( )	( )	( )
D.	Pawl 12/Pawl 10/Matric passed hnua Diploma	( )	( )	( )	( )
E.	Pawl sarihemaw a tlukpui	( )	( )	( )	( )

F. Pawl li passed ( ) ( ) ( ) ( )

G. School kallova ziak leh chhiar thiam ( ) ( ) ( ) ( )

2. In chhungkaw eizawnna

A. SawrkarhnathawkOfficer(Gazetted) lian Entir nan Director,Principal, Engineer, Ukil, BankManager, Doctor, M.L.A., M.P., Lecturer, I.A.S.,Sumdawnghausa etc. ( ) ( ) ( ) ( )

B. Section Officer, Superintendent, HSS/HS Zirtirtu, Asst. ResearchOfficer, Accountant, lemziak thiam lar tak, dawrkai, Instructor, J.E. etc. ( ) ( ) ( ) ( )

C. MS/PS Zirtirtu, Clerk, Stenographer, Technician, Chemist, Electrician ( ) ( ) ( ) ( )

D. Lo nei mi, kuthnathawkemaw a tlukpui Inhlawhfa, chawhmehzuar, kawngpuikama thilzuar, Driver, IV Grade, Second hand zuar, nepnawizuar etc. ( ) ( ) ( ) ( )

3. Thlakhata in sum lakluh zat

A. Rs.30001/- chin chung lam ( )

B. Rs.25001/- Rs.30000/- ( )

C. Rs.20001/- Rs.25000/- ( )

D. Rs.15001/-Rs.20000/- ( )

E. Rs.10001/- Rs.15000/- ( )

F. Rs.5001/- Rs.10000/- ( )

G. Rs.3001/- Rs.5000/- ( )

H. Rs.3000/- hnuai loam ( )

4. I thian in emaw midang in emaw in chhungkua an hmuh dan :

A. Chhungkaw hausa ( )

B. Khawsak pangngai ( )

C. Khawsak harsa ( )

5. A hnuai a mi te hi in chhungkuain in neih apiang thai rawh :

A. (Two Wheeler) Scooter/Motor Cycle ( )

B. 1. Foreign Car ( )

2. Indian car/Jeep/Gypsy/Sumo etc. ( )

3. Bus, Sumdawnna motor lian, JCB, Bulldozer etc. ( )

C. 1. Personal Computer ( )

2. Washing Machine ( )

3. Black & White T.V/Color T.V ( )

4. Portable T.V & Big T.V ( )

5. Refrigerator ( )

6. VCD/DVD ( )

7. Radio/Tape Recorder ( )

6. A. In chhungkuain nangmahni pual In in nei em ? Aw/Aih

B. Nei anih chuan eng anga sak nge?

i) R.C.C Building ( )

ii) A bang Tile leh a chung rangva ( )

iii) A bang dap leh a chung rangva ( )

7. Nangmah emaw i pasalin emaw Kohhranah chanvo pawimawh in chelh em ?

Pasal	**Mahni**
A. Kohhran Upa	Chairperson
B. Committee Member(Tual Upa)	Hmeichhe pawl a Committee member

C.	Deacon eg. Thuhriltu, Sunday School Zirtirtu, Pathian Thuhriltu etc	Deacon eg. Thuhriltu, Sunday School Zirtirtu

8. Nangmah emaw I pasalin emaw khawtlangah (YMA/MHIP) nihna chelh in nei em ?

AW/AIH

		Pasal	**Mahni**
A.	State Level (ram chhung huapin)	( )	( )
B.	District/Group Level	( )	( )
C.	Khawtlang huapin	( )	( )

9. A. Inchhungkuain Nitin chanchinbu in la em ?

i)	La reng thin	( )
ii)	A chang chang in la	( )
iii)	La ngailo hrim hrim	( )

B. In chhungkuain National Chanchinbu (saptawng) in la em?

i)	La reng thin	( )
ii)	A chang chang in la	( )
iii)	La ngailo hrim hrim	( )

Appendix – 3

INTERVIEW SCHEDULE FOR AWARENESS ABOUT FAMILY PLANNING METHODS AND PROGRAMMES (English)

Instructions

There are 29 questions or statements regarding awareness of family planning methods and programs. Four possible answers are given for each question and you have to choose the correct answer from the options given. There is no time limit to complete the test. However, all questions have to be answered. Please do not hesitate to ask if you have any doubts.

1. Small family norm in India refers to parents with:

   a) 4 Children b) 3 Children c) 2 Children d) One child

2. Minimum legal age of marriage for a boy in India is:

   a) 20 years b) 21 years c) 22 years d) 23 years

3. Better mother and child health is insured if child-bearing is restricted to one of the following age groups of the mother:

   a) 10 – 19 years b) 20 – 29 years c) 30 - 39 years d) 40 – 49 years

4. Which if the following birth control measures has a provision for compensation for the Government?

   a) Sterilization b) Abortio c)Circumcision d)Medical termination of pregnancy

5. Which of the following countries was the first to introduce, officially, the family planning programme?

   a) Pakistan b) Sri Lanka c)India d)Bangladesh

6. Identify an Indian state which has the highest female literacy as well as lowest fertility.

   a) Punjab b)Maharashtra c) Mizoram d) Kerala

7. The most densely populated state in India is:

   a) Kerala b) Goa c) Mizoram d) Nagaland

8. The number of children primarily depends on:

   a) God‟s will b) Parents‟ decision c) Instinct d) Fecundity of women

9. The most appropriate age group for mothers to have healthy children is:

   a) 15 – 19 years b) 20 – 29 years c) 30 – 39 years d)40 – 49 years

10. Minimum legal age at marriage for girls in India is:

    a) 16 Years b) 18years c) 17 years d) 19 years

11. Which of the following is a symbol of family Welfare?

    a) Red Cross b) Inverted Black Triangle c) Triangle d)Inverted Red Triangle

12. India‟s family Welfare programme mainly aims at:

    a) Sterilizing a large number of couples

    b) Promoting small family norms for quality life

    c) Increasing the income of the family

    d) Promoting the use of birth control measures

13. Which of the following is an oral contraceptive?

a) Copper-T b)Diaphragm c) Cream or Jelly d)Mala D/Mala M

14. The most widely used method of family planning in Mizoram is:

a) Rhythm b)Vasectomy(Male-sterilization)

c) Tubectomy d) IUD/Copper-T

15. India launched family planning programme in:

a) 1950 b) 1952 c) 1963 d)1975

16. National Policy on family Welfare was declared in:

a) 1976 b)1977 c)1995 d) 2000

17. Which of the following is NOT an Operation Goal of family planning programme?

a) To promote small family norm

b) To promote use of spacing method

c) To ensure adequate supply of Contraceptives

d) To promote productive health care

18. family Welfare includes:

a) Maternal and child care

b) family planning

c) Marriage and Pre-Marriage Counselling

d) All of these

19. family planning programme means:

a) Convincing a couple to have not more than two (2) children

b) Ensuring that a couple adopts Birth Control Measures

c) To plan the size of the family

d) To ensure that all couples undergo Sterilisation after having 2 (Two) children

20. The current slogan of the family Welfare programme in India is:

a) Lesser the children, happier the family

b) Sons or daughters – Two will do

c) Two children – No more

d) Have less – Be happy

21. family planning involves:

a) Sterilisation of Males

b) Sterilisation of Females

c) Abortion

d) Child Spacing

22. The main appeal for family planning is based on a consideration of:

a) Health and welfare of the family

b) Poverty

c) Economic deprivation of backward classes

d) Rapid growth of population

23. Which of the following is not an Oral Contraceptive?

a) Mala D b) Ovral c) Copper-T d) Triquillor

24. Which of the following is the most popular method of family planning in India?

a) Condom

b) The Pill

c) Sterilisation

d) Copper-T

25. Which of the following has not been considered as a family planning Method by the Government of India?

a) Diaphragm

b) Induced abortion

c) Foam Tablets

d) The Rhythm Method

26. Which of the following is often known as, “The most unsafe” method of family planning:

a) Tubectomy

b) Vasectomy

c) The Rhythm Method

d) Condom

27. What is „Nirodh“?

a) Foam Tablet b) Jelly c) Condom d) A Pill

28. Which of the following family planning Methods were found ineffective in India?

a) Condom

b) Diaphragm & Jelly

c) Foam Tablets

d) Rhythm Method

29. Tick the family planning Methods that you are familiar with –

a) The Rhythm Method

b) Diaphragm

c) Jelly

d) Foam Tablets

e) Vasectomy

f) Tubectomy

g) Copper-T

h) Condom

i) Pill

j) Induced Abortion

k) Injections

Appendix – 4

INTERVIEW SCHEDULE FOR AWARENESS OF FAMILY PLANNING METHODS AND PROGRAMMES (Mizo)

Kaihhruaina

Lehkha phek ka pek ah hian zawhna 29, chhungkaw inrelbawlna chungchanga thil hriat tur te an awm a. Zawhna tin hnuaiah khan a chhanna ni thei pali (4) theuh pek an ni bawk a, a pali zingah khan a dik ber thai bial rawh. Chhang zo turin hun bituk a awm lova; amaherawhchu, zawhna 29 zawng zawng te kha chhan vek tur an ni. Hriatthiam loh lai I neih chuan min zawt hreh suh ang che.

1. India rama fa neitlem chhungkua (small family) tih hian nu leh pa

   a) fa 4 nei a kawk b) fa 3 nei a kawk c) fa 2 nei a kawk d) fa 1 nei a kawk

2. India ramah dan anga nupui nei thei chin kum bithliah chin chu:

   a) Kum 20 b) kum 21 c) kum 22 d) kum 23

3. A hnuaia kum bithliah chi hrang hrangte zinga nu leh naute hriselna atana fa neih hun tha ber chu

   a) kum 10 – 19 inkar b) kum 20 – 29 inkar c) kum 30 – 39 inkar d)kum 40-49 inkar

4. Nau piang tam tur khuahkhirhna atana hmalakna chi hrang hrang a hnuaia tarlante zingah hian a khawi berah hian nge Sawrkarin zangnadawmna a pek thin:

   a) Sterilisation b) Abortion

   c) Circumcision d) Nu hrisel loh avanga nau tihtlak

5. Chhungkaw ruahmanna (family planning programme) mumal taka kalpui hmasa ber ram chu a hnuaia ram hrang hrang tarlante zingah hian a khawi ber nge?

a) Pakistan b) Sri Lanka c) India d) Bangladesh

6. India ram State-te zingah hian a khawi ber hi nge ziak leh chhiar thei hmeichhia tam ber nih bakah fa hring tlem ber ni bawk kha han sawi teh.

a) Punjab b) Maharashtra c) Mizoram d) Kerala

7. India rama mihring bitna ber State chu

a) Kerala b) Goa c) Mizoram d) Nagaland

8. Naupang an tam leh tlem innghahna bul ber chu:

a) Pathian kutah b) Nu leh pate-ah

c) a ngai reng d) a changin a sang a, a changin a tlahniam

9. Nu tana nau hrisel tak hring tura fa neih hun chhung tha be rte chu:

a) kum 15-19 inkar b) kum 20-29 inkar c) kum 30-39 inkar d)kum 40-49 inkar

10. India rama dan anga hmeichhe tan pasal neih hun kum bithliah chu:

a) kum 16 b) kum 18 c) kum 17 d) kum 19

11. A hnuaia chhinchhiahna chi hrang hrangte zingah hian a khawi ber hi nge family Welfare chhinchhiahna?

a) Cross sen b) A duma ziak Triangle letling

c) Triangle d) A sena ziak Triangle letling

12. India rama family Welfare programme hian a tum ber chu

a) Nau nei thei lo tura nupa a tam thei ang ber siam

b) Mihring dinhmun a lo that zawk theih nana member tlemte awmna chhungkaw siam

c) Chhungkaw sum thawhchhuah tihpun

d) Nau piang titlem tura hmalak

13. A hnuaia miahte hian a khawi ber hi nge naupai danna a eia ei chi?

a) Copper-T b) Diaphragm c)Cream or Jelly d) Mala D/Mala N

14. Mizorama chhungkaw ruahmanna lama hmanrua kan hman lar ber chu:

a) Rhythm b) Vasectomy (mipa zai/siam)

c) Tubectomy (Hmeichhe zai/siam) d) I.U.D./Copper-T

15. India rama chhungkaw inruahmanna (family planning) programme hman a nih tan kum chu:

a) 1980 b) 1952 c)1963 d)1975

16. family planning hi hnam policy (National Policy) atana puan a nih kum chu:

a) 1976 b) 1977 c) 1995 d) 2000

17. Heng a hnuaia mite zingah hian a khawi ber hi nge family planning thil tumte zinga tel ve lo kha?

a) Chhungkaw member nei tlem siam

b) Chhangkhat tawk a naupai tir

c) Naupai lo tura indanna hmanrua tam tawk taka chhawp

d) Nau neih kawnga hriselna ngaihtuah

18. Chhungkaw hamthatna (family Welfare) in a ken telte chu:

a) Nu leh a nau hriselna ngaihtuah

b) family planning (Chhungkaw inruahmanna)

c) Inneih hma leh inneih hnu a „counselling“ pek.

d) Heng thil pathum a chunga tarlan tak zawng zawngte hi

19. family planning programme awmzia chu:

a) Fa pahnih aia tam nei lo tura nupa tuak tinte hmin

b) Nau pai lo tura indanna an hmang ngei em tih ngaihtuah

c) Chhungkaw member tam lam tur ruahmanna siam

d) Fa pahnih neih hnua nupa tuak tinte nau nei tawh lo tura insiam tir

20. India rama National family Welfare programme-in auhla (Slogan) atana a hman lai chu:

    a) Fa neih tlem hi chhungkaw hlimna a ni (Lesser the children, happier the family)

    b) Fanu emaw fapa emaw, pahnih a tawk (Son or daughter – two will do)

    c) Fa pahnih – a bak angai lo (Two Children – No more)

    d) Fa nei tlem la i hlim ang (Have less – be happy)

21. family planning-in a kaihhnawih thilte chu:

    a) Mipa insiam tir b) Hmeichhia zawk insiam tir c) Nau tihtlak d)chhang tihkhat

22. family planning hma lakna a lo awm chhan bulpui ber chu:

    a) Chhungkaw hriselna leh thatna ngaihtuahna avangin

    b) Retheihna avangin

    c) Ei leh bar zawn kawnga khawsak hniam zawkte avangin

    d) Mihring pung chak lutuk avangin

23. Heng a hnuaia mite zingah hian a khawi ber hi nge Chhangkhatna a eia ei chi (Oral Contraceptive) ni ve lo kha?

    a) Mala D b) Ovral c) Copper-T e)Triquillor

24. India rama chhungkaw ruahmanna (family planning) kawnga hman lar tak kha a khawi ber hi nge le?

a) Condom hman

b) Damdawi ei chi (The Pill)

c) Nau pai theilo tura inseam (Sterilization)

d) Copper-T vuah

25. Heng a hnuaia mite zingah hian India sawrkarin chhungkaw Ruahmanna hmanrua atana a ngaih loh kha a eng ber hi nge?

a) Diaphragm b)Induced Abortion(nau tihtlak luih)

c) Foam Tablets d) The Rhythm method

26. Chhungkaw inruahmanna kawnga hmanraw him lo bera ngaih kha a khawi ber hi nge?

a) Tubectomy b) Vasectomy c) The Rhythm Method d) Condom

27. „Nirodh‟ an tih mai thin kha eng nge?

a) Foam Tablet b) Thil tuihnang hman chi (Jelly) c) Condom d) a eia ei chi (A Pill)

28. Chhungkaw inruahmanna kawnga hmanraw hlawhtling vak lo kha a khawi ber hi nge?

a) Condom b)Diaphragm & Jelly c) Foam Tablets d) Rhythm Method

29. Heng a hnuaia tarlan zinga Chhungkaw Inruahmanna hmanrua i hriat thinte han thai teh le?.

a) The Rhythm Method

b) Diaphragm

c) Jelly

d) Foam Tablets

e) Vasectomy

f) Tubectomy

g) Copper-T

h) Condom

i) Pill

j) Induced Abortion

k) Injections

Appendix – 5

ATTITUDE SCALE TOWARDS FAMILY PLANNING (ENGLISH)

Instruction

Given on the questionnaire are some statements to find out your attitude towards family planning. Some of the statements given will describe how you might feel about family planning. You might agree or disagree with the statements; after reading each statement carefully, please choose the most suitable answer from the options given for the statement i.e.strongly agree, agree, undecided, disagree and strongly disagree. Please note that there is no right or wrong answer; all you have to do is put a „tick" mark on the answer of your choice depending on how you feel about the statement; and move on to the next question in the series. Read the questions carefully and if you have any doubt, please do not hesitate to ask; all the questions given on the questionnaire are compulsory and must all be answered. Please be honest in answering the questions; there is no time limit to complete the test.

STATEMENT

A. POPULATION PROBLEM

1) The rate of population growth is very high in our state and it has to be reduced without any delay.

   a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

2) The increase in population will not cause any problem to the happiness of the people of Mizoram.

   a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

3) Everyone has the responsibility of solving the population problem by lending his/her cooperation to the s tate.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

4) State government should provide all possible help to the people to increase the population in our state.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

5) If nothing is done to reduce the population now, the whole of mankind‟s future, including our children and grandchildren, will find no food and shelter.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

6) Instead of reducing the population, facilities must be made to meet the increased population.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

7) Food scarcity, non-availability of houses and unemployment problems are all due, only to the increased population, which can be solved only by reducing the population.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree..

8) The rapid increase of population in our State s the indication of giving births to more number of children than what the parents can support, which should be reduced.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

9) Rapid population growth is desirable since it ensures increase in the number of young people.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

10) In view of rich natural resources in our state, the population growth is not a big problem.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

11) Larger population means a prosperous state.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

12) It is immoral to impart population education to children in their young ages.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

B. FAMILY PLANNING

13) The only solution to the miseries caused by the increased population is to accept family planning programs with all seriousness.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

14) More children in the family means more happiness and security for the parents in their old age.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

15) A family, with one child, is more happy and prosperous than a family with many children.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

16) More children in the family means more income and strength to the family and therefore, family planning need not be adopted.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

17) The state government has introduced the family planning program as an integral part of its plan for modernizing and improving the economy of the state to provide more happiness to the people, and therefore, we must adopt family planning

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

18) family planning should not interfere with the number of children a couple would like to have.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

19) All sections of people in the state, irrespective of religion, race, or ethnic group, should adopt family planning program by having at least 3 – 4 years of interval between two children.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

20) Upbringing of children is better in a small family.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

21) Large family means a higher status in the society.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

22) Larger the gap between the children, better they are brought up.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

23) Larger families cannot afford to have a balanced diet.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

24) Younger the mother, healthier the child.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

25) Legal age of marriage for girls should be raised from 18 to 21 years of age.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

26) Smaller the family, better is the quality of life.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

27) Limiting the number of children is against the will of God.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

28) A couple should have as many children as they want, even if it leads to a large family.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

29) family size should be limited to only two children.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

30) Children in smaller families can get better education.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

31) Small family norm weakens the family institution.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

32) Small family norm is against Christianity.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

33) Food and living places are going to be a very big problem in future, if we do not strictly carry out family planning.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

34) Mizoram, being deficit state,it is essential to adopt small family norms.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

35) Church and other NGOs like YMA and MHIP should start a campaign for the adoption of small family norms.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

36) Facility for distribution of ration, through Public Distribution System, should be withdrawn from those families that do not adopt the family planning programmes of the Government.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

37) Benefits of reservations in jobs should not be extended to the people that violate small family norms established by the Government.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

38) Benefits of reservation of seats in educational institutions should not be extended to the children whose families have violated the small family norms.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

39) Families adopting small family norms should be given certain incentives and recognition.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

40) Those persons that violate the small family norms should be debarred from contesting village council, assembly and parliamentary elections.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

41) The children of those families that violate small family norms should not be given government jobs.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

42) In view of the less density of population in Mizoram, family planning programmes should not be imposed on people.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

C. BIRTH CONTROL

43) Every family, after giving birth to one child, should practice birth control to reduce the rapid increase of population.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

44) Birth control should not be forced upon the people. It should be left to the wishes of both husband and wife.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

45) The only practical solution to the population problem is, strictly enforcing birth control programs.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

46) Birth control is an artificial method of racial suicide. We should not accept it.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

47) Adopting birth control involves some health risk for both men and women.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

48) Economics and social development, size and quality of labour force, educational and employment opportunities would meet with great disastrous consequences if our state does not adopt some radical birth control methods urgently.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

49) Mizo women, irrespective of their socio-cultural, economic and religious background, should not be disturbed with the birth control program. They must have freedom to give birth to as many children as they desire.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

50) Adopting birth control may lead to vices in marital relationships

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

51) The rapid growth of population in our state is the result of high fertility (birth) rate occurred among the young men and women who have not realised the miseries caused by the population

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

52) At present, we have reduced the death rate and increased the longevity (long life) of our people by advanced medical methods, and therefore, we must also reduce the fertility (birth) rate.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

53) The rapid increase of population can never be controlled without limiting the fertility (birth) rates. Therefore, we must lend our cooperation to the government to solve this problem.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

54) We must encourage high fertility (birth) rates to have more children and also try to find out ways and means to bring them up, whatever difficulties we met in our life.

a) Strongly Agree b) Agree c) Undecided d) Disagree e) strongly disagree.

Appendix – 6

ATTITUDE SCALE TOWARDS FAMILY PLANNING (MIZO)

Kaihhruaina:

Heng a hnuaia ziakte hi chhungkaw inrelbawlna chungchanga ngaihdan chi hrang hrang te an ni a. A ziak thenkhat te hi I ngaihdan leh pawm zawng a niin emaw a nilo maithei a. A ziakte hi ngun taka I chhiar hnu in, a ziak hnuaia chhanna awm i.e. strongly agree, agree, undecided, disagree leh strongly disagree te zingah hian I pawm ber leh I ngaihdan hnaih ber thai bial rawh. I ngaihdan leh pawm zawng ngawih ngawih a nih chuan „strongly agree" kha thai bial rawh; I ngaihdan a nih ve chuan „agree" kha thai bial la; ngaihdan fumfe i neilo a nih chuan „Undecided" kha thai bial rawh; I ngaihdan nilo leh pawm zawng a nih loh chuan „disagree" kha thai bial roh; tin, i ngaihdan nen a in per san fe chuan „strongly disagree" ah khan thai bial mai tur a ni. A thu ziak zawng zawng kha pakhatmah hmaih lovin chhang kim vek tur a ni. Chhanna dik leh dik lo a awm lova; chhang zawh hun tur „minute" bituk a awm heklo. Hriathhiam loh lai I neih chuan min zawt hreh suh ang che. I ngaihdan diktak tlang takin tilang hram bawk ang che.

STATEMENT

A. MIHRING PUNG CHAK AVANGA HARSATNA LAM THIL

1) Kan state ah hian mihring kan pung chak em em a, hei hi muang khaw tlai hauh lova kan tihtlem a ngai a ni.

   Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

2) Mihring pun chakna hian Mizorama mipuite hlimna hi a khawih buai pha tak tak lo a ni.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

3) Mihring pun chak lutuk tur venna kawngah mi tinin Sawrkar tanpui turin mawhphurhna kan nei theuh ani.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

4) Mihring kan lo pun chak deuh theihna turin sawrkarin a theih ang kawng kawngin mipuite hnenah tanpuina a pe tur a ni.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

5) Mihring pun zelna hi kan ti tlem a nih loh chuan, naina kan thlah lo awm zel tur kan tu leh fa te chuan chenna tur leh eitur an hmu zo loving.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

6) Mihring pung tur tih thlem lam aichuan mihring lo pung zelte‟n kan mamawh thil chi hrang hrang kan hmuh theihna tura hma lak zawk tur a ni.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

7) Mihring lo pung zelin a kan ei tur tlakchhamna te, chenna in leh hnathawh tur neilo chungchanga harsatnate hi mihring pung zel tur tihtlem a nih chauhin sutkian theih a ni.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

8) Kan state-a mihring lo pung chak ta viau hi chawm zawh tak aia tam nu leh pate‟n fa kan neih vang a nia, hetiang hi kan titlem ngei tur a ni.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

9) Mihring pung chakah hian thalaite pawh an lo tam nge nge a, chuvangin mihring pung chak hi a duhawm a ni.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

10) Kan state leilung hausakna nasa tak han thlir hian mihring kan pung chak kan tithe hi chu harsatna a la tling pha tak tak lo ve.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

11) Mihring tam hi ram tan (state) hausakna a ni nge nge.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

12) Naupangte hnenah mihring pung chak tihtlem tul zia lam zirtir hi thil diklo tak a ni.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

B. CHHUNGKAW RUAHMANNA (FAMILY PLANNING) LAM

13) Mihring pung chakin harsatna a thlen chi hrang hrangte sutkian a nih theihna tur chuan Chhungkaw Ruahmanna (family planning) hi tih tak taka kan kalpui a ngai a ni.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

14) Fa ngah hi nu leh pate tan kum a lo upat zelah pawh hlimna leh himna a lo ni nge nge.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

15) Fa ngah te ai chuan pakhat chauh fa nei chhungkuate hi an hlimin an khawsa thei zawk.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

16) Fa ngah chu chhungkaw chakna leh hausakna ber a nih avangin fa nei tlem tur zawnga Chhungkaw Ruahmanna kan tih hi thil pawm chi a nilo.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

17) Chhungkaw Ruahmanna (family planning) hi state sawrkarin ram hmasawnna tur leh tih changkanna tur, mipuite pawh an lo hlim zawkna tura a ruahman a nih avangin kan zui ngei tur a ni.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

18) Chhungkaw Ruahmanna kan tih hi nupate‟n fa neih an duh zat thu-ah a inrawlh tur a ni lo.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

19) Chi leh sakhua thliar hauh lovin ram chhung (State) mi zawng zawngin Chhungkaw Ruahmanna hi an zuiin a tlem berah kum 3 emaw kum 4 emaw tal kar dana neiin fa pahnih aia tam nei tur a ni lo.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

20) Fa nei tlem chhungkuate chuan fate an enkawl tha zawk a ni.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

21) Fa ngah chhungkua te chu khawtlangah an ropui nge nge a ni.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

22) Chhangkhat tawk taka fa neite chuan an fate an enkawl puitling tha zawk nge nge a ni

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

23) Fa ngah chhungkua te chuan inbuk tawk takin chaw tha eitur an fate hnenah an pe theilo.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

24) Fa hringtu nu chu a naupah poh leh a fa pawh a hrisel nge nge.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

25) Dan anga hmeichhe pasal neih hun chu kum 18 bithliah hi kum 21-ah tihsan ni se

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

26) Fa nei tlem chhungkua te khawsak phung leh dinhmun chu a tha nge nge

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

27) Mahni duh thu a fa neih tlem ngawt hi Pathian duh dan nen a inkalh tlat a ni.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

28) Chhungkaw lian tak poh ni dawn mahse nupa tinte‟n an duh zah zah fa an nei tur a ni.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

29) Chhungkaw len zawng chu a tam berah fa pahnih aia tam lo ni ngei se.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

30) Chhungkaw member tlemna a naupang te chuan zirna tha an dawng nge nge a ni.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

31) Chhungkaw member tih tlem hian chhungkaw kal zel tur a ti derthawng a ni.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

32) Mahni duhthua fa nei tlema chhungkaw intihtet hi Kristian inzirtirna nen a inkalh a ni.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

33) Chhungkaw Ruahmanna hi khauh taka kan kalpui a nih loh chuan hun lo kal zelah ei tur leh chenna in hi harsatna lian tak a la tling ngei dawn a ni.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

34) Sum leh paia mahni inphuhru zo lo Mizoram State-te ang phei hi chuan Chhungkaw member intitlem kawng hi khauh taka pawm ngei tur a ni.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

35) Kohhran leh tlawmngai pawlchi hrang hrang YMA leh MHIP angte hian Chhungkaw member in ti tlem tura ruahmanna hi mipuiin an pawm ngei theihna tura beihpui thlak awm tak a ni

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

36) Sawrkarin a siam Chhungkaw Ruahmanna pawm duhlo te chu ration dawr atanga mamawh chi hrang hrang man tlawm zawka an lei ve phalsak tawh loh ni se.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

37) Chhungkaw member ti tlem tura ruahmanna zawm ve duh lote chu Sawrkar hnuaia hna hrang hrang in hauhsak kawnga hamthatna hi pek ve loh ni se.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

38) Chhungkaw member titlem tura ruahmanna zawm ve duhlo te chu zirna in chi hrang hranga „seat" inhauhsak kawnga hamthatna pek ve loh ni se.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

39) Chhungkaw member titlem tura ruahmanna zawmtute chu lawman atan hamthatna chi hrang hrang dawn kawngah duhsak leh hriat bik ni se.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

40) Chhungkaw member titlem tura ruahmanna zawm duh lote chu V.C. inthlanah te, MLA leh MP inthlanah „seat" an chuh ve phalsak loh ni se.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

41) Chhungkaw member ti tlem tura ruahmnanna duhlo chhungkaw fate chu sawrkar hnaah lak ve loh ni se.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

42) Mihring kan la tam tawk loh dan ngaihtuahin Mizoram angahte hi chuan fa nei tlem tur zawnga Chhungkaw Ruahmanna hi intuk luih ve rih loh ni se.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

C. NAU PIANG TUR DANNA (BIRTH CONTROL)

43) Mihring pung chak lutuk tur venna atan chhungkaw tinin fa pakhat an neih chinah chuan „Naupiang tur danna (Birth Control) hi hmang ngei ni se.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

44) Tihluihnain „Naupiang tur danna‟ hi inhmantir loh tur a ni. A hmangtu tur nu leh pate duhthlanaah dah ni se.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

45) Mihring pung zel avavnga harsatna sutkian dan tur ber chu khauh taka „Naupiang tur danna‟ inhmantir a ni.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

46) Naupiang tur danna „Birth Control‟ hi mihring insuatna siam chawp a ni a. Kan hmang tur a nilo.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

47) Naupiang tur danna „Birth Control‟ hian a hmangtu hmeichhia leh mipa hriselna a ti derthawng a ni.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

48) Kan state ah hian naupiang tur danna „Birth Control‟ hi tihdan thar awmze nei zawka kan beih vat loh chuan eizawnna lam leh vantlang nun hmasawnna kawngah te, hnathawk thei tam lam leh thiamna kawngah te, zirna leh hna thawh chungchangahte harsatna kan la tawk ngei dawn a ni.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

49) Vantlang khawsak phunga an dinhmun te, eizawnna lam leh sakhaw lama an dinhmunte chu eng pawh nise kan Mizo hmeichhiate hi naupiang tur danna „Birth Control‟ thil ah hian tihbuai hauh loh tur a ni. An duh zat zat fa nei tura zalenna an nei ngei tur a ni.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

50) Naupiang tur danna „Birth Control‟ hmang hian nupa karah kawng hrang hrangin harsatna a thlen thei a ni.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

51) Kan state a mihring pun chakna chhan ber hi chu mihring pun chak avanga harsatna awm theite hr eve hauh lova nupui pasal innei la naupang bawk site‟n fa tam tak tak an neih avang a ni ber.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

52) Tunlai hunah chuan damdawi lama thiamna leh hmasawn zelna avangin mi kan dam rein mitthi zat pawh mihring tam lam ngaihtuahin a tlem tial tial zel a, chuvang chuan fa pawh kan hrin tlem a ngai ta a ni.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

53) Fa hrin tam lamah bithliah chin kan neih loh chuan engti kawng mahin mihring pung chak zel tur hi kan veng theilo ang. Chuvangin he harsatna sukiang tura Sawrkar hmalakna hi kan thlawp tur a ni.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

54) Fa tam tak hring zel turin kan infuih sauh sauh anga, eng ang harsatna pawh tawk ma hi la tha taka anmahni enkawl turin kawng kan dap zel mai tur a ni.

Ka pawm hle Ka pawm Ngaihdan neilo Pawm lo Pawm lo hle

Appendix – 7

QUESTIONNAIRE ON FAMILY PLANNING PRACTICES (English)

INTERVIEW SCHEDULE FOR FAMILY PLANNING PRACTICES

Instructions

On the sheet of paper given to you, there are 10 questions regarding family planning practices. Please read each question carefully and answer them. All questions have to be answered and there is no time limit to complete the test. Please be honest while answering and do not hesitate to ask if you should have any questions or doubts regarding the statements or questions on the sheet.

1. What was your age at the time of your marriage? _____

2. How many children do you have? Male_____ Female_____
   Total_____

3. Give details about their Order of Birth, Gender and Age:

	Order of Birth	**M/F**	**Age**
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____
4)	_____	_____	_____
5)	_____	_____	_____
6)	_____	_____	_____
7)	_____	_____	_____
8)	_____	_____	_____
9)	_____	_____	_____

4. During your married life, have you adopted any family planning Method/s to limit your family size? Yes / No

5. If yes, what methods you have adopted?

_____

_____

6. During your married life, have you undergone Spacing by adopting any family planning Method/s? Yes / No

7. If Yes, what method/s have you adopted?

_____

_____

8. What was your age when you were blessed with the First Child? _____

9. How old were you when you gave birth to your youngest child?

_____

10. In your opinion, how many children should a Normal Mizo family have?

_____

Appendix – 8

QUESTIONNAIRE ON FAMILY PLANNING PRACTICES (Mizo)

Kaihruaina

Lehkha ka pek ah che hian zawhna 10, chhungkaw inrelbawlna chungchanga I thil chin leh tihdan, a awm a. Zawhna zawng zawng kha ngun taka I chhiar hnu in, chhungkaw inrelbawlna chungchanga nangmah ngeiin I tihdan emaw chin dan ang milpui in zawhna tin te kha chhang ang che. Zawhna 10 te hi chhan zawh vek tur an ni; eng zawhna mah kha chhang lova dah tur a nilo; chhan zawh hun tur chhung bituk a awmlo. Zawhna hriatthiamloh lai I neih chuan, khawngaihin min hrilh hreh suh ang che.

1. Kum engzat i nih in nge pasal i neih? _____

2. Fa engzat nge i neih? Fapa_____ Fanu_____ Total_____

3. An chanchin kimchangin dah rawh.

Upat dan in dawtin	**M/F**	**Kum**
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____

4. In inneih chhung hian family planning method/s Chhungkaw member control nan i hmang tawh thin em? Aw / Aih

5. „Aw“ a nih chuan eng Method/s nge i hman?

_____

_____

6. In inneih chhung hian chhang khatna turin family planning Method/s i zawm em?

Aw / AIH

7. „Aw“ a nih chuan eng method/s nge i zawm?

_____-

_____

_____

8. Fa hmasa ber i neihin kum engzat nge i nih? _____

9. I fa hnuhnung ber pianin kum engzatnge i nih? _____

10. I ngaihdanin Mizo chhungkaw pangngai tak hian fa engzat nge nei se i tih?

_____

Appendix – 9

Interview Schedule for family planning programs run by the Government

1. Annual Reports
2. Legislative Procedures
3. Physical and Human Resources
4. State Level Policy
5. Kinds of programs being conducted
6. Use of mass media for social messaging
7. State of Population Education in school text-books or as a separate course
8. B.A. Education (honours)

Although questions were asked, keeping in mind the above mentioned points, there are no actual questions to be reproduced.

BRIEF BIO-DATA OF THE CANDIDATE

NAME	:	VANLALTANPUII
FATHER'S NAME	:	V.L. REMA (L)
DATE OF BIRTH	:	11.10.1973
ADDRESS	:	H. No. MC-3, CHALTLANG VENGLAI, AIZAWL, MIZORAM
GENDER	:	FEMALE
RELIGION	:	CHRISTIAN
OCCUPATION	:	Asso. Prof., IASE, H&TE Govt. of Mizoram
MARITAL STATUS	:	DIVORCED
EDUCATIONAL QUALIFICATION	:	M.A. (Edn.), M.Ed.
Ph.D REGISTRATION No. & DATE	:	MZU/Ph.D/495 of 15.05.2012
DEPARTMENT	:	EDUCATION, MIZORAM UNIVERSITY
TITLE OF THE THESIS	:	AWARENESS AND ATTITUDE OF MIZO WOMEN TOWARDS FAMILY PLANNING IN RELATION TO THEIR EDUCATION AND DEMOGRAPHIC VARIABLES

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ABSTRACT

AWARENESS AND ATTITUDE OF MIZO WOMEN TOWARDS FAMILY PLANNING IN RELATION TO THEIR EDUCATION AND DEMOGRAPHIC VARIABLES

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DEPARTMENT OF EDUCATION

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ABSTRACT

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Submitted in partial fulfillment for the requirement of the Degree of Doctor of Philosophy in Education of Mizoram University, Aizawl

I. Rationale :

The Family Planning Program in Mizoram was launched in the mid-nineties under the auspices of the Health Department, Govt. of Mizoram. Initially, the Mizo people were not appreciative of the Family Planning Program and were more or less against it. The reason for this was that the Mizo people believed that their population was very small when compared with the population of the other inhabitants of various states of India. Besides this, the Mizo people had a misconception about the meaning of Family Planning. They thought that acceptance of Family Planning meant giving birth to only two (2) children. With the strong belief that the Mizo population was very small as compared to the other states, the idea of giving birth to no more than two(2) children was totally unacceptable.

Majority of Mizo people are Christians. The Roman Catholic Church absolutely prohibits abortion and does not encourage its members to follow any Family Planning programs. Similarly, the Presbyterian Church issued pamphlets in 2007 which were to be read compulsorily in all its Churches. The gist of the pamphlets were simply fostering a negative attitude towards the Family Planning Programs. The Baptist Church also propagated negative attitudes towards Family Planning Programs amongst its members in a similar fashion.

The Mizo people are not aware of the fact that Family Planning services have the potential to improve the quality of their lives and also their economic welfare. They tend to ignore the fact that by not accepting Family Planning services they are denying the Mizo women to have healthy children and become healthy mothers. They are unaware of the fact that knowledge of Family Planning also increases and limits the interval between births and that delaying the birth of a child until the mother turns 20 years is beneficial to both the mother and the infant.

Increasing population growth is a world-wide problem today and Mizoram is no exception. Mizoram possesses about 0.64 percent of the country's area but its inhabitants form 0.081 percent of the total population of India. The density of population of Mizoram (52 per sq.km) is far below than the All India level (382 per sq. km). If we look at these figures we feel quite comfortable but it should be noticed

in the light of the fact that only about 1/3 of the total area of this state is suitable for inhabitation.

The state's development policy concern was that between 1961 and 1991, population increased two and a half times to 689,756 in 1991 and rose up to 8,88,573 in 2001. Within the last 90 years its population has multiplied 10 times **[Table 1.3]**.Its growth rate was always significantly higher than the all India average.

According to the 1991 census, Mizoram at All India basis had 6^{th} position in terms of its population growth (38.98 percent). No doubt, according to the 2001 census, its growth rate has decreased from 38.98 percent to 29.18 percent but its position has moved one step up (i.e. from 6^{th} to 5^{th} position). These rapid increases in the population growth will tax the resources of the state.

Other factors could include socio-economic measures, urbanization, female literacy, marriage age, infant and child mortality, and female participation in the labour force. The proportion of women of reproductive age and post-partum in fecundity were the two main proximate determinants of the maintained fertility. The impact of major socio-economic factors such as female literacy, female age at marriage, infant and child mortality, and women's participation in the work force have not reduced fertility thus far.

Mizoram cultural practices have always favoured higher age at marriage. Factors which may have strong impacts on Mizoram fertility like religion, ethnicity, and family structurehave not been examined. Contraceptive use was considered key to reducing future fertility, but the Family Planning Program had been late in starting in the state. Government priority areas should be concentrated on a vigorous implementation of the Family Welfare Program, involvement of religious leaders and voluntary agencies in the Family Planning Programs, initiation of an awareness program about population growth by the Education Department, effective implementation of Child Care Programs, advocacy of breast feeding, and encouraging research studies on Population after the creation of a reliable database. Total Fertility Rate (TFR) was 4.0 percent in 1981 and the Total Marital Fertility Rate (TMFR) was 6.3 percent.

The high growth rate of population may be because of various factors like migration from neighboring countries like Myanmar and Bangladesh and increased flow rate of Indian citizens seeking jobs. Illegal immigration, from neighboring countries such as Bangladesh, Nepal and Myanmar, which is a time bomb that will explode eventually, has shot up drastically in Mizoram. Latest reports put the illegal migrants at 10,000, but looking at sheer settlements of aliens, one can say the demographics of the land has been changed by Bangladeshis, as also those from other states who come here to find work.

The close border connection with Myanmar makes Mizoram one of the largest migrant population in the country. The state has a population of about 10 lakh or one million. Of that figure, some 70,000 to 80,000 are migrants from Myanmar, largely Chins from the neighboring Chin State and SahGing Division. Most of these have fled the unsettled economic conditions in their country in a desperate search for work over the past two decades and more. There are a handful of political refugees, Refugee leaders in Mizoram and Delhi say that this figure is unlikely to be more than 70 i.e. political figures who cannot return home because of threats they face. Mizoram has felt the direct impact of the economic disaster and humanitarian crisis that is sweeping across Myanmar, and its border regions. There has been a sharp change in attitudes here towards the Chins - ranging from welcoming in the mid-1990s to outright condemnation and hostility more recently - but one cannot move away from the reality that the state has hosted a migrant population which is nearly one-eighth of its own size for nearly 20 years. The impact of militarization, lack of peace and under-development in Myanmar are the reasons for this flight across borders. If conditions at home were as attractive as conditions here, people would not move. This is one of the cardinal principles of out-migration, especially of refugees - people move away from unstable situations where they feel under threat, from harsh political, environmental and economic situations.

But in addition to these, there are other reasons which are directly related to the Mizo people such as religious and social beliefs, Family Planning, early marriages etc.In the olden days, the Mizo society was governed by beliefs garnered through

their religious and social values. These factors could, no doubt, contribute to the rise of population in the past. The Mizo society is a tribal society and before the advent of Christianity, the Mizo people were 'Animists' who worshipped trees, rocks, rivers and other forces of nature and the Mizo people were agriculturists who practiced 'Jhum Cultivation'. This type of cultivation promoted the trend of a big family in the past. The more the family members, the more the production rate in terms of the harvest because there would be more man-power to work in the fields. Therefore, they firmly held the belief that everyone in the society should reproduce as much as possible. Big and huge families were respected due to the sheer size of the family and also due to the sheer amount of crops that they harvested from their fields; which was considered a sign of wealth in the past.

It is also one of their religious beliefs that when a person died, he went to a place called 'Mitthi Khua' which can be literally translated as 'City of the Dead'. The spirits of the dead people had to go to the city of the dead where a person named 'Paul' would be waiting at the gate entrance with a big catapult; among the many people who crossed the gate are the bachelors, who, if they have not copulate with at least 30 maidens during their lifetime, would be shot by Paul using his catapult and the wound caused would last for 3 years. Therefore, to avoid this fate, the bachelors in the olden Mizo society would try and copulate with as many maidens as possible. This act has a very high chance of increasing population as no means of contraceptives were known back then. It is also noteworthy that the Mizo people were divided into tribes and each tribe resided in a stipulated area; and these different tribes were constantly at war amongst themselves which also resulted in the promotion of a big family norm. The more the people in a tribe, the more likely they are to defeat their enemies.

Therefore, it is evident from what has been mentioned that the Mizo society was characterized by blind faith and superstitions. However, with the advent of Christianity, education also came into the picture; education was able to deal with many issues. However, education did not seem to change their attitudes towards family planning. This is evident in the fact that when Indira Gandhi introduced the concept of family planning to the Mizo people, it was met with skepticism and negativity even by the literate Mizo people.

Mizoram is a late starter in higher education and the first institution for higher education was established in 1958 by the name of Pachhunga University College. Mizoram University came into being only in 2001. Due to the late start in higher education, Mizoram lags behind in many aspects and family planning and its methods could be one of them.

It is noteworthy that the Northeast Indian Ethnic studies on population and its related issues are very less and not many in number; especially in the State of Mizoram as there have been no studies regarding Knowledge, Attitude and Practices of Family Planning in Mizoram; the current study is the pioneer and pilot study in relation to the KAP of Family Planning in Mizoram. Majority of the existing information regarding population and its related areas in Mizoram came from the Government of India through the Censuses conducted over the past decades. The present study is also undertaken with the objective of assessing the level of awareness of different Family Planning methods, the attitudes of Mizo women towards Family Planning and also seeks to find out the current practice of Family Planning methods followed by Mizo women of reproductive age group.

More specific knowledge can be acquired from this study about the factors that determine the non-acceptance of Family Planning Programs which will enlighten the Health Department to develop suitable programs for awareness of the benefits of Family Planning and enable them to create a positive attitude towards the Family Planning programs among the Mizo women.

Hence the investigator has set out to find a solution to the rapid increase of population by studying the awareness of and attitude towards family planning programs among Mizo women in relation to their education , occupation , socio-economic status and rural-urban background.

II. Statement of the Problem:

The problem of the present study has been stated as follows :

"Awareness and Attitude of Mizo Women towards Family Planning in Relation to their Education and Demographic Variables.**"**

III. Research questions :

1) Does education have any influence on the awareness level of Mizo women in relation to family planning programs?
2) Does occupation have any influence on the awareness level of Mizo women in relation to family planning programs?
3) Does socio-economic status have any influence on the awareness level of Mizo women in relation to family planning programs?
4) Does the locale have any influence on the awareness level of Mizo women in relation to family planning programs?
5) Does education have any influence on the attitude of Mizo women in relation to family planning?
6) Does occupation have any influence on the attitude of Mizo women in relation to family planning?
7) Does socio-economic status have any influence on the attitude of Mizo women in relation to family planning?
8) Does the locale have any influence on the attitude of Mizo women in relation to family planning?
9) Does education have any influence on the family planning practices of Mizo women?
10) Does occupation have any influence on the family planning practices of Mizo women?
11) Does socio-economic status have any influence on the family planning practices of Mizo women?
12) Does the locale have any influence on the family planning practices of Mizo women?

IV. Objectives of the Study :

1) To examine the status of awareness of Mizo women about various family planning methods in relation to their education.

2) To examine the status of awareness of Mizo women about various family planning methods in relation to their occupation.

3) To examine the status of awareness of Mizo women about various family planning methods in relation to their socio-economic status.

4) To examine the status of awareness of Mizo women about various family planning methods in relation to their rural – urban background.

5) To study the attitude of Mizo women towards family planning in relation to their education.

6) To study the attitude of Mizo women towards family planning in relation to their occupation.

7) To study the attitude of Mizo women towards family planning in relation to their socio- economic status.

8) To study the attitude of Mizo women towards family planning in relation to their rural – urban background.

9) To study the family planning practices among Mizo women in relation to their education.

10) To study the family planning practices among Mizo women in relation to their occupation.

11) To study the family planning practices among Mizo women in relation to their socio-economic status.

12) To study the family planning practices among Mizo women in relation their rural – urban background.

13) To study opinion on certain issues related to family planning.

V. Research Hypotheses :

1) There is a significant difference among Mizo women with different educational backgrounds in relation to their awareness about various family planning methods.

2) There is a significant difference among Mizo women engaged in different occupations in relation to their awareness about various family planning methods.

3) There is a significant difference among Mizo women having different socio-economic status in relation to their awareness about various family planning methods.

4) There is a significant difference among Mizo women from rural and urban backgrounds in relation to their awareness about various family planning methods.

5) There is a significant difference among Mizo women with different educational backgrounds in relation to their attitude towards family planning.

6) There is a significant difference among Mizo women engaged in different occupations in relation to their attitude towards family planning.

7) There is a significant difference among Mizo women having different socio-economic status in relation to their attitude towards family planning.

8) There is a significant difference among Mizo women from rural and urban backgrounds in relation to their attitude towards family planning.

9) There is a significant difference among Mizo women with different educational backgrounds in relation to their family planning practices.

10) There is a significant difference among Mizo women engaged in different occupations in relation to their family planning practices.

11) There is a significant difference among Mizo women having different socio-economic status in relation to their family planning practices.

12) There is a significant difference among Mizo women from rural and urban backgrounds in relation to their family planning practices.

VI. Null Hypotheses :

For the purpose of testing, the aforesaid research hypotheses were transformed into the following null-hypotheses:

1) There is no significant difference among Mizo women with different educational backgrounds in relation to their awareness about various family planning methods.

2) There is no significant difference among Mizo women engaged in different occupations in relation to their awareness about various family planning methods.

3) There is no significant difference among Mizo women having different socio-economic status in relation to their awareness about various family planning methods.

4) There is no significant difference among Mizo women from rural and urban backgrounds in relation to their awareness about various family planning methods.

5) There is no significant difference among Mizo women with different educational backgrounds in relation to their attitude towards family planning.

6) There is no significant difference among Mizo women engaged in different occupations in relation to their attitude towards family planning.

7) There is no significant difference among Mizo women having different socio-economic status in relation to their attitude towards family planning.

8) There is no significant difference among Mizo women from rural and urban backgrounds in relation to their attitude towards family planning.

9) There is no significant difference among Mizo women with different educational backgrounds in relation to their family planning practices.

10) There is no significant difference among Mizo women engaged in different occupations in relation to their family planning practices.

11) There is no significant difference among Mizo women having different socio-economic status in relation to their family planning practices.

12) There is no significant difference among Mizo women from rural and urban backgrounds in relation to their family planning practices.

VII. Operational Definitions :

(i) Awareness:

The term ***'Awareness'*** in the present study, refers to the existence of idea, on the part of the people, that there are certain methods by means of which a couple can postpone or even completely stop a pregnancy while following, at the same time, a normal conjugal life.

(ii) Family Planning Practices:

The term ***'Family Planning Practices'*** in the present study, means family planning methods actually being followed by people to control their family size.

(iii) Attitude :

The predisposition of theindividual to evaluatesome symbol or objector aspect of his world in afavourable and unfavourable manner.

VIII. Delimitation of the Study:

The present study shall be confined only to those Mizo women who are living within the state of Mizoram.

IX. Organization of the Report :

The report of the present study has been divided into five (5) chapters to facilitate a systematic presentation.

Chapter I - Introduction:

The first chapter is an introduction which begins with the concept and status of population growth in the world, India and Mizoram. Besides, the chapter deals with the rationale of the study, statement of the problem, research questions, objectives and research hypotheses and null hypotheses of the study. Operational definitions and delimitations of the study have also been incorporated in this chapter.

Chapter II - Review of Related Literature:

This chapter deals solely with the review of related studies on family planning both in India and abroad. The review is further sub-divided into three sections, namely:-

1. Review of studies related to awareness in relation to - education, occupation, socio-economic status and rural / urban locations.
2. Review of studies related to attitude in relation to - education, occupation, socio-economic status and rural / urban locations.
3. Review of studies related to family planning practices in relation to - education, occupation, socio-economic status and rural / urban locations.

Chapter III - Methodology:

Chapter III describes the methodology adopted for the present study. The method of study, population, sample size and sampling design, construction of tools, collection and tabulation of data and the statistical techniques applied for data analyses have been discussed in this chapter.

Chapter IV – Data Analysis and Interpretation:

Chapter IV deals with the data analysis and interpretation. However, this chapter has been further sub-divided into three sections, namely :-

1. Analysis and interpretation of data with regard to the awareness of Mizo women about various family planning methods in relation to their level of education, occupation, socio-economic status and rural-urban backgrounds.
2. Analysis and interpretation of data with regard to the attitude of Mizo women toward family planning in relation to their levels of education, occupation, socio- economic status and rural-urban backgrounds.
3. Analysis and interpretation of data with regard to the Family Planning Practice actually followed by the Mizo women in relation to their age of marriage, number of children, age at birth of first child, age at birth of last child, size of ideal family, spacing, adoption of family planning methods and spacing methods adopted.

Chapter V –Major Findings, Conclusions and Recommendations and Suggestions for

Further Research:

The fifth chapter is the concluding chapter which is devoted to major findings, conclusions, recommendations and suggestions for further research.

X. Methodology :

1. Method of Study:

As the study was expected to examine and describe the existing status of awareness, attitude and practices of Mizo women relating to family planning programs, therefore, the investigator decided to use the descriptive method of study.

2. Population, Sample and Sampling Design :

a) ***Population of the Study :***

All the married Mizo women residing in the state of Mizoram constituted the sample of this study. The **[Table – 3.1]** gives an overall

population of women in various districts. However, the classified data on the number of married women was not available. Perusal of data vide the same table reveals Mizoram population as per 2011 census consists of 49.4 percent of females and 50.6 percent males. A district wise comparison of gender composition of population reveals that other than Aizawl district, the population of males is higher than females in all other districts.

b) ***Sample and Sampling Design :***

A sample consisting of 1164 married Mizo women was selected from all 8 districts of Mizoram through stratified proportionate random sampling design. **[Table – 3.2]**

3. Composition of Sample in Terms of Independent Variables

a) Composition of Sample in Terms of Level of Education

In terms of level of educational background, 412 women (35 percent) were from Elementary Education background, 544 women (47 percent) from Secondary & Higher Secondary Education background and 208 (18 percent) from Higher Education backgrounds.

b) Composition of Sample in Terms of Occupation

In terms of occupational structure, the sample of this study comprised of 202 (17 percent) women from different professions, 147 (12 percent) from clerical background, 229 (19 percent) business women, 155 (13 percent) farmers, 123 (10 percent) daily laborers, and 308 (27 percent) housewives.

c) Composition of Sample in Terms of Socio-Economic Status

In terms of socio-economic status, the sample of this study comprised of 358 (31 percent) women from Low Socio-Economic Status (LSES), 709 women (61 percent) from Middle Socio-Economic Status (MSES) and 97 women (8 percent) from High Socio-Economic status (HSES).

d) Composition of Sample in Terms of Location

In terms of rural-urban composition, the sample of the study consisted of 451 women (39 percent) from urban areas and 713 women (61 percent) from rural areas. A perusal of data vide **[Table-3.2]**further reveals that the percentage of sample of urban women in all eight districts varied from 35.4 percent from Lunglei district to 41.4 percent from Kolasib district. For more specific details on district wise composition of rural and urban sample one can look into the **[Table - 3.2]**.

4. Tools and Techniques of Data Collection :

a) <u>Socio-Economic Status Scale</u>

To find out the Socio-Economic Status of the respondents, Socio-Economic Status Scale developed by LallianzualiFanai and R.P.Vadhera was adopted and administered to the respondents. The scoring key developed by the authors was used for scoring of the SES Scale.

b) <u>Awareness Scale about Family Planning Methods and Programs</u>

To find out the status of awareness among Mizo women about various family planning methods and programs, an awareness scale was constructed by the investigator as there was no readymade scale that could be used. The steps and procedures adopted for its construction have been explained as follows:

i. Collection of statements

For construction of statements to measure the awareness, the investigator consulted available literature related to awareness of family planning methods and programs. A total of 40 statements were framed for the first draft. A thorough study of the statements was made by the investigator's guide and the statements were reduced to 35 statements. These 35 statements were set in the form of multiple choice questions and distributed to experts in the field of family planning for content analysis. After the editing by 5 experts

and try out on a sample of 10 women, these 35 items were reduced to 29. Thus, the final draft of this questionnaire has only 29 statements.

ii. Establishment of Reliability

To ensure that the awareness scale has the desired reliability to generalize the findings to the target population, the scholar split her awareness scales into two halves on the basis of odd and even items, and worked out the coefficient correlation between two halves with Product Moment Method which came out to be 0.59. The reliability of the half-test was then converted into the self-correlation of the whole test by using Spearman-Brown Prophecy formula (Garrett, page no. 339) which came out to be 0.74.

iii. Establishment of Validity

The content validity of the scale was established on the basis of opinion of experts in the field of family planning.

iv. Scoring of the Awareness Scale

A scoring key, wherein all the correct answers of each multiple choice question were provided, was developed by the researcher. Each correct answer was given a score of one (1) and a wrong answer yielded a score of zero (0). Thus, the highest score a respondent could get was thirty nine (39) [Item 29 having a total score of eleven (11)] and the lowest score obtainable was zero (0). The scores of all the 1164 respondents were classified and arranged into tables according to the independent variables as well as the objectives of the study.

c) <u>Attitude Scale towards Family Planning</u>

There was no readymade scale available that could be readily used to study the attitude of Mizo women towards family planning, therefore, an attitude scale towards family planning was constructed by the investigator following Likert's method. The steps and procedures adopted for its construction and standardization have been explained as follows:

i. Collection and Editing of Statements

For construction of statements to measure the attitude, the investigator consulted available literature related to attitude towards family planning. A total of 92 statements were framed for the first draft. A thorough study of the statements was made by the investigator's guide, and the statements were reduced to 69 statements. These 69 statements were distributed to experts in the field of education and family planning for content analysis. After the editing, 60 statements were selected for the second draft of the attitude scale.

ii. Try Out

The draft attitude scale consisting of 60 statements was administered to 30 married women in order to find out whether the scale would be good enough for the population for whom it was intended. For this purpose, the 30 respondents were asked their understanding of the statements as well as their degree of acceptance or rejection of the statements. After analyzing their responses, 7 statements were rejected on the basis that it could not be fully comprehended by the 'try-out group'. This resulted in 53 statements being retained for the third draft.

iii. Item Discrimination

To find out the discriminating value of each item, the third draft was administered to 150 married women in Aizawl. After scoring, the top 27 percent and the bottom 27 percent of respondents were set aside. For determining discrimination value of each statement, 't-test' was applied. The items having insignificant t-value at 0.05 level of confidence were rejected. The final Attitude Scale that was used for data collection comprised of 50 statements out of which 29 were positive statements and 21 were negative statements.

iv. Establishment of Reliability

For establishing the reliability of the test, the 'Split-Half Method' was employed by the investigator. The whole scale was split into two halves by taking equal number of Positive and Negative statements. The co-efficient of reliability was computed using 'Spearman – Brown Prophecy Formula'. The co-efficient of reliability of the whole scale came out to be 0.80.

v. Establishment of Validity

The content validity of the scale was established on the basis of opinion of experts in the field of Education and Family Planning.

vi. Scoring of the Attitude Scale

The items on attitude scale were scored following the scoring procedure suggested by Likert. Positive statements were scored as 5,4,3,2 and 1 for strongly agree, agree undecided, disagree and strongly disagree responses, respectively. On the other hand, negative statements were scored as 1,2,3,4 and 5 for strongly agree, agree, undecided, disagree and strongly disagree responses, respectively. The scores of all the 1164 respondents were classified into tables according to the independent variables as well as the objectives of the study.

d) <u>Questionnaire on Family Planning Practices</u>

To find out the actual Family Planning Practices, a questionnaire was developed by the investigator after going through the related literature on family planning methods and practices. A total of 10 questions were set concerning issues such as the age at marriage, number of children, age at birth of first child, age at birth of last child, whether spacing is followed or not, whether methods of family planning were adopted and size of ideal family.

i. Establishment of Reliability

The establishment of reliability of a questionnaire is not quite the same as that of a test for which scores are obtained. As this questionnaire was designed to find out the status of family planning practices among the Mizo

women, the responses to the various items of the questionnaire do not necessarily reflect the intensities of the various family planning practices. The responses to the different items of the questionnaire were not scores in the usual sense of the term. Moreover, every item in this questionnaire was independent and measures a different dimension. Therefore, responses to the various items could not be added like scores. So, the well-known methods of establishing reliability like Split-half, Alternate or Parallel form and Rational Equivalence methods were not applicable. However, to ensure the reliability of the said questionnaire, the investigator applied 'test-retest' method by administering it twice on a sample of 20 women with a gap of two weeks and found it to be reliable.

e) Interview Schedule for Family Planning Programs run by Government

To find out the status of family planning programs run by the state government, the investigator personally interviewed the officer in charge of the Reproductive and Child Health program. The investigator had also conducted telephonic interview with the Jt. Director, Family Planning, Department of Health & Family Welfare, Govt. of Mizoram. The investigator gathered a lot of useful information regarding the family planning programs run by the Government.

As no NGO in Mizoram was ever involved in the propagation and implementation of family planning programs, therefore, the investigator did not develop any questionnaires in this regard.

4. Administration of Tools and Collection of Data

All the four tools of data collection namely, Socio-Economic Status Scale, Awareness Scale about Family Planning Methods &Programs, Attitude Scale towards Family Planning, and Questionnaire for Family Planning Practices were personally administered to 1200 women selected proportionately from all the eight (8) districts of Mizoram. Before administering these tools the investigator introduced herself and explained the

purpose and importance of the study. Besides, they were also ensured that information supplied by them will be kept strictly confidential and used for the research purpose only. After establishing the necessary rapport, all the aforesaid four tools were administered. The respondents were given enough time to ponder over all the statements in each of the three tools so as to ensure a truthful response from them. However, after scoring of all four tools it was discovered that 36 respondents had not completed one tool or another. Thus, these 36 women were not included for the analysis of data because of incompleteness their responses and the scholar was left with only 1164 women respondents for data analysis.

5. Tabulation of Data

The data collected for the study was examined carefully. After screening the incomplete responses, 1164 complete responses out of 1200 were available for final analysis. The classified materials were recorded accurately in mathematical terms, that is, marking and counting frequency tallies for different items on which information was gathered. Each respondent was assigned a serial number and their details regarding age, level of education, occupation, locale and the scores obtained on Socio-Economic Status, Awareness about Family Planning Methods and Programs and Attitude towards Family Planning was entered in a tabulation sheet. Keeping in view the different nature of data gathered through the questionnaire on Family Planning Practices, a separate master table was prepared for data entry on various issues related to Family Planning Practices such as Age at marriage, Number of children, Age at birth of first child, Age at birth of last child, Size of Ideal family, Adoption of Spacing and Adoption of Family Planning Method.

6. Statistical Techniques for Analysis of Data

The analysis of data was done by using both descriptive and inferential statistical techniques described as under:

1. Frequency, percentage, cumulative percentage, mean , median, mode, standard deviation and skewness were used to study the nature of distribution of scores with regard to the age at marriage, number of children, age at birth of first child, age at birth of last child, size of ideal family and spacing.
2. Product-Moment Correlation followed by Spearman-Brown Prophecy Formula to establish reliability of the Awareness Scale and Attitude Scale.
3. 't' test for item discrimination as well as to find out the significance of difference in attitude towards family planning, and awareness about family planning methods & programs in relation to education, occupation, socio-economic status and rural/urban background of Mizo women.
4. Chi-square test to test the hypothesis of independence in relation to the association between family planning practices and education, occupation, socio-economic status and rural/urban background of Mizo women.

XI. MAJOR FINDINGS, RECOMMENDATIONS AND SUGGESTIONS :

I. <u>Findings in Relation to the Awareness of Family Planning Programs and Methods</u>

A. Awareness of family planning programs and methods in relation to educational level-

1. There exists a significant difference between the means of elementary vs secondary and higher education level groups of women with regard to their awareness of family planning programs and methods.**[Table – 4.1.a & Fig – 4.1.a]**. Mizo group of women with

higher level of education has more awareness towards family planning methods and programs as compared to elementary and secondary education level groups of Mizo women. However, there is no significant difference between elementary vs secondary education level of Mizo women regarding awareness of family planning.Therefore, from the study, it is evident that higher level Education is needed for awareness of Family Planning and its methods. This is also evident in the fact that, before higher education was initiated in Mizoram or prior to 1958 (before the initiation of the first Higher Education Institution – Pachhunga University College), Family Planning was viewed by the people from a negative perspective. This justified that, for people to have a positive outlook or awareness on Family Planning and its methods, Higher Education is needed among Mizo women.

B. Awareness of family planning programs and methods in relation to occupational background-

1. There exists a significant difference between the means of professional vs business,clerical, farmers, housewives and laborers groups of women with regard to their awareness of family planning programs and methods.**[Table – 4.1.b(i) & Figure – 4.1.b(i)]**.The Mizo women from professional group are most aware about family planning programs and methods as compared to any of their counterparts i.e. Mizo business-women, clerical, farmers, housewives and labourer groups of Mizo women.

2. There exists a significant difference between the means of business vs clerical groups of women with regard to their awareness of family planning programs and methods **[Table – 4.1.b(ii) & Figure – 4.1.b(ii)]**. The clerical group of Mizo women have more awareness.

3. There exists no significant difference between the means of business vs farmers, housewives and laborers groups of women with regard to their awareness of family planning programs and methods **[Table – 4.1.b(ii) & Figure – 4.1.b(ii)]**.

4. There exists no significant difference between the means of clerical vs farmers and housewives groups of women with regard to their awareness of family planning programs and methods **[Table – 4.1.b(iii) & Figure – 4.1.b(iii)]**.There exists a difference in awareness of family planning methods between the clerical vs. farmers. However, there exists no difference in the awareness level of family planning methods between clerical and housewives group of Mizo women.

5. There exists a significant difference between the means of clerical vs laborers groups of women with regard to their awareness of family planning programs and methods **[Table – 4.1.b(iii) & Figure – 4.1.b(iii)]**.Clerical group of Mizo women have more awareness.

6. There exists no significant difference between the means of farmers vs housewives groups of women with regard to their awareness of family planning programs and methods **[Table – 4.1.b(iv) & Figure – 4.1.b(iv)]**.

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7. There exists a significant difference between the means of farmers vs laborers groups of women with regard to their awareness of family planning programs and methods **[Table – 4.1.b(iv) & Figure – 4.1.b(iv)]**. The difference is in favour of the farmers group of Mizo women.

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8. There exists no significant difference between the means of housewives vs laborers groups of women with regard to their

awareness of family planning programs and methods **[Table – 4.1.b(v) & Figure – 4.1.b(v)]**.

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C. Awareness of family planning programs and methods in relation to socio-economic status

There exists a significant difference between the means of LSES vs MSES, LSES vs HSES and MSES vs HSES groups of women with regard to their awareness of family planning programs and methods. **[Table – 4.1.c & Figure 4.1.c]**. Mizo women from HSES are most aware about family planning and its methods; followed by MSES and LSES respectively. It is evident from this study, the higher the socio economic status (SES) the higher the awareness level.

D. Awareness of family planning programs and methods in relation to locale

There exists a significant difference between the means of rural vs urban women with regard to their awareness of family planning programs. **[Table – 4.1.d & Figure – 4.1.d]**.The study showed that the group of Mizo women from the urban areas have more awareness about family planning and its methods as compared to the Mizo women from rural areas.

II. Findings Relating to the Attitude Towards Family Planning Programs

A. Attitude towards family planning programs and methods in relation to educational level-

1. There exists no significant difference between the elementary vs. secondary education level groups of women with regard to their attitude towards family planning programs and methods. **[Table – 4.2.a & Figure – 4.2.a]**

2. There exists a significant difference between the means of elementary vs. higher and secondary vs higher education level groups of women with regard to their attitude towards family planning programs and methods. **[Table – 4.2.a & Figure – 4.2.a]**. The higher educational level group of Mizo women have a more positive attitude towards family planning as compared to the Mizo women with elementary or secondary educational level.

B. Attitude towards family planning programs and methods in relation to occupational background

1. There exists no significant difference between the means of professional vs. business, clerical, farmers and housewives groups of women with regard to their attitude towards family planning programs**[Table – 4.2.b(i) & Figure – 4.2.b(i)]**

2. There exists a significant difference between the means of professional vs laborers groups of women with regard to their attitude towards family planning programs **[Table – 4.2.b(i) & Figure – 4.2.b(i)]**.Mizo women holding professional occupations tend to have more positive or favourable attitude towards family planning.

3. There exists no significant difference between the means of business vs. clerical and housewives groups of women with regard to their attitude towards family planning programs **[Table – 4.2.b(ii) & Figure – 4.2.b(ii)]**

4. There exists a significant difference between the means of business vs. farmers and laborers groups of women with regard to their attitude towards family planning programs **[Table – 4.2.b(ii) & Figure – 4.2.b(ii)]**. The business group of Mizo women have a more favourable and positive attitude towards family planning than their counterparts from farmers and labourers group of Mizo women.

5. There exists no significant difference between the means of clerical vs farmers and housewives groups of women with regard to their attitude towards family planning programs **[Table – 4.2.b(iii) & Figure – 4.2.b(iii)]**.

6. There exists a significant difference between the means of clerical vs laborers groups of women with regard to their attitude towards family planning programs **[Table – 4.2.b(iii) & Figure – 4.2.b(iii)]**. The Mizo women with clerical jobs have more positive attitude towards family planning and its methods.

7. There exists no significant difference between the means of farmers vs housewives and laborers groups of women with regard to their attitude towards family planning programs **[Table – 4.2.b(iv) & Figure – 4.2.b(iv)]**

8. There exists no significant difference between the means of housewives vs laborers groups of women with regard to their attitude towards family planning programs **[Table – 4.2.b(v) and Figure – 4.2.b(v)]**

C. Attitude towards family planning programs and methods in relation to socio-economic status

There exists no significant difference between the means of LSES vs MSES , LSES vs HSES and MSES vs HSES groups of women with regard to their attitude towards family planning programs**[Table – 4.2.c & Figure – 4.2.c]**

D. Attitude towards family planning programs and methods in relation to locale-

There exists no significant difference between the means of rural vs urban women with regard to their attitude towards family planning programs**[Table – 4.2.d & Figure – 4.2.d]**

III. Findings on the Family Planning Practices

A. Age at marriage

1. The average age of women at the time of marriage is 21.37 years. The median value is 20.71, which indicates that fifty (50) percent of the women get married before attaining the age of 20.71 years, and the remaining fifty (50) percent get married after attaining the age of 20.71 years. Further, the mode value being 19.33 indicates that majority of the respondents get married at the age of 19.33 years. **[Table – 4.3.b(i) & Figure – 4.3.b(i)]**

2. The statistics relating to age at marriage is positively skewed, which indicates a large concentration of scores near the lower end of the distribution. This means that the number of women getting married at younger age is relatively larger than those who get married late. The positive skewness in the present context suggests that fertility span of majority of women is much longer, and gives them a scope to give birth to more children**[Table – 4.3.b(ii)]**

B. Average number of children born to a woman

1. The average number of children that a woman gives birth to is 3.67 children. The median value is 3.85, which indicates that fifty (50) percent of the women gave birth to less than 3.85 children, and the remaining fifty (50) percent gave birth to more than 3.85 children. Further, the mode value being 4.21 indicates that the majority of the respondents gave birth to 4.21 children.**[Table – 4.3.c(i) & Figure – 4.3.c(i)]**

2. The statistics relating to number of children is negatively skewed which indicates a large concentration of scores near the higher end of the distribution. The negative skewness in the present context suggests that the

number of women giving birth to more than 3.67 (Mean) children is much larger than those who gave birth to less than 3.67 children (Mean). From the aforesaid statistics one can easily understand why the population growth in the state is always higher in relation to the growth at all India level.**[Table – 4.3.c(ii)]**

C. Average age of women respondents at the time of birth of first child

1. The average age at which the respondents gave birth to their first child is 22.27 years. The median value is 21.88, which indicates that fifty (50) percent of the women gave birth to their first child before attaining the age of 21.88 years, and the remaining fifty (50) percent gave birth to their first child after attaining the age of 21.88 years. Further, the mode value being 21.1 indicates that most of the respondents gave birth to their first child at the age of 21.1 years.**[Table – 4.3.d(i) & Figure – 4.3.d(i)]**

2. The statistics relating to the age at the time of birth of the first child is positively skewed which indicates a large concentration of scores near the lower end of the distribution. The positive skewness in the present context suggests that number of women giving birth to their first child before 22.27 years (Mean) is much larger than those who gave birth to their first child after 22.27 years (Mean).The aforesaid statistics relating to the age of women respondents at the time of birth of their first child, like age at marriage, suggests that they have relatively longer span for expansion of their family. Further, giving birth to the child at a young age, as is indicated by the statistics in table 6.3b, is not healthy for both the mother and the child.**[Table – 4.3.d(ii)]**

D. Average age of women respondents at the time of birth of last child

1. The average age of a woman at the time of birth of the last child is 33.35 years. The median value is 33, which indicates that fifty (50) percent of the women gave birth to their last child before attaining the age of 33 years and the remaining fifty (50) percent gave birth to their last child after attaining the age of 33 years. Further, the mode value being 32.3 indicates that most of

the women gave birth to their last child at the age of 32.3 years.**[Table – 4.3.e(i) & Figure – 4.3.e(i)]**

2. The statistics relating to the age of a woman at the time of giving birth to the last child is also positively skewed which indicates a large concentration of scores near the lower end of the distribution. The positive skewness in the present context suggests that number of women giving birth to their last child before 33.35 years (Mean) is much larger than those who gave birth to their last child after 33.35 years (Mean). The positively skewed distribution here should be taken as desirable because most of the women respondents completed their family at the right age**.[Table No. 4.3.e(ii)]**

Further, the mean age of 22.27 years at the time of birth of first child **[Table – 4.3.d(ii)]**and mean age of 33.35 at the time of birth of last child **[Table – 4.3.e(ii)]**suggests that most women respondents take around 11 years to complete their family to their desired size.

E. Perception of women regarding the size of an ideal family size

1. The ideal family size, as perceived by the women respondents should on an average consist of 4.59 children. The median value for the same is 4.31 children, which indicates that fifty (50) percent of the women agree that an ideal family size should include 4.31 children, whereas the remaining fifty (50) percent opine that an ideal family size should include more than 4.31 children. Further, the mode value being 3.75 indicates that most of the respondents believed that an ideal family size should include 3.75 children.**[Table – 4.3.g(i) & Figure – 4.3.g(i)]**

2. The statistics relating to perception of women regarding the size of an ideal family size is positively skewed which indicates a large concentration of scores near the lower end of the distribution. The positive skewness in the present context suggests that number of women who perceive ideal family size to be less than 4.59 children (Mean) is much less than those who wish it to be more than 4.59 children (Mean). Although it is relieving to have a positively skewed distribution in relation to the ideal family size, the average

size of ideal family i.e. 4.59 children (Mean) suggested by the respondents in itself is much beyond the ideal family size norm suggested by the family planning programs.**[Table – 4.3.g(ii)]**

F. Association between level of education of women and their family planning practices

1. There is an association between the level of education of a woman and her adoption of family planning method for spacing.Education of Mizo women could lead to the practice of family planning and its methods. The higher the educational level, the higher the awareness and the likelihood that the person would practice family planning and its methods as education is the key to fostering a positive outlook towards family planning.
2. Adoption of family planning method for limiting of family size is also associated with the level of education of a woman.Through education, one could clearly understand the detrimental effects of population on the economy; likewise, a huge family puts a lot of pressure on the finance of the family which in turn affects the way the family functions. Therefore, it is possible that, educated Mizo women are aware of these which could lead to adoption of family planning practices (apart from the spacing method) which could even be permanent in nature like vasectomy and tubectomy.

G. Association between occupation of women and their family planning practices.

1. There is an association between the occupation of Mizo women and her adoption of family planning method for spacing.It is evident from the study that 95.7 percent practices spacing method which is a high percentage. However, the gap generated between the birth of children could improve as the average gap is only 2.39 years between births. Fifty percent of the Mizo women leave a gap of less than 1.76 years between births of children.
2. Adoption of family planning method for limiting of family size is not associated with occupation of women.

H. Association between the level of SES of women and their family planning practices.

1. There is no association between the level of SES of women and their adoption of family planning method for spacing.
2. Adoption of family planning method for limiting of family size is associated with level of SES of women.This could be because families from the middle and low SES are not well off to be able to afford a big family; due to this they might want to limit the number of children in the family due to economic constraints by resorting even to permanent means of limiting one's family size other than spacing.

I. Association between Rural and Urban background of Women and their family planning practices.

1. There is no association between the rural-urban background of women and their adoption of family planning method for spacing.
2. There is no association between the rural-urban background of women and their adoption of family planning method for limiting of family size.

IV. <u>Interview Schedule for Family Planning Programs run by Government</u>

1. Annual Reports
2. Legislative Procedures
3. Physical and Human Resources
4. State Level Policy
5. Kinds of Programs being conducted
6. Use of mass media for social messaging
7. State of Population Education in school text-books or as a separate course
8. B.A. Education (honours)

Although questions were asked, keeping in mind the above mentioned points, there are no actual facts to reproduce in relation to the exact questions. However, it may be pointed out that:

1) The Family Planning Cell that was initially set up in the mid-nineties did not function as it was supposed to mainly due to the reason of un-acceptance of family planning among the Mizo people. (as mentioned in the rationale)

2) The Family Planning Cell was renamed Reproductive and Child Health (RCH) and slowly the program got underway and began to be accepted.

3) The RCH program uses the same guidelines that were used when it was functioning under the Family Planning Cell. However, since the term, "Family Planning" was no longer visible, the Mizo people started accepting it.

4) Under the Family Planning Cell, there was a shortage of staff and therefore records were not maintained properly.

5) Under the RCH program, the staff have increased including three (3) doctors to the total staff of ten (10) people.

6) There is also a Jt. Director, Family Planning, in the Department of Health & Family Welfare, Govt. of Mizoram who was very helpful but had limited knowledge and referred the investigator to have talks with former retired Directors of the Department.

7) Previous Directors of the Department of Health & Family Welfare, Govt. of Mizoram, also stressed on the failure of the Family Planning Cell and most of its programs due to un-acceptance by the Mizo people.

8) With regard to annual reports and legislative procedures, they are more or less non-existent.

9) Before the RCH program, there was no actual State level policy.

10) Under RCH, mostly awareness campaigns are carried out where-in the doctors, who are a part of the staff, give talks on the benefits of healthy family planning practices.

11) Earlier, mass media was not used for social messaging of family planning related topics. However, recently, under the RCH, measures are being taken to use the mass media for promoting the use of healthy family planning practices.

12) Recently, population education related topics have been included in the school text books. However, Population Education as a separate paper is included in the B.A (Education) and B.Ed syllabus.

IV. Recommendations

1. Awareness programs can be conducted by the concerned officers of the Health & Family Welfare department to inform the young girls about the harmful consequences of giving birth at a young age i.e. 16 to 19 years.

2. Introduction of sex-education at the secondary level of education should be taken in to serious consideration by the concerned authorities.

3. Awareness programs can also be conducted by the concerned officers of the Health & Family Welfare department to inform the married women about the advantages of adopting spacing methods and adopting family planning methods to limit the size of their families.

4. Concerned officers of the Health & Family Welfare Department should pay more attention to the rapidly increasing growth rate of the Mizo population and actually carry out remedial measures to prevent further high growth rates in future.

5. In order to encourage the married women to use modern contraceptives for spacing between the birth of children, the Health and Family Welfare Department needs to provide available information about the benefits of modern contraceptives.

6. Information and relevant services related to reproductive health should be continuously delivered to newly married couples through awareness campaigns conducted by the concerned officers.

7. The concerned officers of the Health and Family Welfare department need to undergo intensive training in order to realize the harmful consequences of a rapid growing population.

8. More in depth knowledge about the religious & cultural beliefs and social norms related to family planning practices with regard to married Mizo women for further research should be carried out.

9. Last but not the least, the Mizo people, as a whole, need to be given more information on what Family Planning actually means and the benefits that they can reap by following healthy family planning practices.

V. Suggestions for Further Research

The future researcher may take up research on the following topics :

1. Family planning practices of different ethnic groups like Lai, Mara, Mizo, Chakma, Bru etc. residing within Mizoram.

2. Attitude and family planning practices of Mizo women belonging to different denominations.

3. Socio-political and religious factors responsible for consistently high growth rate of population.

4. Attitude and family planning practices of Mizos, Nagas, Khasis, Garos and Jaintias.

5. Total Fertility Rate (TFR) and Total Marital Fertility Rate among women belonging to different ethnic group in various north eastern states can also be taken up for further research.

6. Awareness, attitude and family planning practices of Mizo males in relation to their education and occupation, socio economic status, and denomination.

7. Role of elderly people in the family, and religious leaders in encouraging young people in different ethnic and religious groups to have more children.

8. Opinions of husbands and wives on various issues relating to the family planning.

9. Size of the family: Relative role of husband and wife in decision making.