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"A Study to Assess the Factors Affecting Acceptance of Intrauterine Device (IUD) Among Rural Women of Hirebagewadi, Belgaum."

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Abstract: *"A Study To The Factors Affecting The Acceptance Of Intrauterine Device (IUD) Among Rural Women Of Hirebagewadi 'B' Sub-Center Belgaum.*
The objectives of the study were to:
1) To identify the factors affecting the acceptance of IUD.
2) To find out the association between identical factors and socio-demographic variables.
The conceptual framework for the study w as based on the Rosenstock's Health Belief and Pender's Health Promotion model. It had three components namely individual perception, influencing factors and likelihood of action. Individual perception are the negative reactions are perceived by rural married women which are influenced by knowledge, physiological, psychological, socio-cultural and economical factors leading to misconceptions and myths towards non acceptance of IUD as a spacing method. Likelihood action in the present study believes that the subjects will be troubled in their mind with same questions they had responded at the time of interview will prompt them to think about IUD and likelihood action to accept it.
A study assumes that level of knowledge will strongly affect the acceptance of IUD. Also the socio-demographic variables and the factors are also directly influencing on the non acceptance of IUD.
The descriptive research study was adopted for this study. The independent variable was the intrauterine device (UD) and dependent variable was the factors affecting for the acceptance of IUD. The study was conduced on 300rural women by Stratified random sampling technique who are residing in Hirebagewadi 'B' Sub-center. The tool included background proforma and structured questionnaire on factors affecting for acceptance of IUD. The data was analysed in terms of both descriptive and inferential statistics.
The major findings revealed that,
1) The majority of the women had average knowledge of the family planning and IUD.
2) According to responses given by women, physiological (29.63%), economical (29%), knowledge (37.5%), psychological (41.57%) and sociocultural factor had direct or indirect influence on non acceptance of IUD as a spacing method.
3) There was statistical significant association between the factors (knowledge, physiological, psychological, socio-cultural and economical) and socio-demographic variables such as age of women, educational status of both women and their husbands, the religion, nature of family, occupational status of both women and their husbands and monthly income of the family.
The study concludes that due to scattered knowledge of women regarding contraceptives were leading to myths and misconceptions in the factors of physiological, psychological, socio-cultural factors for non acceptance of IUD as a spacing method.
Hence the research hypothesis is excepted.
On the basis of the findings the following recommendations are made:
1) A similar study for a larger sample for other rural setting.
2) A similar study can be conducted for urban married women.
3) Comparison can be done between the rural and urban women.
4) A study to assess the knowledge, attitude and practice of contraception (IUD) among all the members of the team.

I. Introduction

There has been a tremendous expansion in health care infrastructure over the cast three decades. But there was No improvement in some of the maternal and child health indices, which suggest that, the poor utilization of available facilities. Family planning is not synonymous with birth control. It is more with birth control.

India is the first country in the world to launch a nationwide family welfare programme with full government support. In temporary methods like IUD and condoms were introduced, but IUD insertions was picked up only from the year 1970-71.

These family planning programmes helps millions of people, providing reproductive health care. (Usage of contraceptive is increased from 10% (1969) to 35% in 1998 and continuously risen), that saves lives (saves 150,000 women live each year, millions of infants and children every year, i.e. 65 deaths 1,000 and breast feeding saves 6 million of children each year), avoids unintended pregnancies (i.e. avoids must of estimated 78,000 maternal deaths that results from unsafe abortion about 13% of 585,000 maternal death each year), protect from HIV/ STIS diseases. (every day another 16,000 people become infected with HIV 5.8 million each year and about 333 million new cases of STIS occurs each year) and offers more choices. (H also provides better assessment of reproductive health services including contraception to almost 1 billion people (i) (One sixth's of the world's population aged between 10 and 19).

At of 31st March 1999 about 74.22 million couples (44% of 168 million eligible couples in the reproductive age groups 15-44 years) were effectively protected against contraception, by one or the other family planning methods. In that only 74% of IUD was used as a contraception and still about 56% of eligible couples were unprotected against conception.

As more people choose family planning fertility falls and population growth slows which protect the environment by conserving resources, preserves clean air and water, improves health, cases pressure on cities and helps to avoid conflict. Slower population growth aids development. It buys time and with more of the population in their productive yeas, provides a demographic bonus that can be invested in education, job creation, health care and other efforts to raise living standards.

But in fact every 12 or 13 years another billion of people (growing by nearly 80 million people each year) are added to the world's population almost all in developing countries. The United Nations has projected that world population will be 8.9 billion in 2050, nearly a 50% increase over the current 6 million. So the NPR= 1 can be achieved only if the CPR exceeds 60% were the couple protection rate is an indicator of the prevalence of contraceptive practice in the community at present it is (-----).

The family welfare programme was a priority health programme for our country, inspite of integrated and converted efforts the programme has been able to male an appreciable reduction of crude birth rate 27.2 (1997).

This was because majority of the couples (223 million couple) had undergone sterilization only after achieving their desired family size of more than three children. Therefore the programme has shifted its focus on spacing methods with the purpose of bringing about a decline in country's birth rate.

But choosing a contraceptive involves a variety of considerations, from personal prediction, method availability and cost, to a host social, cultural economic and psychological factors which vary from person to person, place to place and time to time.

Several studies on contraception choice conducted world wide, have been reported that men as well as women in many developing countries do not like to use traditional or modern temporary methods of contraception due to their side effects and/ or reduction of sexual pleasure. It also greatly depends on various aspects of the cultural environment in which people live or interpersonal communication. Among the common factor for non acceptance of contraceptives are inconvenient or unsatisfactory services, lack of information, fears about contraceptive side effects and apposition from husbands, relation or community and lack of involvement of local leadings. So about 133 million births occurs in the world annually of this total one in four (33 million) is estimated to be unintended – either mistimed or never wanted.

For better acceptance of contraceptives on a spacing method adequate funding, favorable policies and popular support are important to the success of family planning programme. Programmes needs to support not only from clients but also form the general public and especially, from health officials, policy makers, funding agencies, the news media, employers, health care providers, women'sorganizations and religious and community leaders.

II. Need for the study:

On May 11, 2000 India acquired a unique position in the population history of the world by crossing the staggering one billion mark which was the total population of the world in not too distant past (1800 AD). The China-India duo thus forms a unique club of billion plus population and no other country of the world may ever grow to this size in the future. The recently conducted 2001 census has enumerated India's population at 1,03 billion. The heartening fact, however is that since 1981, there has been a steady deceleration in the growth rate of India's population and decline has been the sharpest during 1991-2001 decade for which both the birth and death rates are important components which are responsible for the population growth. India and other developing countries are facing with a dilemma of higher birth rate and a declining death rate. The major causes

are universality of marriage, early marriage, low level of literacy, customs and another more important aspect is absence of family planning services.

The family welfare programme in India explains that small differences in the family size will make big differences in the birth rate and maintaining small family with proper spacing method ultimately. The family will have a tremendous impact on the population growth. So, the objective of FWP is that the people should adopt the "small family norm" to stabilize the country's population at the level of some 1533 million by the year of 2050 AD. The current emphasis is on three themes – "sons or daughters two will do", "second child after 3 years", and "Universal immunization".

As of 31st March 1999, about 74.22 million couples (44% of 168 million eligible couples in the reproductive age group 15.4 years) were effectively protected against conception by one or the other family planning method world wide and (36.10 million in India). According to NRR demographic indicator, the present level of NRR in India is 1.5 and the Govt. of India adopted policy of attaining NRR of 1 by the year 2006, and it is possible when at least 60% of eligible couples are effectively practicing family planning.

According to WHO population reports, family planning benefits individuals and countries in many ways. Among the most important ways are:

Saving women's lives: Avoiding unintended pregnancies could prevent about one-fourth of all maternal deaths in developing countries. Especially, using contraception helps avoid unsafe abortions to end unintended pregnancies. It also enables women to limit births to their healthiest childbearing years and to avoid giving birth more times than is good for their health.

Saving children's lives: Spacing pregnancies at least two years apart helps women have healthier children and improves the odds of infants' survival by about 50%. Limiting births to a woman's healthiest childbearing years also improves her children's chances of surviving and remaining healthy.

Offering women more choices: For many women, controlling their own childbearing by using effective contraception, can open the door to education, employment, and community involvement. Also, couples who have fewer children are more likely to send their daughters as well as sons to school.

Apart from these benefits, there are other benefits like slower population growth helps to protect the environment.

A lot of unplanned pregnancies happen in the first few months after child birth making mother and baby vulnerable to the risks. Family planning could avoid most of the estimated 78,000 maternal deaths that result from unsafe abortion. World wide if all couples who do not currently want to have a child use effective contraception, most of the estimated 46 million induced abortions each year would not occur. As many as 20 million of the 46 million abortions annually are unsafe.

When we closely look at the contraceptive use for spacing methods from NFHS I to NFHS II[nd]programme, we find that there is only 2% increase in using a spacing method. The NFHS II reveals that 16% women in the country have an unmet need for family planning (40 million in 1027 million population). To reach 64% of proposed CPR from 48 of present rate we need to meet 16% of unmet needs. The reasons for unmet needs are lack of knowledge, lack of appropriate family planning and motivational services in the area, concept of more children for labour or for economy, disapproval of one of the partners or family members.

Though the IUD is an ideal contraceptive method found to be the best because it has long life, is reliable, safe and easy to reverse, but making a choice suffered certain setback involving a variety of considerations, like personal predictions, method, availability and cost, social, cultural, economic, demographic and psychological factors which vary from person to person and place to place and time to time.

The investigator during the interaction with women in the community field experience observed that though the people have understood the importance of small family norm and have widely accepted the terminal method as a solution for this but not spacing methods and IUD as specific method. Further, because of so many factors which are affecting the acceptance of IUD. The major reason was lack of knowledge, demand of more children in a short period, domination of husband and elder people, fear of post IUD physiological changes, absence of universal acceptance of the said method in the community. A study which was conducted by Madhumita Das and SanghmitraAcharyaon "Factors Influencing Family Planning Method Choice In West Bengal And Assam" revealed that currently married women uses less spacing method, acceptance of sterilization increases along with increase in age, son preference makes choosing of spacing method and retention of IUD was found less because it was removed by personal reason than medical reason. Religion also influences family planning where non Hindus used both traditional and modern spacing method compared to Hindus.

Thus the observation made by the investigator during field experience while working as a clinical instructor and also the findings based on literature review, strongly felt that there is a need to assess the factors affecting the acceptance of intrauterine device among rural women. That is why the study is undertaken.

1. Objectives Of The Study

1.1. To identify the factors affecting the acceptance of IUD.
1.2. To find out the association between identified factors and socio-demographic variables

1) Hypothesis

2.1. There is relationship between the identified factors and acceptance of IUD among rural women

3) ASSUMPTIONS

3.1. Lack of knowledge will strongly affect the acceptance of IUD.
3.2. Sex, religion, education, nature of family, occupation, family income and present obstetric status have direct impact on the level of knowledge and acceptance of Intrauterine Device.
3.3. Physiological, psychological, socio-cultural and economical factors have direct influence on the acceptance of IUD.

4. Delimitation

4.1. The study will be limited to rural married women who are pregnant or conceived at least once of Hirebagewadi PHC, Belgaum.

5. Projected Outcome

5.1. Results of the study will help the nurse to know the various reasons affecting the acceptance of IUD as a contraceptive device among the rural women.
5.2. Findings will help the nurse to prepare the appropriate educational material in such a way that, the couple will be motivated to accept IUD.

6) Operational Definitions

6.1. Rural women: Refers to the female individuals aged between 15 to 45 years, married and have undergone the experience of pregnancy and residing in the rural area where the study will be conducted.
6.2. IUD: It is Cu-t: 200 B, one of the contraceptive devices supplied by government of India through family welfare programme for spacing the pregnancies.
6.3. Factors: Refers to the components such as demographics, knowledge, physiological, psychological, soci-cultural and economical contributing to the acceptance of the intrauterine contraceptive device (IUD) as expressed by the respondents.
6.4. Acceptance: Refers to the way of thinking and living that is adopted voluntarily on the basis of knowledge, attitude and responsible division by individual and couple influenced by the factors.
6.5 Knowledge: These are the facts what respondent know about family planning in general, IUD as a method of spacing children and benefits which are expressed through statements.
6.6. Physiological factor: Refer to the immediate or late post implantation of IUD changes in the reproductive system as expressed by the respondents for their voluntary unwillingness.
6.7. Socio-cultural factor: Refers to the behaviour and feeling of other women towards them who have adopted IUD. This is the reason for their unwillingness to adopt IUD.
6.8. Psychological factor: Refers to the reactions (way of thinking) of the respondents towards IUD which affects their voluntary willingness.
6.9. Economical factors: Refers to the feeling which is expressed by individuals or respondents regarding the effect of IUD on their domestic work and earning.

7. Methodology

This chapter presents description of research approach, research setting, research design, population, sample setting and sample technique used for the present study. It also describes the technique of data collection and development and use of tool, pilot study and a plan of data analysis.

7.1. RESEARCH APPROACH

The selection of research approach is the basic procedure for the conducting research inquiry. The study undertaken is descriptive in nature describes the facts and characteristics of 300 rural married women of Hirebagewadi 'B' Sub-center with an aim to identify the factors affecting the acceptance of IUD as spacing method as assessed by structured interview schedule.

7.2. RESEARCH DESIGN

Research design depicts the overall plan for organization of scientific investigation[52]. It helps the researcher in the selection of subjects, manipulation of independent variables, application of the suitable statistical method to be used to interpret the data.

The selection of design depends upon the purpose of the study i.e. research approach and variables to be studied. In the present study, descriptive survey was carried out on 300 rural married women of Hirebagewadi 'B' Sub-center of Hirebagewadi PHC taluk and District Belgaum for the purpose or providing an accurate portrayal of a graph of subjects with specific characteristics affecting the acceptance of IUD (Cu-T.200) as a spacing method.

7.3. VARIABLES

A variable is any phenomenon or characteristic or attitude under study[61]. Variables are the measurable characteristics of a concept consisting logical group of attitudes.

7.3.1. Independent or intervention variable

It is one where the investigator manipulates or introduces the situation[52]. The independent variable in this study is IUD (Cu-T 200).

7.3.2. Dependent variable

It is the outcome measure hypothesized to represent the effect of the intervention[52]. The dependent variable in the present study is factors affecting acceptance of IUD (Cu-T 200).

7.4.INCLUSION CRITERIA

Rural women who are

7.4.1. Pregnant

7.4.2. Conceived at least once and are in reproductive age

7.5. EXCLUSION CRITERIA

7.5.1. Couple who have undergone permanent family planning method

7.5.1. Couple with primary and secondary sterility

7.6.RESEARCH HYPOTHESIS

Hypothesis is a statement of the predicted relationships between the variables under study which one wishes to analyse (Notter, 1988)[52]. In view of establishing relationships between the variables under study, two research hypothesis were stated.

7.6.1. There is a relationship between the identified factors and acceptance of IUD among rural women.

7.6.2. There is a significant association between the identified factors and acceptance of IUD among rural women**.**

7.7. SETTING OF THE STUDY

The study was conducted at Hirebagewadi 'B' Sub-center, Belgaum District which is at a distance of 22 kms south of Belgaum.

7.7.1.POPULATION

The target population for the study were the rural married women residing in Hirebagewadi 'B' Sub-center aged between 15 to 45 years. Purposes of selecting this age group for the study were;

7.7.1.1.To know IUD being a simple and reliable method of spacing, why women are reluctant to use it.

7.7.1.2. To find out the level of knowledge and awareness of the rural women towards IUD.

7.7.1.3. To know what are the misconceptions and myths prevailing among the rural women regarding contraception in general and IUD in specific.

7.7.1.4. To know why majority of the women are adopting sterilization as a method of family planning after achieving the desired size of the family and not using any spacing method to space the pregnancies.

The total number of subjects included in this study were 300 rural women residing in the Hirebagewadi 'B' Sub-center selected through stratified random sampling method.

7.8. SAMPLE AND SAMPLING TECHNIQUE

Polit and Hungler (1995) states that the sample consists of subject population selected to participate in a research study[61]. Sampling refers to the process of selecting the samples for the study.

The sample for the present study consisted of 300 married rural women between the age group between 15-45 years.

As on 31st March 2003 the total population of Hirebagewadi PHC was 33,700 covering total 6 sub-centers out of which Hirebagewadi 'B' Sub-center was selected through lottery method for the study.

The information regarding the subjects were obtained from Junior health workers, leaders of MahilaArogyaSangh and Anganwadi workers with prior permission from the authorities of Taluka Health and Family Welfare Office, and local leaders of Hirebagewadi 'B'. Sub-center. The house to house survey was done to find out who could meet the required inclusion criteria.

7.9. METHOD OF DATA COLLECTION

A validated structured interview schedule was used to identify the factors affecting for acceptance of IUD. Since subjects were a combination of literate and illiterate, therefore the structured interview schedule was used as uniform method of data collection.

7.10. DESCRIPTION OF THE TOOL

Questionnaire was structured into two parts

7.10.1. Part I: Background data proforma

Comprises of socio-demographic information of the subjects

1) Age
2) Religion
3) Present obstetric status
4) Socio-economic status scale providing information regarding type of family, educational status of woman and her husband, occupational status of woman and her husband and monthly income of the family.

7.10.2. Part II – Factor questionnaire

Structured interview schedule was developed to find out the factors affecting the acceptance of IUD.

In the identified factors questionnaire, the questions were grouped under following headings.

		Number of questions
1)	Knowledge factor	17
2)	Physiological factor	9
3)	Psychological factor	10
4)	Socio-cultural factor	13
5)	Economical factor	15
	Total number of questions	54

The scoring pattern adopted was '1' mark for a correct and '0' for wrong answer.

Tick (✓) mark was put in the appropriate columns after receiving the answers from the respondents.

7.11. FACTOR SCORE

The factors score was categorized and arranged using the following formula i.e. mean x ± 1 standard deviation. These scores were arranged as follows.

1) If the score is less than mean x – 1 standard deviation: Poor
2) If the score is between mean x – 1 standard deviation to mean x + 1 standard deviation : Average
3) If the score is more than mean x + 1 standard deviation : Good

7.12. STATISTICAL TREATMENT APPLIED

7.12.1. Frequency and percentage were used to describe the data

7.12.2. Central tendency mean and standard deviation to assess the identified factors.

7.12.3. Chi square test was applied to determine the association between the socio-demographic data and the factors

7.12.4. CONCEPTUAL FRAMEWORK

Conceptual models are used to organize global ideas about individuals, groups and situations in a meaningful way to guide the thinking, observations and interpretations of people[61].

In the present study, the conceptual framework is based on the Rosenstock's Health Belief and Pender's Health Promotion Model (1997) [58].

The above models were developed to explain how some people take specific precautions to avoid complications and are directed towards increasing the level of well being while others fail to protect themselves[58].

With the help of the above models, the present framework was designed to find out the perceptions of the married rural women leading to nonacceptance of IUD and to suggest interventions that might reduce their

reluctance. In the study the framework depicts that there are three variables have been manifest into three phases. Those are individual perceptions, influencing factors and likelihood action.

***Ind*ividual perceptions:**

These are negative reactions perceived by the rural married women such as perceived susceptibility of pregnancy, contracting STDs, heavy bleeding, opposition from husband or family members or community, infertility and inability to carry out day to day activities and domestic work earning if they use IUD.

Influencing factors:

These are the following perceptions of rural married women influenced by negative reactions leading to misconception and myths towards use of IUD as a spacing method.

1) Knowledge factor
2) Physiological factor
3) Psychological factor
4) Socio-cultural factor
5) Economical factor

Table 1

Distribution of subjects according to socio-demographic variables

	Variable	Frequency (f)	Percentage (%) n=300
1	**Age (years)**		
	15-19 years	53	17.7
	20-24 years	164	54.7
	25 years and above	83	27.6
2	**Educational status of women**		
	Non formal education	53	17.8
	Primary education	115	38.3
	Secondary education	106	35.3
	Higher secondary and above	26	8.6
3	**Educational status of husbands**		
	Non formal education	63	21
	Primary education	72	24
	Secondary education	87	29
	Higher secondary and above	78	26
4	**Religion**		
	Hindu	254	84.7
	Muslim	46	15.3
	Christian	0	0
5	**Type of family**		
	Nuclear family	44	14.6
	Joint family	229	83.7
	Extended family	27	1.7
6	**Occupation of women**		
	House wife	266	88.7
	Labourer	30	10.1
	Professionals	4	1.3
7	**Occupation of husband**		
	Skilled	78	26
	Semiskilled	172	57.3
	Unskilled	50	16.7
8	**Monthly income of family (Rs.)**		
	Below 2000 Rs.	60	20
	2001-3000 Rs.	126	42
	3001-4000 Rs.	84	28
	4001 Rs. and above	30	10
9	**Present obstetric status**		
	Not pregnant	212	70.7
	Antenatal	68	22.7
	Postnatal	20	6.6

The data presented in table 1 reveals that majority of the women (54.7%) were in the age group of 20-24 yeas and only 17.7% were in the age group of 15-19 years, 38.3% of women had primary level of education, while 17.8% had no formal education. Majority (29%) of husbands had secondary level of education and only 10% had no formal education. Majority (84.7%) of women were Hindus and 15.3% were Muslims. Regarding the type of family, 83.7% of women were from joint family and 15.3% were from extended family. Majority (89.9%) of women were housewife, 57.3% of husbands were semiskilled workers. Most of the families (62%)

had income less than Rs. 3000 per month. Present obstetric status is concerned, 70.7% of women were not pregnant and 6.6% of women were postnatal during the study period.

Table 2:
Distribution of the factors expressed by the subjects or respondents

S. No.	Area	Total score	Frequency	%
1	Knowledge factor	17	1910	37.5
2	Physiological factor	9	711	29.63
3	Psychological factor	10	1247	41.57
4	Socio-cultural factor	13	2152	53.18
5	Economical factor	5	435	29

n=300

Table 2 depicts that economical factor (29%) and physiological factor (29.6%) have scored lowest as compared to the socio-cultural factor (53.18%). It also indicates that knowledge and psychology too are influencing factors for non acceptance of IUD since the score is 37.5% and 41.57 respectively

Table 3:
Association between the age of women and identified factors

Factors Age (yrs)	Knowledge			Physiological			Psychological			Socio-cultural			Economical		
	Poor	Ave	Good	Poor	Ave	Good	Poor	Ave	Good	Poor	Ave	Good	Poor	Ave	Good
15-19	26	20	7	34	17	2	13	34	6	17	27	9	16	18	9
20-24	53	81	30	65	58	41	53	73	38	35	102	27	61	49	54
25 above	23	40	20	24	39	20	22	35	26	16	53	14	13	34	36
Chi x^2	7.89			21.45			8.45			3.059			11.7		
DF	4			4			4			4			4		
P	P > 05**			P < 0.001*			P > 0.05**			P > 0.5**			P < 0.02*		

* Significant ** Not significant

Table 3 reveals that there is a statistically significant association between the age of the woman and physiological factor at $p < 0.001$ level of significance and economical factors at $p < 0.02$ level of significance.

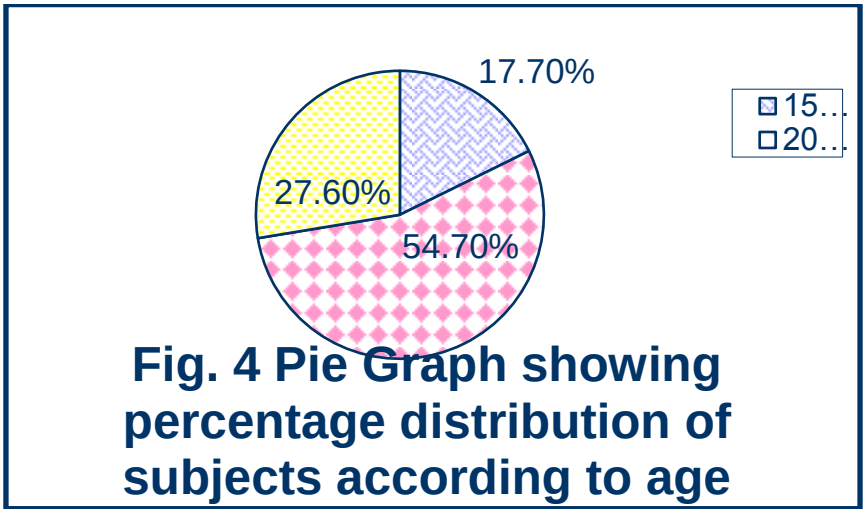

Fig. 4 Pie Graph showing percentage distribution of subjects according to age

Table 4:

Association between the educational status of women and identified factors

Factors W. Edu.	Knowledge			Physiological			Psychological			Socio-cultural			Economical		
	Poor	Ave	Good	Poor	Ave	Good	Poor	Ave	Good	Poor	Ave	Good	Poor	Ave	Good
Non formal	38	14	1	37	13	3	28	22	3	16	35	2	26	21	6
Primary	46	62	7	51	48	16	35	62	18	39	67	9	36	66	13
Secondary	12	54	40	34	45	37	15	49	42	9	67	30	29	64	13
Higher Secondary & above	1	9	16	2	7	17	0	7	19	2	14	0	2	16	8
Chi ^{2}	123.8			58.9			52.01			47			18.2		
DF	6			6			6			6			6		
P	P<.001*			P<.001*			P<.001*			P<.001*			P<.01*		

* Significant ** Not significant

Table 4 shows that there is a statistically significant association between the educational status of women and identified factors (knowledge, physiological, psychological, socio-cultural and economical) at $p < 0.001$ level of significance.

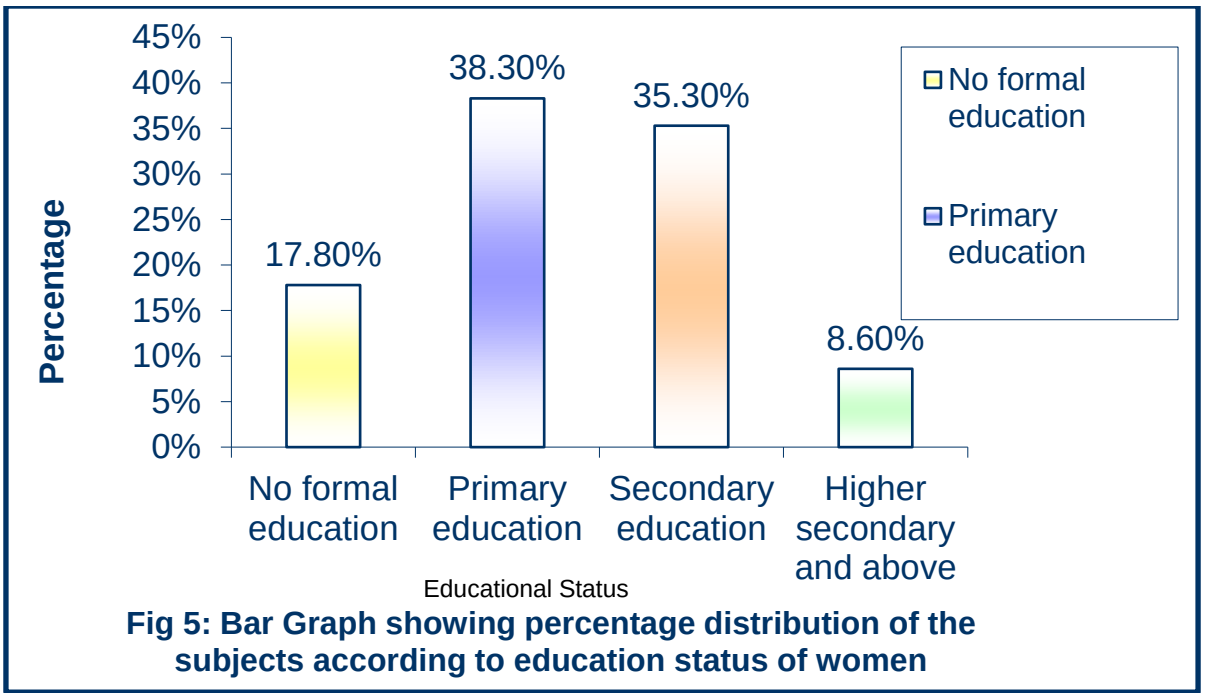

Fig 5: Bar Graph showing percentage distribution of the subjects according to education status of women

Table 5:

Association between the husband's education and identified factors

Factors H. Edu.	Knowledge			Physiological			Psychological			Socio-cultural			Economical		
	Poor	Ave	Good	Poor	Ave	Good	Poor	Ave	Good	Poor	Ave	Good	Poor	Ave	Good
Non formal	30	25	8	30	25	8	24	29	10	20	36	7	23	34	6
Primary	34	27	10	41	21	10	27	30	15	24	37	11	23	36	13
Secondary	22	49	16	35	40	12	19	48	20	16	61	10	27	49	11
Higher Secondary & above	7	25	16	15	20	13	6	27	15	5	32	11	13	24	6
Graduate	4	15	11	4	8	18	2	11	17	2	17	11	8	16	6

Chi ^{2}	32.57	45.3	33.6	27.2	5.23
DF	8	8	8	8	8
P	P<.001*	P<.001*	P<.001*	P<.001*	P> 0.05**

* Significant ** Non significant

Table 5 explains that there is a statistically significant association between the educational status of husbands and identified factors (knowledge, physiological, physiological and socio-cultural) at p< 0.001 level of significance.

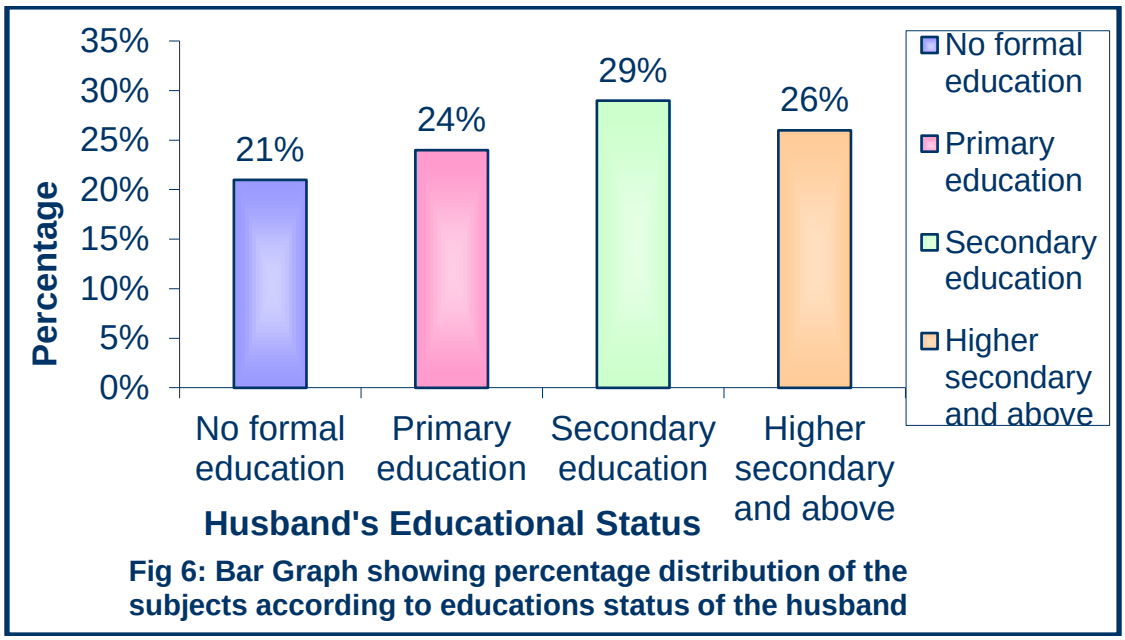

Fig 6: Bar Graph showing percentage distribution of the subjects according to educations status of the husband

Table 6:

Association between the religion and the identified factors

Factors / Religion	Knowledge			Physiological			Psychological			Socio-cultural			Economical		
	Poor	Ave	Good	Poor	Ave	Good	Poor	Ave	Good	Poor	Ave	Good	Poor	Ave	Good
Hindu	113	91	50	104	95	55	60	126	70	52	155	47	69	148	37
Muslim	20	20	6	22	19	5	19	21	6	14	29	3	24	17	5
Chi ^{2}	1.56			2.85			7.88			5.2			11.29		
DF	2			2			2			2			2		
P	P>0.01**			P>0.1**			P<0.02*			P<0.05*			P<0.005*		

* Significant ** Non significant

Table 6 expresses that there is a statistically significant association between the religion and psychological at p< 0.02, socio-cultural at p < 0.05 and economical factor at p < 0.05 level of significance.

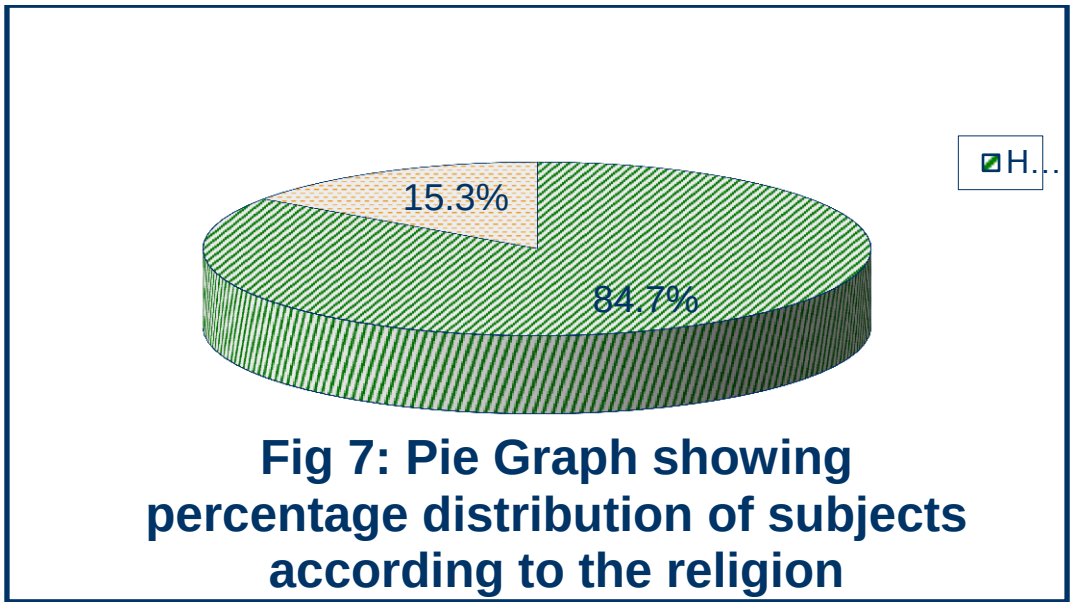

Fig 7: Pie Graph showing percentage distribution of subjects according to the religion

Table 7:

Association between the type of family and identified factors

Factors	Knowledge			Physiological			Psychological			Socio-cultural			Economical		
Type of family	Poor	Ave	Good	Poor	Ave	Good	Poor	Ave	Good	Poor	Ave	Good	Poor	Ave	Good
Nuclear Family	18	14	12	17	19	8	5	26	13	11	26	7	13	24	7
Joint family	74	119	36	98	84	47	74	98	57	51	140	38	72	123	34
Extended family	10	12	5	11	11	5	9	11	7	6	16	5	7	17	3
Chi ^{2}	6.88			0.77			8.27			0.244			1.16		
DF	4			4			4			4			4		
P	P>0.1**			P>0.8**			P>0.05**			P>0.8**			P>0.05**		

* Significant ** Non significant

Table 7 depicts that there is a statistically non significant association between the type of family and identified factors (knowledge, physiological, psychological, socio-cultural and economical) at $p > 0.01$, $p > 0.8$, $p > 0.05$, $p > 0.8$ and $p > 0.5$ level of significance respectively.

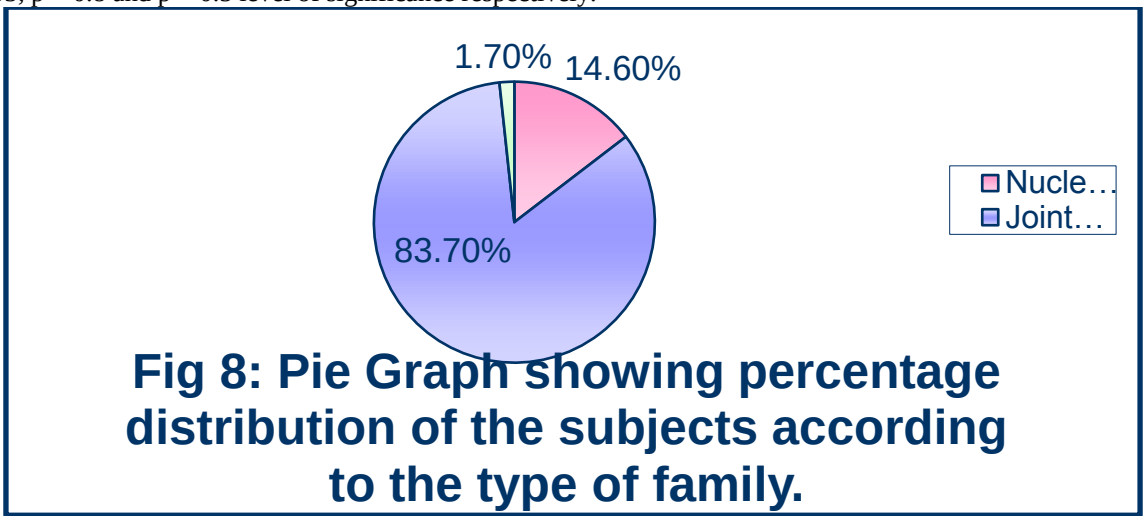

Fig 8: Pie Graph showing percentage distribution of the subjects according to the type of family.

Table 8:
Association between the occupation of women and identified factors

Factors	Knowledge			Physiological			Psychological			Socio-cultural			Economical		
Occupation	Poor	Ave	Good	Poor	Ave	Good	Poor	Ave	Good	Poor	Ave	Good	Poor	Ave	Good
House wife	54	160	52	107	98	61	73	126	67	58	164	44	80	144	37
Labourer	13	8	5	17	8	5	12	11	7	12	14	4	14	13	3
Chi ^{2}	20.06			20.96			2.9			4.96			3.5		
DF	2			2			2			2			2		
P	P<0.001*			P<0.01*			P>.1*			P>0.05**			P>0.1**		

* Significant ** Not significant

Table 8 represents that there is a statistically significant association between the occupation of women and knowledge at $p < 0.001$ and physiological factors at $p < 0.01$ level of significance respectively.

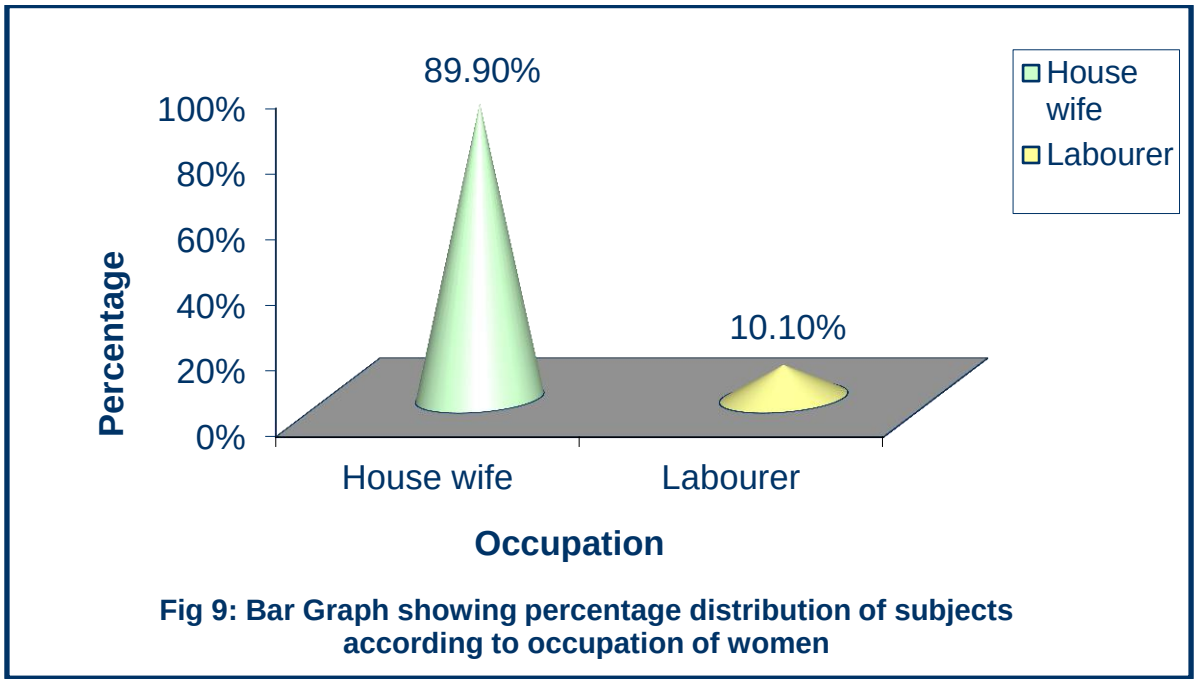

Fig 9: Bar Graph showing percentage distribution of subjects according to occupation of women

Table 9:
Association between the occupation of the husband and identified factors

Factors	Knowledge			Physiological			Psychological			Socio-cultural			Economical		
Occupation	Poor	Ave	Good	Poor	Ave	Good	Poor	Ave	Good	Poor	Ave	Good	Poor	Ave	Good
Skilled	20	35	23	24	24	25	14	38	26	17	34	27	25	38	15
Semiskilled	49	87	36	70	67	35	35	90	47	29	112	31	48	100	24
Unskilled	31	18	1	26	23	1	24	22	4	22	26	2	20	27	3
Chi ^{2}	28.18			16.75			22.5			32.34			6.54		
DF	4			4			4			4			4		
P	P<0.001*			P<0.005*			P<.001*			P<0.001*			P>0.1**		

* Significant ** Not significant

Table 9 explains that there is a statistically significant association between the occupation of the husband and identified factors (knowledge, physiological, psychological and socio-cultural) at $p < 0.001$ level of significance.

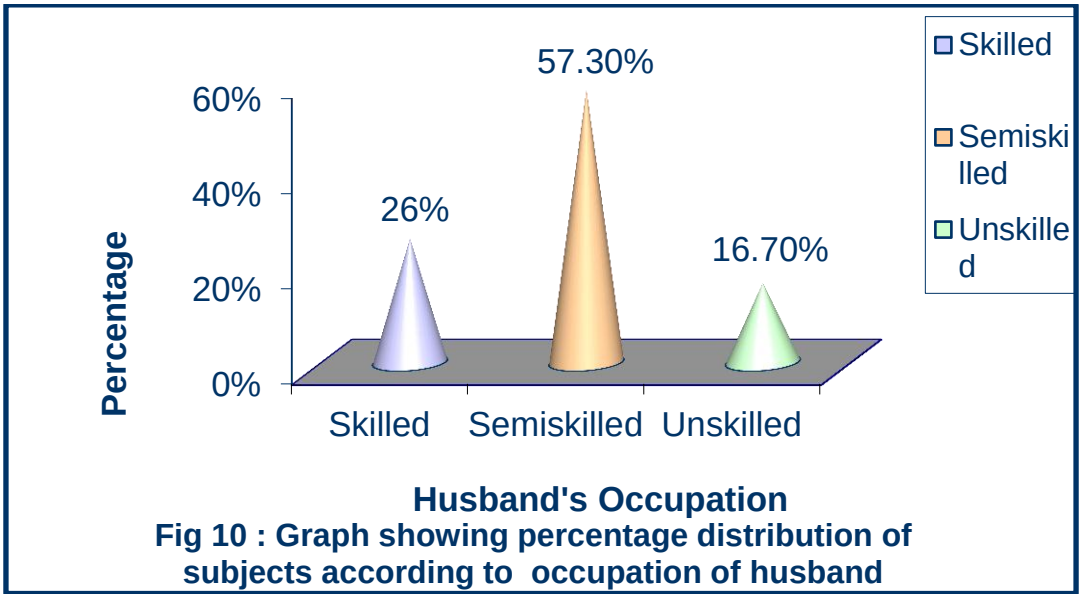

Fig 10 : Graph showing percentage distribution of subjects according to occupation of husband

Table 10:

Association between the monthly income of the family and identified factors

Factors	Knowledge			Physiological			Psychological			Socio-cultural			Economical		
Income	Poor	Ave	Good	Poor	Ave	Good	Poor	Ave	Good	Poor	Ave	Good	Poor	Ave	Good
Below 2000	37	16	7	35	21	4	29	24	7	30	25	5	35	19	6
2001-3000	32	67	27	46	54	26	27	67	32	22	90	14	34	72	20
3001-4000	21	46	17	34	28	22	19	41	24	13	50	21	15	53	16
4001& above	6	13	11	9	12	9	4	13	13	5	16	9	7	21	2
Chi ^{2}	32.35			15.6			26.4			4.2			33.5		
DF	6			6			6			6			6		
P	P<0.001*			P<0.02*			P<.001*			P<0.001*			P<0.001*		

* Significant ** Not significant

Table 10 expresses that there is a statistically significant association between the monthly income of the family and identified factors (knowledge, physiological, psychological, socio-cultural and economical) at $p < 0.001$ level of significance.

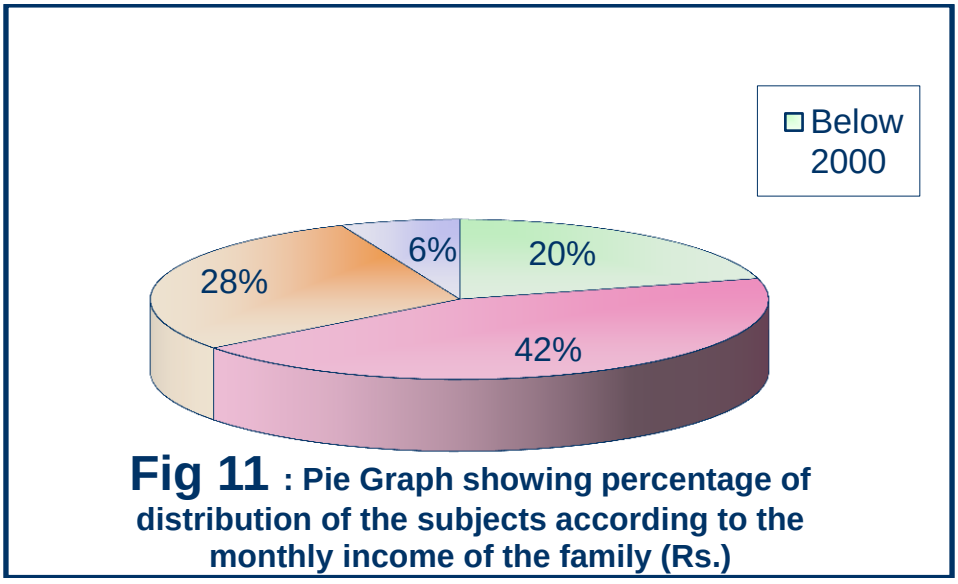

Fig 11 : Pie Graph showing percentage of distribution of the subjects according to the monthly income of the family (Rs.)

III. Conclusions

Based on the findings of the study, the following conclusions were drawn.

- Overall the knowledge of the women on contraception was average.
- Misconceptions and myths in the form of physiological, psychological and socio-cultural factors had direct influence on the non acceptance of IUD.
- Economical factor was also indirectly affecting the acceptance of IUD.
- There was a statistical significant association between the factors (knowledge, physiological, psychological, socio-cultural and economical) and socio-demographic variables such as age of women, educational status of women and their husbands, the religion, nature of family, occupational status of both women and their husbands and monthly income of the family.

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