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# Rural, Tribal, Young Women's Plans of Post-Partum Contraception, Preconception and During Pregnancy- A Community Based Study in Hilly Forestry Region with Extreme Poverty

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## Abstract

***Background:** Globally low and inconsistent use of contraceptives contribute to many unintended pregnancies. Despite its positive impact in reducing maternal child mortality and morbidity, utilization of contraceptives is very low in many developing countries. Potential of planning family, preconception and during pregnancy has not been researched well. Studies of women's intentions of planning family, preconception, during pregnancy are not many.*

***Objective:** Community based study was carried out to know rural tribal women's plans preconception and during pregnancy about contraceptive use after birth.*

***Material Methods:** Study was conducted in tribal communities of 100 villages. In these 100 villages community based mother and child care activities were initiated after having developed health facility for 24 hrs 7 days services in one of these 100 villages. Information about women's plans of contraceptive use after child birth was collected from preconception women and pregnant women. All the women were interviewed in villages. A total of 2400 nonpregnant and 1040 pregnant women of 15-45 years were study subjects.*

***Results:** Overall 1907 (79.45%) of 2400 women wanted to use some contraception, after their next birth. Around (20%) did not. Out of 1907 also 541 (28.36%) said use of contraceptive was to be decided by their husbands. Among 1040 pregnant women 216 (20.8%) said they wanted to use but were undecided about type and additional 606 (58.3%) said they would use the contraceptive of their husbands choice and 118 (20.6%) had no plans.*

***Conclusion:** Quite a few women had no plans of contraceptive use neither preconception nor during pregnancy. Many said their husbands will decide. A lot of awareness is needed and empowerment to help them decide for themselves.*

**Keywords:** *Preconception, During Pregnancy, Awareness, Plans of Contraception.*

## Background

The World Health Organization (WHO)[1] reported that an estimated 94 per cent of the population of the world lived in countries with policies that favored family planning, still five of every six couples of reproductive age did not use adequate measures for preventing birth. Despite its positive impact in reducing maternal and child mortality and morbidity, the utilization of contraceptives is very low in many developing countries. Millions of women worldwide are sexually active, do not want to become pregnant either for the time being or never, but are not using any

contraceptive. Gafar et al[2] reported that although the numbers of those using contraceptives has increased, determinants of contraceptive use among married women in many countries remained illusive. Globally low and inconsistent use of contraceptives by young people contributed to many unintended pregnancies. However providing quality contraceptives, to sexually active young people also continues to be a global concern. The Govt. of India launched an official Family Planning Program in 1952 and spent a huge amount of resources during the last seven decades but the program failed to achieve desired results[3]. The potential of planning contraception preconception and during pregnancy has not been researched well. Ali et al[4] reported that globally 214 million women of reproductive age in developing regions have unmet needs of modern contraceptives.

## Objective

Community based study was carried out to know rural, tribal women's plans preconception and during pregnancy about contraception after birth.

## Material and Methods

Study was conducted in tribal communities of 100 villages of hilly, forestry Melghat region of Amravati Maharashtra, India after institute's ethics committee's approval. These villages were around the village where 24 hrs 7 days services were started as a concept of social accountability. After creating health facility, community based services for mother and child care were initiated in 100 villages around. So it was decided to find out about contraception plans of women in these villages. After consent information was collected either at their residence or mother child care centers. Information included awareness regarding contraceptives and plans of using contraceptives. Women of reproductive age with chances of pregnancy were randomly included, minimum 20 from each village and pregnant women were randomly included in the study, 10 minimum in each village to get information about their plans of contraceptive use. Interviews included awareness and plans of contraception after childbirth. Information was collected by research assistant with five days in a week visits to villages. Predesigned and pretested tool was used with some questions having yes or no answers and others open ended. A total of 2400 women of 15-45 years preconception and 1040 pregnant women were the study subjects.

## Results

Overall 1907 (79.4%) of 2400 women wanted to use some contraceptive, 20.6% had no plans. Of those who wanted also 541 (28.36%) said it was going to be decided by their husbands, 258 (31.16%) of 828 women of 20-24 year age said so. Overall 241 (28.3%) out of 850 with primary education and 189 out of 864 (21.88%) of low economic class said they will like to use oral contraceptive pills (OCP). A total of 187 of 953 (19.6%) illiterate women said they wanted their husbands to use condom. (Table I)

Among 1040 pregnant women, 145 (13.9%) said they wanted their husbands to use condom, 9 (0.9%) said they will use intrauterine contraceptive device (IUCD), 24 (2.3%) said injectable contraception, 15 (1.4%) OCP, 25 (2.4%) said they will have sterilization. However 216 (20.8%) women said they wanted to use some contraceptives but were undecided and 606 (58.3%) said they would use the contraceptive of their husband's choice.

Overall 206 out of 358 (57.1%) with secondary education said they will use contraceptive of their husbands choice, while 76 (12.3%) of 618 belonging to lower economic class said they wanted their husbands to use condom, 11of 43 (25.6%) postgraduate studied said sterilization. Among 618 lower economic class women 19 (3.1%) said they will like to use injectable contraceptives and 8 (1.3%) sterilization. None in upper class said they will use any contraceptives. Three out of 40 laborers (7.5%) said OCPs, 192 (20.4%) of 943 housewives wanted husbands to use condom. Women with single live births preferred injectables and those with many babies said OCP's. (Table I, II)

## Discussion

The perception of women regarding use of contraceptives as well as the extent to which planning family is adopted by people need to be assessed for population control. Various studies have shown that other than physical access to services various social factors were responsible for preventing the women from using different modes of planning family[5-7]. In the present study among 2400 preconception study subjects, 321 (13.38%) said they wanted their husbands to use condoms, only 99 (4.13%) said they will use

IUCD, 111 (4.63%) said injectable contraceptives, 411 (17.13%) said OCPs and 157 (6.54%) said they will have sterilization. However 267 (11.13%) said they wanted to use contraception but were undecided about the type of contraceptive. Additional 541 (28.36%) said they would use contraceptives of their husbands choice and also 493 (20.54%) had no concrete plans for post birth contraception. So overall 1301 (54.20%) out of 2400 preconception study subjects had no plans of use of contraception. All 1040 pregnant women asked about post-partum contraception, all said they will use contraceptives. However 16 (1.5%) said they wanted their husbands to use condom, 31 (3.0%) said IUCD. 27 (2.6%) said injectable contraceptives and 34 (3.3%) said OCP, 34 (3.3%) said they will have sterilization. However 554 (53.3%) said they wanted to use contraception but were undecided on the type of contraception and 344 (33.1%) more said they would use the contraceptive of their husband's choice. So though they said they would use contraception but 86% pregnant women had no concrete plans for contraception after birth.

Prusty[8] reported that knowledge and use of temporary contraceptive methods were considerably lower among tribal women compared to their non-tribal counterparts. Low acceptance due to phobia of adverse health consequences, accessibility to and lack of sound knowledge of contraception were the leading reasons for not using contraceptives. The unmet need for planning family among them was quite high. Researchers suggested educating women and their husbands about use and benefits of modern contraceptives to solve the problems of high unmet need for planning family among these tribal women. A simultaneous attention to the health systems strengthening component is crucial for ensuring sustained delivery of good-quality contraception supply system. Mozumdar et al[9] did a study and reported that women's choice of contraceptive could be improved in rural India if providers gave appropriate information prior to and during the acceptance of a method and if facilities were equipped to provide a range of choice of contraceptives. Das et al[10] and Hailu et al[11] also reported very high prevalence of unmet need of family planning among tribal population. Age of mother, occupational status of mother, number of children and knowledge of mother about modern contraceptives were the independent predicators for unmet need of modern contraception. Sharma et al[7] reported that the knowledge of contraceptives was almost universal and most of the tribal women were aware of at least one modern method, however only 42% were users of family planning, 32.7% had female sterilization and 1.8% male sterilization. So 82% current users in tribal population were sterilization users only. Bi-variate results showed that use of sterilization increased with age of women, marital duration, female literacy, and number of surviving male children. Minhas et al[11] reported that their study revealed that the most common method of contraception practiced in the study population was tubectomy. A range of psychosocial factors played major role in decision making. Chakraborty et al[12] reported that social factors like age, educational status of women and their husbands, socioeconomic status, age at marriage and age at first pregnancy were important determinants. Das et al[13] using NFHS IV (2015-16) data published by Ministry of Health and family Welfare (MoHFW) India also reported that the use of modern contraceptives had association with place of residence, age, education, wealth index among the young couples of both tribal and non-tribal married women. In a study Chhabra[14] reported many young couples at risk of pregnancy did not use any contraceptive with not much of difference between rural and urban women. Though illiterate women did not use any contraception, nor their husbands used condom, very few primary school educated had used IUCD. There was no difference in the use of contraceptives in high secondary school or graduate women. Aliyu et al[15] and Chipeta et al[16] reported that contraception use among study participants was low despite good knowledge of modern contraception. because considerable misinformation prevailed regarding contraceptive methods' side effects. Preconception and during pregnancy plans need to be made as the availability and quality of permanent village-based government health care also affected the use of modern contraception. Yitayal et al[17] did a cross-sectional community-based survey in Ethiopia and reported that the health extension programs when implemented fully could increase the utilization of contraceptives in the rural community and improved family planning. Sebastian et al[18] did evaluation about behavior change, communication, intervention integrated into the existing government programs to

increase knowledge use of the lactational amenorrhea and postpartum contraception through counseling by community workers and reported targeted behavior communication were effective and feasible strategies for promoting postpartum contraception during pregnancy. Daniel et al[19] assessed contraceptive demand and use, and related attitudes and knowledge and reported culturally appropriate, community based communication programs that targeted youth and those who influenced their decisions created demand for contraception among young couples and lead to increased contraceptive use. In the community-based cross-sectional study by Dingeta et al[20] conducted among young married women (14–24 years of age) in Eastern Ethiopia one-third of married young women had unmet needs for contraception. It was reported that more efforts to empower women to make decisions that affected their own life and providing appropriate family planning information were necessary to reduce the burden of unmet needs among young married women. In the present study preconception or during pregnancy most women were undecided and most said husbands were to decide. In patriarchal societies gender inequalities continue and men played a critical role in the decisions on family matters. Minhas[11] and Akhtar et al[21] reported that only 52.8% interviewed women knew importance of using contraceptives. Gafar et al[2] did a study in Indonesia and reported that women's age, the number of living children, education, wealth index, and access to information influenced contraceptive use among these women. Reversible contraception are promising method to reduce adolescent pregnancy because of their high efficacy rates. Otieno et al[22] reported that change in fertility rate across societies is a complex process that involves changes in the demand for children, attitude about family planning and greater accessibility to contraception. The improvement of service delivery in general precisely touching on the availability and the uptake of quality birth control technologies was one of the most feasible means through which countries can fast track their fertility transitions. Mason et al[23] suggested that educating women and couples about the dangers of short birth intervals and promoting and providing contraceptives can reduce rapid, successive pregnancies. It is essential women plan before pregnancy and during pregnancy for appropriate contraception. Klerman[24] reported that family planning services must include counselling, which provided an opportunity to discuss the advantages of planning preconception and during pregnancy. So intervention measures including Information Education Communication (IEC) and Behaviour Change Communication (BCC) activities were needed to be implemented. Chacko[25] also reported that the availability and quality of permanent village-based government health care affected the use of modern contraception. The use of temporary family planning methods was negligible. Biggs et al[26] did a study to understand women's experiences accessing emergency contraception (EC) services and the extent to which providers supported women's autonomous contraceptive decision making was limited and found that young women seeking EC appreciated learning about other contraceptive methods, but did not want to get pressured to adopt a method in addition to EC. Findings highlighted the importance of respecting young women's contraceptive decisions for building and maintaining provider's trust and suggested that contraceptive counseling approaches that prioritize specific methods may reduce some young women's trust in providers and use of reproductive health services. Kaller et al[27] reported that women have varied and well-considered reasons for choosing each EC method.

Casey et al[28] did a study to analyze contraceptive use among sexually active young women aged 15–24 in the health zones served by the partners' programs and reported that meaningful engagement of adolescent and young women contributed to better outcomes. Creating an enabling environment by addressing gender and social norms, however, was key to meeting the demand for contraception and this must start preconception.

Makola et al[29] reported that a considerable number of adolescent girls and young women still face challenges in using contraception. The results also suggested that family planning interventions should target those who had not given birth in order to reduce unplanned and or unintended pregnancies and associated risk factors preconception the best.

Thulaseedharan[30] reported that as in other states of India, female sterilization was the most widely used contraceptive method even in Kerala where women have higher levels of education compared to most other

states in India with the unique preference for female sterilization when the family size was complete. But higher education delayed sterilization in young women due to delayed marriage and childbirth. Women empowerment, proper information and assuring availability and accessibility to different methods can gradually change the dominant preference for female-oriented permanent method of contraception.

Tran et al[31] did a study and reported that the intervention package did not have a significant effect on the overall use of effective modern contraceptives but significantly increased implant use in women post-partum who lived in urban settings upto a year after childbirth.

Leon et al[32] did a study reported that because of their high effectiveness, convenience, and ease of continuation, availability of LARC should be expanded and their use promoted, including among young and nulliparous women. In the present study quite a few talked about injectables. Tran et al[33] reported that postpartum family planning (PPFP) information and services can prevent maternal and child morbidity and mortality in low-resource countries, where high unmet need for PPFP remains despite opportunities offered by routine postnatal care visits, reported that the primary outcome is modern contraceptive method uptake at twelve months postpartum.

Wu M et al[34] did a study about association between study to evaluate the rates of short interpregnancy interval pregnancies and deliveries among women who receive immediate postpartum long-acting reversible contraception. Study confirms that women who received immediate postpartum Intra Uterine Device and implants have lower rates of short interpregnancy interval pregnancies. Implications making immediate postpartum LARC widely available is a promising public health approach to health women achieve a longer interpregnancy interval.

## CONCLUSION

Quite a few women had no plans of contraceptive use. Many said their husbands will decide. A lot of awareness is needed and empowerment to help them decide for themselves.

**TableI.** *Preconception Contraceptive Plans*

| Variable Age | Total | Yes | | | | | | | | | | | | | | No | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Condom | % | IUCD | % | Injectable contraception | % | Oral contraception | % | Sterilization | % | Don't know | % | Husband will decide | % | No | % |
| **15-19** | 336 | 11 | 3.27 | 0 | 0 | 26 | 7.74 | 35 | 10.4 | 24 | 7.14 | 28 | 8.33 | 89 | 26.4 | 123 | 36.6 |
| **20-24** | 828 | 67 | 8.09 | 25 | 3.02 | 4 | 0.48 | 172 | 20.7 | 56 | 6.76 | 91 | 10.9 | 258 | 31.1 | 155 | 18.7 |
| **25-29** | 736 | 52 | 7.07 | 63 | 8.56 | 45 | 6.11 | 179 | 24.3 | 56 | 7.61 | 78 | 10.6 | 105 | 14.2 | 158 | 21.4 |
| **30-34** | 333 | 164 | 49.2 | 11 | 3.30 | 20 | 6.01 | 12 | 3.60 | 7 | 2.10 | 41 | 12.3 | 61 | 18.3 | 17 | 5.11 |
| **35-39** | 93 | 15 | 16.1 | 0 | 0.00 | 11 | 11.8 | 6 | 6.45 | 5 | 5.38 | 18 | 19.3 | 20 | 21.5 | 18 | 19.3 |
| **40-45** | 74 | 12 | 16.2 | 0 | 0.00 | 5 | 6.76 | 7 | 9.46 | 9 | 12.1 | 11 | 14.8 | 8 | 10.8 | 22 | 29.7 |
| **Total** | **2400** | **321** | **16.3** | **99** | **5.19** | **111** | **5.82** | **411** | **21.5** | **157** | **8.23** | **267** | **14.0** | **541** | **28.3** | **493** | **20.5** |
| **Education** | | | | | | | | | | | | | | | | | |
| **Illiterate** | 953 | 187 | 19.6 | 32 | 3.36 | 35 | 3.67 | 103 | 10.8 | 65 | 6.82 | 104 | 10.9 | 178 | 18.6 | 249 | 26.1 |
| **Primary** | 850 | 72 | 8.5 | 54 | 6.35 | 30 | 3.53 | 245 | 28.8 | 39 | 4.59 | 99 | 11.6 | 241 | 28.3 | 70 | 8.24 |
| **Secondary** | 506 | 58 | 11.5 | 13 | 2.57 | 35 | 6.92 | 58 | 11.4 | 38 | 7.51 | 48 | 9.49 | 94 | 18.5 | 162 | 32.0 |
| **Higher Secondary** | 91 | 4 | 4.4 | 0 | 0.00 | 11 | 12.0 | 5 | 5.49 | 15 | 16.48 | 16 | 17.5 | 28 | 30.7 | 12 | 13.1 |
| **Graduate Postgraduate** | 0 | 0 | 0.0 | 0 | 0.00 | 0 | 0.00 | 0 | 0.00 | 0 | 0.00 | 0 | 0.00 | 0 | 0.00 | 0 | 0.00 |
| **Total** | **2400** | **321** | **16.3** | **99** | **5.19** | **111** | **5.82** | **411** | **21.5** | **157** | **8.23** | **267** | **14.0** | **541** | **28.3** | **493** | **20.5** |
| **Profession** | | | | | | | | | | | | | | | | | |
| **Housewife** | 275 | 24 | 8.73 | 20 | 7.27 | 12 | 4.36 | 75 | 27.2 | 21 | 7.64 | 15 | 5.45 | 62 | 22.5 | 46 | 16.7 |
| **Laborer** | 958 | 78 | 8.14 | 44 | 4.59 | 31 | 3.24 | 174 | 18.1 | 66 | 6.89 | 119 | 12.4 | 250 | 26.1 | 196 | 20.4 |

| | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Own Farm Laborer** | 468 | 74 | 15.8 | 15 | 3.21 | 32 | 6.84 | 100 | 21.3 | 21 | 4.49 | 20 | 4.27 | 100 | 21.3 | 106 | 22.6 |
| **Work Away Form Our Village** | 699 | 145 | 20.7 | 20 | 2.86 | 36 | 5.15 | 62 | 8.87 | 49 | 7.01 | 113 | 16.1 | 129 | 18.4 | 145 | 20.7 |
| **Total** | **2400** | **321** | **16.3** | **99** | **5.19** | **111** | **5.82** | **411** | **21.5** | **157** | **8.23** | **267** | **14.0** | **541** | **28.3** | **493** | **20.5** |
| **Economics** | | | | | | | | | | | | | | | | | |
| **Upper** | 147 | 24 | 16.3 | 10 | 6.80 | 8 | 5.44 | 13 | 8.84 | 21 | 14.2 | 20 | 13.6 | 39 | 26.5 | 12 | 8.16 |
| **upper middle** | 183 | 13 | 7.10 | 39 | 21.3 | 12 | 6.56 | 6 | 3.28 | 9 | 4.92 | 17 | 9.29 | 72 | 39.3 | 15 | 8.20 |
| **Middle** | 544 | 44 | 8.09 | 16 | 2.94 | 28 | 5.15 | 123 | 22.6 | 33 | 6.07 | 99 | 18.2 | 59 | 10.8 | 142 | 26.1 |
| **Upper lower** | 662 | 91 | 13.7 | 18 | 2.72 | 37 | 5.59 | 80 | 12.0 | 52 | 7.85 | 78 | 11.7 | 172 | 25.9 | 134 | 20.2 |
| **Lower** | 864 | 149 | 17.2 | 16 | 1.85 | 26 | 3.01 | 189 | 21.8 | 42 | 4.86 | 53 | 6.13 | 199 | 23.0 | 190 | 21.9 |
| **Total** | **2400** | **321** | **16.3** | **99** | **5.19** | **111** | **5.82** | **411** | **21.5** | **157** | **8.23** | **267** | **14.0** | **541** | **28.3** | **493** | **20.5** |
| **Parity** | | | | | | | | | | | | | | | | | |
| **P0** | 105 | 8 | 7.62 | 0 | 0.00 | 4 | 3.81 | 3 | 2.86 | 0 | 0.0 | 4 | 3.81 | 5 | 4.76 | 81 | 77.1 |
| **P1** | 411 | 47 | 11.4 | 38 | 9.25 | 24 | 5.84 | 110 | 26.7 | 40 | 9.73 | 30 | 7.30 | 84 | 20.4 | 38 | 9.25 |
| **P2** | 672 | 136 | 20.2 | 13 | 1.93 | 14 | 2.08 | 115 | 17.11 | 17 | 2.53 | 87 | 12.9 | 190 | 28.2 | 100 | 14.8 |
| **P3** | 453 | 27 | 5.96 | 26 | 5.74 | 23 | 5.08 | 52 | 11.4 | 54 | 11.9 | 58 | 12.8 | 167 | 36.8 | 46 | 10.1 |
| **P4** | 250 | 67 | 26.8 | 6 | 2.40 | 16 | 6.40 | 40 | 16.0 | 8 | 3.20 | 29 | 11.6 | 26 | 10.4 | 58 | 23.2 |
| **P5 Above** | 509 | 36 | 7.07 | 16 | 3.14 | 30 | 5.89 | 91 | 17.8 | 38 | 7.47 | 59 | 11.5 | 69 | 13.5 | 170 | 33.4 |
| **Total** | **2400** | **321** | **16.3** | **99** | **5.19** | **111** | **5.82** | **411** | **21.5** | **157** | **8.23** | **267** | **14.0** | **541** | **28.3** | **493** | **20.5** |

**TableII.** *Pregnant Women's Plans of Contraceptive Use After Childbirth*

| **Variables** | **Total** | **Contraceptive after birth** | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **AGE** | | **Condom** | **%** | **IUCD** | **%** | **Injectable contraception** | **%** | **Oral contraception** | **%** | **Sterilization** | **%** | **Don't know** | **%** | **Husband will decide** | **%** |
| 15 to 19 | 323 | 38 | 11.8 | 0 | 0 | 8 | 2.5 | 0 | 0 | 0 | 0 | 43 | 13.3 | 234 | 72.4 |
| 20 to 24 | 536 | 88 | 16.4 | 8 | 1.5 | 12 | 2.2 | 11 | 2.1 | 11 | 2.1 | 148 | 27.6 | 258 | 48.1 |
| 25 to 29 | 109 | 16 | 14.7 | 0 | 0.0 | 2 | 1.8 | 3 | 2.8 | 2 | 1.8 | 18 | 16.5 | 68 | 62.4 |
| 30 to 34 | 68 | 3 | 4.4 | 1 | 1.5 | 2 | 2.9 | 1 | 1.5 | 11 | 16.2 | 6 | 8.8 | 44 | 64.7 |
| 35 to 39 | 4 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 1 | 25.0 | 1 | 25.0 | 2 | 50.0 |
| TOTAL | **1040** | **145** | **13.9** | **9** | **0.9** | **24** | **2.3** | **15** | **1.4** | **25** | **2.4** | **216** | **20.8** | **606** | **58.3** |
| **EDUCATION** | | | | | | | | | | | | | | | |
| ILLITERATE | 56 | 0 | 0.0 | 0 | 0.0 | 2 | 3.6 | 0 | 0.0 | 0 | 0.0 | 8 | 14.3 | 46 | 82.1 |
| PRIMARY | 321 | 42 | 13.1 | 3 | 0.9 | 21 | 6.5 | 5 | 1.6 | 3 | 0.9 | 68 | 21.2 | 179 | 55.8 |
| SECONDARY | 358 | 69 | 19.3 | 3 | 0.8 | 0 | 0.0 | 9 | 2.5 | 0 | 0.0 | 71 | 19.8 | 206 | 57.5 |
| HIGHER SECONDARY | 196 | 41 | 20.9 | 2 | 1.0 | 0 | 0.0 | 0 | 0.0 | 3 | 1.5 | 2 | 1.0 | 148 | 75.5 |
| GRADUCATE | 66 | 30 | 45.5 | 0 | 0.0 | 1 | 1.5 | 0 | 0.0 | 8 | 12.1 | 8 | 12.1 | 19 | 28.8 |
| POST GRADUCATE | 43 | 23 | 53.5 | 1 | 2.3 | 0 | 0.0 | 1 | 2.3 | 11 | 25.6 | 5 | 11.6 | 2 | 4.7 |
| TOTAL | **1040** | **205** | **19.7** | **9** | **0.9** | **24** | **2.3** | **15** | **1.4** | **25** | **2.4** | **162** | **15.6** | **600** | **57.7** |
| **ECONOMIC STATUD** | | | | | | | | | | | | | | | |
| UPPER | 43 | 35 | 81.4 | 2 | 4.7 | 0 | 0.0 | 2 | 4.7 | 0 | 0.0 | 1 | 2.3 | 3 | 7.0 |
| UPPER MIDDLE | 51 | 21 | 41.2 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 11 | 21.6 | 5 | 9.8 | 14 | 27.5 |
| UPPER LOWER | 142 | 49 | 34.5 | 0 | 0.0 | 1 | 0.7 | 1 | 0.7 | 4 | 2.8 | 37 | 26.1 | 50 | 35.2 |
| LOWER MIDDLE | 186 | 24 | 12.9 | 2 | 1.1 | 4 | 2.2 | 4 | 2.2 | 2 | 1.1 | 41 | 22.0 | 109 | 58.6 |
| LOWER | 618 | 76 | 12.3 | 5 | 0.8 | 19 | 3.1 | 8 | 1.3 | 8 | 1.3 | 168 | 27.2 | 334 | 54.0 |
| TOTAL | **1040** | **205** | **19.7** | **9** | **0.9** | **24** | **2.3** | **15** | **1.4** | **25** | **2.4** | **252** | **24.2** | **510** | **49.0** |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **PROFESSION** | | | | | | | | | | | | | | | |
| HOUSEWIFE | 943 | 192 | 20.4 | 8 | 0.8 | 23 | 2.4 | 3 | 0.3 | 29 | 3.1 | 212 | 22.5 | 476 | 50.5 |
| OWNFARM LABOUR | 53 | 11 | 20.8 | 1 | 1.9 | 0 | 0.0 | 9 | 17.0 | 6 | 11.3 | 7 | 13.2 | 19 | 35.8 |
| LABOURER | 40 | 2 | 5.0 | 0 | 0.0 | 1 | 2.5 | 3 | 7.5 | 0 | 0.0 | 21 | 52.5 | 13 | 32.5 |
| OTHERWORK | 4 | 0 | 0.0 | 1 | 25.0 | 0 | 0.0 | 1 | 25.0 | 0 | 0.0 | 0 | 0.0 | 2 | 50.0 |
| TOTAL | **1040** | **205** | **19.7** | **10** | **1.0** | **24** | **2.3** | **16** | **1.5** | **35** | **3.4** | **240** | **23.1** | **510** | **49.0** |
| **PARITY** | | | | | | | | | | | | | | | |
| P.1 | 117 | 0 | 0.0 | 0 | 0.0 | 5 | 4.3 | 0 | 0.0 | 0 | 0.0 | 91 | 77.8 | 21 | 17.9 |
| P.2 | 103 | 5 | 4.9 | 11 | 10.7 | 7 | 6.8 | 0 | 0.0 | 0 | 0.0 | 23 | 22.3 | 57 | 55.3 |
| P.3 | 155 | 0 | 0.0 | 6 | 3.9 | 9 | 5.8 | 18 | 11.6 | 21 | 13.5 | 79 | 51.0 | 22 | 14.2 |
| P.4 | 204 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 106 | 52.0 | 98 | 48.0 |
| P.5 Above | 461 | 11 | 2.4 | 14 | 3.0 | 6 | 1.3 | 16 | 3.5 | 13 | 2.8 | 255 | 55.3 | 146 | 31.7 |
| **TOTAL** | **1040** | **16** | **1.5** | **31** | **3.0** | **27** | **2.6** | **34** | **3.3** | **34** | **3.3** | **554** | **53.3** | **344** | **33.1** |

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