M. M. Gandotra

Mass Vasectomy Camp—An Evaluation

Introduction

THE official Family Planning Programme in India laid emphasis on the 'Clini-cal Approach' to family planning during the first and second Five Year Plans. Later, the emphasis shifted to 'Extension Education Approach' during the Third Five Year Plan, followed by the 'Cafeteria Approach' in the Fourth Five Year Plan. There followed an experimentation with the 'Camp Approach'.

This Mass Vasectomy Camp Approach was tried on a large scale in Ernakulum District in Kerala in November, 1970. It was followed up in some districts in few other States. Gujarat is the first state in the country to undertake mass vasectomy camps during the period November 1971 to January 1972. The 'Camp Approach' to family planning has raised many questions and its proper evaluation is necessary for choice of policy options available. This paper thus attempts to evaluate the services offered and the type of people covered, in a camp, in one of the Districts of Gujarat viz. Baroda District, where vasectomy camps were held during the above mentioned period. This study may be useful in suggesting an appropriate organisational set up for camps when they are held.

The Data

The Data used in this study were obtained from a 'Mass Vasectomy Camp Evaluation Study for Baroda District' undertaken by the Demographic Re-

search Centre, Baroda in 1972. Baroda District was divided into two parts, Rural and Urban, and the sampling design was prepared separately for each part.

To draw a sample from rural Baroda District, multi-stage stratified sampling design was used with Taluka as the primary unit and village as the secondary unit of sampling. Three percent of the vasectomy cases done during the camp period, were included in the sample. The size of the sample so selected from rural Baroda District is 613.

On the other hand, a two stage stratified sampling design was used, in urban Baroda District, with urban centre as the primary unit. Here again three percent of the vasectomy cases done during the camp period in Baroda city were included in the sample. The size of the sample selected in Baroda city is 222.

Who Received Vasectomy Camp Services ?

Demographic and socio-economic characteristics of the recipient of vasectomy services during the camp would throw light on the segment of the population which has come forward for such services. They would also help to ascertain the policy implications for the segment of population netted during the camp. Further, they may be helpful in arriving at a decision whether this programme, directed to draw specific groups of the population, is really necessary.

In what follows, only demographic characteristics of the population, who were given vasectomy services during the camp period, are discussed.

Age

In the rural sample, the percentages of vasectomy cases, whose wives were in the age group 20-29, 30-39 and 40-44, were found to be 22.4, 39.1 and 17.0 respectively. Another 17.9 percent of the sterilised men had wives who had reached the age 45 and over and the remaining 3.6 percent were found to be either unmarried or had lost their wives through separation or death at the point of sterilisation. For the latter group, the question of wife's age at that time did not arise.

A significant finding of this study is that some 39 percent of the men sterilised in the camp included those (i) whose wives had attained menopause (18.9 percent) ; or (ii) who were secondarily sterile and were not using any method of family planning (12.4 percent) ; or (iii) who were either unmarried or separated or widowed (3.8 percent); or (iv) whose wives were in the age group 45 and over (2.1 percent), all in whose case reproductive performance could be expected to be very low ; or (v) whose either of the spouses had been sterilised earlier (1.8 percent).

Hence even if this particular section of the population (which is substantially large in proportion) has been entirely excluded from the sterilisation programme, no harm would have been done to the programme since the demographic impact of the programme in reducing births due to sterilisation of this particular group, would be practically nil. The omission of this group from the programme would probably have reduced the total cost of the programme quite considerably.

In Baroda City, on the other hand, only 5.4 percent of the sterilised men had wives aged 45 or more. The percentages of cases with wives in the age groups 20-29, 30-39 and 40-44 were found to be 22.8, 53.6 and 10.4 respectively. Contrary to the rural sample, the percentage of sterilised men in the city, who were either unmarried or separated or widowed at the time of sterilisation was found to be around 1.8, that is, roughly about a half of that observed in the rural sample. Obviously the urban group accepting sterilisation in the camp was relatively younger than the rural.

Altogether about 26 percent of the sterilised cases in the camps were found to be not proper for sterilisation because of the following reasons : (i) roughly 7.7 percent with wives in menopause ; (ii) 2.3 percent with wives aged 45 and over ; (iii) around 12.2 percent secondarily sterile; (iv) about 2.3 percent either unmarried, or primarily sterile, or separated or widowed, and (v) 1.8 percent of the cases where either of the spouse had already been sterilised.

Number of Living Children

In the rural sample interestingly 2.6 percent of those who accepted the vasectomy services during the camp period had no living child ; 4.2 percent had one and another 15 percent had two living children. Thus, the percentage

of those who had two or less living children at the time of sterilisation was 21.8 whereas the corresponding percentage in the 'regular sterilisation (non-camp) programme in the rural part of the District in 1968, was 11.7 and in the 'All India Sterilisation Programme' it was 11.1. The percentage of those who had 3 to 4 children living was 43.4, of those with five or more living children, 34.3. For the remaining 0.5 percent of cases, the requisite information was not available. The mean number of children was 3.9 for the camp, as compared to 4.2 for the 1968 rural Baroda District sterilisation programme.

These findings reveal that the rural vasectomy camps are able to reach a substantially large proportion of men for sterilisation who have fewer living children in comparison with the regular sterilisation programme. Such netting of a larger proportion of men with fewer children for sterilisation in the camp may be due to one or more of the following reasons. The incentives offered in the camp were larger than those offered in the regular programme ; personal influence or pressure exerted by the organisers of the camp. Coercion in some cases may not be ruled out. The removal of fear of vasectomy operation because of mass approach in the camp may be another factor.

In Baroda city, the percentage of sterilised men with no living child was as low as 0.5. Further, the percentages of acceptors with one child and of those with two children were 3.1 and 14.0 respectively. Thus, for the city the percentage of sterilised men with two or less living children comes to 17.6 as compared to 21.8 for rural sample. In the city the percentage of sterilised cases with 3 to 4 children was 50.5 and of those with 5 or more living children, 30.6. For the remaining 1.3 percent of the cases, the requisite information was not available.

An interesting result that emerges out of this study is that the mean number of living children for the acceptors in the city is 4.02 and in the rural part of the District, 3.94. The difference between the two is not statistically significant. In other words, both the rural and urban groups appear to have accepted vasectomy after having had a mean number of about four living children.

It may be pointed out, however, that the mean number of live births for the urban and rural groups were 5.05 and 5.43 respectively. This difference between the rural and the urban groups is comparatively larger. The reason

for this larger difference can perhaps be attributed to comparatively higher portality in the rural areas.

Sex Composition of Family

An interesting finding of this study is that in the rural sample 7 percent of the sterilised men did not have even a single male child when they underwent sterilisation. In the families with sons, the first child was a son in as many as 51 percent of the cases, while the second was a son in about 25 percent of the cases, and third was a son in around 10 percent of the cases. In the remaining 7 percent the fourth or a higher order was a son.

In Baroda city, only 5 percent of the sterilised men did not have a son at the time of sterilisation. Here the rank of the first son in the family was found to be first in about 54 percent of the cases, second in about 24 percent of eases and third in about 9 percent of cases. It was fourth or higher in 7 percent of cases. For the remaining one percent of the cases the information was not available.

These findings clearly indicate that in about seven percent of the cases in both the rural and urban Baroda District the couple had waited for a son even after having attained a family size of three daughters or more, before deciding about sterilisation.

Sources of Referral*

(a) *The Rural Sample*

Various categories of persons in rural Baroda district are responsible for motivating people to accept vasectomy services in the camp as shown below :

1. *Family Planning Programme Personnel,* like Doctors, Auxiliary Nurse Midwives; Family Planning Field workers etc.

2. *Staff from the Collector's Office, Revenue Department / and the Police Department* (such as Taluka Development officer, Mamlatdar, Talati and Police Sub-Inspector.

*The sum of percentages for all sources of referral adds to more than 100 as some of the respondent received information from more than one source of referral at a time.

3. *Local Influential personnel* such as Taluka Panchayat Pramukh, Sarpanch, Teacher, Gramsevak, Police Patel, Homeguard and Congress worker.

4. *Friends, Neighbours and Relatives.*

5. *Motivators, other than friends, neighbours or relatives.*

6. *Group Discussion in the village.*

7. *Mass media.*

About 77 percent of the men came to know about vasectomy services offered in the camp through one or more of the first three categories mentioned above. In another 14 percent of the cases *Friends, Neigbours and Relatives* acted as promoters. Sources of referral like *Motivators other than friends, neighbours or relatives* and *Group Discussions in the village* seem to have attracted an almost equal percentage (8 percent) of men about sterilisation services in the camp. About 4 percent of the acceptors were found to have come to know through the mass media and for 1 percent of the cases, the source of referral was not available.

MOST INFLUENTIAL PERSONNEL IN MOTIVATION.* As indicated earlier, the camp campaign was launched by a wide variety of personnel, belonging to (i) Government Department and (ii) the Local Leaders of the community. Personnel beloning to the *Collector's office, Revenue Department and Police Department* seemed to rank first among them. The percentage of acceptors in this case was found to be 26. *Family Planning Programme Personnel* in the second rank claimed around 21 percent of cases while the third rank goes to *Local Influential Personnel* claiming 19 percent of the cases. *Friends, Neighbour and/or Relatives* especially the *Operated Friends, Neighbours andlor Relatives* were successful in bringing the above 13 percent of the total acceptors.

Self promoted cases were as high as 11 percent. Of these 11 percent of the cases about 7 percent were such who came to know about the camp services from one or more of 1-6 categories of sources mentioned earlier. But when the question of accepting the vasectomy services came they made the decision

*Here again the sum of percentages does not add upto 100 because for some respondent there were more than one category of influential persons at a time.

on their own and not under somebody else's influence. Only about 8 percent of the cases accepted the services because of the influence of Motivators other than Friends, Neighbours or Relatives. The rest of the cases accepted the camp services either because of the *Influence of Group discussions (2.45 percent) in the village* or because of the influence of more than one of the seven categories of personnel mentioned earlier. Information was not available for another (2.45 percent)j!jof the cases.

(b) Baroda City

In Baroda city various categories of persons who acted as source of referral is somewhat limited. Different categories of people who acted as the source of referral in Baroda city for vasectomy services in the camp were as follows :

1. Family Planning and other Hospital staff,
2. Mill Workers, Fellow workers and Friends.
3. Relatives.
4. Supervisors and Officials in the Institution of employment of respondent.
5. Mass Media and Group Gossip.

In about 46 percent of cases the knowledge of mass vasectomy camp seems to have been given by *Mill workers, Fellow workers and Friends* and in another 27 percent of cases *Family Planning and other Hospital Staff* acted as the Chief promoters. *Supervisors and Officials in the institution of employment of the respondent does,* claim 27 percent of the cases. *Mass Media and Group Gossip* could attract only about 6 percent of the cases and Relatives could net another 5 percent of the cases.

It is significant that the secondary source of referral, like the *Mill workers, Fellow workers and Friends and Supervisors and Officials in the Institution of employment of respondent,* was found to be more effective than the primary source of referral viz. *Family Planning and other Hospital staff.* The source *Mill workers, Fellow workers, Friends* was found to be the best in netting 43 percent of the respondents. 23 percent of the respondents, receiving knowledge about vasectomy camp from different sources, had decided to undergo

vasectomy on their own. *Family Planning and other Hospital Staff and Supervisors and Officials in the Institution of employment of respondent* taken together ranked third in influencing people to accept vasectomy in the camp with the percentage of cases around 15, while relatives were successful in bringing about four percent of the total acceptors to the camp.

Role of Incentives

Incentives received per acceptor in the camp in the rural area, varied from Rs. 60 to 90 in cash with or without an additional article in kind and in the city from Rs. 60 to 170 in cash with or without an article in kind. The variation is more extensive in range in the city as employers had given special additional incentives to their workers going to the camp. For example Municipal Corporation of Baroda provided to their employees and other persons who were : (i) lepers or (ii) mentally disordered or (iii) Major handicap or (iv) beggers, an additional sum depending upon the types of categories to which they happened to belong. Municipal Corporation of Baroda gave a bucket to all and an additional sum of (i) Rs. 100 to those who accepted vasectomy after having only 2 living children (ii) Rs. 50 to those who accepted vasectomy after having 3 living children and (iii) Rs. 25 to those who accepted sterilisation after having more than 3 living children.

In rural areas, the Government had made provision of Rs. 60-65 in cash per acceptor in the initial stages of the camp period, but later raised the amount per acceptor to Rs. 70. Some of the Taluka Panchayats were very enthusiastic and provided some additional funds for distributing partly in cash or partly in kind, like Dhoti, Bucket etc. Some Taluka Panchayats even entered into a spirit of competition so as to provide vasectomy services to the maximum possible number of men, and ultimately to win an award. This spirit of competition amongst the persons concerned might have reached such a leval that the eligibility criterion was perhaps compromised in some cases.

It is creditable to note that apart from the Taluka Panchayats, even some 'Motivators' sometimes donated in part or in full the amount which they received from the Government as motivational charge, to the acceptor. Some of the Motivators thus played a significant role in increasing the case load in their own fashion.

To about 92 percent of the sterilised men in rural areas, the incentive was

an additional source of attraction. The remaining 8 percent of cases reported that they might have undergone sterilisation even if the camp had not offered any incentive to them. In response to the question 'In what form would you prefer incentives ?' i.e., whether in cash only ; or in kind only ; or incentives in any form; almost all the respondents had the same reply viz. 'Incentive in any form would be welcome'.

In the city, about 43 percent of the vasectomy acceptors were reported to have received Rs. 70 per acceptor in cash with or without kind. Another 14 percent of the cases received Rs. 75 with or without kind. About 4 percent of the sterilised men received a cash of Rs. 80, with or without any kind. And roughly 23 percent of the acceptors were paid Rs. 85, with or without kind. Another 12 percent of the sterilised men were fortunate enough to receive an incentive of Rs. 90 and over, with or without any kind, while the remaining 4 percent of the cases were those who accepted sterilisation in the initial stages of the camp programme and were paid only Rs. 60-65, with or without any kind. For about two third of cases (66 percent), incentive was an additional source of attraction.