SUMMARY AND CONCLUSIONS

This chapter presents a summary of the findings and conclusions along with some suggestions with reference to sterilization in a rural set up.

The study examines the patterns of semblance and difference with reference to the acceptance and non-acceptance of surgical contraception by the two caste groups who speak the same language, live in the same area and profess the same religion but occupy different ranks in the socio-economic hierarchy. No study of this kind has been attempted so far with reference to this region, viz., Rayalaseema in Andhra Pradesh.

The area of the study includes randomly selected villages situated in Chandragiri Mandal. Of the 1200 respondent couples, 600 are from the upper castes of Kamma and the other 600 are from the lower castes of Harijan. Both the male and female spouses are interviewed instead of only female spouses because the decision to adopt sterilization is made by husbands in a majority of the cases.

The empirical data are collected with the help of a prepared schedule and some traditional techniques like
interviews, group discussions and case histories. While analyzing the data, t, \(\chi^2\), 'r' test, and regression techniques are employed to assess the effect of different socio-economic and input variables on sterilization.

The socio-economic status dimensions of the Kamas and Harijans differ to a great extent. The Kamas are socially and economically dominant. On the other hand, the Harijans occupy the lowest rung of the social ladder. Almost all of them are poor agricultural labourers. They follow several local religious traditions which are in many respects different from those of the Kamas.

The level of education is low among the Kamas but it is still lower among the Harijans. Female literacy is least in both the Kamas and the Harijans. The average number of years of schooling of men among the Kamas and the Harijans is 4.47 and 1.09 respectively while that of women in the two strata is negligible and insignificant. Regarding the occupational status of men, a majority (55\%) of the Kamas are owner-cultivators, whereas a majority (65.3\%) of the Harijans are agricultural labourers. In the case of employment of women, a majority of the Kama females (84.3\%) are house-wives whereas a large number of Harijan females (95.6\%) are agricultural labourers. Almost all the Kamas possess land while only one-third of the Harijans own land, that too small holdings. On average, landed property possessed by the Kamas and the
Harijans is 3.74 and 0.54 acres respectively. The differential patterns of income are reflections of the differential patterns of land-ownership. The average annual income of the Kamma (Rs. 4,425.49) is almost three times that of the Harijans (Rs. 1,603.69).

The demographic profiles of the Kamma and Harijans also show some patterns of difference besides a few patterns of semblance. Single blessedness is looked down upon by the Kamma as well as the Harijans. Marriage is not only desirable but also inevitable for both the castes. However, the age at marriage of both men and women among the two castes differs. For men the mean age at marriage is 24.20 years for Kamma and 21.70 years for Harijans. In the case of women the respective ages are 10.25 and 13.31 years for Kamma and Harijans. Early marriage among the Harijans as against the late marriage among the Kamma is one of the major causes of high fertility in the former in contrast with the low fertility in the latter. In accordance with this difference the number of living children in the two caste groups differs. The average number of living children is 3.43 among the Kamma while it is 4.12 among the Harijans. The mean number of male living children is more among the Harijans (2.24) than among the Kamma (1.92). Infant and child deaths are more among the Harijans than the Kamma. The average number of the infant and child deaths is 0.56 among the Kamma and 0.90 among the Harijans. The ideal number
of children preferred by the Kamaas is less than that preferred by the Harijans. The mean ideal number of children preferred by the two caste groups are: Kamaa males: 2.89, Kamaa females: 1.12; Harijan males: 4.16 and Harijan females: 4.17. With regard to the sex of the children almost all the couples of the study desire at least one son. Nonetheless, the preference for sons is more intense among the Harijans than in the case of Kamaas. All these demographic factors are favourable for increased fertility among the Harijans in contrast with that of the Kamaas.

The impact of demographic variables on the adoption of sterilization by the Kamaas and Harijans show marked diversities. To start with, the two groups differ with regard to the age at which contraception is adopted. The average age of the vasectomy adopters is 31.80 among the Kamaas and 42.50 among the Harijans, while the average age of the tubectomy adopters is 29.00 and 39.41 in the two caste groups respectively. These figures reveal that demographically the age at adoption of sterilization among the Kamaas is more effective to reduce birth-rate than that among the Harijans. The results obtained in the $\chi^2$ test have shown that as age increases the rate of adoption of sterilization increases. This clearly shows that the age has a highly significant effect on the adoption of sterilization.

The number of living children and sons is also more among the adopters of vasectomy or tubectomy in the case of Harijans.
than in the case of Karmas. Further, the number of surviving children in general and sons in particular has a positive and direct association with the adoption of sterilisation.

in both the castes the infant/child mortality is far less in the case of the adopters than in the case of the non-adopters. Therefore, infant/child mortality has a significant inverse correlation with the adoption of sterilisation.

The results obtained in the study with regard to the relation between the effects of socio-economic factors and adoption of sterilisation also show differences between the Karmas and Harijans. The hypothesis advanced in this context is that 'the higher the socio-economic status, the higher will be the level of sterilisation'. The results of the study support the above hypothesis. Economic status seems to be the basis of differential fertility and acceptance of sterilisation.

With regard to the influence of caste on the adoption of sterilisation, there is a significant association between the two variables. Adoption is higher among the Karmas who belong to the upper caste but lower among the lower caste group, viz., Harijans. As high a percentage as 44.00 of the respondents among the Karmas in striking contrast with as low a percentage as 14.50 of those belonging to the Harijan community adopted sterilisation. This shows that caste status has a dominant influence on adoption.
Education also seems to be a significant factor for the adoption of sterilization. The average years of schooling of the acceptors is more than that of the non-acceptors among the Kammns, while it is contrary among the Harijans. However, the impact of literacy on the adoption of sterilization is significant only in the case of the Kammns. That the level of education has no significant effect in the case of the Harijans may be due to the fact that the educational level of the Harijans is negligible and almost nil. Among the low educated in the Harijan group, it is observed that the level of education (though very low) has a negative relationship with the rate of adoption. Hence, it may be stated that in general among the Harijans the level of literacy does not seem to have any effect on the adoption of sterilization.

Occupation is an index of economic status. In the rural areas, a majority of the Kammns are owner-cultivators and the Harijans are the agricultural labourers. The degree of adoption of sterilization by the owner-cultivators among the Kammns is the highest but surprisingly it is nil among the Harijans. No doubt, there are agricultural labourers from the two caste groups, but their numerical strength is too small among the Kammns as against the too many among the Harijans. In the case of this labour group the number of adopters is the highest among the Harijans and the lowest among the Kammns. Further, the level of adoption among the tenants, village officials and the other occupational categories is neither too high nor too
low, hence of intermediate level in both the caste groups.

The influence of occupation on the occurrence of sterilization by women is not clear cut. Fewer number of Kamma women who are house-wives and more number of Harijan women who are agricultural labourers have adopted sterilization. Of course, this is inconsistent with the theory of role incompatibility. The adoption of tubectomy by the women following other categories of occupations in both the caste groups is of intermediate level. However, the chi-square test results reveal that occupation has a significant association with the adoption of sterilization among the Harijan males as well as females. But it is not so in the case of occupation of men and women among the Kammans.

The pattern of land-holding in relation to sterilization is significant. Ownership of land indicates the economic status of the respondents. While almost all the Kamma respondents own lands, only about one-third of the total number of Harijan respondents own lands. Further, the size of the land-holding of the Kammans is greater whereas it is smaller and uneconomic in the case of the Harijans. The possession of landed property reveals that the Kammans are economically much better off than the Harijans. The results of chi-square test establish that land-holding has a significant association with the adoption of sterilization among the couples of both the caste groups. Thus there is a direct association between landed property and
adoption of sterilization among the Kamas as well as the Harijans, even though the land possessed by the Harijans is limited.

The differential patterns of income of the two caste groups have a bearing upon the adoption of family planning. In general the average income of the Kamas is much higher than that of the Harijans. There are a good number of adopters of sterilization in the higher income group of Kamas, while in the case of the Harijans the adopters are more in the lower income group. The chi-square test also discloses a significant association between income and adoption of sterilization among the two caste groups.

In summary, an analysis of the socio-economic variables, viz., caste, literacy, occupation, land-holding and income reveals that the association between these variables and adoption of sterilization is not similar in both the caste groups. The relation between land-holding and income with adoption of sterilization is significant both among the Kamas and the Harijans. Whereas literacy has a significant influence on the adoption of sterilization by the Kamas, it is not significant in the case of the Harijans. On the other hand, occupation has a significant effect on the Harijans, while its effect on the Kamas is insignificant. The relationship of occupation and acceptance of sterilization is not the same for the two caste groups. In the case of Harijans a vast majority
of the adopters come under agricultural labourers (men and women) while the main chunk of adopters among the Kamaas are owner-cultivators and housewives. Caste status has also positive and significant effect on the adoption of sterilisation; the percentage of adopters of sterilisation is more among the Kamaas than among the Harijans.

The influence of programme input variables on the adoption of sterilisation is also distinctly discernable. Especially, the impact of communication and incentive with reference to sterilisation can be perceived in the study area. The diffusion of information on family planning process and the methods of family planning has taken place through three kinds of communication media, viz., mass media, family planning personnel and peers. Of these three media, peers stand as the first source of information on family planning to the Kama and Harijan couples in the reproductive age followed by the programme personnel and mass media. Further, it is also found that peers act as a significant source of information to females rather than males. On the other hand, the programme workers and mass media are important sources of information to men rather than women in the two caste groups.

With regard to decision-making, family planning personnel are the most significant sources for influencing the adoption of sterilisation by the Harijans while peers from the most important source for influencing the decision-making by the
The influence of mass media as sources of knowledge and adoption of sterilization in rural areas is less effective compared to the other two media because of widespread illiteracy, lack of adequate radio, cinema and other facilities of mass media. Their influence on the adoption of sterilization is more on the Kamma than on the Harijans.

The dissemination of knowledge about family planning methods and their adoption is a concomitant of communication media. Vasectomy and tubectomy are known to all the subjects of the present investigation. The other methods, viz., condom and I.U.D. are also known to a fairly good number of respondents. All these methods of birth control are popularized by the family planning personnel in the study area and hence known to a majority of the respondents. On the other hand, the subjects have very limited knowledge of the oral pills due to lack of much information from the family planning workers. Whereas some of the respondents among the Kamma have knowledge about rhythm, withdrawal and abstinence, those belonging to the Harijan community have no knowledge of such methods of birth control. Very few of them know only about withdrawal, as the Kamma respondents know more number of methods of fertility control than the Harijans, a good number of the former have adopted the methods of fertility control. The adopters know more number of methods than the non-adopters in the two strata of the study area. The above facts suggest the validity of the hypothesis advanced with regard to communication facilities,
vis., 'the greater the degree of motivation facilities, the greater will be the acceptance of sterilization'.

Besides communication media, incentives in general and monetary incentive in particular helped to minimize the big gap between theory and practice of sterilization. The monetary incentive has little effect on the adoption of sterilization by the Kamas, while it has a significant effect on the adoption of sterilization by the Harijans, especially the poor agricultural labourers. Only 1.89 per cent of the adopters among the Kamas are influenced by the monetary incentive while as many as 45.97 per cent of the Harijan adopters are motivated by the pecuniary benefit. This divulges that a very good number of poor people are attracted by the monetary incentive. Regarding adequacy of the monetary incentive, 85.50 per cent of the respondents among the Kamas and 91.00 per cent of the Harijans reported that the present incentive offered is very inadequate.

Regarding the role of increased incentive to the tune of Rs. 1000.00 for every sterilization, 79.50 per cent of the Kamas and 79.99 per cent of the Harijans reported that it will have a highly significant effect on the adoption of sterilization.

The respondents are also of the opinion that it is better to introduce graded incentives in the place of a flat rate incentive. Graded incentives are justified in terms of social justice also. A majority of the respondents in the two caste groups reported that graded incentives will attract more young
couples to adopt sterilization. The acceptance of sterilization by young couples will be effective demographically also.

Majority of the respondents in the two strata of the present study are against the postponement of incentive payment, even if it is more. They are much interested in on-the-spot payment of substantial amount for increased adoption. Therefore, only 11.50 per cent of the Kammas and 4.00 per cent of the Harijans are favourable to old-age pension as an incentive whereas 84.00 per cent of the Kammas and 39.00 per cent of the Harijans are against it. That is, they feel that old-age pension and other social security schemes will not help the acceptance of sterilisation by many. Thus the above results uphold the hypothesis that 'the more attractive the incentive offered, the more will be the level of acceptance of sterilisation among the poor in general and the Harijans in particular'.

The reasons for acceptance or rejection of sterilisation are mainly socio-economic, demographic and psychological. The main socio-economic reason for the acceptance of sterilisation by the Kammas is to provide children with better opportunities in life. This is followed by other reasons like, economic inability to support more number of children and incentive money. This is true for both the sexes among the Kammas. However, the reasons for the acceptance of sterilisation by the Harijans are different. Among the Harijans the main reason

*The remaining number of respondents have no opinion about old-age pension as an incentive.
for adoption of sterilization by the males in incentive money followed by economic inability to support more number of children and to provide children with better opportunities in life. The principal reason for adoption of sterilization by the women among the Harijans is economic inability to support more number of children. The other reasons are to provide children with better opportunities in life and incentive money.

There are also several reasons for preferring the sterilization by the eligible couples in both the caste groups. A majority of the couples among the Kamaras (43.56%) seems to have adopted sterilization believing that it is a safe and trouble-free method. The next best reason is that it stops child-birth permanently (32.9%). Other reasons such as unawareness of other methods, incentive money, health of spouse and persuasion of the spouse are minor ones among the Kamaras. However, monetary incentive attracted a bulk of the Harijans (45.93%) to adopt sterilization. The rest in the order of importance are persuasion of the spouse, unawareness of other methods, stops child-birth permanently, other methods are unreliable and troublesome and health of the spouse. Persuasion of the male spouse in both the caste groups is one of the important reasons for the adoption of sterilization by women.

An analysis of the reasons for the non-acceptance of vasectomy or tubectomy shows that they are not the same for both the sexes. In the order of importance, the significant
causes for the non-acceptance of vasectomy by the males are:

- desire for more number of children (30.50%), fear of after-effects (27.14%) and unreliability (21.43%). All others are very minor reasons such as lack of religious sanction, fear of death of children, reluctance of the spouse etc. To the non-acceptors of tubectomy among the females, the main causes are:

- want to have more children (35.71%), fear of after-effects (19.05%), and against the will of God (16.86%). The insignificant reasons are: unreliability of the method, fear of death of children, resistance of the spouse and so on. The reasons for the non-acceptance of sterilization by the Harijans are also more or less similar to those expressed by the Kamas.

Three important reasons for the non-acceptance of sterilization among the Harijan males and females are:

1. desire for more children. This is given by 40.00 per cent of the males and 39.92 per cent of the females.
2. afraid of after effects which is reported by 39.00 per cent of men and 25.64 per cent of women.
3. sterilization is against the divine will. 13.75 per cent and 19.63 per cent of male and female respondents respectively, have given this reason. The other reasons are of negligible importance in both the cases. They are unreliability of the methods, fear of the death of children, opposition of the spouse, etc.

Regarding the future plan of contraception by the non-acceptors (who said that they want more number of children as
(given in Table-3:4), it is encouraging among the Kamasas while it is not so among the Harijans. The preference of the future acceptors of family planning among the two groups is for both male and female sterilization. Only 19.44 per cent of the Kamasas are against the acceptance of family planning whereas 68.05 per cent of the Harijans are against it. It shows that the hard core of the non-acceptors are more among the Harijans than the Kamasas. Hence, there is greater need for motivating the Harijans to accept family planning.

Family planning in India is an essential part of the total strategy of improving the welfare of the people, particularly the poor and illiterate. Greater welfare is, in fact, the only reason for establishing family planning programmes. People need small families not because they are against having more children but because they want every child to have the best opportunity possible in life. They want their children to inherit a better world than their own. This is the aim of every father and mother, and this is the objective of planned development.

There is a great need for micro-family planning programmes in India. At present the family planning programmes in India is sponsored, planned and financed by the Central Government but it is implemented by the State Governments. This means that the programme strategies including the pattern of services to be provided, the types of methods to be emphasized, the number of persons to be prescrib
different states are decided by the Central Government, whereas the state governments are responsible for providing these services and achieving the targets set by the Central Government. This has given rise to the concept of providing uniform pattern of services in different states of the country. However, all the states do not need the same pattern of family planning programme because of their differential patterns of socio-economic development. More intensive programme may be necessary in backward states than in others. Likewise, as a result of their differential socio-economic status, couples like to adopt different contraceptives. Then the emphasis should be not on a uniform macro-policy but on particular micro-policies to suit the needs of different states, regions and subjects. Therefore, there must be flexibility in the approach of the family planning programme and the personnel responsible for its implementation at the state level must be given sufficient freedom to devise suitable policy measures for the successful implementation of the programme. Thus, instead of following a uniform national population policy based on macro-economic-cum-social approach, it is more desirable to have a state level policy articulated by micro-economic-cum-social considerations.

In view of the finding that duration of marriage is the most prominent determinant of fertility behaviour and of contraception, it is an imperative requisite to raise the age at marriage in general and girls in particular. The ideal may be
20 years for girls and 25 years for boys. The rise in age at marriage of girls not only reduces the actual reproductive period, but also makes them mentally mature to think and decide what is good for them. Therefore, suitable legislative measures may be worked out and strictly enforced to achieve the intended results of increased contraception and reduced fertility.

With regard to reduction of infant mortality and facilitating increased acceptance of family planning, there must be an integrated approach. An integrated package programme of maternal and child-care, which amongst other items also includes nutrition, education and immunization against the common communicable diseases, such as diphtheria, tetanus, tuberculosis and whooping cough may be developed not in isolation but as a part of general health-care in order to facilitate increased adoption of family planning methods.

Another suggestion that may be quite useful in this context is that people in the rural areas ought to be enlightened about the fall in the infant mortality at present due to improved medical and health facilities and must be assured by family planning workers that their children have a better chance of survival than in the past. This must be done in such a way that the poor and illiterate in the rural areas must be convinced about the reduced infant mortality and the likelihood of fair chance of survival for all the children they begat.
Education in the psychological context is very important for the overall development of the personality of an individual. In a social sense, it creates enlightenment and in the demographic context it acts as a motivating factor for the promotion of family planning. Universal education will not only help social and economic change but also assist the demographic transformation. In this connection, the government must take special interest in the promotion of literacy among the urban poor and rural masses. Education of girls is more useful in this regard since it leads to increase in age at marriage, nature thinking and improvement in status.

Population education may bring lasting effect on the attitudes of people. The future parents in the High Schools and Colleges must be taught about the consequences of rapid population growth and the need for birth control. This influences the younger generations to accept the small family norm as future parents. The population education also should be spread through the net-work of non-formal education such as the adult literacy programmes, part-time programmes for drop-outs and instructions through mass media particularly for the illiterate and semi-literate couples. Thus, both formal and non-formal education can be made effective in providing the people access to information on child-health practices and family-planning appliances. Such an integrated approach will be more helpful in rural areas where literacy, specially that of women, is nominal.
Modernization of agriculture results in socio-economic development and sustained overall fertility decline in the rural areas. Adequate modern technology is not existing in the rural areas. If farmers are provided with adequate modern technology and with the essential complement of agricultural inputs, then rural development and along with it modernization takes place. This process of rural transformation influences the attitudes, outlook and life-styles of rural folk and creates favourable climate for increased contraceptive adoption and fertility decline. For instance, in the Punjab State the rapid development of agriculture and the consequent change in the outlook and life-styles of people in the country-side has made the Punjabis favour smaller families and this facilitated increased practice of contraception.

A majority of the rich among the Kammans and a substantial number of the poor among the Harijans have adopted sterilization. In other words, a majority of the poor among the Kammans and the well-to-do among the Harijans are not enthusiastic about sterilization. How to correct this anomaly? Modernization of agriculture, adequate provision of employment and the resultant economic development may transform the poor Kammans into well-to-do and induce them to adopt sterilization.

The same solution cannot be applied to induce the well-to-do Harijans to adopt sterilization. The well-to-do Harijans think that their children can prosper through the advantages
guaranteed by the constitutional safeguards and up to a
privilege. Under such constitutional guarantees maintaining
many children is no problem to them. Hence, the reasons for
their non-adoption of sterilization are extra-ordinary. In
such rooting out such incorrect attitudes from their minds
through constant persuasion, appropriate education and
proper education remains to be the only solution. How about
the poor Harijans? The poor Harijans also are no less un-
reasonable than the well-to-do Harijans, after all they have
adopted sterilization only after acquiring a large family.
This situation must also be rectified. Modernization of agri-
culture and economic development may improve employment
opportunities and better their economic status. Once the poor
Harijans become well-to-do, they may also develop an incorrect
attitude towards sterilization. They may believe that children
are no burden to them. To correct this attitude the solution
shall be similar to the one that has been applied for the
correction of the wrong attitudes of the well-to-do Harijans.
Here, one should not lose sight of the role of incentives and
disincentives. Continuation or curtailment of special
privileges may be used as incentives or disincentives to both
the poor and well-to-do Harijans. Special privileges may be
provided only to the poor Harijans till they become economically
better. They may be discontinued in the case of well-to-do
Harijans. Further, the family members of those who have availed
themselves of these facilities once may be disallowed from doing
as above. In view of the practical situation, regardless of census, creed and religion, all the really deserving poor people who adopt sterilization shall be given a few special privileges, such as educational and employment opportunities and special incentives. Moreover, through intensive education everyone must be impressed that family planning is meant for the welfare of all the people and even the poor also suffer if it is neglected or rejected.

There is no gainsaying that the family planning programmes should be revamped to make them reach the poor as they have not reached the disadvantaged groups of population in urban and rural areas. The programmes can be successful only when people at grass roots level are motivated to practice contraception to regulate fertility, because their number is inconceivably large and fertility control on their part can substantially reduce the national fertility level. The crux of the problem, therefore, lies in reaching the poor people who need the services of family planning most. As such major efforts to diffuse family planning information and practice should be concentrated on the people at grass roots, who are mostly illiterate and ignorant and not willing to limit their fertility. The appropriate way of doing this is to provide adequate health and family planning services through properly equipped mobile hospital services in the villages. Taking the family planning services to the people rather than expecting them to visit the
Clinics and hospitals is most essential.

Social security measures such an old-age pension scheme, old-age insurance scheme, old-age assistance, and so forth may be provided to parents to reduce parental dependency on children in old-age. These measures are to be implemented even though they are costly in a country like India.

Development of family planning infrastructure that includes provision for adequate inputs is essential. It can improve the performance of the family planning programme. The population and area to be covered by the workers must be viable for providing effective motivation and adequate services. The workers are to be given orientation training in the health and family planning services once a year in the headquarters of the Panchayat Samiti by the medical officer of the Samiti.

Introduction of ideal contraceptives is necessary. In this context cafeteria approach may be followed. According to this approach, instead of offering any one or two methods in the programme, several methods are offered, giving a wide choice for the client to choose the best of the lot that suits his/her taste. Further, the innovation and introduction of an ideal contraceptive which is cheap, safe and convenient to use in addition to being highly effective will undoubtedly influence more number of people to accept fertility control devices. It is needless to mention that new methods that are
already developed or are being developed such as long lasting injectibles for women (Depo-Provera-124), birth control vaccines and pills for men (desogestrel) may be very helpful in this direction.

Attempts may be made to dispel wrong notions of the after-effects of contraception. Particularly, the fear of harmful after-effects of sterilization and other methods is a major hurdle against the success of the programmes. Therefore, suitable steps such as proper follow-up of adopters to treat and advice on real, imaginary and psychological problems shall be taken. At present the follow-up services are very poor. The interest of the family planning workers is more in locating, persuading and motivating a prospective acceptor than attending on him after adoption. Different communication media such as radio, press and satisfied adopters may be exploited to counter the false, baseless rumours and to dispel the medically baseless psychological fears. There is a greater need for this measure in the rural areas where the majority are illiterate, ignorant and superstitious.

Sometimes those who accept sterilization without adequate confidence in the method do more harm than good to the programmes, because they may develop psychological problems as a result of sterilization and communicate and spread the same to those who come into contact with them. The same may be true for users of other contraceptives as well. Therefore, it is necessary and
essential that one who wants to adopt a method, particularly sterilization, should be properly screened and advised by the doctor/medical worker before he/she actually adopts it. If the prospective adopters are weak, or suffering from ill-health or sickness they must be advised not to undergo surgical contraception. Otherwise, they attribute their existing ailments to the adoption of family planning and do more damage to the programme by spreading incorrect information.

For the success of family planning, communication programme may be revised and strengthened on the following lines. Family planning must be transformed from just a programme of the Government of India into a genuine mass movement. For this purpose an entirely new motivational strategy is to be worked out in collaboration with the State Governments, educational institutions (Universities, Professional Colleges, etc), local bodies and voluntary organizations, in a massive effort. This is essential if real headway is to be made in the family planning programme.

The effort at mass communication must take into account the local circumstances, particularly in a big developing country like India, where there are vast social, cultural and economic differences between not only different States but also between communities and castes. The message and means of conveying it must suit local conditions. Unless the message and the means are tailored to the varying needs of differing
audience, there is small chance of the communication effort
meeting with success. For instance, to think that a particular
family planning communication strategy will effectively cover
everyone whether he is a landless labourer living in the rural
areas, or a rich businessman or an educated employee living
in a metropolitan city, is an unrealistic view. Family planning
communication strategy may keep in its orbit the social mores,
traditions and milieu of different sections of people in the
society. Hence, uniform communication programmes for motiva-
tion are not enough but different specific programmes to suit
the socio-economic background of different sections in the
society are necessary.

Mass communication strategy for a specific task like
family planning cannot be effective in isolation. Mass persua-
sion aimed at selling the idea of family limitation is not
enough. It has to become part of a package programme. It must
tackle simultaneously the other related problems. Family
welfare, nutrition, child care, the status, education and
rights of women, and the economic benefits of a smaller and
healthier population are all parts of this package.

For mass communication to succeed, it is important that
there should be a movement on the part of all those who purpose
is to keep in touch with the public. The most important among
them are naturally the politicians. Therefore, it is essential
for political parties, especially the party in power, to adopt
the communication needs of planned development as a matter of national priority. The family planning message must find expression in the public speeches of politicians at every opportunity and occasion (Hasan 1979). Otherwise, mass communication on family planning will continue to be in a political vacuum, which impedes the success of the program.

Identification of groups/castes on the basis of their fertility and acceptance/rejection of contraception would help to rationalize the inputs of the family planning programmes. This information provides clues to the programme workers to channelize more effort in educating and motivating such groups with high fertility and low acceptance while at the same time providing only the necessary inputs to the communities with low fertility and high acceptance. The agencies involved in family planning motivation should attempt to work harder among the Harijans and very poor illiterate couples among whom the level of adoption is remarkably low.

The success or failure of the government's family planning efforts depends to a large extent on its ability to motivate the majority of rural population to adopt family planning methods. Mass media are of no great help in the rural areas where widespread illiteracy and poverty exist. Inter-personal communication through family planning workers, teachers and local leaders can be of great help in this regard. An integrated approach of both the above media — meetings, seminars,
exhibitions and films shows may attract, motivate, and create favourable climates for the acceptance of family planning by the rural couple rather than any one of the communication media. Therefore, to motivate and to create favourable attitudes towards family planning among the rural illiterate and poor, an intensive family planning communication programme with a judicious combination of different media may be established and implemented.

There must be an extensive and intensive educational effort to popularise the small family norm. Door-to-door motivational work to convince people about the benefits of small family must be carried out. That is, where the density of dedicated field workers (inputs) is high, the highest acceptance rate can be attained, even in the rural areas, among the poor as well as the illiterates.

Local midwives (dais) and practitioners of indigenous medicine may be involved as potential sources of information in the programme to educate and motivate rural masses and to make them accept small family norm and family planning. They must be given adequate training in contraceptive technology so as to enable them to explain the techniques of using the contraceptives and their effects. Some incentives may be given to the said sources to take interest in the propagation of planned parenthood. This measure is useful to accelerate the concept of family planning in the countryside.
Community health volunteers are another potential resource to be fully exploited in the maintenance of sanitation and health in the rural areas, besides the promotion of family planning programmes. Dedicated workers are the greatest asset in this regard. At present, these community health volunteers are only honorary workers and they are being paid Rs. 50.00 per month as honorarium. They ought to be made full-time, regular employees of the State Government with a salary of at least Rs. 250.00 per month to make them responsible workers. At least once in a year they must be given orientation training in the headquarters itself not only to keep them abreast of the latest information in medical and contraceptive techniques but also to acquaint them with the sanitary and health needs of local villagers.

Students, medical as well as non-medical, who comprise a class of future contributors for population growth may also be stimulated to become educators and motivators of eligible couples through social service organizations such as the National Service Scheme (N.S.S.) or individually. The students who successfully motivate a certain specific number of couples say 25 may be given scholarship for one year. Through this approach, the students will come to know more of the problems and consequences of rapid population growth and they themselves will favour small families and advise others to have small families.
Community radio sets can be installed in every settlement of the Harijans (scheduled castes) to educate and activate them to accept family planning through radio programmes. All India Radio (A.I.R.) can give prominent place to family planning propaganda in its daily programmes.

Screening of films and film strips in the villages by the family planning workers/health staff must be more frequent. It should be at least once in a fortnight. The films should reflect the advantages of a small family and dangers of a big family.

The system of incentive payment must be designed with great care if it is to be both efficient and attractive to the target population. Apart from the size of bonus, timing of payment is a key element because the more immediate the payment the more attractive it usually is. Immediate rewards are undoubtedly more effective than delayed rewards.

The precise incentive programme sufficient to achieve fertility reduction goals in any particular country will depend upon local circumstances. An incentive programme that is suitable to industrial workers or tea estate employees may not be quite fit to agricultural labourers in the countryside. Similarly, a scheme that is successful in Taiwan or Singapore may be a failure in a sub-continent like India. So, in designing an incentive system local circumstances must be kept in mind.
one has yet to put forward a monetary incentive scheme that appears likely to reduce the birth rate significantly while at the same time being financially and administratively feasible and politically and socially acceptable. Current programmes have suffered from adverse publicity arising from stray cases of abuse and fraud. Proposals to provide positive incentives (i.e., payments to induce desired behaviour) often founder on their higher costs and administrative impracticability. Proposals to provide negative incentives (e.g., penalties for large families) typically fail to attract support because of their inability to penalise parents without penalising their children at the same time.

Given present technology, sterilisation is the only method suitable for large bonuses of this type. The insertion of an I.U.D. is easily verified, but since the I.U.D. can also be easily removed, its continued use is hard to confirm. There is also the possibility of multiple collection of incentive money through successive reinsertions. Methods that must be used daily or at the time of intercourse, such as condoms, oral pills and other traditional methods, are all unsuitable for any incentive scheme. Only in the event of a technological break-through, such as the development of a long term injection or implant, will some method other than sterilisation will be suitable for giving incentives.

In the rural areas among the different methods of family
planning sterilisation in the past popular, most of the rural folk have neither knowledge nor facility to adopt the other methods. Those couples who know the other methods have no confidence in their effectiveness in preventing conception. That is why there is need for designing a suitable incentive programme for sterilisation in rural areas. Keeping the rural circumstances in mind, an incentive programme is suggested hereunder for better results.

Most of those who have advocated anti-natalist incentives are economists, who portray incentives as an investment for developing countries to prevent population growth from continuing to offset the nation's economic growth and development. A number of economists have tried to estimate the average value of the "avoided birth" in India. These estimates of the value of a birth averted in India at 1960-61 prices came to Rs. 712.00 (Jhingan 1969), Rs. 1,500.00 (Kapoor 1971) and Rs. 4,600.00 (Jhingan 1971). The range of these estimates for India have varied from Rs. 540.00 to Rs. 21,000.00 (Jhingan 1973). These estimates would give us a clue to the amount that can possibly be paid to the adopters. Thus, there is no agreed formula for calculating the value of a prevented birth but it is generally accepted to be very high in a developing country like India. So these estimates can be used by the responsible authorities as the upper limit on the amount of money they can justifiably spend on preventing a single birth.
The indication is that since the figure is so large, they can afford to spend a great deal of money, if necessary, without wasting the nation's productive resources.

Based on these estimates, the incentive money may be increased substantially to say Rs. 1000.00 for each sterilization of male or female in the case of young eligible couples aged below 30 years and with two children. For the rest of the eligible couples who are aged above 30 years and have more than three children an amount of Rs. 500.00 may be given as incentive. If it is not possible to determine the age easily, in that case incentive money may be paid on the basis of the number of children only at the rate of Rs. 1000.00 for those who have two or less children, and Rs. 500.00 for those who have three or more children. This amount must be regarded by the finance ministries of the Centre and the States as practicable from fiscal point of view because the benefit to the economy is several times more than the money spent.

Further, this graded system of incentive payment is demographically effective, equalizes the psychological impact of the incentive on the young and aged and socially justifiable.

It is needless to point out that monetary incentives cannot easily influence the decision of the rich. Many of the well-to-do voluntarily come forward to adopt family planning. Most of the rich receive money incentive from the government and distribute it to the medical staff who conduct the operation.
However, a majority of the poor people are really inclined and attracted by the money incentive which is an essential barrier for them. We hold before if the amount is substantially increased to say, Rs. 1000.00 for a sterilization irrespective of sex, this may attract several non-adopters particularly those in the lower income groups to change their attitude towards family planning. Hence, the amount must be given only to the people belonging to lower income groups. Rich people with 10 acres of wet land or 20 acres of dry land, or Rs. 10,000.00 annual income in the villages need not be paid any incentive for adopting sterilization. They adopt sterilization not for the monetary gain but because they have felt the need for planning their families.

This is so in the case of government employees too. The Government of Andhra Pradesh is giving two incentive increments for all its employees and quasi-government employees, if the employee or his/her spouse undergoes sterilization with one or two children. If the children are more than two the incentive is one advanced increment. This facility need not be extended to better paid employees such as gazetted officers and others who draw a monthly basic salary of Rs. 750.00 or more. The educated, employed and economically well off adopt family planning not because the Government is giving them one or two increments but because they feel the need for limiting the size of their families. The incentive increments are not the motivating factors in their case. Since the Government has provided
this facility, they are enjoying, but it is not because of the facility they are adopting a permanent family planning method. In the case of a young married officer, two advanced term- ments works out to several thousand of rupees in his service. This may be stopped and only employees getting a basic pay of less than Rs. 750/- may be given this facility prospectively. This incentive scheme of paying a substantial amount of money to the poor also leads to social and economic justice. Targeting an incentive scheme for poor families is proposed in advanced countries also to encourage small families among the poor (Ramohan 1971:105). 

Promoters (canvassers/diffusers) are an important media of family planning communication and knowledge outside the government bureaucratic structure. They are effective sources of family planning propagation, motivation and protection. They are paid at present only Rs. 5.00 for promoting a voluntary. This facility must be extended to tubectomy also. The promoter's incentive money may be increased to Rs. 10.00 for each case of sterilization irrespective of sex. This may attract more number of canvassers to the task of promoting family planning acceptance, since this will be substantially remunerative for them.

Since there are inadequate number of government doctors to carry out the whole burden of family planning work, private doctors may be induced and involved in this work by paying
attractive incentives. It is expected that if these incentives are high enough, private doctors will find it advantageous to take over many jobs now performed by government doctors. As such private doctors may be paid $25.00 for vasectomy and $50.00 for tubectomy as incentive for providing their services. This facility may attract rich eligible couples who are hesitant to undergo sterilization in a government hospital, to private nursing homes where better facilities do exist.

Apart from the monetary incentive for sterilization, non-monetary incentives such as lands and homesteads may also be assigned to adopters of sterilization in rural areas. Here also depending on parity and age, lands may be assigned to the adopters on the basis of variable rates. The government may also give them loans on priority basis for the improvement of their land and cultivation. This non-monetary incentive would be highly attractive for villagers because they are so much attached to land. A choice may be given to adopters either to opt for non-monetary or monetary incentives. It is needless to mention that giving land for example as an incentive cannot be misplaced either by the adopters or the officials.

Incentive scheme meant for sterilization is a better one compared to the incentive schemes with regard to other methods. It is a one-time payment immediately made after the operation and easy to administer. It is not so in the case of incentive schemes for other methods. They require a good amount of record-
Keeping and supervision, lest duplicate or absent payments may be made. Reasonably, the higher the incentive, the greater will be the risk of false reporting and the need of supervision - which will be not only expensive but administratively cumbersome. Therefore, it is suggested to have a massive and attractive incentive scheme for sterilization only, in the vast expense of rural areas until other more effective and attractive methods of family planning are evolved.

References:


## APPENDIX-I

### Year-Wise Achievement of Sterilizations in India, Andhra Pradesh, Chittoor District and Chandragiri Samithi

<table>
<thead>
<tr>
<th>Year</th>
<th>India</th>
<th>Andhra Pradesh</th>
<th>Chittoor District</th>
<th>Chandragiri Samithi</th>
</tr>
</thead>
<tbody>
<tr>
<td>1967-68</td>
<td>18,39,811</td>
<td>1,70,796</td>
<td>792</td>
<td>66</td>
</tr>
<tr>
<td>1968-69</td>
<td>15,65,817</td>
<td>2,05,071</td>
<td>2,597</td>
<td>218</td>
</tr>
<tr>
<td>1969-70</td>
<td>14,22,118</td>
<td>2,08,679</td>
<td>2,779</td>
<td>455</td>
</tr>
<tr>
<td>1970-71</td>
<td>13,29,914</td>
<td>2,25,064</td>
<td>7,779</td>
<td>692</td>
</tr>
<tr>
<td>1971-72</td>
<td>21,87,336</td>
<td>2,75,869</td>
<td>14,703</td>
<td>1,014</td>
</tr>
<tr>
<td>1972-73</td>
<td>31,21,856</td>
<td>3,39,767</td>
<td>17,945</td>
<td>151</td>
</tr>
<tr>
<td>1973-74</td>
<td>18,42,402</td>
<td>1,42,778</td>
<td>3,016</td>
<td>713</td>
</tr>
<tr>
<td>1974-75</td>
<td>13,53,859</td>
<td>1,26,542</td>
<td>3,551</td>
<td>213</td>
</tr>
<tr>
<td>1975-76</td>
<td>25,68,754</td>
<td>1,14,955</td>
<td>4,901</td>
<td>337</td>
</tr>
<tr>
<td>1976-77</td>
<td>82,61,173</td>
<td>25,946</td>
<td>1,722</td>
<td>1,722</td>
</tr>
<tr>
<td>1977-78</td>
<td>9,47,597</td>
<td>3,3,370</td>
<td>4,377</td>
<td>633</td>
</tr>
<tr>
<td>1978-79</td>
<td>-</td>
<td>-</td>
<td>6,463</td>
<td>633</td>
</tr>
</tbody>
</table>

---

Sources:
- Director of Medical and Health Services, Monthly bulletin on the Family Welfare Programmes in Andhra Pradesh, Hyderabad, May 1978, P. 10.
- Letter of District Medical and Health Officer, Chittoor District, Andhra Pradesh, dated 29.6.1980.