Chapter VI

Summary and Conclusions
1. Background

Contraception has been practised within the family unit for thousands of years. Various civilizations and cultures used a variety of plant extracts, herbs and mechanical devices to control fertility. The sudden population growth after the Second World War necessitated fertility control to be extended from the family to societal levels. The fertility has been declining very fast in most countries of the world over the past three-four decades, and it continues to decline almost everywhere. The role of family planning in fertility reduction is well proved and it deserves a special focus within the framework of reproductive health. The health and economic benefits of family planning constitute good reasons for making it the central focus of national programmes.

Helping women and their partners to adopt family planning to avoid risky and unintended pregnancies would save the life of many mothers and children as well as create opportunities for women to participate in productive activities. In spite of the progress that has been made, there are still hundreds of millions of couples worldwide who wish to plan their families but have no access to information or quality services. In the modern era, the family planning programme managers are beginning to identify the need to increase couples' support and participation for good reproductive health care for the families.

Family planning is the most important component of reproductive health services that can make the maximum impact over a broad range of reproductive health issues. Contraceptive prevalence is influenced by two factors: demand for fertility regulation, and the use of contraception in case of such a demand. The demand would generally be influenced by socio-economic and demographic conditions such as place of residence, age, age at marriage, levels of education, religion, caste, type of family, total number of children and their sex, incidence of abortion and child loss, exposure to mass media messages, access and availability of health services, occupation, income and standard of living. All these have a bearing on the perceived costs and benefits of having more children, and on the demand for contraception.

The perceptions of costs and benefits of children could differ across geographical region, religion and society. The cultural factors may influence the idea of fertility regulation and of specific contraceptives. In general, the focus of contraceptive services has been mainly on methods, and not on clients. Even though
the organized family planning program in India and elsewhere was originally designed to improve the quality of life of ordinary people by enabling them to choose a small family size, the program has not been so successful in making people aware of a variety of birth control methods. For many people, the word family planning still stands for sterilization. The program has not succeeded in addressing the problems associated with adopting birth control methods. Not many studies have been conducted on why a certain section of population is not practicing fertility control measures while others are practicing it.

2. Summary

This study is an attempt to analyse the socio-economic and demographic determinants of the acceptance of modern contraceptives in India, and in the demographically advanced states in particular. The ‘demographically advanced’ states were identified on the basis of their total fertility rate- those states with a total fertility rate below the replacement level, that is, less than 2.2 living children. According to National Family Health Survey 1998-99, there are five states in India, namely Goa, Himachal Pradesh, Karnataka, Kerala and Tamil Nadu those have achieved the below replacement level of fertility. So these states were selected for detailed analysis in this study. The primary survey was also conducted among 386 currently married males in 20-39 age group to clarify some of the questions the secondary data analysis was able to answer, such as why certain sections are more among the acceptors, why the utilisation of private health services are increasing, how the education levels influences the utilisation of family welfare services across religion and different economic strata, etc.

This study comprises of six chapters. In the first chapter, an attempt was made to describe the problem of over population and the methods to reduce its burden on socio-economic development. Various theories pertaining to fertility, contraception and quality-quantity of children have also been discussed. An extensive review of earlier studies on the socio-economic and demographic characteristics and correlates of the acceptors of contraceptive methods conducted in different countries as well in different states in India are given. The objectives of the study and hypotheses that were tested during the course of this study are also given in this chapter. It is found that even though there were many studies on the correlates of contraceptive use in India and elsewhere, not much extensive studies were conducted among men, who are
active as well as the authoritative members in the family unit, and there are insufficient interpretations on the higher use of contraceptives among socio-economically backward sections of the population as well a higher contraceptive use among less educated couples.

The second chapter narrates the area, data and methodology used in this study. In order to find out the correlates of the use of modern contraceptives, the National Family Health Survey Reports and datafiles for 1992-93 and 1998-99 were used. The clarifications in the findings of the correlates and determinants of contraception have been done with the help of an in-depth primary survey in one of the demographically advanced states of India, Kerala. This chapter also narrates the methodology adopted in the selection of sample respondents for primary data collection. A description of the explanatory variables and their importance, and the rationale for adopting statistical techniques in the study for higher-level analysis also have been discussed in this chapter.

The study used selected tables from the reports of the National Family Health Survey conducted during 1992-93 and 1998-99, and the Rapid Household Survey under Reproductive Child Health Survey 1998-99 to explain the interrelationship of many of the covariates to contraceptive use in India. It also made use of the raw data files of the NFHS Survey data for these five ‘demographically advanced’ states as well as that of All India files of the two rounds of National Family Health Surveys for further analysis to understand the magnitude and direction of the explanatory variables on use of contraception in the past, ever and current use, with the help of a set of logistic regression equations. Since most of the acceptors of modern methods are practicing the permanent method of sterilisation in India, special attention has been given to identify the factors influencing the use of modern methods from that of traditional methods.

A primary survey was conducted among 386 currently married men in the 20-39 age group in Kollam district of Kerala during 15th May to 10th July 2001 with the help of a pre-tested and well-structured questionnaire. Two urban wards and six rural villages selected for the survey and 50 samples from each of these places were collected. The two urban wards were chosen from coastal area of the district; three
villages each were selected from plain and hilly region of district to understand if there is any influence of geographical location on contraceptive behaviour.

The third chapter analysed the interstate variations in the socio-economic and demographic characteristics among the users and non-users of family planning methods in India based on tables constructed from NFHS first and second round data and reports. It is found that, even though the knowledge of contraceptives is universal in India, only a little more than half of the eligible women know all modern methods. Except for Karnataka, all the demographically better off states had a better knowledge on modern methods. It is found that the place of residence, caste, education and living conditions are affecting this knowledge of all modern methods and the source of obtaining these services. Among ever and current users of contraceptives, female sterilisation is found to be most common and the contraceptive usage increased during 1992-93 to 1998-99. The factors such as higher age of the women, higher levels of education, religion (Hindus), caste (general population), number of living children and their gender (male), source of supply (public sector) and previous use of contraceptives (used earlier) were found to be positively affecting the present use of contraceptives in these states as well in India.

The reasons cited for discontinuation of previous method/s showed that majority stopped their past use because of method related problems and the need for additional children. Only a minority of the non-users reported they were opposing the contraceptives. It can be said that, once the couples achieved their desired number and gender combination for their children, majority may go for sterilisation. The selected states shows minimum unmet need for spacing and limiting their fertility than other states of India.

In the fourth chapter, an attempt has been made to analyse the socio-economic and demographic specialities in demographically advanced states in India with the help of logistic regression equations. Current use of any method and any modern method in demographically advanced states in India is positively influenced by characteristics such as higher age of women, the number of living children, higher levels of educational attainment by both the partners, working status, mass-media exposure in India, and the number of living sons. The factors adversely affecting the use of modern methods of family planning are found to be, urban place of residence,
social backwardness in terms of castes, tribes and religion, preference for sons, the experience of child loss, still births or abortion and a very high age at marriage.

Residence in urban areas, high preference for boys, belonging to socially and economically disadvantaged sections of the society, prior experience of child loss or abortion or stillbirth and those who married at a higher age seems to depreciate the use of any contraceptive methods up to 50 percent in even in demographically better off states in India. Those women who are working for wages have up to 50 percent possibility of adopting a contraceptive method than those not working, in these states. The women in their later stages of reproduction, those with education, had exposure to family planning from mass media messages, better standard of living and having at least one living son have shown to accept family planning procedures 1.5 times more than others in their respective category.

The use of modern contraceptives in the demographically better of states shows that, the variables such as, belonging to rural areas, members of social and economical backward tribe and religion, preference for sons, experience of child loss or abortion or stillbirth and higher age at marriage depreciate the contraceptive usage up to 50 percent than their counterparts. Women who completed their fertility (usually they have higher ages), levels of education of the partners, those who are working and those have good exposure to family planning messages, those have comparatively better standard of living conditions and those with at least one living son are more than 1.5 times likely to adopt modern contraceptives than their counterparts in these states.

The fifth chapter deals with the findings of the primary survey. The background characteristics of the acceptors of modern contraceptives described in other important studies and a detailed analysis of the primary data collected for this study is included. It is found that many socio-economic and demographic variables are influencing the practise of contraceptives in Kollam district of Kerala state. The variables negatively affecting the use of modern contraceptives in Kerala are found among members belonging to Christianity. These factors depress the use of modern contraceptives by almost 50 percent. The variables such as belonging backward caste group, if they have a higher number either sons or daughters, and if the number of sons is equal or more than that of daughters, husband-wife discussion on family
planning, and if the husband is employed, has shown to have a 50 percent positive effect in acceptance of modern contraceptives in Kerala.

The sixth and final chapter summarises the findings and discusses the results. The conclusions derived from the analysis of the study along with the policy implications and suggestions were also included in this chapter.

3. Major Findings

The knowledge of family planning methods, especially that of female sterilization is almost universal in India. But knowledge of all modern methods varies across states, and the factors such as place of residence, caste/tribe, levels of education and type of residence influences the knowledge. The percentage having knowledge on the source of obtaining these methods also vary across the state, but the demographically advanced states shown a higher awareness on the sources. The majority of the acceptors are found to be the practitioners of permanent (sterilization) methods, and the use of modern spacing methods is very less.

Logistic regressions on the current use of any method and modern methods on All India and the five demographically advanced states have shown the following results. The rural place of residence, high preference for boys, belonging to socially and economically disadvantaged sections of the society, prior experience of child loss or abortion or stillbirth and those who married at a higher age seems to affect inversely up to 50 percent the use of any contraceptive methods. Those women who are working for wages have up to 50 percent possibility of adopting a contraceptive method than those not working, in these states. The women in their later stages of reproduction, those with education, and have had exposure to family planning from mass media messages, better standard of living and having at least one living son have shown to accept 1.5 times more than others in the reference category.

The use of modern contraceptives in demographically better of states shows that, the characteristics like, residing in rural areas, social and economical backwardness in terms of caste, tribe or religion, preference for sons, experience of child loss or abortion or stillbirth and higher age at marriage depreciate the contraceptive usage up to 50 percent than their counterparts. Women who completed their fertility (usually they have higher ages), levels of education of the partners, those who are working and those have good exposure to family planning messages, those have comparatively better standard of living conditions and those with at least one
living son are more than 1.5 times likely to adopt modern contraceptives than their counterparts in these states.

It is clear from the analysis that, the variables such as exposure to mass-media and husband wife discussion on family planning methods, literacy and higher levels of education, eradication of poverty and raising the living standards, reducing infant and child mortality rates, economic independence of women and promoting more gender equality of children in the family could increase the acceptance of contraceptives in Indian states, and thus could reduce the burden of overpopulation. Ensuring socio-economic development to all sections of the society is the best step towards achieving below replacement level of fertility in India.

4. Conclusions

Although the modern fertility transitions are well along their historical path, deep uncertainty remains about their future course. Theoretically, a strong fertility-reducing goal may be incompatible with an unmet need-based family planning strategy where people desire a large family size. In order to merge reproductive freedom, quality of care and national demographic goals, it is important to define the dynamics of unmet needs and related issues and use this information in the decision-making process.

The important reasons for lower acceptance of modern contraceptives are;

a) Accessibility: Lack of access to fertility limitation services is the main constraint in countries like India. With a further enhancement in accessibility, more and more couples from the disadvantaged sections of the population will be able to utilise contraceptive services,

b) Contraceptive choice: The capacity of a couple or an individual to choose the method suits their needs from a variety of methods. Awareness on various methods of contraceptives other than sterilisation, and the advantages and disadvantages among couples in their reproductive age group should be given priority, rather than incentive based sterilisation programmes. The broader contraceptive options will automatically increase the overall contraceptive usage, and

c) Prioritisation of the service: By giving priority to the under-served, under-utilizing sections of the population at macro and micro-level, the outreach of family planning programme could be widened.
d) Improving the Quality of the Service: By improving the quality of the services provided, the programme could reduce the failure chances. It is an important aspect, as the news on contraceptive failure spreads like wildfire, and it badly affect the acceptance of prospective users.

Adequate funding, favourable policies, and popular support are important to the success of family planning programmes. These programmes need support not only from the clients and officials, but also from general public. Strong commitment and support from the part of health care officials, policy makers, donor agencies, governmental and non-governmental organisations, the news media, and political, religious and community leaders are important for better implementation of health and family welfare programmes. Powerful evidence and persuasive arguments are needed to attract the eligible couples to adopt family welfare measures. This kind of advocacy encourages others who support family planning to speak up and to dismiss the vocal opposition raised by cynics.

Although the knowledge levels of family planning are almost universal, contraceptive use is low and unmet needs are high in India. It is both desirable and legitimate to make a wide range of methods available, especially more effective methods. The wide availability of effective methods through the public or private sector is necessary to achieve high levels of effectiveness in countries like India. In a country like India, success of the family planning programme is entirely dependent on the strategy of the programme to suit and meet the need of the different groups of inhabitants. More attention is to be given to contraceptive switching patterns, use dynamics and related factors. The follow-up system to be strengthened, and its direction should not be method oriented, but the welfare of the client. So it would be meaningful if we have the details of knowledge, attitude and practice of family planning by among different social groups.

Some of the states, namely Goa, Himachal Pradesh, Karnataka, Kerala and Tamil Nadu, in India have reached a below replacement level of fertility and many states will come to replacement level fertility very soon. The fertility decline is happening almost at the same pace in both rural and urban areas of the country. The experience of fertility decline in Kerala has shown the importance of female literacy and outreach of the programme amongst the poorest sections of the population. The literacy programmes in the state were able to create an attitude among the poor that, in
the era of unemployment, fewer children with better quality will be better. In Tamil Nadu, the mass media exposure ignited and motivated women and health workers to achieve a substantial reduction in maternal and child mortality rate through better utilisation of family welfare services. Goa has shown the importance of eradication of poverty and antenatal care of pregnant women.

Ensuring better quality of family welfare services delivered through public and private health service providers will increase the suitability of contraceptives in India. Ensuring socio-economic development such as education, provision of health facilities, economic opportunities will positively influence the reproductive behaviour of eligible population in the country. The importance of education and mass media propagation of family planning messages is very much indispensable in the effective implementation, promotion and effective utilisation of family welfare programmes in India. The program's ultimate success lies in making the people achieve a better standard of living.