CHAPTER-2

RESEARCH METHODOLOGY
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Research Methodology

2.1 Research Design

The present research is a micro exploratory study of the adoption of family welfare programmes. However, before proceeding it is necessary to have an overview of the broad theoretical positions in fertility studies on the one hand and social work intervention levels and perspectives on the other, so as to outline the framework of present research. Patel\(^1\), on examinations of fertility studies, finds four prominent trends: macro-structural, micro economic, psycho-social, and socio-economic and also noted that Demeny\(^2\) classifies macro structural and socio-economic studies under ‘general socio-economic studies’ and within this broad category made distinction between the macro- and micro-level. Patel’s further discussion of these seems to present two broad regroupings i.e. macro studies (macro-structural and socio-economic) and micro studies (micro-economic and psycho-social). The former assumes the dominance of social structural and socio-economic factors in constraining fertility outcomes of passive or docile couples and their analyses of fertility differentials are scarcely concerned with the purpose of human agents and their subjective orientations. While the latter, views fertility behaviour as a

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\(^1\) Patel, *Fertility Behaviour*, pp. 1-3. Much of the discussion on fertility models is most humbly quoted from these pages.


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result of factors that actors comprehend and control. In other words, couples on the basis of their knowledge and assessment tend to ‘make happen’ a given fertility pattern. Thus, while one over-emphasizes the calculative knowledge of couples, the other remains silent about the day-to-day social activity of reproductive agents. Patel concludes that overall these focus on the subjective orientations of actors or on the broad objectives/structural features of the society circumventing fertility behaviour. In this backdrop the researcher contention is to focus on institutional mechanisms through which both subjective and objective realms are made operative.

The present research focuses on these institutional mechanisms, and given the collective and unique nature of Indian rural family, as a social institution, the family is taken as a unit of study. Further, the collective value system of Indian society, ethos and community solidarity are preserved and mutates through the institution of family, of which fertility behaviour and adoption of family welfare programmes are no exceptions. It is also noted that ‘the family as a unit is the best compromise between a macroscopic unit like society and microscopic unit like the individual- it contains the essence of both’³. There is another significant reason for taking ‘family’ as a unit of study and the answer lies in values of social work in India. A more recent model in social work, that is generalist social work, ‘focuses on intervention at all system levels. The definition of the problem, issue, or need, not the method alone, determines the strategies that social workers and clients select.’⁴ Dubois and Miley further

³ Khan, Family Planning among Muslims in India., p. 13.
noted that ‘social work clients may be at any level in the social systems
continuum- at the microlevel, individuals, families and groups; at the
midlevel, formal groups and organizations; at the macrolevel, community,
society, or even the world community; and even the professional system of
social work.’^ Social work profession in India still struggles against
accusations that it is a western transplant (legacy of American professional
social work)^ and that there is a need for ‘indigenisation of social work’.^ Very recently, Desai noted, ‘the ideologies of professional social work in India
have had to face some similarities and some contradictions with reference to
the Indian ideologies, based in its social ethos, religions and indigenous social
movements. The Indian society is structured by families and communities,
whereas, the western social work approach is individualistic. The ideology of
Indian social work profession today seems to have evolved as a combination
of focus on individuals, families and communities [italics mine].^ However,
the generalist social work’s focus on social system continuum and micro level
units of interventions make the ‘family’ as best fit unit of study in Indian
society which also resonates with the ‘global social work perspective’^.

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^Ibid., p. 71.

^ Murli Desai, Ideologies and Social Work- Historical and Contemporary Analyses, Subject
Curriculum Series for Social Work Education (Jaipur and New Delhi: Rawat Publications,

^ On this issue P.D. Kulkarni observed ‘there has been an almost non-stop cry- rather
exaggerated, if not some what misplaced- for indigenisation of social work teaching and social
work practice in India. There is a constant accusation of our being heavily dependent upon
imported models, techniques, literature, and so on.’ He strongly noted ‘I do not wholly agree
with this charge’. P.D. Kulkarni, “Teaching of Social Sciences in Schools for Social Work,”
The Indian Journal of Social Work 61, no. 2 (2000), p. 193, 195. Also see P.D. Kulkarni,
"The Indigenous Base of Social Work in India," The Indian Journal of Social Work 54, no. 4
(1993).


^ To my limited understanding of the subject, social work profession with its client centred
approach (which is much quoted as a reason for its indigenisation) has developed (rather
evolved) a specialised body of knowledge and skills which are intrinsic to social work practice
Hence, the family as unit of study takes the present research more close to Indian model of social work instead of western social work unit ‘individual’ and family welfare programmes much-criticised unit ‘couple’. Thus, from social work perspectives, as well, the present research is a micro level study.

Thus in the light of insight gained from literature review and the outlined justification of the study and research design, the present research proceeds to achieve the following objectives.

Objectives

The central objective of the study is to explore the dynamics of personal and familial characteristics in the adoption of family welfare programmes. That is to understand how the personal and familial characteristics first become operative (if any, under the influence of socio-economic variables) and than operates (through intra-house dynamics of communication and power relations within the family) to determine the very process of contraceptive adoption. A number of studies have shown the importance of socio-economic variables and rural reproductive pattern in fertility decisions and contraceptive adoption. Here endeavour is to see how these much acknowledged variables stimulate the personal and familial characteristics, which in turn determine the process of contraceptive adoption. Thus study focuses on the following objectives:

any where in the world. I dare to say that social work profession’s foundations are global in nature and like any other disciplines and professions; it has an element of adaptability to be effective locally. More recently, with globalisation as watch word, researchers have started pondering over the issue of internationalising social work education to respond adequately to emerging global changes, issues, needs and problems. Specific reference here may be made of an article- David Cox, “Internationalising Social Work Education,” *The Indian Journal of Social Work* 61, no. 2 (2000).
1. To analyse and assess the influence of socio-economic correlates, and the personal and familial characteristics in the adoption of family welfare programmes.

2. To analyse the nature and impact of rural women reproductive trajectory in the adoption of family welfare programmes.

3. To explore the intra-house dynamics of communication and power relations in the adoption of family welfare programmes.

4. To understand how personal and familial characteristics operate to influence the process of contraceptive adoption.

Hypotheses

In the light of objectives, following hypotheses are posited for verification in this study-

1. Higher the caste, education, income and outside employment, higher the adoption of family welfare programmes.

2. Poorer the reproductive trajectory of woman, poorer the adoption of family welfare programmes.

3.1 Higher the scope of discussion on family issues (wider the communication domain), higher the adoption of family welfare programmes.
3.2 Higher the mutual decision making in family, higher the adoption of family welfare programmes

4.1 More positive the personal and familial response to contraceptive methods, more the adoption of contraceptives.

4.2 More participatory the decision making process, more the adoption of contraceptives.

2.2 Universe and sample selection

The present research focuses on analysis of Lodha block\textsuperscript{10}, which lies in Aligarh district, Uttar Pradesh (henceforth UP). UP lies in the north zone of India (see Map 1\textsuperscript{11}) and is most populous state of India and falls in the category of BIMARU states. BIMARU is an acronym used by Ashish Bose for four demographically poor performing states and hence stands in alphabetical order for Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh (BIMARU). Bose himself noted these four states are truly sick (‘bimāru’ in eastern Hindi dialect), demographically, socially, economically and politically. Bihar is the picture of anarchy. UP situation is not better than Bihar.\textsuperscript{12} Bose further clears the comparative picture and has shown that the population of BIMARU states will increase from 39.6 per cent in 1991 to 51.4 per cent in

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\textsuperscript{10} Block in India is a development unit below the district and above the village. In India, all the development programmes and schemes are executed from these development blocks. However, it is different from sub-district, which is called tehsile and is a revenue and administrative unit. Thus, hierarchy from village may be constituted as village, block, tehsile and district.


\textsuperscript{12} Bose, Beyond Demography- Dialogue with People., p. 151.
2051 while the population of the southern states will decrease from 23.2 per cent in 1991 to 16.5 per cent in 2051.\textsuperscript{13}

Map 1: Location of Uttar Pradesh in India

The pathetic demographic condition of UP is equally evident from the report of Registrar General’s Expert Committee on Population Projections. Assuming that a Total Fertility Rate (TFR) of 2.1 per woman will pave the way for population stabilisation, the committee made the projections shown in table 2.1.

Table 2.1: Year by which Projected TFR will be 2.1 in selected States

<table>
<thead>
<tr>
<th>States</th>
<th>Year</th>
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</thead>
<tbody>
<tr>
<td>South</td>
<td></td>
</tr>
<tr>
<td>Kerala</td>
<td>1988</td>
</tr>
<tr>
<td>Tamil Nadu</td>
<td>1993</td>
</tr>
<tr>
<td>Andra Pradesh</td>
<td>2002</td>
</tr>
<tr>
<td>Karnataka</td>
<td>2009</td>
</tr>
<tr>
<td>North</td>
<td></td>
</tr>
<tr>
<td>Rajasthan</td>
<td>2019</td>
</tr>
<tr>
<td>Bihar</td>
<td>2039</td>
</tr>
<tr>
<td>Madhya Pradesh</td>
<td>Beyond 2060</td>
</tr>
<tr>
<td>Uttar Pradesh</td>
<td>Beyond 2100</td>
</tr>
</tbody>
</table>

Source\textsuperscript{14}: Registrar General’s Expert Committee on Population Projections, 1997

\textsuperscript{13} Ibid., p. 151.
These projections further highlight the poor performance of UP in population stabilisation process. The condition of UP has further worst in other indices as well. The table 2.2 shows the comparative profile of India, Kerala (the model Indian State to have first achieve the below replenishment level of population growth) and UP (State in which lies the study area).

Table 2.2: Comparative profile of India, Kerala and Uttar Pradesh (UP)

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>India</td>
<td>1027</td>
<td>1.70</td>
<td>54.16</td>
<td>933</td>
<td>25</td>
<td>8.1</td>
<td>16.3</td>
<td>64</td>
<td>3.3</td>
<td>19.5</td>
<td>46.2</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Kerala</td>
<td>31.38</td>
<td>1.05</td>
<td>87.86</td>
<td>1053</td>
<td>6.8</td>
<td>6.4</td>
<td>0.4</td>
<td>18</td>
<td>1.8</td>
<td>22.0</td>
<td>39.6</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>UP</td>
<td>168.05</td>
<td>2.2</td>
<td>42.98</td>
<td>898</td>
<td>31.6</td>
<td>9.7</td>
<td>21.9</td>
<td>60</td>
<td>4.8</td>
<td>19.6</td>
<td>38.0</td>
<td></td>
</tr>
</tbody>
</table>

Source:
2. Col. 6-9, SRS Bulletin on Vital Statistics, October 2003

Thus UP has performed poorly in almost all parameters and as table 2.1 and 2.2 show it is worst in the country in terms of fertility rate although CPR reaches near to that of Kerala. As per Census 2001 results, UP still has as much as 97942 (against 112804 in 1991) villages- of which 16.77 per cent are with just 200 or less population, more than 50 per cent have sex ratio of 900 or less, just 10.66 per cent villages have literacy rate of 60 per cent and above and in case of female literacy the percentage of villages in the 60 and above

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literacy rate category is only 3.52 per cent. In terms of districts also, UP have as much as 70 districts with wide spatial variations.

Aligarh with a population of 2.99 million is one of the seventy districts of UP and is located at 27.30 N latitude and 79.40 E longitude on the western part of UP (see Map 2). It is at a distance of 180 km from New Delhi (India’s capital city). The national highway (NH-83) connects Aligarh to Delhi. Aligarh is known across the world for its lever pad locks industry. In India it has largest cluster of lock manufacturing units. Aligarh district is divided into six sub-districts (tehsile) and 12 blocks (see Map 3). The study area Lodha comes under tehsile Koil and is one of the twelve blocks of Aligarh District. Lodha is located on three sides of Aligarh city (see Map 4) and have worst vital statistics in the district and due the same reasons, a project entitled Convergence Approach for the Promotion of Reproductive and Child Health in Lodha Block, Aligarh District (hereafter RCH project) was launched in the year 2000 initially for a period of two years and latter extended for another two years to end in December 2004. The agencies, State Innovations in Family Planning Services Project Agency (SIFPSA) and Population Foundation of India (PFI) funded the project. The Department of Sociology and Social work, Aligarh Muslim University (AMU), Aligarh implemented the project. One can also understands the poor reproductive health profile of Lodha block from the fact that in year 2001-2002 it has lowest sterilisation and against the target it achieved only 35.29 per cent and situation was even worst in 2002-2003 as it

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16 Ibid.
achieved only 29.12 per cent of the sterilisation targets while there were also blocks in Aligarh to have more than cent per cent against the targets. Furthermore and most importantly, the researcher brief involvement in the RCH project and related other field experiences while supervising the social work students in the same block resulted in taking Lodha as a unit of study in the present research.

17 District data presented as a part of Agenda for 4th AGM of DIFPSA (District wing of SIFPSA).
Sample selection

Lodha block as per Census 2001\(^1\) has a population of 200642 scattered in 92 Gram Panchayats and 142 villages, out of which 136 are revenue villages and rest 6 are without habitation. Lodha has sex ratio of 848 females per thousand males, which is below the national and state average. As per the end term evaluation of RCH project in December 2001\(^2\) the eligible couples in Lodha were 27564 with a CPR (Contraceptive Prevalence Rate) of 38.5 per cent. In terms of health administration, Lodha has one PHC (Primary Health Centre), more recently three more additional PHCs are established, and 28 sub-centres. One of these sub-centres is Jalalpur. Jalalpur sub-centre covers four villages namely Alapur Garhia, Ashrafpur Jalal, Alahadadpur Nivry and Rorawar (see Map 4). All together these villages constitute a population of 10091 in the coverage area of Jalalpur sub-centre\(^3\).

Thus, against the norms of a sub-centre at 5000 populations in plain areas, the population coverage of Jalalpur sub-centre is too large.\(^4\) It may be noted that against the population norm of PHC at 30000 population Lodha has more than six times larger population coverage (that is 200624 population at one PHC). However, noting the reverses, more recently three additional PHCs are

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\(^1\) The block level data as per Census 2001 are derived from Records of Block Development Office, health statistics at Primary Health Centre (PHC) at Nehra and office of ICDS at block headquarters.

\(^2\) It refers to data from RCH project in Lodha.

\(^3\) GOI, Census of India 2001: Cd-3 (Uttar Pradesh).

\(^4\) As per Government of India (GOI) notification, the primary health care structure in the country has been established as per the following norms: Sub-Centre at 5000 population in plain areas and at 3000 population in hilly/tribal areas; PHC at 30000 population in plain areas and 20000 in hill and tribal areas and the CHC at 120000 population in plain areas and 80000 in hilly and tribal areas.
established to supplement the Lodha PHC at Nehra and along with that three sub-centres are also provided with an additional RCH worker to supplement the task of Auxiliary Nurse Midwife (ANM).

The Jalalpur sub-centre is one of those three sub-centres to have an additional RCH worker. Further the Jalalpur sub-centre has a sex ration of 849 and with an average household size of 6.26 person. The sub-centre Jalalpur owing to its proximity with the block headquarters and quick access to city is a centre of many project offices and organisations. Moreover, in the year 2005-2006 (April- March) it has highest number of sterilisation done (24 in number) in

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22 These RCH workers are appointed on basis in Category “C” districts where the status of RCH is poor and the infrastructure, roads and electricity is also generally weak, the task of the ANM is more difficult. See GOI., "National Family Welfare Programme.", p. 145.
comparison to other sub-centres. The profile of sterilisation cases in Jalalpur across two decades is given in table 2.3.

Table 2.3: Profile (Average) of Sterilisation cases under Jalalpur sub-centre

<table>
<thead>
<tr>
<th>Profile of cases (Average)</th>
<th>1995-2005</th>
<th>1985-1995</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sterilisation cases</td>
<td>19.4</td>
<td>7.5</td>
</tr>
<tr>
<td>Average age at sterilisation</td>
<td>30.4</td>
<td>32.2</td>
</tr>
<tr>
<td>Average parity at sterilisation</td>
<td>3.95</td>
<td>3.57</td>
</tr>
<tr>
<td>Son-Daughter Alignment</td>
<td>2.43 + 1.52</td>
<td>2.17 + 1.40</td>
</tr>
</tbody>
</table>

Source: Auxiliary Nurse Midwife Sterilisation Cases Record Register, 1985-2005

As the table shows that age of sterilisation has come down across two decades but the parity instead of declining has increased and thus shows that with the decline in infant mortality, the fertility has not declined. Rather in 2005-2006 the average parity was 4.1 children. In view of above facts and central location of Jalalpur sub-centre, it is taken as the area of study. Thus, the universe of the present study is located in Jalalpur sub-centre of Lodha Block, Aligarh District in the state of UP, India. In the first stage of sampling the nodal village (where sub-centre is located) that is Ashrafpur Jalal and its adjoining village Alahdadpur Nivry are randomly selected as the units of study (see Map 4). It may also be noted that Ashrafpur Jalal has highest household size (that is 7 person) among the sub-centre villages followed by Alahdadpur Nivri (household size 6 person). Moreover, the sex ratio of Alahdadpur Nivri, in comparison to sex ration of Jalalpur sub-centre and Lodha block, is higher i.e. 896 and in case of child sex ratio it is 1030. The village Ashrafpur Jalal has high concentration of Hindus belonging to Lodha Rajput caste (OBC category) and Scheduled Castes (SCs). Alahdadapur Nivri village on the other has mixed population of Hindus and Muslims. The majority of Muslims here
belong to low caste\textsuperscript{23} Alvi Syed (OBC category). In the second stage of sampling, the sample is drawn of contraceptive adopters. Noting the problem of reliable information about the temporary contraceptive adopters, it was decided to adopt sterilisation as the yardstick to define adopters and non-adopters.\textsuperscript{24} To ensure comparability the equal sample of adopters and non-adopters is drawn and finally a sample size of 75 adopters and 75 non-adopters is fixed. Keeping in mind, the focus of study on personal and familial characteristics, it was decided to take only one respondent from a family or household. Thus, the sample is drawn from 150 households. Respondent in case of adopters means the currently married woman in the reproductive age group (15-49 years)\textsuperscript{25} and has undergone sterilisation in last five years not later than that. In case of non-adopters, respondent means any currently married women in the reproductive age group (15-49 years) and has not undergone sterilisation, she may or may not be using any other temporary or traditional contraceptives. Initially, it was planned to select sterilisation cases

\begin{footnotesize}
\begin{itemize}
\item[23] It may be noted that Islam is an egalitarian religion however in India it has come under the influence of endogenous caste system and thus Muslims in India do have caste categories. M.N. Srinivas rightly noted ‘Islam proclaims the idea of equality of all those who prefers the faith, but in India it has been characterised by caste. Muslim caste differs in some respect from the Hindu caste system; there are no ethico-religious ideas justifying the hierarchy or regulating inter-caste relations through ideas of purity an pollution; there are no varna categories. What we have is a hierarchy formed by several \textit{jatis}.’ Mandelbaum citing from other sources also noted that ‘Muslims in all regions of India class themselves into endogamous hereditary groups which are ranked in relation to each other.’ The sociologists like Ghous Ansari and Imtiaz Ahmad have dwelled on this issue and categorised these into \textit{Ashrafs, Azaifs and Arjals}. In this categorisation, the Muslims in the sampled area fall under the category of \textit{Arjals}. See M.N. Srinivas, \textit{India: Social Structure} (Delhi: Hindustan Publishing Corporation, 1982), p. 7; Mandelbaum, \textit{Society in India.}, p. 546; Ghaus Ansari, “Muslim Caste in Uttar Pradesh: A Study of Cultural Contact,” \textit{The Eastern Anthropologists} 13 (1960); Imtiaz Ahmad, “Social Stratification among Muslims,” \textit{Economic and Political Weekly} 10 (1965).
\item[24] Thus, hereafter the adopters refer to sterilisation adopters and non-adopters refer to non-sterilisation adopters. In both categories there may or may not be ever-temporary contraceptive users.
\item[25] The age group 15-49 is taken because same is used in the calculation of Total Fertility Rate (TFR), which is defined ‘the average number of children that would be born to a woman if she experiences the current fertility pattern throughout her reproductive span (15-49 years)’. See GOI, \textit{Women and Men in India 2001.}, p. viii (Explanatory Notes).
\end{itemize}
\end{footnotesize}
from the Record Register of ANM using systemic random. It was soon realised that this list includes only all those cases that ANM of the area has taken for sterilisation, they may or may not be living in that area. Further, the list excludes sterilisation cases, which are done at private hospitals. Thus, it was decided to identify and select adopters with the help of key informants. In case of non-adopters the sample is randomly drawn excluding those households from where an adopter is selected for study. Thus, this sample of 150 households by way of inclusion-exclusion premise represents a wide cross section under the study.

2.3 Tools of data collection and analysis

A complete era of studies on fertility, family planning and contraceptive practice has witnessed use of interview-schedules or questionnaires and today, so is the fervent against these structured techniques and quantitative studies. Rao even noted that an area of human behaviour as intimate as fertility behaviour cannot be understood by simply asking questions. Participant observation and case studies are helpful in providing access to this sensitive domain in human life. On similar lines, Caldwell et al highlight the unique contribution of participant observation and the strength of prolonged personal contacts with the fields. Very recently, Patel saw a strange coincidence that though village studies in India had their golden period

26 For example Rao review of 550 KAP studies on fertility, family planning and contraceptive practice during 1951-74 found that most studies had used interview-schedules or questionnaires with the exception of two that had used observation as a method. See Rao, Studies in Family Planning: India.

roughly during the same period as demographic studies on fertility transition—
from mid 1950s to mid 1970s—there was little communication between the two
genres and thus, she argued her research attempts 'a holistic perspective on
fertility behaviour through monographic study of a village community' to fill
that gap. However, much earlier Djurfeldt and Lindberg argued that dense
descriptions of qualitative data support quantitative data. The present research
is a modest attempt on similar lines.

The research study relies both on quantitative as well as qualitative techniques.
To have more concrete facts survey method shall be used. For this purpose,
pilot tested structured-interview schedule shall be used. The research shall also
use a range of qualitative methodologies that includes case study, key
informant interviews with related health workers/volunteers and focus group
discussions (FGDs) with sampled respondents and more importantly 'informal
discussions' with established old folks in the sampled villages. A total of ten
key informants are chosen. They include ANM (Auxiliary Nurse Midwife) of
the sub-centre under study, two AWWs (Anganwadi Workers), two ASHAs
(Accredited Social Health Activists), three CMCs (Community Mobilisation
Coordinators) and two young ladies (catalysts) with experiences of
reproductive health (RH) activities in the sampled villages. The choice of each
key informant is very rational and purposive, and is quite close to Vansina's

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29 ibid., p. 1.
31 Vansina noted a good key informant is one who still lives the customary life, who recalls
traditional events and customs readily and enthusiastically, and who is old enough to have
acquired some degree of personal experience of his cultural environment. See J. Vansina,
prescription. For example ANM is in the same area for the past twenty years and is unusually (of ANMs) very active, cooperative and hold command in her area. AWWs are well versed and are acting as resource person in reproductive health, one has even worked as community based distributor (CBD) in RCH (Reproductive and Child health) project. ASHAs are newly identified and trained health 'activist' on incentive basic under recently launched National Rural Health Mission (NRHM) of Government of India and thus were very enthusiastic and productive. CMCs though are polio volunteers of Unicef social mobilisation network but in the sampled villages, these chosen CMCs are work a team of health workers and have developed very clear understanding of RH issues and having motivated a number of female for sterilisation. The remaining two young ladies are having previous field experiences in health activities and are very confident and informative, so is reason I introduced them as catalyst. FGDs are planned because these reflect the views of the participants and in a way represent community attitudes. A total of ten FGDs of adopters and non-adopters together and separately, depending on the specific issue for discussions, are planned to crystallise the dynamics of contraceptive adoption and non-adoption. Similar is the rationale for the thirteen case studies of adopters and non-adopters. Many a times in between the research works/ field studies, one comes to know of people with reservoir of information on specific issues (which is usually not available), thus in present research space is provided to exploit the same by way of 'informal discussions'. Researcher's previous and prolonged exposure in the field somehow permits the use of these techniques, which otherwise might not

be so friendly to a male outsider talking to females on most inmate and personal domain. The requisite secondary data on block profile sampled sub-centre shall be collected from block office, primary health centre and district hospital statistics section.

The data thus collected from a sample of one fifty households (75 sterilisation adopters and 75 non sterilisation adopters) shall be tabulated and analysed to test the hypotheses and draw inferences. The reliance is on simple and sophisticated statistical techniques (percentages, mean averages and two tailed t-test, hereafter, t-test), one for the researcher inability to ‘handle’ complex statistical tools and secondly due to the intension to support the quantitative data with dense qualitative data. The results and insights from FGDs, case studies, ‘facts’ from key informants and informal discussions, shall overcome the limitation of limited statistical use.

2.4 Operational terms

Personal and Familial characteristics

Personal characteristics here refer to the characteristics of sterilisation adopters and non-adopters women who are taken as sample of study and include their education, occupation and income. While the familial characteristics refer to the education, occupation and income of their spouses. The familial characteristics, in case of joint family, also include the similar traits of any one person (say father-in-law, mother-in-law, brother-in-law) who influence the major decisions in the family.
Family Welfare Programmes

The term ‘family welfare programme’ is a replacement to the term ‘family planning programme’ renounced by the Indian policy makers for ‘self perceived goods’. To what extent the nomenclature change is beyond semantics and what it actually connotes has already been discussed. Desai made distinction between family planning as self generating voluntary programme and family planning as a population control movement [italics mine]. This distinction qualify the previously held connotation by Lappe and Collins who observed that the ‘family planning as a valuable social service to facilitate individuals self determination and a legitimate way to increase people real options having the goal of providing every couple access to the tools necessary to choose the size of their family, is crucially different from ‘Family Planning Programme’ that purport to alleviate the problem of hunger by limiting population growth. To Raina the scope of family planning, however, is much wider than family limitation. ‘Family planning is a scientific approach to deal with the problems of the family and contributing to the richness of life in family.’ On contrary to Davis ‘family planning is a euphemism for contraception.’ Notwithstanding this, in present research the term family welfare programmes is restricted to ‘dynamic process of contraception adoption, inter play of forces on discussion and decision to adopt contraceptives and consequences thereafter, if any.’

32 Desai, Urban Family Planning in India., p. 136.
Adopters and Non-adopters

Present research focus on the adoption of contraceptives. The difficulty arose from the fact that it is not easy to ensure that the respondent used contraceptives regularly. Therefore, it is decided to accept adopters as those who have adopted terminal method of family planning i.e. female sterilisation. Thus, for the purpose of present research, adopters shall mean those women who have undergone sterilisation, and non-adopters as those who have not undergone sterilisation and that they may or may not be ever temporary or traditional contraceptive user. It may again be noted that sterilisation in the present research is restricted to female sterilisation.

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36 The same problem was also faced by Panandikar and Mehra and the present distinction is borrowed from their classification of acceptors and non acceptors. See Panandiker and Mehra, *People's Participation in Family Planning*, p. 20.