CHAPTER-3

PERSONAL AND FAMILIAL DETERMINANTS OF CONTRACEPTIVE ADOPTION IN RURAL MILIEU
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Personal and Familial Determinants of Contraceptive Adoption in Rural Milieu

It is reported that 'irrespective of urban jobs or the level of education, social expectations and values regarding sex and number of surviving children continue to dominate a couple’s decision to stop or continue child bearing. The individual couple rarely decide their fertility career independent of social norms and compulsions from kin, neighbours, and the community. This is clear from the number of children born to educated and naukri-holding parent(s).'' The present research, as stated earlier, is restricted to a sample of 150 respondents with equal weight to sterilisation adopters (i.e. adopters) and non-sterilisation adopters (i.e. non-adopters) categories. This chapter (and subsequent chapters as well) explores the dynamics of sterilisation adoption or non-adoption ('event'/dependent variable) across major determinants ('properties' / 'conditions' or independent variables). This chapter specifically dwells on the question – how social correlates, and for that matter personal and familial characteristics per se influence the contraceptives adoption.

3.1 Socio-economic correlates of adopters and non-adopters

In fertility studies and those relating to adoption of family planning a whole genre of researchers have emphasized the determining role of socio-economic

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correlates. In continuity with tradition, the present research analysis proceeds with a note on important socio-economic correlates that is religion, caste, family type, land holdings and political participation, and the extent to which they govern the process of contraceptive adoption.

Religion

The Indian population includes followers of six major religions: Hinduism, Islam, Christianity, Sikhism, Jainism, and Buddhism. These six religions account for almost 99.5 per cent of the total population of the country. The NFHS data for 1992-93 show the Muslim TFR to be higher (4.4) than the TFR of Hindus (3.3) by 1.1 children. On the other hand, the IMR among Muslims (77) was about 14 per cent lower than among Hindus (90). However, to interpret these facts properly, Visaria and Visaria noted, ‘it is important to remember that almost 36 per cent of the 101 million Muslims enumerated in 1991 lived in Uttar Pradesh and Bihar, the two states with the highest level of TFR’. A good many of studies have dwelled on Muslims response to adoption of contraceptive methods. Panandiker and Mehra in their analysis of people’s participation in family planning noted that the

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2 Visaria and Visaria, "India's Population.", p. 74.
4 Visaria and Visaria, "India's Population.", p. 74. It can also be noted that these states are persistently poor in vital demographic indices, a reason why Ashish Bose putted them in the category of BIMARU states and more recently, argued that their condition is still poor enough to remain in the same category. See Bose, From Population to People., Bose, Beyond Demography- Dialogue with People.
5 Panandiker and Mehra, People's Participation in Family Planning., p. 29. This study was based on a sample of 220 acceptors of sterilisation and 110 non-acceptors. The sample was drawn from two models, that is, of voluntary organisations (four voluntary organisation from Delhi, Gujarat and Maharastra) and Panchayati Raj Institutions (PRIs) from Madhya Pradesh and Gujrat.
extension workers did not encounter any organised religious opposition to the programme in Delhi. In fact, one of the most successful cases was that of Muslim-majority villages near Okhla. Khan in his study on Muslims of Kanpur noted that majority of the (83.9 per cent males and 64.5 per cent females) respondents were in favour of family planning. He also observed that the majority of them were either moderately or very positively in favour of family planning. Those who were against it were totally against the idea of contraception. A very few were either neutral or moderately against family planning. Further, of the total sample, just 50 per cent had used contraceptives at one time or another. Khan also compared the results with the contemporary fertility survey in Lucknow city and observed that 'the percentage of the 'ever users' in the present study is larger than the 'ever users' of all castes and religious groups in the Lucknow survey. In the Lucknow study, 46 per cent of the Christians, 45 per cent of the upper caste Hindus, 20 per cent of the Sikhs and 17 per cent of the Muslims had ever used any contraceptive. The percentage of the 'ever users' among the lower or middle caste Hindus was below (7 to 8 per cent) the average (31.5 per cent).

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6 Khan, *Family Planning among Muslims in India.*, pp. 149-150.
7 Ibid., p. 160.
8 Ibid., p. 162. Khan further notes that this study contradicts the general belief that Muslims do not accept family planning and fanatics propaganda that if the Hindus adopt the recommended norms of two or three children per couple, they will be reduced to minority by 2051 A.D. and that the Muslims and other non Hindus will become a majority ( Hendre, 1971). This study supports the several other studies ( Pethe; P.E.O.) that have shown that such a suspicion is baseless and that it is factual wrong to say that Muslims are not adopting family planning. See Sudhir Hendre, *Hindus and Family Planning* (Bombay: Supraja Prakashan, 1971)., p. 35; Vasant P. Pethe, "Hindu, Muslim and Demographic Balance in India," *Economic and Political Weekly* (1973)., Planning Commission, "Family Planning Programme in India: An Evaluation," (New Delhi: Programme Evaluation Organisation, Planning Commission , GOI, 1970).
The table 3.1.1 presents the religion-wise break-up of the sampled population in Jalalpur sub-centre, Lodha Block Aligarh (UP). It shows that of the total sample, 69 per cent (104) are Hindus and 31 per cent (46) are Muslims. The cross-table also reflects that in the adopters' category 67 per cent (50) are Hindus while 33 per cent (25) are Muslims, and in case of non-adopters, the Hindus are 72 per cent (54) and Muslims are 28 per cent (21). Thus, the table does not present a clear picture of sterilisation adoption across religions.

### Table 3.1.1: Distribution of Adopters and Non-adopters across the Religion

<table>
<thead>
<tr>
<th>Religion</th>
<th>Sterilisation status</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adopters</td>
<td>Non Adopters</td>
</tr>
<tr>
<td>Hindus</td>
<td>50 (67%)</td>
<td>54 (72%)</td>
</tr>
<tr>
<td>Muslims</td>
<td>25 (33%)</td>
<td>21 (28%)</td>
</tr>
<tr>
<td>Total</td>
<td>75 (100%)</td>
<td>75 (100%)</td>
</tr>
</tbody>
</table>

Source: Survey data

The picture somehow becomes clear if we tabulate adopters and non-adopters together with individual religious groups (i.e. across the rows). In this case among the total Hindus (104) in the sample, 48 per cent (50) are adopters while among the Muslims out of the total (46), the adopters are 54 per cent (25). Further, within each religious category, if we look for ever temporary contraceptive usage among adopters and non-adopters together (table 3.1.1.1), then among Hindus, the ever temporary contraceptive users slightly declines (in comparison to Hindu sterilisation adopters) to 43 per cent (45) while in case of Muslims, the same slightly increases (in comparison to Muslim sterilisation adopters) to 59 per cent.

However, given sample size, it will be too much to generalize that religion is not significant variable in sterilisation adoption, and that Muslims as group
have higher affinity to temporary contraceptives (in comparison to sterilisation) than Hindus whose percentage in the adoption of temporary contraceptives (in comparison to sterilisation) declines. Thus, instead of finding answers in decimals, let's see how the sample population of Hindus and Muslims, adopters and non-adopters themselves relate religion with the contraception.

Table 3.1.1.1: Distribution of Ever Temporary Contraceptive Users (Adopters and Non-adopters) across the Religion

<table>
<thead>
<tr>
<th>Temporary Contraceptive usage</th>
<th>Religion</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hindus</td>
<td>Muslims</td>
</tr>
<tr>
<td>Ever users</td>
<td>45 (43%)</td>
<td>27 (59%)</td>
</tr>
<tr>
<td>Never users</td>
<td>59 (57%)</td>
<td>19 (41%)</td>
</tr>
<tr>
<td>Total</td>
<td>104 (100%)</td>
<td>46 (100%)</td>
</tr>
</tbody>
</table>

Source: Survey data

For this purpose, focus group discussions (FGDs) were organised separately with each religious group. Each group consisted of a total 10 women in the age group 25-40 years. However, both FGDs with Hindus (refer FGD-1), and with Muslims (refer FGD-2) dwelled around the same theme of understanding the religious ‘world view’ of the sampled population in regard to contraception. The discussions in both the groups proceeded systematically around the following issues—perception about children, need of birth control, and if any, the permissible methods of birth control. Further, in both the FGDs researcher was key facilitator, supported by other facilitators namely Auxiliary Nurse Midwife (ANM) and Accredited Social Health Activist (ASHA), both of them proved to be the main icebreakers. In FGD-1 there were 10 women in the age group of 25-40 years and out of these 4 were adopters and 6 were non-adopters. The group in process was also joined/disturbed by an old lady (60
years plus) who was bold enough to comment on the issue harshly and thereafter leave away the group. Her brief ‘observations’ were worth important to be incorporated. In FGD-2 also there were 10 women in the same age group as of FGD-1 (i.e. 25-40 years) and out of these 3 were adopters and 7 were non-adopters. Another old lady (70 years plus) at later stage joined this group also. She made the discussion lively till the end. Her experiences were vast enough to be taken into cognisance. However, researcher (as a key facilitator) remained also attentive enough to avoid group polarization. The researcher summarised the discussions in both FGDs and accordingly draw inferences and presented the same to both groups to ensure their group acceptance.

It came out from FGDs that to both groups children are worth important to continue generations (khandan/kul), and support family and parents; and for the same reasons God (Allah/Bhagwan) bless them with children. Children are God’s blessings to parents (nemat/den). Further, all did consider their inability to afford large number of children and thus necessity to restrict children after a maximum of 3-4 children. However, members within both the groups differed and debated on the issue of how to control childbirth. Some prescribed ‘self control as best control’, others commented on its impracticality. One young lady in Muslim group even said, ‘it is sin to refuse husband (for coitus)’ (hamare yahan ‘mana’ karna gunah hai). The groups were then facilitated towards discussion on temporary contraceptive methods. Among Muslims, younger age groups (less than 30 years) were quite ignorant about modern temporary contraceptives in comparison to Hindus. However, in both groups
most known temporary methods were Oral Contraceptive Pills (OCPs or simply pills called locally as goli) and Condoms (nirodh). Both groups showed no religious constraints or inhibitions in the use of temporary methods but all those who used these argued for their unreliability and side effects. However, the discussions heated up, between both groups, on the issue of sterilisation. In FGD-1, all the Hindu women, including sterilisation adopters, were reluctant in giving outright support for sterilisation. They related sterilisation to becoming ‘infertile’ – which is considered as ‘biggest curse to a women’. Thus, those who have undergone sterilisation argued that they have done the same ‘due to of extreme necessity’ (majbūrī mein karwāya) and expect ‘pardon from God’ (bhagwan māf kare). Another lady, a non-adopter, narrated that God punishes the sterilised women by taking away ‘a living child’ (jindā bachchā mar jātā hai) and even said she has seen many such incidents. In between the discussion came the said old lady (60 year plus) and addressing to sterilised women, she lambasted that ‘they are now neither male nor female’ (kat ke na admi mein na aurat mein) and then more boldly addressed us to be responsible for this ‘sin’ and hence are sinner (ye log pāpi hain) and before anything more she left without replying our humble wish ‘namaste’ (which is a norm to answer in rural Indian traditions). Likewise in FGD-2 there was also divergence. Further, among adopters both the senior and younger age group ladies argued that ‘it is against religion’ (manā hai). The old lady (70 years plus) much prevailed here and became much critical, harsh and vocal as soon as question of sterilisation surfaced. She even warned that ‘had you (researcher) been not from our community (Muslim) and university (AMU, towards which they have respect) we would have thrown you out and even not
asked to sit here.’ But in so quick a manner, was she pacified also to narrate her valuable experiences. She again cited (like in FGD-1) examples of sterilised women experiencing death of living children as post-sterilisation punishment, wrath of God (khudāi mār). Furthermore, the adopters lamented of their compulsion to go for the same. Some argued for confusion over the issue- God knows what is right (Allah Janatā hai sahi kyā). But one young lady, a non-adopter forcefully argued that ‘even the women from the families of religious leaders are going for sterilisation, why can’t we? What else to do? Have children and make them beggar? (mullon ke ghar se karāne ja rahi hain – hum kyon nahi. Phir kya karen – bache paiddā karein aur bhikh mangvayen). One lady educated up to primary level, very brilliantly related the issue to drugs and argued like drugs are permitted to take for illness, though they contain alcohol, which is prohibited in Islam (harām) so is the case of sterilisation (locally called as aprēsan) which is taken as last resort to restrict the birth of more children, who are unaffordable to family and the burden has to bore by women. With these hot discussions in both groups, the members agreed with researcher summary that sterilisation per se is not something one longed for, but is and can be undertaken in the event of necessity like when children are unaffordable. On this note both groups agreed. It may also be mentioned that in process of long discussions in both FGD-1 and FGD-2 members requested and latter on listened to ‘right use of temporary contraceptives’ and sought classifications regarding myths attached to temporary contraceptives. The most common were Intra-Uterine Contraceptive Device (IUCD/IUD/ Cu-T) moving up in body and pills (goli)
producing *garmī* (heat) in body. The researcher\(^{10}\) and ANM warmly clarified the same. Muslim women particularly lamented for the non-availability of temporary contraceptives (which they needed most) and some even asked us to facilitate other women in community who want to go for sterilisation, which we warmly reciprocate.

It is clear from the FGDs (FGD-1 and FGD-2) that women in Hindu or Muslim groups are conscious, clear and quite rational in terms of their religious, cultural or community notions on the one hand and their dire necessities on the other. It is also clear that in most groups there is high unmet need for temporary contraceptives (towards which there are no religious inhibitions). They are even ready for sterilisation, if circumstances warrant so. This point is worth important from policy and programme interventions perspective. Thus there is an urgent need of facilitating the easy availability of temporary contraceptives and counselling for their correct and consistent use to make contraceptive usage effective. This will truly have bearing on fertility rate (towards replenishment level) rather than simple increasing the contraceptive prevalence rate (CPR)!

Caste

The caste system is a unique feature of the Indian social structure. `The institution of caste provides a common cultural idiom to Indians: wherever one

\(^{10}\) Researcher is recently given *Certificate of Competence in RH (Reproductive Health)* Training by Pathfinder International, New Delhi and thus it was pleasure to have more in-depth understanding of the subjects by way of their counselling and clarifications.
may be in India one is in a universe of caste." In the study of any kind of social behaviour, it is desirable that caste should be taken as an independent variable and its influence be understood properly. It has been observed in several studies (for example Mysore study, Chandrasekharan and George, Rele, Wyron and Gordon, and Saksena), that the higher caste couples had relatively lower fertility than those of low caste couples. Mamdani further noted that caste and occupational structure of the village are the important determinants of the villager’s perceptions of the costs and benefits of children. Visaria and Visaria have pondered over the contraceptive use among Scheduled Castes (SCs) and Scheduled Tribes (STs) and argued that the relative poverty of the SC/ST population is presumed to make them suffer from higher than average levels of mortality and morbidity. This is supposed to be compensated for by a higher fertility because of a lower age at marriage as well as the lesser prevalence of the use of contraception. They quoted NFHS data of 1992-93, which confirmed that total fertility was highest among the SCs, followed by the STs and the other non-scheduled castes population; but the difference between the highest and the lowest values was only about 19 per cent. Contraceptive use among the SCs and STs was of the order of 33-

11 Quoted by Mandelbaum who further argued that studies done in all parts of the land confirm this statement of Srinivas. See Mandelbaum, *Society in India.*, p. 228.


4 per cent, about 21 per cent lower than among the 'other' population (42 per cent). However, it is noted that these studies correlate fertility with specific caste groups without taking into account the structural conditions and social norms within a caste influencing fertility behaviour.\textsuperscript{16} Patel in her Rajasthan study further observed that 'the mean number of children born in various caste categories thus does not vary largely among them, and from the overall village mean of 4.94' and concluded that 'there is no linear correlation between caste and fertility'.\textsuperscript{17}

Our sample (from Jalalpur sub-centre) shows that 16 per cent are from general caste category, 41 per cent are from scheduled caste category (SCs) while those from Other Backward Classes (OBCs) are 43 per cent (table 3.1.2).

<table>
<thead>
<tr>
<th>Caste category</th>
<th>Sterilisation status</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adopters</td>
<td>Non Adopters</td>
</tr>
<tr>
<td>General</td>
<td>17 (23%)</td>
<td>7 (9%)</td>
</tr>
<tr>
<td>SC</td>
<td>33 (44%)</td>
<td>28 (37%)</td>
</tr>
<tr>
<td>OBC</td>
<td>25 (33%)</td>
<td>40 (53%)</td>
</tr>
<tr>
<td>Total</td>
<td>75 (100%)</td>
<td>75 (100%)</td>
</tr>
</tbody>
</table>

Source: Survey data


\textsuperscript{17} Patel, \textit{Fertility Behaviour.}, p. 67.

\textsuperscript{*} The percentage totals with superscript * here and afterwards in this thesis show a variation of \(\pm 1\) (i.e. 99 or 101 instead of total 100) owing to repeated numbers after decimal points and the rounding off of the same.
It also shows distribution of adopters and non-adopters across caste categories. Among adopters 23 per cent belongs to general category, 44 per cent to SCs and 33 per cent to OBCs. In the case of non-adopters, 37 per cent are SCs and 53 per cent are OBCs, while in the general category non-adopters are 9 per cent. Thus in the study area the percentage of sterilisation adoption among SCs is quite higher than general category (almost 20 points) and also from OBCs (10 points). Further in case of adoption the t-test also shows significant relationship across caste categories ($t= 5.413; \ P= .032$). The table 3.1.2.1 presents the distribution of ever-temporary contraceptive users across individual caste categories. It shows that in general category only 40 per cent are ever temporary contraceptive users while among SCs and OBCs the percentages are 43 per cent and 53 per cent respectively.

<table>
<thead>
<tr>
<th>Temporary Contraceptive usage</th>
<th>Caste Category</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>General</td>
<td>SC</td>
</tr>
<tr>
<td>Ever users</td>
<td>10 (42%)</td>
<td>26 (43%)</td>
</tr>
<tr>
<td>Never users</td>
<td>14 (58%)</td>
<td>35 (57%)</td>
</tr>
<tr>
<td>Total</td>
<td>24 (100%)</td>
<td>61 (100%)</td>
</tr>
</tbody>
</table>

Source: Survey data

A comparison of table 3.1.2 and 3.1.2.1 shows that among SCs themselves caste category the relative percentage of ever-temporary contraceptive usage (43 per cent) is almost same as in case of sterilisation adoption (44 per cent). However, the matrix changes in the general and OBCs categories. In general category percentage of ever-temporary contraceptive users increased to 42 per cent (table 3.1.2.1), which is quite significant in comparison to 23 per cent adopters in the same category (table 3.1.2). Similarly, ever-temporary
contraceptive users among OBCs also increased to 55 per cent in comparison to 33 per cent sterilisation adopters in the same caste category. Thus in case of temporary contraceptives the variations between general category and SCs is minimal although OBCs are more than 10 points ahead of two in the case of temporary contraceptive adoption. Here it is also pertinent to be noted that these inferences should be read in the light of the fact that OBCs here includes both Hindu and Muslim OBCs. And also that Hindu OBCs in Lodha block belong to Rajput Lodha Caste, which is a land owning casts in this region. Further, SCs are only among Hindus, while general represents Hindu higher castes and Muslims upper strata.

Family Type

Kingsley Davis\(^1\) looking for institutional pattern favouring fertility argued that in the extended family the burden of marriage and of child bearing does not fall upon the parents, but upon the entire family and is so diffused that the burden to any one person may be seen as relatively light. Further, the presence of numerous relatives means that the wife is not particularly burdened with the care of the young children. Poffenberger\(^2\) has noted that the retention of traditional values and comparative lack of husband-wife communication in a joint family are also factors that may favourably influence fertility. Nag Moni\(^3\) on contrary argued that a nuclear family also may lead to an increase

\(^1\) Kingsley Davis, "Institutional Pattern Favouring High Fertility in Underdeveloped Areas," *Eugenics Quarterly* 2, no. 1 (1955).


\(^3\) Moni Nag, "Family, Type and Fertility" (paper presented at the World Population Conference, Belgrade, 1965).
in the number of children because of greater privacy and greater chance of
sexual activity. While Mishra\textsuperscript{22} argues that it (nuclear family) may reduce the
fertility also by increasing husband and wife communication and empathy. On
other extreme Mathen\textsuperscript{23} in his Singur study found no significant difference
between the family size of couple living in single families and those living in
joint families. More recently, Patel\textsuperscript{24} also find hardly a significant difference
in fertility in simple and complex households. Khan\textsuperscript{25} in the light of his
Kanpur study crystallised the subtle issues inherent in explaining the
relationship between fertility and family type and observed that it is
interesting to note that the fertility of the nuclear family in its early stage
(duration of marriage zero to nine years) is quite high as compared to the
corresponding figure for joint family. The difference in fertility is negligible
for females with ten to thirteen years of married life and just reverses for
female married twelve or more years before the survey. This may be because
in a nuclear family couples get more privacy. Young couple in a joint family
get fewer opportunities to mix together due to both shyness and lack of space.

As the duration of marriage increases, the shyness gradually decreases and the


\textsuperscript{24} Patel, *Fertility Behaviour*, p. 64. Patel has also strongly emphasized on futile exercise of correlating family type with fertility without taking into account the development process of household. She noted 'at one time a household may be simple, complex, or a variation thereof. If the development process of the household is disregarded, then it would seem that the children of a couple were all born in one household type. The analysis will not convey how many children were born before and after the change in the household structure (type).’ See Patel, *Fertility Behaviour*, pp. 65-66., on development process of household see M. Fortes, "Introduction," in *The Development Cycle of the Domestic Groups*, ed. J. Goody (Cambridge: Cambridge University Press, 1958.), A.M. Shah, *The Household Dimension of the Family in India* (Delhi: Orient Longman, 1973), J.W. Ryder, "Interrelations between Family Structure and Fertility in Yucatan," in *Anthropological Studies of Human Fertility*, ed. B.A. Kaplan (Michigan: Wayne State University Press, 1976).

\textsuperscript{25} Khan, *Family Planning among Muslims in India*, pp. 71-72.
reduced rearing cost of children resulting from mutual cooperation and assistance among the family members may cause higher fertility. In contrast to the joint family, in the nuclear family as the number of children increases, the economic responsibility of the parents also increases. Here the father alone has to bear the economic burden thus he may decide to control the number of children.

In the present research the adopters and non-adopters are cross tabulated across the family type. The nuclear or joint typology is used simply to see variations in personal and familial dynamics in contraceptive adoption. Thus in a nuclear family the focus is on husband and wife both and how they individually and as a family affects the process of contraceptive adoption. In the same stream, the joint family represents husband, wife and at least one significant other (i.e. mother-in-law (sāsī), father-in-law (sasur) or elder brother-in-law (jyeth) who matters in family decisions making). Thus, nuclear and joint categories only represent the variation in dynamics of communication and power relation in contraceptive adoption. Table 3.1.3 shows that in the total sample, 75 per cent are nuclear families and remaining 25 per cent are joint families. This again reflects the increasing peri-urban nature of Lodha block which surrounds Aligarh city from three sides, in general and Jalalpur sub-centre in particular where the city has penetrated and impact is apparent outwardly. The table also informs that among adopters 76 per cent are from nuclear family while 24 per cent are from joint families. Similarly among non-adopters, the percentage of those belonging to nuclear family is 73 and of those in joint are 27 per cent. Thus the given sample does
not present the clear picture across family types. Looking at table 3.1.3 horizontally, i.e. across rows one finds that of the total respondents in nuclear family type, 51 per cent are adopters while of that total in joint families, the percentage of adopters is 47 per cent. Thus, within each family type the percentage of adopters is more in nuclear family than in joint family.

<table>
<thead>
<tr>
<th>Family type</th>
<th>Sterilisation status</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adopters</td>
<td>Non Adopters</td>
</tr>
<tr>
<td>Nuclear family</td>
<td>57 (76%)</td>
<td>55 (73%)</td>
</tr>
<tr>
<td>Joint family</td>
<td>18 (24%)</td>
<td>20 (27%)</td>
</tr>
<tr>
<td>Total</td>
<td>75 (100%)</td>
<td>75 (100%)</td>
</tr>
</tbody>
</table>

Source: Survey data

Similarly, in respect to ever temporary contraceptive usage, the percentage of ever users is 48 per cent in nuclear families while it is 47 per cent in joint families (table 3.1.3.1). Thus, the family typology (nuclear /joint) in the sample is insignificant in case of ever-temporary contraceptive usage and in case of sterilisation; nuclear families have an edge over the joint families. However, the inference needs more qualitative inputs.

<table>
<thead>
<tr>
<th>Temporary Contraceptive usage</th>
<th>Family Type</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ever users</td>
<td>Nuclear</td>
<td>54 (48%)</td>
</tr>
<tr>
<td>Never users</td>
<td>Joint</td>
<td>58 (52%)</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>112 (100%)</td>
</tr>
</tbody>
</table>

Source: Survey data

On the question- do family type matters in the contraceptive adoption? If yes, how? We can attempt more qualitative answer in the case study (refer CSN-1). Guddo, a Muslim lady aged 30 years having 5 children (3 sons and 2 daughters) against a total of 8 pregnancies and has undergone sterilisation at
the age of 28 years. Presently, she is working as a volunteer (health) in govt. programmes like polio eradication, DOT (Tuberculosis) programmes and also liaison with ANM to provide sterilisation cases, who towards the end of year needs sterilisation cases to fulfil her prescribed ‘target’. Guddo answers the above questions from her own experiences and those of other sterilisation adopters in her community. In her opinion and experiences, family type matters a lot especially in case of sterilisation adoption. She argued that in nuclear families normally husband and wife come to agreement looking over the number of children and poor family conditions, and even in course of disagreement wife can attempt unilateral decision to undergo sterilisation, after which husband is left with nothing but to pacify himself as is evident from responses like to say ‘whatever happens is good’ (*jo hua achēhhā huyā*). However, in the case of joint family, particularly, if both father-in-law and mother-in-law are alive, the process of sterilisation is bit complicated. It is very difficult for the poor women to secure support of mother-in-law and through her of family patriarch. Usually, husbands, even if in agreement, do not talk to their elders on this issue. Guddo is of opinion that in joint families either permission is not granted or it takes such a long time that one ends with another child, so was her case. Further in joint families, women cannot dare to take extreme step of understanding sterilisation until and unless, husband’s implicit consent is there. However, in the case of temporary usage there is no much difference, and the data in table 3.1.3.1 so reflect.
Land holdings and political participation

The question of landownership remains an important variable defining fertility. Visaria and Visaria observed that the average size of household rose with a rise in the size of the landholding possessed by a household, from 3.9 for the landless and 6.2 for households with more than 4 hectares (ha) of land. However, Driver in Central India, Mamdani in Punjab and Patel in Rajasthan did not find any linear correlation between fertility and land ownership. For example, Mamdani noted everyone wanting more children irrespective of land ownership in Khanna villages in Punjab. Many scholars have noted that the struggle for precedence and dominance are endemic in village India and that there is competition for status and power between people within the village. These notions have also bearing on the fertility behaviour for example, both the studies of Khanna villages reported on people's perception that bitter faction fights in villages are won by men, not contraceptives. Patel observed 'I wish to say that having several children, especially sons, is a sure protection for parents against denigration and deprivations. This does not mean that couples have children with the primary and explicit purpose of deriving political advantage.'

26 Visaria and Visaria, "India's Population.", p. 76.
30 Patel, Fertility Behaviour., p. 98.
It may be noted here that in the sampled population the land holding aggregate is much less. For example only 13 per cent (10) of adopters are having their own agricultural land and out of these, majority i.e. 80 per cent (8) has 2 or less bigas\(^{31}\) of land, remaining two have 8 bigas and 50 bigas of land holding. Thus, those involve in agriculture and allied works are either land less labourers or working on leased land or on their own plus leased land. Although among non-adopters also per centage of landholders is almost same 15 per cent (11) but within them 45 per cent have 2 or less bigas of land rest have more ranging from 5-10 bigas with 3 non-adopters to 20, 25 and 109 bigas of land with one each non-adopter. The following case studies further crystallised the issue. Satyawati (refer CSN-2) aged 30 has undergone sterilisation at the age of 28 years with 5 children (four sons and one daughter) against seven pregnancies. Her is a joint family with land holding of 50 bigas. This joint family only consisted of 8 members i.e. both Couples, their 5 children and father-in-law. Satyawati is illiterate but works as a health volunteer and earns a monthly sum of Rs. 500 while her husband remains idle and do not work. Satyawati’s father-in-law carries agricultural activities to supplement the family income. Satyawati argues that with 5 children and puzzled of husband idleness, she went for sterilisation with indirect consent of father-in-law, and even unwillingness of husband. Thus, here economic burden of responsibility falls on significant other (father-in-law) and probably due to same reason he consented and supported her daughter-in-law against idle son wishes. Lets look for another case study from no-adopters but landed

\(^{31}\) Biga is a local land measurement unit and varies from region to region. In Aligarh one acre is equal to five bigas and in terms of more standard unit hectare there are 12 bigas in one hectare.
class. Rajwati (refer CSN-3) aged 38 years is non-adopter (and also never contraceptive user) has 2 children both males (against 2 pregnancies). She lives in a joint family, which consists of 12 members, and the family’s total land acreage is 109 bigas. Her husband is intermediate educated and is a government servant. The head of family is mother-in-law who is also educated upto X standard. Father-in-law mainly looks after agriculture, while her other children are also in service. Rajwati and her family both favour small family of two children (one male and one female) and according to her, children are born late and last child was born at age of 25 so there is no chance of any more child birth and hence she has not used any contraceptives.

The data in table 3.2.2 and the case studies illustrate that skilled work or service put women under duress owing to scheduled hours of work and back home caring of children and family. In the sample population women in the category of service/skilled work are employed in the lock factories in Aligarh city and daily they walk more than 5 km one way (10km to and fro) and that’s why to them any child after 3-4 is least desirable. Thus, outside paid employment of women coupled with service/business occupation of spouse have cumulative effect to favour less children and have sterilisation even if the family has substantial land acreage.

The poor land holding pattern of sampled population is poor so is the case of political participation. Out of the total sample, only 9 per cent (13 out 150) has a family history in politics that also at village level. Out of these, 11 are among adopters and 2 are non-adopters. It may be noted that this participation is not out of long familial political background but the reservation
opportunities provided to women, SCs and OBCs at panchayat level by the 73rd Amendment of the Indian Constitution which provides for reservation across the levels and categories (Article 340-D of the Indian Constitution). However, the political participation is rather encouraging them and exposing them to positive outlook and a quality life. For example, Suchita (refer CSN-4) aged 35 is a non-adopters with three (one son and two daughters) children (no pregnancy waste). Her father-in-law has been elected gram pradhan and family owns 25 bigas of land. Further her husband is a graduate and do service. Suchita is a temporary contraceptive user and maintain the spacing by using of Condoms. For example, her last birth was at the age of 26 years. She said both of us are educated and are capable to correctly use temporary methods (i.e. condom) and hence no need for sterilisation. Further, she argued that her father-in-law keep prodding (indirectly) them for small family and good upbringing of children. He keeps on citing examples of government administrators having small families.

3.2 Personal and familial characteristics of adopters and non-adopters

Education

It is rightly observed that primary education and literacy is one such a vital sector which cannot brook any more neglect, even in the matter of achieving the small family norm.\(^{32}\) Husain’s study\(^{33}\) of Lucknow city showed a steady decline in the general fertility rate with increasing female education even from

\(^{32}\) Mitra, "The Small Family Norm and Literacy.", p. 300.

among the illiterate (163.89) to next category below primary (145.16) and through primary (102.04), secondary (96.20) and higher (63.38). Mason\(^\text{34}\) has commented on women education and contraceptive correlates that improvement in the status of women achieved through education increases their access to other value systems and also improves women’s knowledge, attitudes and practice of family planning. Similarly, Caldwell and others\(^\text{35}\) report from their investigation of demographic change in rural Karnataka that husbands treated wives who had been to school differently and listened to them more closely than husband whose wives had not been to school. More recently, Chaudhury\(^\text{36}\) macro level study of inter state variations also confirms a positive relationship between female education and the use of contraception. The propensity to use contraception in a state rises sharply with increase in the literacy rate of that state. ....It appears that the formal education of girls (for a minimum of 1-4 years) could help India go a long way towards achieving a major breakthrough in the use of contraception and in lowering fertility.’ However, some studies negate the impact of education \(\text{per se}\) on fertility reduction. It was observed in Mysore study\(^\text{37}\) that education below high school had no significant relation with fertility. Driver’s survey\(^\text{38}\) in Nagpur district


\(^{35}\) J.C. Caldwell, P.H. reddy, and P. Caldwell, \textit{The Causes of Demographic Change: Experimental Research in South India} (Madison: University of Wisconsin Press, 1988). Much before Mysore Study revealed that in Bangalore city the average number of children born to ever-married illiterate women above the age of 45 was about 5.4, while that for women with high school or college education was 3.9. See U.N., “The Mysore Population Study.”, cited in Raina, “Research in Family Planning.”, p. 310.


\(^{38}\) Driver, \textit{Differential Fertility in India}.  

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(Maharastra) also indicated a similar relationship between women’s education and fertility. Khan\textsuperscript{39} in his Kanpur study (UP) also noted that the education of husband and wife showed an unexpected but weak negative association with family planning practice, and the reason for this was not clear even to him. Similarly, Patel\textsuperscript{40} argued that there is an inverse correlation between education and fertility in Mogra (Rajasthan). More recently, Parikh and Gupta\textsuperscript{41} argue that the surveys since the late 1970s have sought to explore female literacy and its role in the reduction of fertility. The data available, however, have not been used for a multiple regression analysis of the relationship. They on the one hand quoted from the volume by Jeffery and Basu\textsuperscript{42} which contains number of article summarising evidences from micro level studies from different parts of India and South Asia, and on the other, analysed the data from National Family Health Survey, 1992-93 and concluded that 'female literacy reduces birth rates in Andhra Pradesh and Uttar Pradesh. However, the reductions are surprisingly small in percentage terms. Thus, female literacy even when we account for its impact on the age of marriage and cohabitation is not the magic bullet for population control that it is often thought to be...Female literacy is a critical preconditioning for women's development and must be encouraged. Yet, without overall development, don’t expect miraculous reductions in fertility just from it.'

\textsuperscript{39} Khan, \textit{Family Planning among Muslims in India.}, p. 168.

\textsuperscript{40} Patel, \textit{Fertility Behaviour.}, p. 63.

\textsuperscript{41} Kirit S. Parikh and Chiranjib Gupta, "How Effective Is Female Literacy in Reducing Fertility?," \textit{Economic and Political Weekly} XXXVI, no. 35 (2001), pp. 3391-3392, 3397-3398.

Thus the level of literacy has been much acknowledged, credited as well as
discredited for cumulative effect on fertility and family planning. In the
present study personal and familial educational status of adopters and non-
adopters have been cross-tabulated and presented in table 3.2.1.

Table 3.2.1: Personal and Familial Educational status of Adopters and Non
Adopters

<table>
<thead>
<tr>
<th>Educational status</th>
<th>Adopters</th>
<th>Sterilisation status</th>
<th>Non Adopters</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Personal</td>
<td>Familial</td>
<td>Personal</td>
</tr>
<tr>
<td>Self Illiterate</td>
<td>56 (73%)</td>
<td>25 (33%)</td>
<td>89 (63%)</td>
</tr>
<tr>
<td>Illiterate I-V</td>
<td>8 (11%)</td>
<td>13 (17%)</td>
<td>24 (14%)</td>
</tr>
<tr>
<td>Illiterate VI-X</td>
<td>11 (15%)</td>
<td>28 (37%)</td>
<td>42 (25%)</td>
</tr>
<tr>
<td>Illiterate Above X</td>
<td>1 (1%)</td>
<td>9 (12%)</td>
<td>13 (8%)</td>
</tr>
</tbody>
</table>

Source: Survey data

The above table 3.2.1 shows that among the adopters aggregate (personal and
familial) percentage for illiterates is 53, followed by those, 14 per cent who
have education up to primary level (I-V), another 25 per cent have education
above primary and up to high school (VI-X) and only 8 per cent have
education above high school level. However, within the adopters category as
much as 73 per cent adopters themselves (self) are illiterate followed 11 per
cent with education up to primary level, 15 per cent between VI-X and only 1
per cent have education above high school level. However, only 33 per cent spouses
(husbands) of adopters are illiterate followed by 17 per cent with education up
to primary level, 37 per cent between VI-X and rest 12 per cent have
education above high school level. In regard to their significant others, the
table 3.2.1 shows that among the total significant others in adopters category
(18), just half (50 per cent) are illiterate, followed by 17 per cent each in
remaining three categories i.e. I-V, VI-X, and above X. The table 3.2.1 also sheds light on the education profile of non-adopters. It can be inferred from the table that family aggregate education status of non-adopters is almost same rather slightly better than adopters. For example, among non-adopters the aggregate illiterate percentage is 49 (against 53 per cent of adopters), 20 per cent have education between I-V class (against 14 per cent of adopters) while 18 per cent have education between VI-X (against 25 per cent of adopters) and in above high school group there are 14 per cent non-adopters in comparison to 8 per cent adopters. Coming to differential education level of respondents, their husbands and significant others in non-adopters category, one finds that of the total non-adopter respondents 64 per cent are illiterate, followed by 20 per cent, 9 per cent and 7 per cent in I-V, VI-X, and above X groups respectively.

On further deconstruction of educational categories into illiterate, I to X and above X, one finds that family aggregate of adopters in illiterate category is 53 per cent (against 49 per cent of non-adopters), while in I to X, and above X category for adopters it is 39 per cent and 8 per cent respectively and in the same educational group their counterparts (non-adopters) are 38 per cent and 13 per cent respectively. Similarly, in the same revised grouping, 73 per cent of adopters themselves are illiterate (in comparison to 64 per cent non-adopters), 26 per cent have education between I to X (against 29 per cent non adopters) and finally in above X group only percentage of adopters is one (against 7 per cent of non-adopters). The same if stretched to spouses, one finds that 33 per cent husbands of adopters are illiterate (in comparison to 32
per cent spouses of non-adopters), followed by 54 per cent in I to X (against
48 per cent non-adopters husbands) and 12 per cent in above X group (against
20 per cent non-adopters counterpart). It may also be noted that in terms of
personal and familial educational status of adopters and non adopters the t-
values is significant for the husband of the adopters and non adopter with
higher t-value for non adopters spouses (P = .004) than adopters husbands
(P = .026).

It can thus safely be said that the data from present study do not show any
significant relationship of education and sterilisation adoption. This puts it in
the category of researches (as mentioned above) like that of Anker in Gujarat
and Patel in Rajasthan where education did not have any significant bearing on
fertility behaviour.

Occupation

Occupational composition is one of the crucial demographic variables which
gives a fairly good indication of people’s way of life, their educational and
cultural status and their economic and social organization. Mamdani observed that the demand for population control may be rational in one class
situation but not necessarily in another. For instance, he pointed out that in his
study of Punjab villages, the wage earners and small farmers want large family

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as children are viewed as a source of labour power, as an insurance against old age. So too is the case of the artisans employed in domestic industries who value children as economic assets. Nadkarni also saw the persistence of large families among cultivators than non-cultivators. Samir Amin adds value to this discussion and argued that ‘having large families in an impoverished capitalist country is a form of economic rationality and not irrationality. Large families are often the best or only means of social security and old age pension in a neo-colonial situation.’

The table 3.2.2 shows personal and familial occupation diversity of adopters and non-adopters in the sampled population.

Table 3.2.2: Personal and Familial Occupational diversity of Adopters and Non Adopters

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Sterilisation status</th>
<th>Adopters</th>
<th>Non Adopters</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Personal</td>
<td>Familial</td>
<td>Self</td>
</tr>
<tr>
<td>Housewife/ No work</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agriculture, allied and unskilled work</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Business</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service/ skilled work</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Survey data

In terms of family aggregate across four occupational categories, among adopters family aggregate, 44 per cent falls in the category of housewife or no paid work while aggregate for counterpart non-adopters in the same category

45 Nadkarni, ""Overpopulation" and the Rural Poor."
is 49 per cent. Further, 27 per cent of aggregate adopters (against equal that is 27 per cent non-adopters) are involved in agriculture, allied and unskilled works. In the business, and service/skilled work categories the aggregate adopters percentages are 10 (against 8 of non-adopters) and 19 (against 15 of non-adopters) respectively. Thus, there appears slight variation in aggregate occupation of adopters and non-adopters in business and service/skilled work category and can be extended to interpret that business, service/skilled work categories presents favourable conditions of sterilisation adoption than the housewife/no work or agriculture and allied works which do not differentiate much between adopters and non-adopters. Further, analyses of individual actors (self, husband and significant other) shows that 76 per cent of adopters themselves are in housewife/no paid work category (against 81 per cent non-adopters), followed by 7 per cent in agriculture and allied works (against 8 per cent non-adopters), 4 per cent in business (against 5 per cent non-adopters) and 13 per cent in service/skill work (against 5 per cent non-adopters). Thus among individual adopters and non-adopters personal characteristics, the relationship is significant only in housewife/no work and service/skilled work category (5 points) with inclination towards adoption. Interpreting the table 3.2.2 for the spouses of adopters and non-adopters, it comes that only 8 per cent adopters husband (against 13 per cent non-adopters) are in housewife/no paid work category, 48 per cent husbands of adopters (against almost equal 49 per cent non-adopters husbands) are engaged in agriculture and allied activities. Likewise, 19 per cent are in business (against 12 per cent of non-adopters) and rest 25 per cent (against equal non-adopters) are in service/skilled work category. Thus in the case of husbands of adopters and
non-adopters the difference appears more in business category (7 per cent margin). Further, in respect to significant others of adopters and non-adopters, the table informs that 61 per cent adopters significant others are in housewife/no paid work category in comparison to 65 per cent significant others of non-adopters in the same category. In other three categories, namely agriculture and allied business, and service/skilled work, the adopters significant others are 22 per cent (against non-adopters 15 per cent), nil (against non-adopters 5 per cent) and 17 per cent (against non-adopters 15 per cent) respectively. This shows that the significant others occupational involvement (in paid works) makes them positively related to sterilisation adoption. Further, the table 3.3.2 clearly shows that agriculture, allied and unskilled work category has similar percentage for adopters and non-adopters both as family aggregate and individually.

Income

A plethora of studies have analysed fertility-income calculus and came with interestingly results ranging from positive and negative extremes to zero value coefficients. For example, a plethora of studies47 sounds (monotonically) of high fertility in lower income groups like Chandrasekhar and George for Bengal, Wyon and Gordon, and Mamdani for Punjab, Gaiha for all India rural households, NFHS-2 to mention few. In the same cadre there are those who

dwelled more on rationale for high fertility among lower income groups. Rangarajan and Setia\(^{48}\) have worked on the logic of underlying cost-benefit analysis and observed that the benefit of an additional child will depend upon the income level of the family, the higher the income level, the less will be the need for social security and therefore, the less will be the utility of the benefit of additional children and therefore, family size shrinks. Khan\(^{49}\) in his study interestingly noted that the perceived economic status behaves differently in the two groups of Muslims. It is negatively associated with the use of contraception in the case of the MHO (Muslims with hereditary occupations) and positively in the case of the MNHO (Muslim with non hereditary occupations). The reason may be that in the traditional way of life among the MHO group, family planning is adopted only when their economic position forces them to do so. In contrasts, the MNHO group tend to adopt modern way of life as their income increases. However, the studies\(^{50}\) like Mysore study, Mishra et al study of UP and Rao study of Karnataka found high fertility in high income groups or primarily exploiting class. Another cadre of studies\(^{51}\) report low fertility in low-income groups, for example Anker study of rural Gujarat, Patel study of Rajasthan village. There is also a cadre of studies\(^{52}\) that


\(^{49}\) Khan, *Family Planning among Muslims in India*, p. 165.

\(^{50}\) U.N., "The Mysore Population Study.", Mishra et al., "Family Planning in Uttar Pradesh: A Change Programme and Its Clients.", Rao, "An Investigation into the Differential Behaviour of Economic Classes in Relation to the Family Planning Programme in Mandya District, Karnataka".


negate any significant variation in fertility across income variable in rural areas. Singh, for example, in her study of rural communities in Punjab and Haryana finds little variation in mean number of children across income groups. Jain has rightly contented that fertility differentials between different income groups in rural areas are small, especially because cultural practices, which are determinants of fertility behaviour, do not differ with change in income.

The income levels of the sampled population are shown in table 3.2.3. It shows that in terms of aggregate adopters groupings, 52 per cent are in the less than Rs. 1000 per month income slab (against 46 per cent non-adopters), while 17 per cent are in Rs. 1000-2000 income slab (against 19 per cent in non-adopters category), followed by 20 per cent (against 18 per cent non-adopters) and 11 per cent (against 16 per cent non-adopters) in the Rs. 2000-3000 and Rs. 3000 and above income slabs respectively.

<table>
<thead>
<tr>
<th>Income levels (Rs. per month)</th>
<th>Adopters</th>
<th>Non Adopters</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sterilisation status</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Personal</td>
<td>Familial</td>
</tr>
<tr>
<td>Less than 1000</td>
<td>69 (92%)</td>
<td>10 (13%)</td>
</tr>
<tr>
<td>1000-2000</td>
<td>3 (4%)</td>
<td>22 (29%)</td>
</tr>
<tr>
<td>2000-3000</td>
<td>2 (3%)</td>
<td>29 (39%)</td>
</tr>
<tr>
<td>3000-above</td>
<td>1 (1%)</td>
<td>14 (19%)</td>
</tr>
<tr>
<td>Total</td>
<td>75 (100%)</td>
<td>75 (100%)</td>
</tr>
</tbody>
</table>

Source: Survey data

Further, looking over individual (personal, spouse and significant other) income profiles in the same table 3.2.3, it comes out that 92 per cent of adopters themselves (against 91 per cent non-adopters) falls in less than Rs.
1000 income slab (which starts from zero). Likewise rest 4 per cent, 3 per cent and one per cent are in Rs. 1000-2000, Rs. 2000-3000 and Rs. 3000 and above income groups respectively. The rest of non-adopter women (9 per cent) fall in Rs. 1000-2000 income slab. Turning to their husbands, the data show that only 13 per cent husbands of adopters (against equal per cent of non-adopters spouse) fall in less than Rs. 1000 income slab. Another 29 per cent (against equal per cent of non-adopters spouse), 39 per cent (against non-adopters 35 per cent) and 19 per cent (against 23 per cent non-adopters) falls in income slabs of Rs. 1000-2000, Rs. 2000-3000 and Rs. 3000 and above respectively. Further, moving to significant others of adopters and non-adopters, one finds that 44 per cent adopters significant other (against 5 per cent non-adopters significant other) fall in less than Rs. 1000 income slab, followed by 17 per cent (against 20 per cent non-adopters) in Rs. 1000-2000 income slab and another 17 per cent (against 25 per cent non-adopters) and 22 per cent (against non-adopters 50 per cent) falls in the category Rs. 2000-3000 and Rs. 3000 and above income slabs respectively. Thus in totality both adopters and non-adopters represent the poorer segment of society. It may also be noted that research used a question on net saving but responses in more than 70 per cases were negative i.e. debt instead of saving. On being asked how they manage family expenses, if income falls short of expenditure and the response was uniform that they manage by taking the household necessary items on debt and repay the same latter on. It may also be noted that this phenomena is more persistent among agriculture, allied and unskilled workers who get work for not more than 20 days a month and as per work availability and resultant earnings they manage the family affairs. However, the relative percentage of
non-adopter’s family aggregate is higher in higher income slabs than adopter’s family aggregate. The t-test also shows significance of non-adopters aggregate family income ($t = 3.475; P = .040$) unlike the adopter’s family aggregate incomes ($t = 2.743; P > .05$). Further, in case of incomes of husbands and more particularly of significant others, the variations are sharp among adopters and non-adopters. The result of t-tests show significance for the incomes of adopters husbands ($t = 4.432; P = .021$) and significant others ($t = 3.781; P = .032$). Thus, it may be inferred that unlike Malthusians and neo-Malthusians non-stop cry the poor do not profligate rather poor are more prone to sterilisation as is clear from above discussions.

Thus, in view of data interpretation in above tables 3.1.1 – 3.2.4, and insight developed from focus group discussions (FGD 1-2) and case studies (CSN 1-4) it is clear that since women have to bear the brunt of child upbringing, pregnancies and experience family hassles owing to less income and more expenditure, they become much desperate to stop child birth. This is further exacerbated if mother is employed that also in works like skilled work/service which have a fixed schedule and also require long to and fro movements. The same employment also provides them exposure as well as boldness to finally stop birth, for which they recourse to sterilisation (most reliable and permanent solution). The variables like religion, caste, family type, occupation and income operate differentially to impede or proceed the process of contraceptive (more specifically sterilisation) adoption. The case studies also illustrated, how even the significant others with land holding but bearing the major responsibility of family expenses provides implicit consent (rather
support) to their daughter-in-laws to go for sterilisation. Even the political participation as a result of Constitutional Amendment is favourable to small family norm and contraceptive adoption.

To what extent and of what level child/pregnancy load becomes pinching to women and how the process of adoption moves in family matrix needs to be thoroughly investigated. The next chapters 4, 5 and 6 review the impact of reproductive trajectory women, and intra-house dynamics of communication and power relations and also the chapter 6 reflects how both variables operate differentially in terms of contraceptive typology that is temporary and permanent methods.