CHAPTER-7

CONCLUSION AND WAYS FORWARD
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The population growth in India is a global issue. The growth of population in India is an important determinant of the growth of the world population.¹ The largest countries (China and India) constitute about 38 per cent of the world population; they mainly determine the size of the world population. India has relatively large growth rate. The rate of population growth in 1992 in China and India was 1.5 and 2.0 per cents respectively, and, therefore, though India’s current population size is less than that of China, yet it will add larger numbers to the size of the world population.² In a country of India’s massive population size and incredible diversity, all generalisations, theories and models are hazardous.³ However, in the present research an attempt is made to understand the dynamics of personal and familial characteristics in the adoption of family welfare programmes based on a sample of 75 sterilisation adopters and equal (75) non-sterilisation adopters. The study is undertaken in the light of well-defined objectives and hypotheses and the data thus collected are analysed in specific chapters. This chapter presents the results of study in a more cogent way and in the light of the results ways forward are proposed.

¹ Talwar, "Determinants and Consequences of Rapid Population Growth.", p. 34.
² Ibid., p. 34.
7.1 Results

The results of the present study are summarised here with reference to major objectives of the study and the hypotheses set forth for testing. This subchapter is divided into four major headings which represents for major objectives of the study and thus in the coming paragraphs under each heading one major objective and related hypothesis have been discussed.

Personal and familial characteristics

The present research began with an analysis of data on major and much acknowledged and commented upon socio-economic variables determining fertility and family planning adoption. The socio-economic variables taken for data analysis are religion, caste, family type, land holdings and political participation. In terms of religion there are two major categories that is Hindus and Muslims. It came out that among the total Hindus in the sample 48 per cent are sterilisation adopters and 43 percent are ever-temporary contraceptive users. Among the Muslims, 54 per cent are sterilisation adopters and in terms of ever-temporary contraceptive usage their percentage is 59. The focus group discussions (FGD-1 and FGD-2) amply crystallises the religious worldview of sampled population vis-à-vis contraception. In the sampled population both Hindus and Muslims do not have religious inhibitions/constraints for temporary contraceptives, rather there seems to be a high unmet need for temporary contraceptives and it was quite apparent in their arguments on non-availability of free contraceptive supply. Both groups considered sterilisation
as against nature and a sin but are equivocal to add that it is permissible as last resort to avoid any more childbirth which seems unaffordable to the family.

The sampled population is also grouped in terms of caste categories i.e. general caste, Scheduled Castes (SCs) and Other Backward Classes (OBCs). The percentages of sterilisation adopters across caste categories i.e. general, SCs and OBCs are 23, 44 and 33 per cent respectively. In the sampled population the SCs have highest sterilisation adoption, which is also significant (t = 5.413; P < .05). The variations in case of ever-temporary contraceptive usage among SCs and general categories are minimal that is 43 per cent and 42 per cent respectively, and in the case of OBCs, the percentage of ever-temporary users is 55. These results for SCs and OBCs negate the arguments that poor profligate and have lower adoption of family welfare programmes. Rather most poor category (that is SCs) in the sample performed better.

In terms of family typologies (that is nuclear and joint) the data do not provide a clear picture. However, within the category analysis shows that in nuclear families 51 per cent are adopters while in joint adopters percentage is 47. In case of ever-temporary contraceptive usage the variations are further insignificant (that is 48 per cent in nuclear and 47 per cent in joint families are ever-temporary contraceptive users). Thus relatively (at 4 per cent margin) nuclear families are more conducive to sterilisations than joint families. The case study (CSN-1) also illustrated that in joint families sterilisation adoption is complex and complicated and much delayed process due to intra-house deliberations in making final decision for sterilisation.
The sampled population have poor landholdings. Only a total of 13 per cent among adopters and 15 per cent among non-adopters have land holdings. Further, among adopters, 80 per cent of those having the land, have 2 or less bigas (1 acre = 5 bigas) of land. However, among non-adopters 45 per cent of landholders have 2 or less bigas of land and the rest landholders have land in the rest ranges from 5 bigas to 109 bigas. Thus, apparently landholders are poor sterilisation adopters. However, the case studies (CSN-2 and CSN-3) of clients with 50 bigas and 109 bigas of land make clear that land holding should be read with burden of responsibilities, paid employment of women and occupation categories like business and services of their spouses. Further in terms of political participation or power hegemony, the sampled population do not have long political history. Only a few have familial background of participation at village level that also due opportunities of reservation provided by 73rd Amendment of the Indian Constitution. However, the data show that this is positively influencing the family welfare programmes as 11 out of 13 with political background are adopters and as case study (CSN-4) makes clear that political participation and resultant interactions and exposures are positively stimulating small family norm and contraceptive adoption.

Thus with regard to socio-economic correlates it may be inferred that in the sampled population, religion as a category (across Hindus and Muslims) is not significant while caste is significant at least in sterilisation adoption. SCs are better sterilisation adopters however in case of temporary contraception SCs and general category are at the same platform while OBCs performed better. The family typology also does not presents a clear picture but in case of
sterilisation nuclear families are more conducive. Further, in terms of land holding and political participation, the sample population have poor profile however, those belonging to these categories are either adopters or have positive inclination towards family welfare programmes. The qualitative data more thoroughly reflect that these socio-economic correlates govern and operationalise subjective realms of adopters and non-adopters. For example, religion as an institution governs people’s perception of children and differential acceptance of specific contraceptives that is no inhibitions for temporary contraceptives but much constraints and conservatism for sterilisation and notions are common both among Hindus and Muslims. The same religious rather cultural and community notions regarding sterilisation somehow argues why sterilisation is complex and complicated process in joint families. The data contradict the hypothesis that higher castes have higher adoption rather in case of sterilisation reverse is true, at least among the sampled population. It is also encouraging that those availing the opportunities of Constitutional Amendment have favourable attitude towards family welfare programmes and are even advocating the same among their families.

In the present research the personal and familial characteristics of the sampled population are cross tabulated across three major attributes- education, occupation and income. Coming to education, the family aggregate of adopters in illiterate category is 53 per cent (against 49 per cent of non-adopters), while in I to X standard and above X category it is 30 per cent and 8 per cent respectively. The percentages of non-adopters family aggregate in I to X and above X categories are 38 and 13 respectively. Thus in terms of family
aggregate educational status, non-adopters have better profile. Moreover, in terms of individual categories that is respondents themselves, their spouses and significant others, also the non-adopters are relatively better. Further in terms of individuals, spouses and significant others, the education of husband is significant both for adopters and non-adopters. Thus the sampled population data negate education as having significant bearing on sterilisation adoption.

However, occupation as a variable is significant for family aggregate (unlike education which was significant for husband) of adopters ($t = 3.470; P = .040$). The family aggregate percentage of adopters in house wife/no work category is less than non-adopters but the relative aggregate of adopters is more in business, and service/skilled work categories than non-adopters family aggregate. The aggregate adopters and non-adopters percentage in agriculture, allied and unskilled work categories are same. In the individual category, adopters themselves percentages in comparison to non-adopters counterparts are less in house wife/no work category (5 per cent margin). In case of their spouses, the business category seems more favourable to sterilisation. Further the significant others among adopters are less in house wife/no work category and in relation to non-adopters they are more in paid work category. Moreover, the equal percentage of adopters and non-adopters individual and family aggregates are in agriculture and works and hence negates the significance of this occupational category in the sterilisation adoption. Thus it may be inferred that higher the participation in paid work categories (that is...
service, business etc. instead of house wife/ no work) higher the adoption of sterilisation.

The data on income levels reflect that adopters are relatively poor than the non-adopters. The 52 per cent of aggregate adopters unlike 46 per cent aggregate non-adopters are in less than Rs. 1000 per month income slabs while in Rs. 1000-3000 income slabs aggregate adopters and aggregate non-adopters have equal percentage i.e. 37 per cent and in Rs. 3000 and above income slabs aggregate adopters percentage is 11 against 16 per cent of non-adopters. Thus, unlike the occupation which is significant for aggregate adopters, the income levels are significant for non-adopters personal and familial aggregates. Thus, in terms of relative percentage of non-adopters in higher income slabs and significance of t-value for non-adopters, it may be safely inferred that poor are better sterilisation adopters.

Thus in regards to personal and familial characteristics of adopters and non-adopters following inferences can be drawn: that education and sterilisation are not significantly correlated; that occupation is significant for the adopters personal and familial aggregate and in case of adopters themselves the paid work category is significant while in case of their spouses, the service and business as occupational categories are important; that adopters have poor income levels than non-adopters counterparts.

To sum up, the data contradicts the religious categories as significant in contraceptive adoption and so is the case with education and land holdings. Further unlike the proposed hypotheses the lower castes and low-income
groups have better adoption while the nuclear families and political participation facilitate the adoption of family welfare programmes.

Reproductive trajectory

The sampled population reproductive career stars with an early age at marriage (aggregate mean 15.9 and for adopters and non-adopters the mean ages at marriage are 16.1 and 15.8 respectively), and early childbirth as more than three-fourth have first childbirth at the ages 15-20 years. They have long marital durations, for example among adopters it is 16.1 years while for non-adopters it is 11 years. Further the mean age at youngest/last childbirth is 30.4 years for adopters and 26.4 years for non-adopters. Moreover, the average spacing between successive childbirths is also low. The adopters have experienced an average spacing of 2.29 years and for adopters it is 2.31 years. Coming to presently living children, the average for total sample is 4.1 living children. Among adopters and non-adopters it is 4.8 and 3.4 children respectively. Thus the data amply show that reproductive trajectory of the sampled population is typically same and their pregnancies pattern can be presented as- too soon, too close and more many. The focus group discussions and accounts of key informants also support the quest for first childbirth and even the very first pregnancy declaration has well-defined rituals and celebrations. These discussions also reflect the consciousness and helplessness of women in maintaining the spacing and limiting the family size and the same is the reason for induced abortions. The data also inform that apart from pregnancy load, women are also exposed to the pains and risks of pregnancy wastages and poor safe motherhood and safe delivery practices. Among
adopters, as much as 43 per cent experienced ever pregnancy wastage which is 20 per cent in case of non-adopters and in aggregate 31 per cent experienced ever pregnancy wastages. Among those aggregate adopters and non-adopters who ever experienced pregnancy wastages, 78 per cent experiences abortions (43 per cent natural and 30 per cent induces abortions) and 28 per cent experiences still births. (12 per cent with still births, 15 natural abortions and 16 induced abortions). Further average 75 per cent (both adopters and non-adopters) ever avail any ANC checkups. Similarly more than 50 per cent ever took any IFA tablets during pregnancies and interestingly those who took IFA tablets have poor intake of complete package. As much as, half among the adopters and non-adopters who availed services took less than 100 IFA tablets. In case of TT injections situation is relatively better as 59 per cent among adopters and 75 per cent among non-adopters ever took TT injections. Further in the total sample as much as 67 per cent ever had deliveries at home in presence of traditional birth attendants (dai). Moreover, the FGDs crystallise the inherent risks in delivery practices and cutting of umbilical cords and how both mother and child are exposed to risks of hypothermia and tetanus due to place of deliveries and used of instruments to cut umbilical cord respectively.

Thus, the poor reproductive trajectory of rural women forced them to take recourse in adoption of sterilisation which to them is more safer than unsafe abortions or being further puzzled of pregnancies and pregnancy wastages. The data therefore contradicts the proposed hypothesis that poorer the reproductive trajectory, poorer the adoption of family welfare programmes. This area require much needed attention of public health agenda and can be
Intra-house communication and power relations

In order to understand the significance of intra-house dynamics of communication and power relations, the present research dwelled across two hypotheses, one on communication domains and another on process of decision-making in the family.

Communication domains: The data collected show that there are differential variations of across family issues and discussions on the same with spouses and significant others. For example on general issues like domestic problems, economic and child upbringing issues, a high percentage (70 per cent and above) both among adopters and non-adopters discuss these with their spouses. However, on issues like personal health and hygiene, having small family and limiting family size, the adopters have higher percentages of discussions with their spouses. For example, on personal health and hygiene as much as 53 per cent non-adopters confine it to themselves (that is less discussions with other family members) which in adopter’s case is only 25 per cent. Further, 83 per cent adopters against 53 per cent non-adopters discuss the idea of having small family with their spouse while on the issue of limiting family size, a sizable (85 per cent) adopter discuss it with their spouses against 65 per cent non-adopters. Thus, the adopters have wider communication domains than non-adopters and hence the hypothesis that higher the scope of
discussion on family issues (wider the communication domains), higher is the adoption of family welfare programmes is tested true.

**Decision-making:** Similarly, the decision making of these issues have variations across the issues and also among adopters and non-adopters. On general issues (domestics problems, economic issue and child upbringing) the decision making among both adopter and non-adopters is either by husband or mutually. Further, the decision on the issue of personal health and hygiene is either tackled individually by adopters (31 per cent) or mutually (36 per cent), only in 23 per cent and 11 per cent cases such decisions are taken exclusively by husbands and significant others respectively. Further, higher figures of mutual decision-making are on issues of small family (53 per cent) and limiting family size (52 per cent). It may also be noted that out of only 18 significant others of adopters 16 (89 per cent) became active decision makers on the issue of limiting family size while on other issues significant others do not figure more than 9 (50 per cent). Among non-adopters with regard to issue of personal health and hygiene, 61 per cent non-adopters themselves take decision (against 31 per cent adopters) and only 4 per cent mutually decide (against 36 per cent adopters). Further on the issue of small family 40 per cent argued to mutually decide (against 53 per cent adopters), for 32 per cent by husbands, for another 15 per cent by significant others and 13 per cent are bold enough to decide by themselves only. Similar is the response on limiting family, 39 per cent believe in mutual decision (against 52 per cent adopters), 31 per cent said their husband will decide while 17 per cent argued for significant others and 13 per cent said they themselves will decide. Thus, it
clear from both tables that unlike general issue like domestic problems, economic problems and even child upbringing, the intimate issues like personal health and hygienic, and the issues of small family and family limitation differs in decision making matters and these dynamics have to be considered in any mobilization for small family norm or adoption of family planning. It is also clear from the data that among adopters there is more mutual decision-making and this again supports the proposed hypothesis that higher the mutual decision making in family, higher the adoption of family welfare programmes.

Process of contraceptive adoption

The present research dwelled on the process of contraception- starting with first hearing about contraceptives to idea of usage, and the personal and familial responses thereupon and finally the contraception adoption.

Contraceptive Information

The data show that all the adopters heard of sterilisation (against 93 per cent non-adopters), 85 per cent heard of pills (against 83 per cent non-adopters), followed by 84 per cent adopters who heard of condoms (against 83 per cent non-adopters), 59 per cent heard of IUD (against 51 per cent non-adopters), 51 per cent about injectables (against 45 per cent non-adopters) and just 35 per cent heard of traditional methods (against 25 per cent non-adopters). In terms of timings when first heard of contraceptives, the negligible percentage of adopters and non-adopters heard about contraceptives before marriage except of sterilisation (29 per cent adopters and 36 per cent non-adopters). Further
average 57 per cent adopters and 54 per cent non-adopters heard about condoms, pills and IUD during the period after marriage and II childbirth. While most come to know of traditional methods after III to V childbirth (73 per cent adopters and 79 per cent non-adopters). The peer group emerged out as a significant source for contraceptive information both for adopters and non-adopters. For example, among adopters, 32 per cent come to know of condoms from peers against 37 per cent non-adopters and similarly for other methods, peers contributions are 39 per cent for pills (against 37 per cent non-adopters), 48 per cent for IUD (against 47 per cent non-adopters), 58 per cent injectables (against 50 per cent non-adopters), 31 per cent for sterilization (against 29 per cent non-adopters) and as much as 81 per cent (against 84 per cent non-adopters) heard about traditional methods from their peers. The mass media’s major contribution is in case of sterilization as 21 per cent adopters and 31 per cent non-adopters heard of sterilization from mass media. Coming to government health worker (ANM) as a source, her contribution in case of adopters information is – 21 for condoms (against 18 per cent non-adopters), 14 per cent for pills (against 16 per cent non-adopters), 25 per cent IUD (against 11 per cent non-adopters), 13 per cent injectables (against 15 per cent non-adopters) and 12 per cent fro sterilisation (against 10 per cent non-adopters). Thus, adopters have more information on contraceptives than non-adopters.

**Contraceptive Adoption**

In the total sample (150), the fifty per cent are sterilisation adopters (adopters) and equally are the non-sterilisation adopters (non-adopters). Further in the
sampled population only 48 per cent are ever-modern temporary contraceptive users (51 per cent among adopters and 45 per cent among non-adopters). In aggregate, the response percentage on temporary contraception is more for simple consent (69 per cent adopters and 55 non-adopters), followed by encouragement response (22 per cent in case of adopters and 38 per cent for non-adopters). On personal and familial responses, it may be noted that personal (adopters/non adopters themselves) responses are more positive than familial responses. For example, encouragement response at personal level is higher (42 per cent adopters and 53 per cent non-adopters) than familial (5 per cent spouses and 10 per cent significant others of adopters, and like 29 per cent spouses and 13 per cent significant others of non-adopters). While the familial responses are more in simple consent (87 per cent spouses and 50 per cent significant others of adopters, and 65 per cent spouses and 75 per cent significant others among non-adopters have simple consent response) than the adopters/ non-adopters self responses (55 per cent adopters and 75 per cent non-adopters themselves have simple consent). Moreover in total the responses for temporary contraception are more favourable among non-adopters than adopters and most importantly, there is no response of outright rejection for temporary contraception. However, in case of sterilisation, of the aggregate personal and familial responses, the major responses are of simple consent (51 per cent) followed by that of encouragement (27 per cent) and even 10 per cent responses are that of rejection which was nil in case of temporary contraception. Further, the encouragement response for sterilisation is relatively more among adopters themselves (43 per cent) than their spouses (12 per cent) and significant others (28 per cent).
However, unlike the responses, the decision-making process among adopters is more participatory than non-adopters. For example in case of condom usage, 81 per cent adopters jointly decided with spouses, which is 76 per cent in case of non-adopters. Similarly, in case of oral contraceptive pills 76 per cent adopters (against 73 per cent in case of non adopters) decided jointly with their husbands. Further unlike condoms, in case of pills, the significant others also have participation in decision making, both among adopters and non-adopters. Only among non-adopters, 2 per cent of the pills users have decided to use it by themselves (self only). There are only three cases of intra uterine contraceptive device (IUCD) users, one among adopters and two among non adopters and all decided to adopt the same by their self only decision. In case of sterilisation 58 per cent decided jointly with husband, 11 per cent jointly with significant others. In sterilisation there are also extremes. For example 25 per cent took unilateral decision while in 5 per cent cases the decision making was highly participatory i.e. adopters, their husbands and significant others mutually decided to adopt sterilisation. In only one case, there was no say of adopter while she undergoes sterilisation.

It thus came out from above discussion, that in case of temporary contraception responses are more of simple consent and encouragement than of indifference and even there is no response of rejection. Among non-adopters, the responses are relatively more positive than adopters. However, the process of decision-making is more participatory among adopters than non adopters and probably the same speak of high percentages of adopters in ever-temporary contraception than non-adopters. Similarly, in case of sterilisation
also there is either more mutual decision-making (all adopters, their spouses and significant others) or extreme unilateral decision by women. It may be noted that in case of temporary contraception there was not even a single case of mutual decision-making, this again justifies that in case of sterilisation whole family becomes active thus decision making becomes complex. Thus the hypotheses: i. more positive the personal and familial response to contraceptive methods, more the adoption of contraceptives; and ii. more participatory the decision making process, more the adoption of contraception are tested true.

In view of the supra, and detailed discussions in specific chapters, it is amply clear that contraception is a dynamic process involving family as a whole rather than the individuals. Further, the mutual discussions and participatory decision-making processes governs to a large extent the adoption of contraceptives and becomes more important as one moves from temporary contraception to permanent methods like sterilisation. However, the extent and level of mutual discussions and pace of decision-making in contraceptive adoption depends upon the synchronisation between personal and familial characteristics. This it may safely be said that –higher is the synchronisation between personal and familial characteristics, higher is the adoption of family welfare programmes.

7.2 Ways forward

The state and society both have to compromise their respective expectations from each other and the family planning programme has to be recognised as
an integral part of the overall development plans. It is rightly noted that 'there is no shortcut to population stabilisation. There is no substitute to sustained good work. We must create a situation where people would ask for health and family planning services.' The results of present research proved beyond doubt the importance of the intra-house dynamics of communication and power relations in the contraception adoption and how discussions and delayed decisions in family results in a long gap between the parity at which one decides to limit family and the parity at the time of sterilisation. Thus if proper threshold energy is provided to speed up this process than family planning catch segment will not be the exhausted generation but the potentials groups to substantially strike at TRF. It has also become very evident that unlike sterilisation there are not much inhibitions regarding temporary contraception, rather there is high unmet need. However, the hassles and infectiveness of temporary contraceptives is a cause of concern among the sampled population. From the qualitative data it became crystal clear that the only missing link is the lack of proper counselling and clarification regarding temporary contraceptives which results in incorrect and inconsistent use of temporary contraceptive and hence the resultant effectiveness. It also came out that due to delay in process of decision-making for sterilisation and ineffectiveness of temporary contraception, the women attempt fatal traditional concoctions and unsafe abortions. Thus, there is need of concrete steps for developing such groups within community who can act as catalysts to provide the much needed threshold energy. Here lies the proactive role of Panchayati Raj Institutions (PRIs) and the social worker professionals to

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4 Pathak and Singh, "Fertility Transition in India.", p. 195.
3 Bose, From Population to People., p. 125.
provide true momentum to Cairo goal of informed choices in contraceptive adoption under the umbrella concept of Reproductive Health (RH).

Panchayati Raj Institutions (PRIs): India presents a unique case in terms of the sheer number of people involved and the extreme heterogeneity of its cultures, languages and socio-economic conditions. "To improve the effectiveness of the family planning programme, it must be decentralized to reach the grass-roots level." A Working on population appointed by Planning Commission in 1978 (report submitted in 1980) expressed the opinion that the task will not be easy to achieve unless the programme of family planning had the fullest participation of the people, individual and through their representative institutions, voluntary associations, local organisations etc. and in backdrop to same, a study on people's participation in family planning was launched by Panandiker and Mehra. They compared the two models of people's participation i.e. voluntary organisation and panchyats and selected a sample 30 villages and 3 urban centres from the working areas of four voluntary organisation (from states of Gujarat, Delhi and Maharastra) and two panchayat models covering 15 villages (from Madhya Pradesh and Gujarat). It was observed that the shift was more tactical and the ambivalence was evident from the fact that neither a proper definition of people's participation in this context was made, nor an overall strategy evolved through which such participation could be achieved or ensured. They concluded that despite policy professions, over the years, very little conscious effort appears to have

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7 Panandiker and Mehra, People's Participation in Family Planning.
8 Ibid., p. 10.
been made to move in that direction. The study also noted that voluntary agencies have done relatively better than the two panchayats models both in mobilising participation as well making family planning a popularly acceptable programme. The Tenth Plan also emphasized the need to devolve responsibilities and funds to panchayati raj institutions. More recently, Bose observed India’s planners and policy makers as well as administrators of the family planning programme (lately called RCH programme and very recently called population stabilisation programme) have always emphasized the need for family planning as a “people’s movement” without spelling what exactly is meant by this piece of rhetoric. Even today the so-called people’s movement remains an empty dream. However, with the recent amendments in the Constitution of India and consequent empowerment of Panchayati Raj Institutions (PRIs), there appears a ray of hope. Santha noted that with the 73rd and 74th Constitutional amendments and the passing of Panchayati Raj and Nagar Palika Acts in 1992, the family planning programme is legally brought in the domain of Panchayati Raj Institutions. As result of this constitutional the Article 243G of Indian Constitution provides for ‘power, authority and responsibilities of Panchayats’ and reads:

Subject to the provisions of this constitution the legislature of a State may, by law, endow the Panchayats with such powers and authority as may be necessary to enable to function as

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9 Ibid., p. 249.
10 Ibid., p. 236.
11 Jejeebhoy et al., "Setting the Stage.", p. 20.
institutions of self-government and such law may contain provisions for the devolution of powers and responsibilities upon Panchayats, at the appropriate level, subject to such conditions as may be specified therein, with respect to- (a) the preparation of plans for economic development and social justice; (b) the implementation of schemes for economic development and social justice as may be entrusted to them including those in relation to matters listed in the Eleventh Schedule.\textsuperscript{14}

Moreover, the matters listed in the Eleventh Schedule have 29 subjects and its item 25 reads as ‘Family Welfare’ and further this is preceded by item 23 and item 25 which includes areas ‘Health and Sanitation including hospitals, primary health centres and dispensaries’; and ‘Women and Child Development’.\textsuperscript{15} These provisions make PRIs constitutionally empowered enough to usher in a new era participatory development including family planning and RCH (Reproductive and Child Health). This seems to be the moment where we should abandon the number game and move from population to people.\textsuperscript{16} The recently launched National Rural Health Mission of Government of India have heavily relied on PRIs in the selection, payment and monitoring of the grassroots activist of the programme called as ASHA. However, it came out from very limited experiences that these newly appointed ASHAs have simply became the assistant of health workers. Thus,


\textsuperscript{15} Ibid., p. 391.

\textsuperscript{16} Borrowed from the suggestion on the same put forward way back in 1988 by Ashish Bose. See Bose, \textit{From Population to People.}, p. 24.
the PRIs have an important role in streamlining the programme which has just made its beginning.

**Social work professionals:** It is rightly noted that the mass media can play an important role in promoting awareness, whereas interpersonal communication can play a very important role in changing behaviour and promoting the acceptance of family planning among a variety of people. Here lies the role of social work professionals with their specialised knowledge of human behaviour and scientific skills of handling the problems. During 1970s like others disciplines there were also much initiatives in outlining and streamlining the roles of professional social workers in family planning. The premier social work institute i.e. TISS (Tata Institute of Social Sciences) recognising the need for active participation in family planning programme made compulsory a two-month training course at the Government of India, Family Planning and Research Centre, Bombay to a group specialising in Family and Child Welfare. On this Gore noted that it would be very useful if all other groups could also have this advantage, so that they could become active participants in promoting family planning through their specific responsibilities, whether as a labour welfare officer, child guidance worker, or a social worker. However, that was the time of much talked target centric approach where social workers with their process-oriented approach were poor target chasers. However, with Cairo focus of reproductive rights, individual choices, 

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17 Zodgekar, "Family Welfare Programme and Population Stabilization Strategies in India."


19 Ibid., p. 142.
informed consent and Government of India failed experiments with a plethora of approaches based on targets and now propagation of target free approach and client centred initiatives, provides a space for social work professionals to contribute on this issue. Moreover, the results of this research strongly argue for concentrated efforts to develop such groups who can play the role of animators on reproductive health issues including family planning. In the capacity building of such groups, professional social workers can play a significant role. However, for this it is also necessary that social professionals should be specially trained on such issues during their graduate/post-graduate days and thus there is a need to first make RH training as an integral part of social work curriculum and field practicum.

7.3 Limitations

The study has attempted to explore the dynamics of contraceptive adoption with the help of exploratory research design at micro-level. The study used both the quantitative as well as qualitative data come drawn inferences. However, the study is restricted to a sub-centre with a sample of 150 respondent, 75 sterilisation adopters and 75 non-sterilisation adopters and probably this seems to be the biggest limitation of this research. Further, there are many more dimensions of family welfare programmes however; the research was restricted only to contraception adoption. Nevertheless, the research study was successful in achieving its objectives, and the findings of the study can be effectively used for intensifying the process of contraceptive adoption.