CHAPTER VII
SUMMARY AND CONCLUSIONS
The studies on the adoption of family planning are not adequate enough to throw sufficient light on factors accounting for variations in the extent of adoption from place to place and from one group to another. These variations are yet to be analysed more scientifically. The present study is an attempt in this direction with reference to Anantapur district of Rayalaseema region in Andhra Pradesh. In doing so, the study examined the role of infrastructural, demographic, economic and socio-cultural variables in promotion of family planning adoption.

The study revolved around the following objectives:

1. to examine the trends of family planning adoption in Anantapur district from inception to the present;

2. to analyse the variations in family planning adoption in Anantapur district among different primary Health Centre and Sub-Centres with specific reference to infrastructural variations;

3. to examine critically the influence of selected demographic, economic and socio-cultural variables on family planning adoption through empirical study;
4. to find out the reasons for not adopting family planning, and
5. to suggest some measures for bringing more under the orbit of the family planning and for effective implementation of the programme.

In order to realise the above objectives, a study of family planning adoption in Anantapur district is carried out in historical perspective along with the study of a cross section of the family planning adopters. The historical perspective of family planning adoption in the district covers from 1956 to 1983. The cross sectional study through empirical data is confined to 1982-83. For a detailed study of family planning adoption, six sub-centres from different primary Health Centres are selected, one sub-centre with high performance and one with low performance from each of the three family planning divisions in the district are selected for a detailed study. The variations in family planning adoption with reference to infrastructural factors are critically examined.

The fulfil the objectives of the study, 30 adopters and 30 non-adopters from each of the six Sub-Centres are chosen on stratified random sampling principle. Thus our study is based upon the responses from 180 adopters and
130 non-adopters and from statistical data and information collected from six Sub-Centres and six Primary Health Centres representing all the three divisions in the district. While the information from adopters and non-adopters is elicited with the help of schedules, census, annual reports and information on family planning aspects available with the District Family Planning Bureau, Primary Health Centres and Health units provided the necessary information regarding family planning adoption in Anantapur district.

population and family planning in India.

India's population which was estimated around 100 million at the beginning of the 17th century started growing rapidly from 1521 onwards. With a population of 603 millions (in 1921) and at an annual growth rate of 2.47% some are to be existing population. Many problems faced by India such as shortage of food, clothing, having unemployment and large scale poverty are attributed to population explosion in India. India was the first country to take up family planning as a national policy to check the faster growth of population. With the establishment of family planning boards at Central and State levels in India, family planning became an official
Family planning gained priority during the fourth five-year plan. The National Population Policy of 1976 spelled out the concern of the government over the growing population and envisaged its determination to control population growth through measures such as raising the minimum age of marriage, female education, spread of small family norms, research into reproductive biology and contraception, incentives for family planning adoption, etc.

The modified population policy of 1977 reoriented family planning into family welfare programs. As a result, family planning was given a wider role of raising the standard of living of the people, the provision of employment opportunities, health facility, and in general, covering welfare of the family. While coercive or compulsive family planning was denounced, massive educational and motivational programmes were taken up to make the people accept small family norm voluntarily.

The commitment of the government to family planning can be observed in the financial allocation for this programme in different plan periods. The expenditure on family planning during the 1st plan period was only Rs. 14.5 lakhs which increased to Rs. 15 crores in the
third five year plan and to Rs. 1,000 crores in the sixth plan. Those amounts though are an increase from plan to plan, are inadequate in view of large size of population in the country.

In order to implement family planning programmes effectively, a cabinet committee as the apex body and a central family planning council at the central level, state cabinet committee and state family planning councils at state level have been established in India. Every district is provided with a district family planning bureau with administration, education and information, field operation and evaluation wings. Primary Health Centre and Sub-centre in the villages and urban family planning centres in towns constitute the main grass root agencies implementing family planning in the entire country.

On account of high priority given to family planning in India large financial allocations and vast administrative mechanism, family planning programme produced considerable result. During the initial stages of the programme (1955-62) only sterilization was given prominence. Distribution of condoms was started in the year 1963. During the subsequent year, Diaphragms were introduced, IUCD insertions were carried out from 1965
onwards. By the end of 1982, 362 Lakhs of sterilisations were performed in India of which 60.2 per cent were vasectomies, 953 lakhs of IUCD insertions were carried out. About 4.24 lakhs of people practised other conventional contraceptives. As a result it can be stated that about 17.4 crores of couples were protected by some kind of family planning method till 1982. In other words, 27.00 per cent of the eligible couples in the country were said to be brought under the fold of family planning.

POPULATION SITUATION AND FAMILY PLANNING IN ANDHRA PRADESH

Andhra Pradesh is one of the leading States in India in terms of family planning achievement. It has a population of 53.5 millions as per 1981 census. Ever since the family planning was introduced in the country, Andhra Pradesh recorded lesser growth rate in comparison with the growth of the nation. The birth rate in the state was also relatively less. For instance, the birth in Andhra Pradesh came down from 35.54 per thousand in 1970 to 34.92 in 1976 while the corresponding rates for the country stood at 36.8 and 35.2 respectively.
The fact that Andhra Pradesh was fourth populous state the country in 1961 slid to fifth position in subsequent decades indicates the achievement of the state in the field of family planning. It recorded the highest number of sterilizations during the year 1977-78 and won awards for high family planning achievements five times in the past 6 decades. In total, 37 lakhs of sterilisations and 3.6 lakhs of IUCD insertion took place in the state up to 1982. In addition the state represents a considerable population which is using different conventional contraceptives. As a result, about 39 lakhs of eligible couple in the state have been protected from conception.

Even though family planning adoption in India as well as in Andhra Pradesh state has been on the rise since inception of the programme, yet the population growth rate has not taken significant downward trend. This needs serious consideration.

FAMILY PLANNING IN ANANTAPUR DISTRICT

Anantapur district with 26.15 lakhs of people ranks sixth in Andhra Pradesh by population. Its population recorded continuous growth from 1921 to 1961.
However, the decade 1971-1981 experienced a marginal decline in the growth rate from 19.7 to 19.2. It is mainly on account of lower birth rate achieved by the district during this decade. It has recorded a birth rate of 32.1 compared to 33.4 for the state and 33.9 for the country.

The lower birth rate in the district indicates the successful implementation of family planning programmes. The first family planning clinic in Anantapur district was started way back in 1958. Two more clinics were started during the years 1959 and 1960. 12 urban family planning centres and 92 rural centres came to be established by 1985. A mobile family planning unit was introduced in 1967. More recently, the starting of India Population project added more impetus to family planning in the district.

The district achieved the family planning targets successfully many a time. For instance, the district achieved a performance of 102.00 per cent against the prescribed target for sterilisation in 1981-82. The district achieved highest number of IUCD insertions for any district in the state in 1982-83. Since 1965, as many as 1,31,068 vasectomies and 55,504 tubectomies were conducted in this district. In addition
20,126 IUCD insertions have been carried out. More than 35 lakhs of condoms were supplied to the people in the district. Thus the district has fairly good history of family planning adoption.

FAMILY PLANNING ADOPTION.

INFRASTRUCTURAL VARIABLES:

For understanding the impact of infrastructure over family planning adoption, a study of 6 primary health centres and 6 sub-centres at grass root level has been made with reference to their location, facilities and personnel. Of the sub-centres and Primary Health Centres under study, three have performed well in promoting family planning, while the other three failed to do so.

An analysis of the three primary health centres with a high performance record in their respective regions indicates the following:

1. all these primary health centres have the necessary medical and paramedical staff as per sanctioned strength;

2. the primary health centres have the necessary equipment for field publicity, transport and
facilities for undertaking sterilisations.

3. these primary health centres are directly linked with district headquarters and are within the range of 40 kms, except Gorantla;

4. the primary health centres with high performance have manageable number of eligible couple (around 20,000)

5. all the villages and hamlets under these primary health centres have community health volunteers rendering active help to family planning personnel; and

6. two of the three primary health centres have trained dais in most of the villages.

The three primary health centres with a low family planning record in the district, show the following common features:

1. The primary health centre with low performance are situated far away from the district headquarters.

2. They are not having proper communications and transport facilities.
3. They lack proper buildings for housing the family planning personnel at the headquarters as well as in the subcentres.

4. Two of the three primary health centres do not have any vehicle at their disposal.

5. Some of the positions at primary health centre and at the sub-centres are left unfilled.

6. The headquarters of these primary health centres are located in corners of the primary health centre area and thus most of the sub-centres are situated far off from the primary health centre headquarters.

7. The villages and sub-centres are mostly isolated and are without communication and transport facilities and very few villages are provided with community health volunteers and trained Dais under these primary health centres.

These findings help us to understand the important role played by infrastructural variables at Primary Health Centre level in promotion of family planning adoption. The availability of fullfledged personnel, vehicles, audio-visual equipment and buildings to house the centre
and staff; location of the Primary Health Centre at the centre of the area and within a reasonable distance from the district headquarters; provision of transport and communication facilities and availability of voluntary health volunteers and trained dais in the villages covered by Primary Health Centres are found to have promoted family planning. In the absence of these, the other Primary Health Centres could not achieve the expected result in family planning promotion.

The infrastructure available at the sub-centre level also played a significant role in promoting family planning adoption as per our study. The three sub-centres with a good record of family planning activities present some common features. They are:

1. all of the three sub-centres have female and male multi-purpose health workers; and two of them have health supervisors also;
2. the sub-centres in all the cases are visited by respective Medical Officers regularly;
3. the family planning personnel from these sub-centres are assisted by community health volunteers and trained dais.
4. all the three sub-centres have suitable buildings for the centre and its staff;

5. they have facilities to undertake vasectomy operations;

6. all these sub-centres are located in the vicinities of well developed urban areas and are situated within a range of 11 kms. from Primary Health Centre headquarters;

7. they have suitable transport facilities and are connected by proper roads to the Primary Health Centre and to the nearby urban centre;

8. the villages in which these sub-centres located are fairly developed and have postal and telecommunication facilities, schools and institutions like Mahila Mandalas, youth Clubs, Rythu Sangam, Panchayats and co-operative societies.

In addition to the above common features the following factors also influenced family planning adoption in some of the these sub-centres.
1. The Lakshmanapalli sub-centre staged two mass camps (one for vasectomy and other for Gynaec). 

2. The Vangavolu village has an active health committee consisting of 13 people. The health committee was rendering a lot of help to the family planning personnel in their activities. 

3. The Sub-centre at Kudair was serving as the sectoral headquarters for the multipurpose health workers of that sector. And as such it was staging frequent sectoral meetings.

The three sub-centres with low adoption rate presented the following features:

1. In two of the three sub-centres, the positions of the family planning personnel remained vacant for a considerable period of time;

2. All the three sub-centres are without suitable buildings and equipment;

3. None of these villages have trained Dais;
4. All the three sub-centres are situated at a considerable distance from the Primary Health Centre headquarters;

5. The villages where these sub-centres are located are relatively interior and isolated;

6. Two of the three sub-centres do not have direct road or transport facilities;

7. Two of the three villages, where the sub-centres are located are very backward and without necessary institutions;

8. Most important of all, some failures in sterilization have resulted in developing prejudices among the people towards family planning in two of the three sub-centres under study.

Our study thus reveals that the sub-centres with necessary personnel, buildings and equipment did well to promote family planning. Besides location of the sub-centres at a place nearer to the urban area, availability of transport and communication facilities, presence of schools and other institutions, existence of private doctors, community health volunteers and
trained Dais, involvement of local leaders in family planning activities through local health committees etc. are favourable to family planning adoption. Mass sterilization camps, enhanced the scope of the sub-centre in reaching greater heights. In the absence of most of these features the sub-centres at Toonacherla, Gumpallari, Pallapalli are lagging behind.

It can be thus concluded that adoption of family planning depends on the infrastructural facilities available at the Primary Health Centres and sub-centres.

**DEMOGRAPHIC VARIABLES AND FAMILY PLANNING ADOPTION**

The study examined the relevance of demographic variables, like sex, age at marriage and sterilisation, total number of births, number of living children and their sex, with family planning adoption. It has been observed that out of 180 adopters 78.00 per cent were females. Out study, thus confirmed the findings of Moni Nag and Saha that females are more prone for family planning adoption. While majority of the female adopters married around 18 years of age, male adopters were married after reaching 22 years. The adoption took place among females in most instances when they were in 25 to 30 years.
and among males when they were in the age group of 30 to 35 years. Thus our study concludes that couples around 30 years of age are adopting family planning and in turn fails to agree with the conclusions drawn earlier by Kakar and Saha that family planning adoption was prevalent among the middle aged persons.

As the majority of the adopters in our study have given birth thrice or four times before undertaking family planning, it is concluded that only a few are adopting family planning at the right time. This is confirmed further when enquired into actual number of children of the adopters. Only 15.00 per cent of the adopters in our study got sterilised, when they had two living children. The rest underwent sterilisation after having three or four living children, concurring with the finding of Moni Nag. The popular contention that sex of the children has a bearing on family adoption is found to be baseless in our study. In our sample we find adopters with male children and as well as female children more or less evenly distributed.

Among the demographic variables the extent of family planning adoption is positively correlated with factors like total number of births and age at adoption.
to a greater extent, and to a moderate extent with factors like actual number of living children and age at marriage. There is only positive but insignificant correlation between sex of the children and family planning adoption.

**ECONOMIC VARIABLES AND FAMILY PLANNING ADOPTION**

Occupation, land holdings and income levels have been taken as the economic variables behind family planning adoption. The observation of Kar and Sastie that family planning adoption was more among upper occupational groups was not quite relevant in the case of adopters in Anantapur district. In our study, agricultural labourers, definitely from the lower occupational groups, formed the majority of the adopters. Further our study confirms the findings of Ualidu that the pattern of land holding had no impact on family planning adoption, as the adopters belong to families without land as well as with marginal, medium and larger land holdings.

A significant number of adopters in our sample were among the lower income groups. This finding is in contrast to the observations of Rao, who stated that the rich favoured adoption and not the poorer classes.
The coefficient of correlation between the economic variables and family planning adoption present a varying picture. Occupation of the adopters showed a highly negative correlation. While the income levels projected a positive correlation with family planning adoption, no significant correlation was found between family planning adoption and the land holding pattern.

SOCIO-CULTURAL VARIABLES AND FAMILY PLANNING ADOPTION

Type of the family, caste, literacy and awareness in family planning have been examined with reference to family planning adoption. As the adopters in our sample are predominantly from nuclear families, our findings confirm the earlier observations of Majumdar and Das and of Koler that nuclear family status is congenial to family planning adoption. Regarding caste, our study has concluded that backward castes and forward castes formed the bulk of the adopters. The scheduled castes and scheduled tribes formed only negligible section of adopters. Our findings regarding caste background of the adopters are thus in tune with the conclusion of Saha that lower castes generally restrained from family planning adoption.
As 76.0 per cent of the adopters in our study were illiterates and as 8.00 per cent of the adopters had only primary education, it can be concluded that literacy level is not very important factor in influencing adoption of family planning. Our conclusion also tallies with the observations of Lathak and Irasad and Rajswari.

The awareness levels of the adopters were found to be very high. They had a greater insight into the problem of over population and its effects on food, housing and employment. The adopters regarded family planning as the right solution for such problems. They were also aware of the incentives offered for family planning adoption. But incentives alone did not form the cause for family planning adoption. Majority of the adopters underwent sterilisation as they felt that they have produced sufficient number of children.

FACTORS BEHIND NON-ADDITION:

The demographic and economic features of non-adopters indicate that they are either below 25 years or above 35 years in age that they entered marital life while they were in the age group of 16 to 25 years.
More than 58.00 per cent of the non-adopters have two or less than two children. Non-adopters are found mostly from cultivators and agricultural labour than from other occupational groups. The non-adopters are comparatively more among the landless poor and the small farmers with 2.5 to 5 acres land. Similarly from majority of the non-adopters are found to be lower income families.

The socio-cultural background of the non-adopters indicates that members of joint families as well as scheduled castes and tribes are not much inclined for adoption of family planning for reasons discussed already (Chapter VI). However, the extent and family planning knowledge and state of motivation towards family planning among the non-adopters is highly encouraging. Majority of the non-adopters under the study, were of the opinion that the country is facing the problem of over population. However only a few non-adopters are aware of the implications of over population on various socio-economic issues in the country.

In spite of considerable family planning awareness, the respondents did not adopt family planning due to different reasons, of which the fear of the post-operation
is the predominant one. A significant number were unable to plan their families, even though they themselves were in favour of it, on account of non-acceptance by the other members in their families. Preference for a male child or female child formed the other important reason for non-adoption. A few non-adopters cited religious beliefs and opposition from friends and well-wishers as reasons for non-adoption. Some persons did not go for family planning since they had a single child or a sick spouse.

**HURDLES FOR FAMILY PLANNING ADOPTION AND SUGGESTIONS:**

Our enquiry into the problems faced by the adopters while seeking family planning services indicated some situations hampering family planning adoption. In a sample of 100 adopters, 10.00 per cent had to overcome strong objections from the older members of the family before undergoing sterilisation. About 10.00 per cent of the adopters were unhappy with the medical care that was provided to them while undergoing vasectomy or tubectomy. 75.00 per cent of the adopters feel that they have developed one or the other physiological complications after sterilisation. These complications,
ranging from body pains, abdominal discomfort, physical weakness and swelling of the testicles, in turn indicate that the post-martum services are not properly undertaken in this region.

The adopters in our study offered wide spectrum of suggestions, in the light of their experience, for attaining better results in family planning programmes. They are:

1. Intensification of motivational programmes;

2. Increasing the incentive awards.

3. Appointing suitably qualified personnel in the field as well as in the hospital.

4. Provision of proper facilities for the adopters where they attend family planning agencies to undergo sterilisation.

5. Better medical care and timely supply of required medicines and

6. Providing suitable post-operation care for the adopters.
The non-adopters, on the other hand also came up with suggestions for effective implementation of family planning programmes. They are:

1. Provision of incentives in the form of land and house sites;

2. Extending financial support to the families of the persons undergoing sterilisation, especially during the period of their hospitalisation and convalescence.

3. Providing proper medical care in the post-operation period also and

4. Propagation of family planning among the elder generations also so that they may not object to family planning adoption by younger generations.