Chapter Seven

SUMMARY, CONCLUSION AND POLICY IMPLICATION

1.1. Introduction

Considering the importance of fertility to the development per se and with the observation of high population growth in Dhubri district of Assam this study focused on various aspects of fertility of Assam in general and of the Dhubri district in particular. This study examined fertility dynamics in Assam with a view to knowing how socio-economic factors influence fertility and family planning. A comparative analysis between whole Assam and sample drawn from Dhubri district for its relatively high fertility and population growth rate has been done. The population growth rate is recorded as highest among districts in Assam. Besides presenting levels and trends of fertility, proximate determinants of fertility by socio-economic status are examined. It is also examined how family planning methods are used and how far these are associated in the context of fertility preferences. How levels of fertility get shaped in the context of desire for children and sex preferences remain another important focus of the study.

This section brings together results of each aspect of fertility and discusses to give a more comprehensive view of the findings as well as meaning to the findings. Whether the hypotheses proposed are proven or not by the findings is then examined. Following this, comparison of results with whole Assam and national perspective is drawn. Socio-economic effects on both fertility and family planning remained the main central issue. The chapter ends with conclusion of findings as well as some policy and research recommendations.
This thesis comprises of seven chapters. Four specific objectives and three research questions were framed for the study. The study was carried out with the help of both primary and secondary data.

1.2. Summary of Findings

Fertility and Family Planning: Findings from Assam and Dhubri District

- The results of this study underscore the point that fertility transition has started in Assam. Although TFR for Assam is 2.4 which is little above the replacement level of fertility many districts have reached the below replacement level of fertility. There are 8 districts that have reached to replacement level of fertility or below of it. The TFR varies from 2.0 of Kamrup to 3.9 of Hailakandi. The TFR of Dhubri district is estimated to be 2.6.

- Fertility level measured by Crude Birth Rate (CBR) and Child Ever Born (CEB) also account very high and present similar district wise variation. CBR varies from as low as 18 of Kamrup district to as high as 31.2 of Hailakandi district. CEB varies from 3.2 children in Karimganj district to 2.1 children in Kamrup, while the state average is 2.6 children. CBR and CEB for the Dhubri district were 21.9 and 2.8 respectively.

- The proportions of births for 1<sup>st</sup> and 4<sup>th</sup> order account 37 percent and 21 percent respectively. The most favourable percentage distribution for the birth order 1 and 4+ observed for the district Karbi Anglong accounting 56.9 and 6 respectively. Dhubri comes just below the average of Assam after Tinsukia. The proportions of births for 1<sup>st</sup> and 4<sup>th</sup> order account 42 percent and 22 percent respectively.
Within a particular state again there is wide socio-economic variation in the level of fertility. The fertility level among ever married woman varies by various characteristics like age of the ever married women, place of residence, educational attainment, religions, social groups, and wealth quintiles. In general, CEB is found to be varying negatively with socio-economic status and positively with age of a woman. Besides, variation is observed by place of residence, social group and religious group. Muslims living in rural areas have higher fertility. CEB for Hindus and Muslims accounts 2.46 and 3.1 in Assam. And the pattern of variation by various background characteristics remains almost similar for the state of Assam and the Dhubri district. The state average therefore masks large variations in the fertility levels between subgroups in the state.

Desire of additional children is found very high. Around 80 percent of ever married women aged 15-49 those were not having children, desired for children immediately. The percentage reduces to 60 percent, 14 percent and 8 percent with having 1, 2 and 3+ surviving children correspondingly. It is observed that here is no sex preference, which is usually expected with high fertility rate.

Knowledge about family planning method is found almost universal. The percentage of women knowing any type of contraceptive method account 98.6 percent. There were only some districts like Dhubri, Sibsagar and Golaghat lagging marginally with rates of 94.4, 95 and 95.5 percent respectively.
However, contraceptive prevalence rate (CPR), i.e., the percentage of currently married women using any type of contraceptive method is found low. CPR for Assam recorded 48.6 percent.

As far as distribution of currently using contraceptive methods is concerned, majority of women (32 percent) reported of using pills followed by female sterilization (23 per cent), Rhythm method (21 per cent), and withdrawal (15 percent).

The use of contraceptive method is biased towards females. Around 58 percent of contraceptives are used by females in Assam. Therefore there is lack of male involvement in family planning.

Like fertility use of contraceptive also varies by socio-economic-demographic status of a woman. Through both bi-variate as well as multivariate analysis, it observed that place of residence, women’s education, religion, household wealth and numbers of surviving children are significant determinants of contraceptive use.

Unmet need which indicates potential demand and gap between demand and supply of contraceptive is found very high for Assam. The total unmet need records 22.5 percent for Assam comprising 17.4 percent for limiting and 5.1 percent for the spacing method of family planning. Across districts it varies from least 11.5 percent in Udalguri to 39.6 per cent in Golaghat district.

Unmet need of contraceptive varies by socio-demographic-economic status of a woman too. The general observation is at the early age of reproductive period women experience higher unmet need for spacing and later aged women face for limiting. In aggregate, it is found that unmet need to be
reduced with the increase of age. Similar result is observed for education of women and household wealth status.

**Fertility and Family Planning Scenario: the Study Area**

- Small to medium size villages were selected for sample survey from Dhubri district, Assam. Household numbers in villages range from lowest 92 to highest 699.
- Selected villages characterises socio-economically backwards in terms of literacy, workforce participation, type of work, households income etc. The literacy rate of the selected villages varies from as low as 20.7 percent in Sukhchar to 78.3 percent in Asharikandi village. There is also gender inequality in literacy rate. Females are in general 10 to 15 points behind the males in attaining literacy. The sample area is worse off than the district average in terms of socio-economic status. Majority of workforce in rural area are engaged in cultivation followed by agricultural labourer. But in urban area majorities are engaged in non-agricultural workforce. There is large variation in workforce participation as well as in the type of work. In majority of villages as well as in town areas very less proportion of females participate in the workforce. And those among females participate in the workforce majority of them are engaged in either as agricultural labour or other activity. On the other hand, majority of males are engaged as cultivators.
- Majority of sample population are Muslims (78.1 percent). As far as ethnicity is concerned 73.3 percent are Bengali and 14.9 percent are Assamese. Majority of population belongs to the general category (80.7
percent) followed by other backward class (12.8 percent) and Schedule caste of 6.4 percent.

- Socio-economic status of women, particularly of ever married women aged 15-49 are found very poor. 61.4 percent of ever married women are illiterate. Very few women are engaged in paid workforce. Age at marriage is very low accounting 18 years. Women’s husband education also found low accounting illiteracy rate is 54.2 percent.

- The fertility level is marginally higher among sample households as compared to the state and district averages. The higher level of fertility remains consistent for any measure of fertility like child ever born, birth order or women’s parity.

- The main underlying factors for higher level of fertility in the study area are found to be education and religion. Both women’s and their husband’s education are important to have lower level of fertility. The minority impact is observed to be very strong i.e. Muslim people being minority produce more children as compared to Hindus in order to compete with Hindus. And higher level of fertility observed in the study area is partly explained by high concentration of Muslim population beside poor socio-economic status.

- The use of contraceptive which is the underlying factor in controlling fertility is found very low for the sample area. Only 30 percent couple reported of using any contraceptive. Therefore, contraceptive prevalence rate is found worse in the sample area as compared to district average.
Beside lack of knowledge about contraceptive methods, availability of contraceptives is found to be another important hurdle to the use of contraceptives. It is found that knowledge about contraceptive is not universal. The knowledge is not universal. Only 90 percent of women reported of knowing any method of contraceptives. And those use contraceptives receive contraceptives from mainly private sources like private hospitals, doctors etc. The share accounts 84 percent. The government source accounts only 16 percent.

The low use of contraceptive is the result of both lack of demand and supply of contraceptives. Owing to poor socio-economic status (particularly low education) couples are unaware of family planning methods vis-à-vis less demand for contraceptives. On the other hand, lower demand is fuelled by lack of availability. Particularly government initiatives are less.

Another important observation behind the low use of contraceptive is lack of male involvement as 40 percent of women reported that they were not using contraceptives because of opposition of their husband.

The main important determinant of family planning use is found to be education. Both women’s and husband’s education mainly determine use of contraceptives.

In general, the study area characterises with low socio-economic status, particularly, low education level leading to low use of family planning and its resultant higher level of fertility. The high fertility level is also seen through estimated Total Fertility Rate (TFR) using Bongaarts model
Given the universal marriage and low use of contraceptives, TFR is estimated for the area very high, 5.22. The socio-economic variations in fertility also remain intact in the estimated TFR. For example, it accounts 6.25 and 4.31 among illiterate and literate women. It varies from 5.88 to 4.34 among women belonging to first and fourth income quintiles respectively. As far as religion gap is concerned, TFR estimated as 4.26 and 5.32 for Hindus and Muslim respectively.

1.3. Discussion

Over the last few decades fertility rate in India has been declining. Many states like Kerala, Himachal Pradesh, and Andhra Pradesh etc. have already reached replacement level of fertility. It is also expected that by the next decade the goal of achieving replacement level of fertility will be met for India. Keeping similar pace Assam also has witnessed decline and came close to replacement level of fertility. Nevertheless, Assam needs to go little more to achieve the target and more importantly needs settle inter district variation. There are many pockets having extraordinarily high fertility as found for the study area.

The high fertility level is depicted through any type of fertility measure like child ever born, total fertility rate. Total fertility rate (TFR) estimated using Bongaarts model (1978) accounts as high as 5.22. While universal marriage is almost common norms in India and the study area is no more different, the main factor which makes apart the study in terms of relatively higher fertility as compared to district/state/national average is very low use of contraceptive. Particularly, modern contraceptives are used very less among couples.
The high fertility of the study area gives an indication of adverse socio-economic and demographic characteristics of the study population. In other words adverse socio-economic-demographic characteristics determine high fertility rate. Important factors in determining fertility is reconfirmed in this study with the observation of considerable differences in fertility measures by women's age, age at marriage, place of residence, literacy status, religion, wealth status, workforce participation etc. This variation remains almost similar for use of contraceptives through which fertility mainly reduces. As in other studies, older women have a significantly higher number of CEB. Similarly, those women who are married early were likely to have higher number of children than their counterparts. Early marriage leads a woman to entering into a sexual union and exposes women to childbearing. Again early marriage has many negative consequences for women’s status. An early marriage leads women to drop out from school and entering into the workforce. These education and workforce participation have very significant impact upon women autonomy or empowerment. Women empowerment is an important aspect which has been realised across the globe for achieving any development goal. It acts in eradicating poverty, attaining universal primary education, or achieving sustainable development or enabling universal access to health care (World Bank 2003). Empowered women are not only likely to be engaged in productive activity, they set path for increased productivity for the future generation through making quality human resources. An educated woman takes care of their children better by providing schooling, better health care, and results in better human resource. Gender equality as subset of women empowerment is also linked to environmental sustainability. In simple, older the woman is when she marries, the greater the likelihood that she has
attended school and employed, and greater the chances of having a more equal relationship with her husband and take decision in favour of their own (Kazi and Sathar, 1986).

The rural-urban divide in fertility what has appeared in the study area seems to be result of differences in socio-economic status of people. One reason of low fertility could be that women in urban area use contraceptives more than are rural women. The other reason could be that people who live in rural areas tend to marry at a younger age than people do in urban areas.

Education, which has appeared as most important factor of fertility is well known through earlier studies that the fertility of a woman is negatively associated with her level of education (Balakrishnan et.al., 1993). Education exposes women to information, empowers women, makes them more likely to be employed outside their home environment, and makes them more aware of their own health and the health of their children. All of these variables are negatively associated with the number of children a woman will have during her reproductive life. Similarly, educated women are more likely to postpone marriage, have smaller family size, and use contraception than are uneducated women (Martin 1995).

The results have confirmed that contraception is the strongest factor responsible for high fertility in both rural and urban areas. It is noted that knowledge of contraception is not positively related to use of contraception. This is revealed in the results obtained in the field survey, where knowledge of contraception is nearly universal while the use of contraception is low. Particularly use of modern contraceptive has been very low. Women in the study area as well as in Dhubri district
are believed to be the custodians of family planning use. Around 86 percent of contraceptives were being used by women only.

The variations in contraceptive prevalence are associated with socio-economic status of women. Contraceptive prevalence is positively associated with the level of socio-economic status. Therefore, socio-economic backwardness of the sample area results in low contraceptive usage. Family planning use is the main path through which fertility is determined. That is certainly observed in the study area. Although around 90 to 95 percent of women have knowledge about contraceptives, usage is found very low. Low usage has been the result of both lack of demand and supply of contraceptives. It is seen that government initiatives are not adequate to make family planning methods available. Majority of people those are using family planning methods are buying from private sources and people reasoned ‘cost of contraceptives’ as one of the dominant cause of not using family planning method. The supply side problem is also reflected in the unmet need of contraceptive. As per DLHS-3, the percentage of unmet need accounts as high as 31 percent for the Dhubri district.

Nevertheless preference for limiting family size is found very low in the study area in particular and in the Dhubri district in general. A very high proportion of women with higher birth order or parity desires for additional children. This happens even with having no sex preferences. Son preference is proved as one of the important causes of higher desire for children in India. In India couples have a strong preference for sons over daughters (Arnold 1996, 1997; Cleland, Verrall, and Vassen 1983; UN 1981, 1985; Williamson 1976). A strong preference for sons is proved to be an obstacle to fertility decline if couples continue having children after reaching their overall family-size goal because they are not satisfied with the sex composition of
their children (Mutharayappa et al, 1997). Low use of family planning is partly explained by lack of male involvement in the family planning. It is found that family planning use is female dominated, whole responsibility lies to females. Females share around 70 percent of total contraceptive use. When it was asked for citing reasons for not using contraceptive, around 40 percent women reasoned to ‘opposition of husband’ i.e. husband opposed in using contraceptive method. This is a very important observation and it indicates that mere supply of contraceptives will not help much unless there are initiatives of counseling for males to involve them in the family planning.

Male involvement in regulating family size has been a concern for the health policy makers for quite some time. It is expected that they should have a role in planning the size of the family, prevent sexually transmitted diseases and other health complications. The role of men in such matters is of great importance in India because the sole decision-makers in a vast majority of the Indian families are males. Women need the consent of their husbands before using contraception. Both the ICPD held at Cairo in 1994 and the World Conference on Women at Beijing in 1995 highlighted the hitherto neglected area of need of male involvement in family planning and reproductive health in the context of equity in gender relations and responsible sexual behaviour (United Nations, 1994, 1995).

Barring all important socio-economic factors associated to high fertility level, the most important factor is found to be the impact of religiosity. There seems to be very strong linkages between high concentrations of Muslim population (78 percent) and appearance of high fertility in the study area. In India, there is evidence that fertility is higher among Muslims than among other major religions (Visaria 1974;
Balasubramanian 1984; Das and Pandey 1985). The fertility differentials by religion have been explained by social scientists through developing hypotheses. These are ‘characteristics hypotheses’, ‘particularised theology hypotheses’ and ‘minority status hypotheses’. Fertility differentials occur on account of differences in socio-economic characteristics of populations of various religions (Freedman and Whelpton 1961; Jones and Nortman 1968; Goldscheider and Uhlenberg 1969). It is very normal that people belonging to one religion may be relatively more backward as compared to other religious group and that causes fertility differentials. Variation by income, occupation and urbanisation could appear by religion resulting in different levels of fertility. The religious differential is then the product of the difference in the characteristic and the influence of this characteristic on fertility and not the direct influence of religion as such ‘Particularised theology hypothesis’ attributes the differentials to differences in theological prescriptions on matters directly influencing fertility, such as marriage, contraception, and abortion. ‘Minority status hypothesis’ is that being a minority community leads to a particular kind of fertility behaviour (Goldscheider and Uhlenberg 1969; Day 1984). It might happen that a minority group may restrict family size in order to be able to compete with the majority population or it is also possible that a minority may want to raise its share in the population by having higher fertility.

Some of the earlier studies put more emphasis on the hypothesis on socio-economic differences. Religious differentials in India were ascertained to variations in characteristics (Visaria 1974; Shariff 1996). However, few studies assess the religion effect after controlling for other relevant socio-economic characteristics. Household surveys in Karnataka and Kerala showed that the religion effect persists even after
controlling variables such as education, income, and work status (Zachariah 1984; Rao et. al, 1986). In particular, it was seen that the higher fertility among Muslims compared to Hindus and Christians was not explained by differences in other socio-economic characteristics. This study also shows that minority hypothesis is dominant over socio-economic differences. The fertility gap is observed between Hindus and Muslim even after controlling for all socio-economic characteristics and there is very marginal gap observed for factors like age at marriage, use of contraceptives etc. that directly influence fertility.

Among proximate determinants of fertility, contraceptive use is one of the most important factors contributing to religious differentials in fertility. The particularised theology hypothesis operates primarily on this as certain religious sanctions may bar the use of contraception. It has often been said that Islam does not favour contraceptive use though there is no consensus on the actual position of the religion on this matter; many scholars have noted that there is no absolute bar on contraceptive use for Muslims (Khan 1979; Omran 1992; Chaudhury 1984). In the survey also very minimal number of women reasoned about religion ban. Notwithstanding, the use of contraceptive is found marginally higher among Muslim as compared to Hindus after controlling for other socio-demographic-economic factors.

1.4. Conclusions

The purpose of this study was to understand fertility behaviour and its variations by various socio-economic and demographic characteristics of individuals, and households of Dhubri district in Assam. The main purpose was also to underscore why some areas in Assam lags behind in terms of controlling fertility. Examination using
both secondary and primary data reveals that level of fertility is embedded very much in the socio-economic status and religiosity. Poor socio-economic status of women leaves them unaware about family planning use vis-à-vis higher level of fertility. The problem gets further aggravated when women face discouragement from their uneducated husband. One of the dominant reasons of women not using contraceptive has been husband’s opposition in using family planning method. Husbands, particularly those are uneducated, are very much reluctant to use contraceptives. In other words, there is lack of male involvement in family planning and the problem is stronger among uneducated males.

Among the many variants, education, both woman’s and husband’s, is found to be the single most important factor to influence the use of family planning and its resultant fertility. It is the only factor which can even neutralise the impact of religion. The religion impact is very strong and remains significant after controlling for other variants reduces substantially with the increase of women’s education only.

Nevertheless, high level of fertility in the Dhubri district in general and in the study area in particular has been the result of higher concentration of Muslim population those prefers larger family size across any socio-economic backgrounds as compared to Hindus. Besides existent religion impact, whole issue can be divided into aspects of demand and supply of family planning. While demand for family planning can be enhanced through socio-economic development, particularly women’s education, government initiatives are required to meet supply side challenges, particularly reducing the gap of unmet need in contraceptives.
1.5. **Policy Recommendations**

Based on empirical results the present study suggests the following points to be taken in the policy measures;

- There is need for awareness campaigns to increase the age at marriage. Increased age at marriage will lead women to be educated and empowered that will enable them to make decision on when to get married and have children. The strategies introduced should largely aim to improve the status of women. This can be achieved by intensifying educational opportunities. Therefore, simultaneous awareness campaigns and women’s educational program will reduce early marriage and empower women to make decisions on their fertility. Efforts are required to make women aware of on the use of modern methods of family planning, postponement of marriage that will certainly be very useful in the bid to reduce fertility levels.

- The government should continue its breastfeeding awareness campaign. It is not only important from the perspective of health of the child and the mother; it has strong effect on fertility and the associated benefits of smaller family sizes.

- The information, education and communication campaigns on the methods of family planning, the sources, benefits, and side effects and remedies should be carried out. Efforts are required to eliminate misconception, if any, about modern contraceptives. Most family planning programmes tend to focus mostly on the supply side rather than the demand side of innovation diffusion. There is a need for bringing a variety of family planning methods from which people can choose the best one suited to their needs.
Family planning services should be heavily subsidised to enable every willing woman to keep space, limit or delay pregnancies. It should be available, affordable, accessible and acceptable to all women in the reproductive age group who need them. Health service providers should help by making family planning and other reproductive health services available to women. Further, family planning services need to be provided free in some selected pockets like the study area where use of family planning is very low vis-à-vis fertility level is very high.

Males should be made integral part of family planning. Efforts are required how to involve men in the family planning. The whole responsibility should not be passed on to females. Programs must continue to encourage couple communication, so that couples' family planning decisions are made jointly. Some potential strategies could be face-to-face dissemination of information, encouraging couple communication within communities, training male health workers to discuss family planning with male groups, and strengthening access to, and availability of reversible methods, so that dependence on female sterilisation is reduced.

Family planning providers should be aware of cultural and social structure in which people live. They must respect the values and traditions of user and potential user. The methods advocated should not undermine the user’s attitudes, needs and problems as these affect the approval and use of contraception. Therefore, proper prior research is required in a particular setting on what method is acceptable and does not undermine social and cultural norms.
At last it can be point out that strategy in terms of types of contraceptives, pricing, and target group should be context specific. The universal family planning program will take longer duration to curtail fertility of those who have not responded yet to on-going family planning programs. Therefore, discriminatory pricing policy of family planning method favouring backward regions with fertility is required to be implemented.