OBSERVATIONS ON CERTAIN SITUATIONS RELEVANT TO FAMILY PLANNING

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Fertility surveys carried out in recent years in different parts of India have provided, in general, useful data on various circumstances associated with family planning. Also, there is available in this regard, some valuable information that has been gathered on the basis of records of family planning clinics. It is proposed in this paper to make a few passing observations on some aspects relevant to fertility control like the desired family size, attitudes toward family planning and practice of contraception.

Number of children desired

One of the indicators whether or not a couple is likely to practise family planning is that relating to the desired family size. But our information in this respect is necessarily patchy. It is doubtful if the true nature of such a desire is always revealed clearly by surveys.

As long as fertility is not liable to be controlled at will, the desire to have a specified number of children may not be achieved. The assumption involved here is that the target set by the couples is invariably lower than the physiological maximum (ignoring fecundity impairments or other factors adversely affecting fertility performance which might upset this assumption). On the other hand, such a desire is more easily accomplished under conditions of sustained and effective family planning practice. In this country, with fertility largely uncontrolled, when families are completed there will be a pronounced gap between the desired and realized family sizes, the deaths of children, however, tending to reduce the margin. Nevertheless, taking a broad prospective view, it may be said that the expressed desire for a specified number of children is suggestive of the future levels of fertility when fertility becomes amenable to regulation. It also perhaps indicates the level below which fertility is not likely to fall. In this context, one of the most significant trends to be noted is the differential aspirations in the different socio-economic groups. If a real differential exists and aspirations are

also realized, the future birth rate is liable to be affected in a way determined by the social class configuration of the population.

It may be stated, however, that there is lack of consistency in the results of the surveys carried out in the different areas regarding the number of children desired by the couples in the various social classes. Part of this inconsistency may be attributed to the regional peculiarities. In some of the fertility investigations carried out in this country[7, 13] there were indications that with the rise in the socio-economic status, the number of children preferred also increased. Whether this trend in the number of children desired is a rising one could not be studied on account of inadequate data at the higher levels. The pattern exhibited underlines the importance of economic factors in family size preferences. Further support to this hypothesis is supplied by the nature of the response regarding the number of children preferred under 'existing' and 'ideal' circumstances.[7] In the prevailing conditions, the women would prefer 2-3 children, while under 'ideal' conditions they would prefer 4. On the other hand, contrasting results have been obtained from other studies. In Kanpur, while there was no difference in the number of children desired by illiterate and primary educated women, the number desired was found to be less in the case of secondary and college-educated women[6]. In Bangalore City, a high educational status and a high economic status were found to be correlated with desires to have a small family[15]. If that be so, the implication is that with the extension of popular education and with rising levels of living, large numbers of couples will begin to accept the small family idea and may also make attempts to implement it to the extent possible. However, the diversity in the nature of information available precludes any firm statement being made in this regard.

A close second look, however, at the available data on the number of children desired by couples in the various strata seems to suggest that conclusions based on such information have to be drawn with reservations. The existence and the strength of the desire are perhaps associated with the knowledge and availability of means of achieving such a desire. The desire to have a small family, expressed so often by the rural couples is, therefore, no indication that they will be receptive to family planning. The real desire in most cases has come only after the family has overgrown. Even in other cases, an uncritical acceptance of the respondent's statement on preferences might sometimes be misleading. Stephan has aptly observed: "When we ask people about their preferences and attitudes, what we

actually obtain is not a set of data on motivations but a set of expressed opinions—that is, statements people make in answer to questions"[14].

Attitudes toward family planning

Most Indian studies have testified to the prevalence of a favourable attitude toward family planning even among rural women. In spite of the majority verdict to this effect, there is still some difficulty in its unqualified acceptance. Gleanings from the press lately portray a gloomy picture. A survey (briefly reported in the press[2]) carried out in a village in the district of Thanjavur (which according to the correspondent is one of the most enlightened districts in Madras State) shows that of the 59 couples in the village, only 14 couples expressed themselves in favour of family planning, while a few were indifferent and the rest against family planning. The results of another recent study in West Bengal (also briefly reported in the press[13]) show that about 54 per cent of the women interviewed disapproved of family planning because of their conservative social outlook. So long as people are conservative, as they are now, particularly in the rural sector, the attitudes are also bound to be conservative.

It might, however, be stated that as in the case of desire discussed earlier, an objective evaluation of attitudes toward family planning or family limitation is beset with difficulties in a situation where there is general lack of awareness of family planning. One of the reasons for the more favourable attitude toward family planning among the urban population compared to the rural may be the former's greater awareness of family planning. But ultimately, it is the actual practice that could inhibit fertility and not mere awareness. Though awareness is a necessary precondition to the practice of birth control, the extent of practice is dependent on several other considerations[10].

Practice of family planning

Non-availability of contraceptive supplies has been frequently advanced as one of the chief reasons for the non-practice of contraception. One should, however, remember that mere availability of these will not ensure widespread adoption of birth control[11] Much depends upon the social and domestic organizations, customs and beliefs, which ultimately shape the aspirations of the people regarding family size and practice of family planning.

The practice of family planning in rural areas is said to be non-existent. The available information on family planning is, therefore, confined to certain large towns and cities. It would be interesting to study some of the characteristic features in the practice of family planning.

The practice of family planning by the couples is essentially the product of a certain consciousness in them. The development of this consciousness, and hence the extent and pattern of family planning, are closely related to various factors like the fecundity of the couple, personal desires regarding the number of children and the number one already has, socio-economic status, compelling economic motives and so on. Surveys conducted in rural areas showed a virtual absence of the practice of modern methods of contraception. But the observed association of contraceptive practice with social status in city areas has been stated to be an important factor in the social class differential in fertility[9].

Though only a small proportion of the couples in the poorer sections of the community practise family planning, it is important to note that they were mostly compelled to do so by economic considerations[9]. According to the West Bengal study[13] referred to earlier, 65 per cent of couples who practise family planning do so for economic motives. One wonders, then, how the expected improvement in the economic situation consequent upon the operation of development plans will affect the progress of family planning. Perhaps, with improvement in the economic conditions there might also be a corresponding and favourable change in the social and mental outlook, as is probably exemplified by those in the higher socio-economic classes.

The stage at which family planning is initiated by the couples and the consistency with which it is practised, have an important bearing on fertility. Data in this respect, however, are rather scanty for the Indian population. The information collected in Calcutta[9] shows that most of the couples who had practised contraception had initiated the same within 5 years of their married life, the proportion varying with social status. That a number of them either discontinued the practice afterwards or practised irregularly was evident from the gap between the actual number of children borne by them and the desired number. As family planning is more understood as a process for limiting rather than spacing births, it seems that most of these couples take to family planning *seriously* only at a late

stage of their married life when the size of the family has already become too large.

In recent years, a few studies based on records of family planning clinics operating in some urban centres have been carried out. Though the clinic services are limited in scope in the total family planning situation, the analysis of clinic records have highlighted certain important demographic characteristics of the clinic users. In Kerala it was found that couples visiting the family planning clinics had on an average 4.49 children with the wife's age about 30 years[4]. In Bombay it was observed that the median age of women attending the clinics was 27 years and on an average these women had borne 3.6 children already.[3] It was also observed that women of 35 years and over enrolled more frequently if they had 4 or more live births, than if they had less number of children born. This suggests that an important motive for visiting the clinics was for limiting the number of births rather than for spacing. Only about 20 per cent of these women seem to have made an attempt to use contraceptives before visiting the clinics.

In the Delhi study[1] it was found that the average age of women at the time of their first enrolment at the clinics was 27 years. They had borne, on an average, 3.6 children. Unlike Bombay where only 20 per cent of the women had pre-clinic contraceptive experience, in Delhi about 58 per cent had similar experience. The difference in the socio-economic status of the clinic clientele in the two cities might have contributed to the observed variation. The most commonly used method was the condom, having been used by about 56 per cent of the couples. It is, however, significant to note that about 80 per cent of those using condom or withdrawal found the method unsatisfactory. On the other hand, those who were using diaphragm and jelly were generally satisfied with the method. According to the author of the report, a patient who is satisfied with withdrawal or condom will not go to the clinic while those satisfied with diaphragm and jelly are likely to visit the clinic for check-up and for further supplies. Another point of interest highlighted by the study was that about 23 per cent of the couples were practising contraception after the first pregnancy, and about 48 per cent after the second pregnancy.

In a comparatively smaller study carried out in Sholapur[5], the average age of women attending the clinics for the first time was found to be about 27 years and they had on an average borne 4-5

children. Only about one per cent of the women are known to have practised contraception before they sought clinic advice.

From the foregoing paragraphs it is clear that most of the women attending the clinics did not have previous contraceptive experience. In Delhi, presumably on account of the higher socio-economic status of the women attending the clinics, the proportion who had contracepted prior to the clinic visit was found to be higher than in Bombay or other places. But since, in general, the clinic patients are mostly drawn from the lower socio-economic classes, it might be presumed that for them the time of enrolment at the clinics more or less coincides with the time of first practice. It follows, therefore, that the clinic users start the practice somewhat later during the reproductive period than the non-clinic users. Nevertheless, it seems doubtful that the non-clinic users by their earlier start, could achieve a correspondingly greater reduction in fertility, possibly on account of their inconsistent practice. On the other hand, the clinic attenders being a strongly motivated group tend to pursue family planning with greater consistency. This is generally substantiated by the fact that there was considerable reduction in the post-clinic pregnancy rates whether or not the women had previous contraceptive experience[1, 3].

It may be said that the pattern of contraceptive behaviour is related to contraceptive experience. In communities where contraception is commonplace or firmly established, the pattern may be different from those communities where the practice is less intense or of recent introduction. In the United States of America, for example, the practice is spread out over a wider range of ages[5]. About 50 per cent of the users were found to have started the practice even before the first pregnancy, with another 32 per cent beginning during the interval between the first and second pregnancies. The average number of pregnancies before the first use, however, rose sharply from 0.82 for all users to 1.60 for those who had 4 or more children. This suggests that an important pattern of family limitation for many couples is to postpone using contraception until one or more pregnancies have occurred. The desire to have children early in married life may account for this.

Early marriage in India inevitably leads to the early start of reproduction and by the time the woman is 25 or 30 she usually has 3 or 4 children. If family planning is practised extensively and effectively it will obviously lead to a reduction in the proportion

of higher order births. It is sometimes advanced that the male preponderance in births gradually diminishes with age of woman and order of birth. If that be so, this may affect the sex composition of the future population of India, leading perhaps to a greater disparity in the sex proportions of the population. The consequent change in the demographic situation, though appearing to be inconsequential, may be a study of some speculative interest.

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