THE IMPACT OF STERILISATION ON FAMILY RELATIONSHIPS

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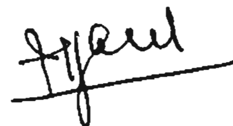
THESIS SUBMITTED FOR THE AWARD OF THE DEGREE
OF DOCTOR OF PHILOSOPHY IN SOCIAL SCIENCES
UNIVERSITY OF COCHIN

1983

DECLARATION

I, Mrs. Thangam Jacob, hereby declare that the thesis submitted by me for the degree of Doctor of Philosophy in Social Sciences is the original work done by me under the supervision of Dr. C.M. George, Reader, School of Management Studies, University of Cochin. I also declare that this thesis has not previously formed the basis of the award of any degree, diploma, associateship, fellowship or other similar title.



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C E R T I F I C A T E

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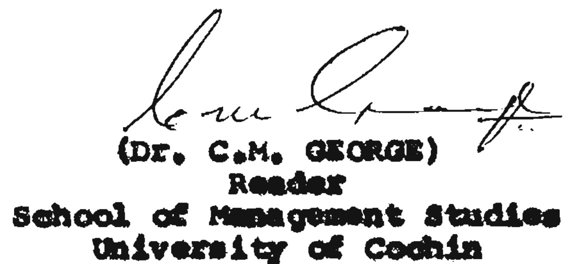

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A C K N O W L E D G E M E N T

I place on record my genuine sentiments of deep appreciation to all who have helped through every stage of this research study. Particularly:

To Dr. J. J. Billings, (Melbourne, Australia) for his inspiration;

To Dr. K.B. Jacob, my husband, for his unstinted support;

To Dr. C.M. George for his persistent guidance;

To my students, Chinnamma, Thangamani and Nanda for their assiduous clerkship;

To Thomas and Kishore of Cochin Computer System for their meticulous data processing;

To Doctors Kuriakose & Santha Kumari for their magnanimous co-operation;

And above all to all the women who graciously disclosed the dossier;

For all your assistance which made this study possible, I acknowledge my sincere indebtedness and profound gratitude.

Mrs. Thangam Jacob.

I

I N T R O D U C T I O N

PART I:

The Problem of Population:
(Global overview of population - National dimensions.)

PART II:

Importance of the Topic:
(World Context of Family Planning - Indian Experience - Sterilisation as a Method.)

PART III:

Methodology:
(Background of study - Objectives - Hypothesis - Area of study - Universe - Sample - Collection of data - Analysis - Limitations - Review of research - Chapterisation.)

C H A P T E R - I

THE PROBLEM OF POPULATION

PART - I

The demographic perspective of the world as a whole and individual nations in particular has been the subject of much intellectual inquiry, debate and writing. This in its wake has churned up a sizeable amount of data, statistics and forecasts, much of which continues to be controversial. Yet, this maze of data asseverates certain unmistakable facts of which none can afford to remain unconcerned.

The world population today in 1982 stands at a staggering figure of 4 billions. Fifteen years ago it was only 3 billions. It took 30 years to add the fourth billion, whereas, nearly hundred years were required for the third billion. And it took the entire history of man-kind prior to the middle of the nineteenth century to reach the first billion. By the turn of this century, the world population is projected to cross 6 billion.[1]

The awesome potential of scientific innovations holds out the promise of a glorious future for mankind, or

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[1] "Seven billion by 2010 - Family Planning in the 1980s", *People*, Vol.8, No.2, (1981), London, p.26.

may just as well result in a charred mass of this planet, rendering futuristic projections to the realm of imagery. "After a certain density is reached, man himself becomes a pollutant; his environment deteriorates no matter what steps he takes to preserve it. The sewage, the garbage, the air pollution, the need for ever more highways and parking lots, the demand for larger schools and more stores, the depletion of natural resources like water and molybdenum...... these combine to destroy the natural setting in which man thrives.

Further, if one adds the noise, the physical elbowing, the wear and distortion of the nervous system, the psychic shock of ever greater numbers of people striving through strikes and social disturbances for their share of a diminishing wealth, the frustrations of no garbage collection and trains that do not function, one is confronted by a psychological pollution that may in the end make life less worth living".[2]

GLOBAL OVERVIEW

The total increase of population in the present century is calculated to be 1985 million. Fiftyeight per cent of this happened in the last twenty years.

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2 Michener James, The Population Cancer, The Quality of Life, (1971), Conn. (p.102).

Table - 1

Growth of Human Population from 1 million B.C. to A.D. 2000

Approximate Period or Year	*Total Population*
c. 1,000,000 B.C.	125,000
300,000	1 million (and the following numbers are in millions)
25,000	5
8000	10
1000	100
A.D. 1	250
1500	300
1650	565
1700	623
1750	728
1800	906
1830	1,000 (first billion or a thousand million)
1850	1,194
1900	1,608
1920	1,811
1925	2,000 (second billion)
1930	2,015
1940	2,249
1950	2,509
1960	3,008 (third billion)
1970 (estimate)	3,500
2000 (projection)	6,000 to 7,000

Source: Adopted from Chandrasekhar, S., "Infant mortality", Population Growth and Family Planning in India - 1972, p.245.

As the table shows, throughout the 19th Century, annual growth rate was only 0.5 per cent per year. The first half of the 20th Century accounts for a growth of 0.8 per cent. A sudden increase to 1.8 per cent was witnessed during the 1950's. It reached 2.3 per cent during the following decade. With a marginal increase in the growth rate in the 70's the rate continues currently at 2.4 per cent.

Seventy per cent of the world's population live in the less developed regions of the world, which include the Latin American countries and all of Asia except Japan, Korea, Taiwan and Singapore. These Asian countries alone account for 75 per cent of the world's under developed population. All European countries, North America, Soviet Union, Australia, New Zealand, Japan and temperate South America are among the developed nations.

Attempt to control mortality has always been a major social activity throughout the history of human civilization. But at no time before the 19th century has control of births ever been an obsession with society. The world's attitude to population problems has undergone radical changes in the last three decades. The widening disparities between the living standard of the developed and the less developed nations have become increasingly disturbing to the poorer nations. The efforts of the less developed nations to provide minimum welfare for their people have not been successful because spiralling population continues to negate the achievements of the developmental programmes.

As resources waned and population rose, people grew poorer. Unemployment became chronic and urban slums mushroomed. And thus development programmes came to nought.

Medical advances which increased life expectancy were responsible for the population explosion. Similar

advances in contraception now give humankind the power to control births at will.

When 136 Governments of the world met in Bucharest in 1974 to discuss problems of world population growth, opinions on family planning were far from convergent. Even countries that were aware of their demographic problems failed to recognize family planning as a direct solution. After much debating over the issue of population and development the conference accepted the compromise formula that development is the best contraceptive.

AFTER BUCHAREST

The world has come a long way after Bucharest. A recently completed analysis[3] by the U.N. Population Division of population policies in 158 countries provides ample evidence. The study revealed the following:-

1. Eighty per cent of the developing world's population resides in countries whose Governments desire a lower rate of population growth : seventeen per cent in countries whose Government consider the growth rate to be satisfactory; and only three per cent in countries whose Governments desire higher rates. In contrast nearly all Governments of developed countries want to maintain their rate of growth or to increase it. The

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3 A deeper understanding since Bucharest by Leon Tabah, People, Vol.6, No.2, 1979, p.14.

prospect of a demographic decline seems to evoke greater concern than the prospect of moderate or even rapid growth.

2. Governments of four-fifths of the 138 countries consider the rate of population growth as an important factor in national development. Less than a fifth of all countries think that although important, population growth is not of major importance.

3. Excessive unemployment, preservation of the environment, conservation of natural resources, more equitable distribution of income, greater savings generation, and greater efficiency in the overall working of society are arguments for choice to regulate demographic growth. The industrialised nations argue for an increased rate of growth to meet the needs of more abundant manpower, stimulation of their economies, and other reasons of national interest.

4. Excepting China no underdeveloped country with a population of more than 20 million inhabitants wants to increase its rate of demographic growth.[4]

5. A direct relationship exists between the size of population and the speed with which Governments recognise administrative difficulties arising from large size. The most populous countries have been the

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4 Changes in population policy of China, favouring population limitation was subsequently reported. (Population Reports: Population and Birth Planning in the People's Republic of China: Series 1, No.25, Jan.-Feb., 1982, J590).

first to adopt policies of fertility regulations: India in 1952, China in 1950, Bangladesh and Pakistan in 1958, Indonesia in 1967, Mexico in 1971 and Brazil recently in 1977.

6. The developing nations desirous of attaining lower rates of population increases prefer quicker direct methods of intervention rather than indirect methods of birth prevention.

7. The majority of developing countries have made modern methods of contraception available whether for direct or indirect objectives.

The findings clearly show that the reservations expressed in Bucharest on the topic of birth regulation do not exist at present. The task before developing nations today is to effectively implement their programme of population control; conviction and goodwill are present. Presently Governments all over the world are becoming aware of the need to progress on several fronts other tha limiting action to population control only. Developing nations are not satisfied with their present high levels of mortality for instance. They recognize that the objective of raising the life expectancy level to 62 years in all countries by 1985[5] will not be achieved. The need to diversify population policies beyond control of mortality and fertility to cover areas such as population

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5 Dr. Halfdan Mahier, "Health for all by the year 2000", _World Health_, February-March, 1981, (WHO), p.2.

distribution, rural and urban and inter-state migration, distribution of resources, balanced economic development and environmental health is being recognized. The ultimate objective of all population policies and programmes is accepted today as the "Enhancement of Human Welfare" and not reduction of numbers. More than ever the world conscience is being aroused to the realisation that population problems cannot be treated in isolation but are linked with other problems which humanity faces.

INDIAN SITUATION

India has only 2.4 per cent of the world's land area but supports 15 per cent of the world's population. In the absence of a proper census before the year 1972, estimates of India's population before this period would only be approximate. Studies of available records and documents show that between 1600 B.C. and 300 B.C./it was estimated to the tune of 100 million according to certain authors. Kingsley David has put this figure at 125 millions and claims that the same figure continued for over a century and half till the year 1750. The growth later was slow but steady till the year 1870 when a sudden acceleration in growth took place.

The first census count in India was done in the year 1872, with subsequent decennial censuses. It is pointed out that the early censuses were under-enumerations. Corrections were made to the early counts by adjusting all censuses to that of the years 1931 and 1941.

Table - 2

Growth of India's Population from 300 B.C. to 1971 A.D.

Period or census year	*Population in millions (adjusted to the present area from 1891)*	*Increase or decrease in millions*	*Percentage variation during the preceding decade*
300 B.C.[1]	About 100	—	—
1600 A.D.[2]	130	—	—
1750[3]	130	—	—
1847[4]	133	—	—
1881[5]	253	—	—
1891[6]	236·7	—	—
1901	236·3	−0·4	−0·20
1911	252·1	15·8	5·73
1921	251·4	−0·7	−0·31
1931	279·0	27·6	11·01
1941	316·7	37·7	14·22
1951	361·1	44·4	13·31
1961	439·2	78·1	21·50
1964[7] (midyear estimate)	471·6	—	—
1970[8] (midyear estimate)	550	—	—
1971 census	547·3	108·1	24·48

Source: Adopted from Chandrasekhar, S., Infant Mortality, Population Growth and Family Planning in India-1972, p.248.

A cursory look at the table reveals that till 1921 the growth of India's population was very slow and unsteady. However, the pattern shows definite change during the later years. From 1921 onwards the growth rate was not only positive but it was consistently rising. While the annual growth rate between 1901 and 1951 was 0.83 per cent the post-independence era between 1951 and 1981 saw an annual growth of 2.13 per cent.

Between 1961 - 1971, the growth rate reached 24.8 per cent, the highest that has been reached at any period. The annual growth rate for this period has been

calculated as 2.2 per cent. At this rate of annual growth, it was estimated that the population of the country is likely to double in 32 years.

Analysis of India's population changes during the 20th century reveals that spurts in growth have taken place from the fifties. From 361 millions in 1951 it grew up to 547.9 million in 1971, which is an increase of 187 millions or more than 50 per cent. The 1981 census count has placed the population at 648 million as on the first March. With the present trend of growth continuing the projections are that the Indian population would be 1,025 million by the year 2000 A.D.

The census results have been quite disturbing. The decadal growth rate for 1971 - 1982 at 24.8 per cent was not much lower than that of 1961 - '71, inspite of the continuing family planning campaign of the Government. The results have also caused concern because the count exceeded by 12 million the projection made for India by the Expert Committee on Population Projections.[6]

IMPLICATIONS

The population question is not merely quantitative but also qualitative in nature, as the implications of population growth upon the quality of life and the well-being of the people are vitally important.

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[6] Registrar General and Census Commissioner, Report of the Expert Committee on Population Projection, Paper-I of 1979, Government of India, New Delhi, 1979.

The most glaring fact that sharpens the crises in Indian Society today is the massive de-humanizing poverty of the masses of people. Of the 690 million inhabitants in India today, some 297 million live on or just above the poverty line (defined by the Central Government Pay Commission as barely getting the minimum required diet for moderate activity), while some 300 millions are below this line unable to obtain even the minimum required for human survival. Such poverty naturally leads to mass-ive malnutrition. Possibly 70 per cent of India's population are under-nourished both qualitatively and quantitatively. The tragedy of such massive poverty in terms of hunger, weakness, impaired ability for doing sustained work, diminished resistance to disease, retarded intellectual growth, etc. is unnerving.

Rapid population growth is accelerating demands on the global availability of living space, water supply, forest products, industrial raw materials, mineral resources, energy fuels and arrable land. The rich nations are not willing to help enough and the newly industrialising countries have severe resource problems of their own. Hence countries will have to depend on their own resources to face problems squarely and provide a better life to their people.

> "This natural inequality of the two powers of population, and of production in the earth, and that great law of our nature which must constantly keep their effects equal, form the great difficulty that to me appears insurmountable in the way to the

> perfectability of society. All other arguments are of slight and subordinate consideration in comparison of this. I see no way by which man can escape from the weight of this law which pervades all animated nature. No fancied equality, no agrarian regulations in their utmost extent, could remove the pressure of it even for a single century. And it appears, therefore, to be decisive against the possible existence of a society, all the members of which, should live in ease, happiness, and comparative leisure; and feel no anxiety about providing the means of subsistence for themselves and families."[7]

FAMILY PLANNING PROGRAMME

It is in this context that the family planning programme in the country gained a paramount place in its developmental programmes through successive Five Year Plans. The country can ill afford to spare any efforts to accelerate its developmental schemes lest the people fall into a despairingly hopeless situation with no escape from their sub-human existence. The urgency of population control through effective use of contraceptive technology was recognized and the result was the official launching of its family planning programme in the year 1953. After 3 decades, the results have been not satisfactory; targets have not been achieved; population growth is not checked.

It is realised that the hopes and aspirations of the millions to move towards prosperity and social security can only be achieved through their acceptance of a small family norm.

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7 Thomas Robert Malthus, First Essay on Population, Chapt.1, Macmillon, London, 1978, p.16.

The new twenty-point programme formulated and published by the Central Government of India highlights the issue of family planning as a programme to be promoted on a voluntary basis as a "People's movement". The urgency in the matter is brought to focus with realism and unambiguity.

> "The population of India has doubled itself since Independence, from 34.2 crores in 1947 to 68.4 crores in 1981. It is obvious that a further increase in population at the present rapid rate will nullify all the gains of our development effort. Reduction of death rate has been brought about through improvement in public health and medical aid. But we have not been able to make any appreciable curb on fertility. The birth rate per thousand population is estimated to be about 37 for the mid-census period of 1971-81. At the current growth rate the population will cross the 100 crore mark by A.D. 2000. The sixth Plan document has laid down the goal of reducing the birth rate to 21, the death rate to 9 and the infant mortality rate below 50. This target will require that the percentage of couples practising family planning should go up from 22.5 per cent to 36.5 per cent by 1984 - 85".[8]

The adoption of a small family norm does not imply birth prevention alone, but spacing of births too. Education in family planning will bring about "Conception by choice" it is hoped.

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[8] Government of India, Directorate of Advertising and Visual Publicity, The new 20 point programme, Information and Broadcasting, New Delhi, 1982.

P A R T - II

IMPORTANCE OF THE TOPIC

The subject of family planning assumes importance in the context of humanity's efforts to improve the "Quality of Life" by controlling the "Quantity of Life".[9]

The precise relation between population changes and development has been a controversial issue for a very long period in the history of nations especially in the post-war period. It does not remain any longer an issue for debate in recent years. How can population obstruct, retard or enhance development? Is it possible to speed up development with effective policies of population control? These are questions for which answers are being sought by countries that are involved in programmes of self-development as well as by those that are genuinely interested in assisting the developmental processes of other nations.

Development is an extremely complex phenomenon wherein population change is only one variable. It is difficult to identify and assess accurately how population growth can affect the pace of development of a nation economically. Similarly, it is not easy to predict what is the optimum size of population where the health

9 Family Planning Foundation, "Scope of Demographic Research in India: A Status Study on Population Research in India", Vol.II Demography, p.5.

of citizens is assured and maintained. "When the quality of the population improves in terms of education and health standards, the demand for quantity will go down".[10] The International Conference on Primary Health Care held in Alma Ata[11] identified family planning as an essential element in Health Care.

BUCHAREST PLAN OF ACTION[12]

The World Population Conference held in Bucharest in the year 1976 adopted a world population plan of action taking into consideration the inter-relationship between population size and socio-economic development. In unambiguous terms, the Conference emphasised:

> "The principal aim of social, economic and cultural development of which population goals and policies are integral parts is to improve levels of living and the quality of life of the people. Of all things in the world, people are the most precious. Mankind's future can be made infinitely bright. . . . . Population and development are inter-related: population variables influence development variables and are also influenced by them; thus the formulation of a World Population Plan of Action reflects the international community's awareness of the importance of population trends for socio-economic development, and the socio-economic nature of the recommendations contained in this plan of action reflects its awareness of the crucial role that development plays in affecting population trends. Population policies are constituent elements of socio-economic development policies, never substitutes for them......".

The family's pivotal role as the basic unit of society was given recognition to and the right of couples

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10 Demery, L., "Population and Human Resource Planning", Asian-Pacific Population Programme News, Vol.II, No. 1&2, 1982, p.14.

11 W.H.O., World Health, February-March, 1981, Geneva.

12 Action taken at Bucharest - U.N. Centre for Economic

to have the number of children they desire was emphasized. "All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education, and means to do so........". The inability of many couples all over the world to exercise their right effectively because of poor economic conditions, social norms, inadequate knowledge of effective methods of family regulation and the inavailability of contraceptive services, was an object of serious concern for the Assembly. However, the need to reconcile individual reproductive behaviour with the needs and aspirations of society was also pointed out.

The obvious aim of the Plan of Action adopted at Bucharest was to make it a policy instrument that will guide national and international strategies for cooperative action towards humanity's progress and development.

JAKARTA RESOLUTION[13]

At the Jakarta International Conference on Family Planning held in April 1981, world leaders asserted their recognition of Family Planning as an essential component of any broad-based development strategy that seeks to improve the quality of life of the individual and of communities. In very bold terms, the conference exhorted nations to meet the challenge of the 1980s "........in

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13 "Family Planning in the 1980's", People, Vol.8, No.3, 1981, p.21.

securing the political commitment, financial and human resources to meet the family planning needs of 900 million couples of child-bearing age".[14] The projections are that the developing nations will have twice the number of child-bearing couples by 2000 A.D. Successful implementation of family planning programmes was thus observed to be a decisive factor in shaping the future world.

WORLD FERTILITY SURVEY RESULTS[15]

The World Fertility Survey, the largest Social Science Research Project ever undertaken, has brought out valuable information and observations regarding fertility situations of 41 developing and 19 developed countries. The survey has exposed the tremendous shortage of family planning services all over the world, particularly in the developing nations. An alarmingly high level of unwanted pregnancies was noticed in many countries. Large numbers of women in various countries were having more children than they wanted. The survey results pinpoint the urgent task of Governments to make high quality family planning services much more widely available.

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14 Population Reports Series M No.5, May-June, 1981, M.200.

15 People, Vol.7, No.4, 1980,p.4.

WORLD BANK RECOMMENDATIONS[16]

The World Development Report for 1981 issued by the World Bank in August underlined the close link between poverty and rapid population growth. It also drew attention to the "Increasingly desperate predicament" of the poorer developing countries. The report urged nations to promote policies that would increase economic growth and step up the availability of family planning to couples. It also pointed out that appropriate forms of social and economic change and the diffusion of the means of birth control were both necessary to reduce fertility.

According to new population projections by Mr. Hollis Chenery the World Bank's Vice President for development policy, the number of poor expected to be in the world by 2000 A.D. could be reduced by half if the developing countries achieved a modest cut in population growth, combined with better income distribution and a speed-up in economic growth. With a slightly improved continuation of current trends, the proportion of poor in non-communist developing countries would decline from 38 per cent of the population in 1975 to only 16 per cent (or about 475 million) by the end of the century. Three types of improved strategy could cut this proportion further according to Mr. Chenery.

1. A slow-down in population growth of only 0.25 per cent could cut the numbers in poverty by 68 million.

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[16] Briefing - People, Vol.7, No.3, 1980, p.27.

2. A 1.0 per cent increase in the annual rate of economic growth could reduce this to 335 million.

3. By improving income distribution so that the poorest three-fifths of the population receive at least 45 per cent of the increase in national income the numbers of poor would be reduced to 305 million, or 10.5 per cent of the population of the non-communist developing world.

The combination of all these three strategies according to Mr. Chenery would result in only 8 per cent of the population (or 221 million) remaining in poverty by 2000 A.D.

I.U.C.N. RESOLUTION[17]

Strong support for a closer working link between resource conservation and Family Planning was voiced at the 15th General Assembly of the International Union for Conservation of Nature and Natural Resources (I.U.C.N.) at Christchurch, New Zealand, in October. The assembly recognized through a resolution that "the conservation of the environment, wise use of natural resources, and the stabilization of human population, are issues that are fundamentally inter-related and that acceptance of this is crucial to the achievement of these three objectives". Pointing to the need for formulating policies that would increase awareness of the links between population, development and resources, the assembly acknowledged the

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17 "Population Links", People, Vol.9, No.1, 1982, Earthwatch, p.7.

need for responsible national population probes and family planning programmes which provide for individual choice" and urged Governments "to develop strategies which interrelate policies for population, production and consumption, sustainable utilisations of natural resources and the conservation of the environment".

BEIJING CONFERENCE[18]

The first Asian Parliamentarian's Conference on Population and Development held in Beijing on October, 1981 echoed the Asian determination to achieve the goal of 1 per cent population growth rate in the continent by the end of the century. The Asian nations were deeply concerned about their population of 2.6 billion which was nearly 60 per cent of the global population but formed 90 per cent of the world's poorest. It was projected to increase by another billion before the century ended.

SIXTH COMMONWEALTH HEALTH MINISTER'S MEETING[19]

In Tanzania where 29 member countries were represented the theme 'Health and the Family' was discussed. Specific recommendations were made to Commonwealth member Governments for the formation of national policies aimed at resolving the problems presented by "the elderly, the

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18 Highlights from the Asian Conference of "Parliamentarians on Population and Development", Asian-Pacific Population Progress News, Vol.10, No.4, 1981, p.4-5.

19 Asian-Pacific Population Progress News, Vol.10, No.1&2, 1981, p.6.

infirm, urban slums, improper housing, lack of family planning, inadequate national nutritional programmes and poor health education programmes". (Underline mine)

TWIN THRUSTS

The population and resource equation has never puzzled mankind as it is today. For the first time people all over the world are planning their lives on the assumption that resources are limited, bringing about a major turning point for all mankind. At Bucharest the National Leaders dispersed with the message that development is the best contraceptive. The Beijing Conference asserted the importance of development as the ideal contraceptive but with the added recognition that the demographic variable itself is an important factor in the attainment of development levels. Thus, to any nation that is struggling to give a better life to its people, family planning and socio-economic development are inseparable twin thrusts that need to be applied in their planning strategies.

CONTRACEPTIVE TECHNOLOGY

> "A revolutionary change in contraceptive technology and practice has imparted more heavily on reproductive behaviour than have economic, social and political changes".[20]

Societies everywhere at all times had their own ways of controlling fertility. The concept of

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20 Leridon, Henri, "Fertility and Contraception in 12 Developed Countries", Family Planning Perspectives, Vol.7, No.2, June, 1981, pp.70-78.

contraception therefore is not new. However, the technology of contraception begins with the present century only.

The industrialised West witnessed a revolution in contraception from the early 1960's with introduction of hormonal contraceptives including oral contraceptives, and injectables, intra-uterine devices, improved procedures for abortion, female sterilisation and so on. The contraceptive revolution stimulated the family planning programmes in developing countries, where family planning was dependent on ancient and traditional methods. Use of modern contraception is growing in developing countries today. Out of a total of 1000 million fertile couples in the world today, 275 million are covered against unwanted pregnancies either through official programmes of the Governmental or by other non-governmental and private agencies.

POPULAR METHODS

Contraceptive Prevalence Surveys[21] being conducted throughout the world show that the pill and voluntary female sterilisation are the two most widely used contraceptive methods today. It is estimated that sterilisation as a method of fertility control continues to grow in importance steadily. While estimates show a total of 20 million sterilised couples in 1970, the figure has grown to 75 millions by 1976. This means that one-third of

21 "Population Reports", Contraceptive Prevalence Surveys Series M No.5, May-June, 1981.

the contracepting couples around the globe are acceptors of sterilisation.

Table - 3

Prevalence of Sterilisation in the World Nations over years

Country or continent		Year 1970	1975	1977	1978	1980
China	-	4	30	35	36	40
India	-	7	17	22	22	24
Asia (excluding China&India)	-	1	2	3.5	4	5
U.S.	-	3	8	9.7	12	13
Europe	-	3	4.5	5.5	10	11
Latin America	-	1	2	3	4.5	4.5
Canada	-	0.5	0.5	1	1	1
Africa	-	0.5	0.5	0.5	1	1
		20.0	65.0	80.8	80.0	100

Source: Population Reports, E.No.6, March-April, 1981.

The table clearly shows the increasing popularity which sterilisation has been gaining over the years throughout the world nations. The trend continues till today except in the case of China where the IUD is the most commonly used contraceptive method and sterilisation ranks second in popularity.[22]

22 "Population and Birth Planning in the People's Republic of China", Population Reports, Series 1, No.25, Jan.-Feb., 1982.

LEGAL STATUS OF STERILISATION

Sterilisation is no longer considered a physical mutilation that is condemned by criminal codes. The disappearance, or collapse of legal barriers to voluntary sterilisation in both developed and developing nations confirms that the decision whether to be sterilised or not is left with the individuals involved rather than to medical experts or law makers. Wherever sterilisation has been given legal sanction, the procedure has been receiving wider popularity progressively.

The experience of Indian Family Planning programme illustrates the point. Countries such as Tunisia, Korea, Nepal, Sri Lanka, Brazil and other Latin American countries, Netherlands, U.S. etc. are other examples where voluntary sterilisation is becoming the most popular method for birth prevention.

THE INDIAN EXPERIENCE IN FAMILY PLANNING

The Government of India recognised the detrimental implications of unchecked population growth for its economic and developmental plans and the result was the adoption in 1951 of Family Planning as an Official Programme of the Government and its incorporation into the Five Year Plans.

> "Nowhere in the world was there any relevant experience from which India could draw of an deliberate Institutionalised effort by a Government to bring down the birth rate of its people,

> particularly in a predominantly agricultural and traditional society whose people live in our 560,000 villages with wide spread illiteracy and where social pressure for a small family is absent."[23]

Although initially the Family Planning Programme was given a health and welfare orientation, later its goal was shifted to reducing the birth rate for purposes of population control. The shift in emphasis necessitated changes in operational strategies, restructuring of organizational machinery, fixing of targets, making of projections, continuous processes of evaluation and so on.

Massive funds were injected into the programme successively starting with a modest fund of 14 lakhs rupees in the 1st Plan, the allocation steadily rising to 2.16 crores, 24.86 crores, 284.43 crores and 497.36 crores in the successive plans. The VI Plan allocation is a colossal sum of 1,000 crores of rupees.

The initial target laid down by the Government in 1951 was to reduce birth rate to 20 per thousand within 25 years. However, performance over the years proved the targets laid down as unrealistic. Targets were not realized. The Fourth Plan projected a reduction of the birth rate from 39 per thousand to 32 by 1974 and to 25 in another 5 - 7 years. With political instability intervening during the period, proposed reductions could

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23 Misra D. Bhaskar, "The Indian Family Planning Programme and Family Planning Programme of Indian States", Journal of Family Welfare, XX(1), Sept., '73, pp.26-48.

not be achieved. During the sixth plan there was again a rethinking to scale down the target to a more reasonable level of 30 by the end of the plan.

The Sixth Plan envisages reaching the target of a birth rate of 30 per thousand by 1985. This can be achieved with an operational plan which includes 25 million voluntary sterilisations in addition to 5 millien I.U.D insertions and an annual level of 5 million users of conventional contraceptives between 1978 and 1983.[24]

The long range objective of the Government is to reduce the birth rate to 21 per thousand by the year 1995-2000. This implies that 60 per cent of the eligible couples totalling 116 millions will have to be made family planning acceptors.

Estimates show that since the inception of the Family Planning Programme in the country 22.8 per cent of the estimated total of 11.38 crores of eligible couples whose wives are in the child-bearing age of 15-40 are currently protected by one or other of the approved methods of Family Planning as on 31 December 1980.[25]

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[24] Rabi Ray, "Physician and Population Change", Address at the National Seminar, March 1979, Jaipur.

[25] Government of India, Publications Division, "Impact of the Programme", India 1981, New Delhi, 1981.

According to the VI Plan estimates 36.3 per cent of the eligible couples will be protected against pregnancy by the year 1985. This means that the birth rates will be reduced to 25 per thousand by the end of the Sixth Plan. The hopes of attaining the target become bleak in view of the set-back which the programme suffered from 1977 - 1980. Figures show that protection was reduced to 22.5 per cent in March 1980 from that of 23.9 in March 1977.

The 1981 Census results have shown[26] that the growth rate which was steadily increasing since 1941 has been arrested. While 19 states and Union Territories recorded decline in growth rate during 1971-81, therewwere only 9 states during 1961-71. It is pointed out that but for the family planning programme 29 million more heads would have been counted in the census giving an unprecedented growth rate of 30 per cent. However, there is the realisation that even the 24.8 per cent growth rate is alarmingly high.

STERILISATION

When non-surgical methods of contraception fail or are unlikely to succeed in mass acceptance, surgical sterilisation of either sex may appear to be a

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26 Government of India, "Family Welfare Programme in India", Year Book 1980-81, New Delhi , p.5.

rational alternative. The prevailing tendency is to search for contraceptive technologies capable of bringing about more rapid solutions to problems. Sterilisation has thus been receiving wider acceptance in the country as is the case all over the world as a method that combines efficiency, permanency and economy in the long run.

Analysis of the family planning performance of India reveals the increase in popularity which sterilisation has secured over the years.

Table - 4

Statewise presentation of the percentage of eligible couples in India protected by sterilisation and other methods by Jan.1972 and March 1980.

India/State	January 1972			March 1980		
	Sterilisation	Other methods	All methods	Sterilisation	Other methods	All methods
India	8.9	3.9	12.8	20.2	2.4	22.6
A Jammu&Kashmir	5.2	2.8	8.0	8.9	1.4	10.3
Rajasthan	3.9	2.0	5.9	11.6	1.8	13.3
Uttar Pradesh	4.0	2.1	6.1	8.8	2.8	11.6
Bihar	4.4	1.4	5.8	11.7	0.6	12.3
B Karnataka	7.6	2.2	9.8	20.8	2.1	22.9
Punjab	9.3	13.4	22.7	19.4	5.7	25.0
Andhra Pradesh	12.3	1.5	13.8	26.2	0.5	26.7
C Haryana	8.5	9.8	18.3	23.8	6.5	30.3
Gujarat	14.9	3.1	18.0	29.7	3.2	32.8
Madhya Pradesh	8.1	2.3	10.4	20.2	0.9	21.1
Maharashtra	16.3	2.5	18.8	34.0	1.1	35.2
West Bengal	8.0	1.6	9.6	20.9	1.1	22.0
D Orissa	11.7	4.6	16.3	23.5	1.3	24.8
Kerala	14.4	3.3	17.7	28.2	1.2	29.4
Tamil Nadu	13.4	2.5	15.9	27.3	1.3	28.6

Source: Journal of Family Welfare, XXVIII, No.2, Dec., 1981, p.14.

While the popularity of sterilisation all over the country is encouraging, whether the method will meet the needs of all couples that are at the risk of unwanted pregnancy is debatable. Being irreversible, the method will not be acceptable to young couples that have not completed their families and those who want to wait by spacing. Four or five children are considered to be the ideal family size of average Indian parents. Hence sterilisation is sought by mothers after para 3 or 4 which reduces the demographic effectiveness of the programme. However, the official family planning programme in India has come to be heavily dependent on sterilisation based on the observation and belief that this is the best method that will suit the illiterate masses and also one that will be effective. It is estimated that each procedure averts 1.5 to 2.5 births for women with poor access to other family planning methods. Considering the number of years of protection it provides to the woman, sterilisation unquestionably is the most cost-effective method of regulating fertility.

TUBECTOMY

The steadily growing popularity of sterilisation has been responsible for the intensive research that is carried on in perfecting the method as an ideal contraceptive for all. Significant technological advances have

already taken place in the last decade and a wide range of methods is available today.

Because of new techniques made available and extensive training programmes given to medical men, the preference in many countries has shifted from male to female sterilisation. In the 1960's male sterilisation was stressed in India. In 1975 and 1976 female procedures have overtaken male procedures. The global experiences in family planning according to methods have been estimated. The table below gives the percentage of currently married women aged 15-44, who are currently using contraception by method.

Table - 5

Popularity of female sterilisation over that of the male - a global feature - in percentage

Table 3. Percentage of Currently Married Women Age 15-44 Currently Using Contraception, by Method

Region, Country & Year	Any Method	Orals	Sterilization Female	Sterilization Male	IUD	Condom	Injectable	Spermicides	Diaphragm	Rhythm	Withdrawal	No Method[a]
ASIA												
Korea, Rep. of 1979	54.0	7.1	14,5	5.9	9.6	5.2	0.2	0.6	b	7.3	3.6	46.0
Thailand 1978	52.7	21.9	13.0	3.4	4.0	2.2	4.7	0.0	b	1.3	2.1	47.3
LATIN AMERICA & CARIBBEAN												
Brazil												
Piauí State 1979	30.9	10.1	15.4	0.0	0.0	0.1	0.0	0.2	0.0	2.6	2.5	69.0
São Paulo State 1978	63.9	27.9	15.6	0.3	0.4	6.5	0.0	0.5	0.1	5.2	7.3	36.1
Colombia 1978	47.6	18.9	7.4	0.2	7.8	1.5	1.3	2.4	b	4.1	4.0	52.4
Costa Rica 1978	65.0	25.4	13.0	0.8	4.8	9.3	2.0	1.3	b	5.1	3.4	35.0
El Salvador 1978	34.4	8.7	17.8	0.2	3.3	1.5	0.4	0.4	0.0	1.7	0.3	65.6
Guatemala 1978	18.1	5.4	5.9	0.4	1.3	0.7	1.1	0.3	0.1	2.8	0.3	81.8
Jamaica 1979	54.9	23.8	9.8	0.0	2.0	6.5	11.4	0.6	0.1	0.2	0.5	48.1
Mexico 1978	40.9	15.0	7.4	0.1	6.9	1.1	3.1	1.5	b	2.9	3.0	59.1
Panama 1979-80	60.6	19.0	29.3	0.4	3.7	1.7	0.8	0.9	0.5	2.9	1.4	39.4
Paraguay 1977	24.0	10.1	———2.9———		3.4	1.8	0.7	0.5	0.0	1.6	2.9	76.0
OTHER												
Tunisia												
Jendouba 1979	31.7	7.3	16.1	0.0	6.9	0.3	0.0	0.3	b	0.6	0.3	68.3

[a] Includes those using pre- and postcoital herbs and douches
[b] Women using diaphragm included with those using spermicides

Source: Adopted from Population Reports: Contraceptive Prevalence Surveys, Series M, No.5, May-June 1981, M.167.

Excepting China where the I.U.D. is the most widely used method of contraception (with 50 per cent of all contraceptive users relying on I.U.D's), sterilisation has come to be the most popular method of contraception all over the world. Even in the case of China, it is reported sterilisation is the second most widely used method relied upon by 30 per cent of all contraceptors. Available data on sterilisation in China shows that in most provinces tubectomy out number vasectomies by a wide margin.[27]

The Indian experience in sterilisation is not entirely different from the global feature. Since the inception of the sterilisation programme in India in the year 1956, 33.44 million sterilisations were done upto the end of March 1981 thereby recording a rate of 48.8 per thousand population.[28] Analysis of sterilisations over the years show that the proportion of tubectomies to total sterilisation has been steadily increasing while vasectomies show a steady decline.

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27 "Population and Birth Planning in the People's Republic of China", Population Reports Series-I, No.25, Jan.-Feb., 1982.

28 Government of India, Ministry of Health and Family Welfare, "Family Welfare Programme in India", Year Book 1980-81, New Delhi, p.6.

Table - 6

Family Planning Performance in the Different Five Year Plans

Period	No. of Sterilisations		Total
	Vasectomy	Tubectomy	
II Plan (January 1956 to December 1960)	70,965	81,712	152,677
III Plan (January 1961 to March 1966)	1,068,638	304,528	1,373,166
Inter-plan period (1966-67 to 1968-69)	3,816,583	575,413	4,391,996
IV Plan (1969-1974)	6,571,106	2,432,520	9,003,626
V Plan (1974-75 to 1977-78)	8,437,064	4,795,491	13,232,555
1978-79	390,922	1,092,985	1,483,907
1979-80	472,687	1,305,237	1,777,924
1980-81*	434,576	1,593,938	2,028,514

*only provisional

Source: Adopted from Year Book 1980-81, Family Welfare Programme in India.

Estimates do reveal that the popularity which female sterilisation has been receiving all over the world is being confirmed by the Indian experience in family planning.

PART - III

METHODOLOGY

BACKGROUND OF STUDY

The investigator has been teaching 'Family and Child Welfare' to post-graduate students of Social Work for well over a decade. A few research studies on family planning undertaken by students, have also been assisted by the researcher.

Participation at the Bucharest Population Conference in the year 1976 aroused greater interest in the subject as an issue of great national importance. Sterilisation was at this time gaining status in the country as an official programme of the Government.

In 1978, upon the personal invitation of Dr. Billings, J.J., the well-known expounder of the 'Cervical Mucus Method of Natural Family Planning', the investigator had the occasion to undergo a month's training on N.F.P. in Melbourne, Australia. While in Melbourne, the report of a follow-up study of vasectomy cases presented by Dr. Hume of Sydney Medical College, stimulated the thinking of the investigator along the lines of doing a similar follow-up study of sterilisation which had not caught the attention of many researchers at that time in India.

After return, possibilities of obtaining sufficient number of sterilisation cases for the study were ascertained and the decision to make the study the subject of a doctoral thesis was finally made.

PROSPECTS OF THE RESEARCH

As a student of Family and Child Welfare it was felt that a scientific investigation into the effects of sterilisation on family relationships would be worth undertaking. Existing prejudices of workers in the field, especially that of family welfare workers, against sterilisation as an effective method of control could be removed to some extent if the findings proved that sterilisation improved the family's well-being. On the other hand, the weaknesses of the method if exposed in terms of its limited scope to bring about family welfare would point up the fact that dependence on sterilisation as the most effective method, needed rethinking.

Insight into reasons for the programme not gaining mass acceptance could also be gained. With no studies available on the impact of sterilisation on relationships within the family between husband-wife, and parent-child, this research was undertaken.

OBJECTIVES OF THE STUDY

The study was undertaken to investigate the following:-

(a) The effect of female sterilisation on the interpersonal relationships between spouses.

(b) The benefits of sterilisation on the relationships between parents and children.

(c) The motivating factor behind the choice of sterilisation by women.

(d) The desirable and undesirable aspects of the surgical method of permanent pregnancy termination according to women acceptors of sterilisation.

HYPOTHESIS FOR VERIFICATION

(a) Although sterilisation is projected officially as the ideal method for the illiterate masses of India the people have not come to accept it as such.

(b) Sterilisation as a method of birth prevention has not succeeded in making an impact upon people as the one that promotes happiness of parents and children.

(c) The fear that sterilisation will permit extra-marital indulgence does exist among people and such fear will lead to loss of respectability for the method.

(d) Couples who feel that their family lives have been affected adversely by sterilisation are those whose family lives have not been happy before the operation.

(e) Well-adjusted couples undergo sterilisation without its affecting adversely their future family lives.

(f) Sterilisation is resisted by people because it is a surgical procedure requiring hospitalisation.

(g) Fear of child and infant mortality is an obstacle that stands in the way of early sterilisation by couples.

(h) Psychological and religious barriers present serious hurdles in persuading couples to get sterilised.

SELECTION OF THE AREA OF STUDY

The study was confined to Ernakulam, a District centrally situated in the State of Kerala which shot into world renown by the massive family planning campaign for vasectomy in 1966. The District may be considered a miniature of Kerala as it is representative of the whole populace. The District contains a variety of groups and classes which may be found in any other part of Kerala in density and distribution, by religion, language, rural-urban features, economic standards, education etc.

DISTRICT OF ERNAKULAM AT A GLANCE*

Area of the District	..	2,377 sq.km.
Number of Revenue Divisions	..	2
Number of Taluks	..	7
Number of Panchayats	..	87
Number of Villages	..	99
Number of Blocks	..	15
Number of Municipalities	..	7
Number of Corporations	..	1
Total Populations (1981)	..	25,33,265
Male	..	12,66,509
Female	..	12,66,509

Population per Sq.Km.	..	1,052
Total working force (1971)	..	734,823
Males	..	532,211
Females	..	202,612
Cultivators	..	155,272
Agricultural labourers	..	92,224
Non-agriculture workers	..	59,310
Literary		
Literates (without regard to educational level)	..	612,915
Primary level	..	213,529
Matriculates & above	..	43,286
Illiterates	..	795,312

*District Publication, Ernakulam, 1982.

THE UNIVERSE

For convenience of selecting and meeting respondents, the District General Hospital situated in the City of Ernakulam on Broadway, was felt to be the most suitable institution for conducting the study. The hospital is well known over the State for its long years of service drawing patients from all over the District and neighbouring regions for general and specialised medical care and treatment. With record of one sterilisation in 1961, the programme picked up momentum by the year 1977 with 1,445 cases and the trend has been maintained since. During the year 1979, 1,471 females underwent sterilisation and this number formed the universe of the study. They formed the potential respondents too.

Table - 7

Sterilisations done in Ernakulam District Hospital between 1970-'80

Year		Procedure	
		Vasectomy	Tubectomy
1961	-	3	1
1962	-	6	14
1963	-	5	11
1964	-	12	6
1965	-	6	14
1966	-	16	22
1967	-	35	56
1968	-	50	55
1969	-	31	49
1970	-	275	60
1971	-	1	33
1972	-	Nil	3
1973	-	4	131
1974	-	9	88
1975	-	15	89
1976	-	110	41
1977	-	262	1445
1978	-	600	1400
1979	-	265	1471

Source: Register maintained in the District Hospital, Ernakulam.

As the table shows terminal methods of vasectomy and tubectomy had not gained popularity till the year 1976. From 1977 onwards considerable momentum was built up in favour of both methods especially tubectomy.

After reaching a maximum of 600 during the year 1978, the number of vasectomy acceptors met with a steep decline which continued. However, the popularity of tubectomies on the other hand was steadily increasing from 1976 onwards. When the study was undertaken in 1979 vasectomy cases were difficult to obtain as three or four operations alone on an average per week were conducted. Prior information regarding requests for vasectomy could not also be obtained. On account of these difficulties in obtaining vasectomy acceptors, men were excluded from the study.

SELECTION OF THE SAMPLE

Instead of attempting to cover the whole universe which was not necessary, it was decided to draw a reasonably high percentage (20%) sample from the anticipated universe to ensure reliability. The figure touched three hundred. It was therefore decided to select 300 respondents.

The advice of Dr. Billings to reduce to the minimum variations in time after operation was heeded. This was made possible by studying the first ones that came for the operation within a specific period instead of resorting to any sampling procedure. The period after operation was felt to be important in determining its impact on the quality of relationships in the family.

The study had progressed to the stage of data collection by June 1979. The investigator therefore started collection of data from July 1, 1979. Three hundred women were sterilised at the Family Planning Clinic of the hospital between July 1, 1979 and November 8, 1979. All these three hundred women were included in the sample.

METHOD AND SEQUENCE OF DATA COLLECTION

Separate pretested interview schedules were used to collect data at three different stages of contact with respondents. Help of two trained Social Workers (Post graduates) specialised in Family and Child Welfare was also taken to interview and collect data.

The majority of women acceptors of sterilisation were post-partum. The practice in the hospital was to admit interval sterilisation cases a day prior to operation. Therefore pre-operation interviews could be conveniently held in the hospital ward.

Routine post-operative check-up was done at the hospital one month after the operation. This opportunity was availed by the investigator to make the first follow-up interview. Out of 300 women 203 had turned up for the check-up and were therefore available for the first follow-up interview.

The second follow-up interview was done six months later. Although a second check-up by the doctor was not a routine, the co-operation of the doctor was obtained to arrange for a second follow-up interview at the hospital. The Doctor's personal interest to check the post-operative cases a second time and give treatment wherever indicated was conveyed to the women. This was an added incentive for women to report for the second follow-up. Besides verbal instructions women were also given a card to remind them when they were due for the visit. In addition they were also contacted by post as a further reminder.

Table - 8

Details of follow-up of 300 cases

Time		Number	Percentage
*a	One month after interview with instruction alone	203	67.66
*b	Six months after interview with instruction and postal contact	118	39.33
	Returned post cards	18	
	No response	65	

*a One month after: Between one and three months after sterilisation.

*b Six months after: Between six and ten months after sterilisation.

As the table shows only 118 women turned up for the six-month-after interview. Out of the 18 post cards

that were returned three addressees were followed up. One had moved out and the address was not known. Two could not be traced which indicated that the addresses given were wrong.

Four women who did not respond were contacted personally in their houses. None of them had any complaints and this according to them was the reason for not reporting for the interview.

It is presumed that the women who did not respond for the second follow-up had no complaints after sterilisation and therefore were not interested to make a visit to the hospital.

TOOLS OF DATA COLLECTION

Different interview schedules were used for the three interviews.

Schedule No.1: It contained questions eliciting detailed information regarding the personal and family data of respondents, the demographic, social, and economic profile of the family, women's assessment of their interpersonal relationships with spouses, the quality of parents' relationship with children, motivating factors behind sterilisation, fears surrounding the operation, and expectations from it.

Schedule No.2: The second schedule contained mainly queries regarding the experience of the operation, the level of recovery reached and fears and expectations for the future.

Schedule No.3: This was mainly to elicit women's own assessment of their positive and negative experiences in the area of husband-wife relationship, and parent-child relations. Their own efforts in motivating other women for sterilisation were also explored. Their expectations for the future and fears as a consequence of the operation were also enquired into.

A large number of questions that were not relevant to the particular area of investigation were included in all the schedules. This had to be done in order to establish rapport so essential for a study of this nature probing into intimate matters of personal lives.

PRETEST

The Government Hospital in Mattanchery formed the venue for pretesting the prepared schedules. Post-partum sterilisations are regularly done in the hospital and it was not difficult to get women for interview as they were inpatients. Eight women were interviewed the day before sterilisation. The interview was helpful in modifying several questions and deleting a few ambiguous ones from the schedule.

Interview schedules were administered to women who had come to the hospital for check-up between one and two months after operation. This was done to avoid waiting for the pretest of the second and third interview schedules. Administration of these schedules on five women each enabled the investigator to improve upon the areas of enquiry as well as question frame. Although the schedules were felt to be too lengthy, on administration the experience was not discouraging.

Reluctance and non-cooperation in discussing personal matters were anticipated. However the experience was contrary. Women were curious to know the "why" of the interview initially. When they were told that the attempt was to help women plan conception and child births better their enthusiasm was remarkable. They showed keen interest to answer questions without hesitation or shyness. Even when interview took place in the presence of other women who were staying with them in the hospital, responses were free and uninhibited. These positive experiences during the pretest was responsible for the investigator not being unduly concerned about the length of the interview. A minimum of twenty-five minutes was required for each interview..

ANALYSIS OF DATA

The three sets of interview schedules contained extensive information each reflecting subtle human attitudes, and hence large number of variables were to be analysed before arriving at reliable conclusions. As such, quick sifting capabilities of a computer were relied upon to develop the various tables.

Initially each subject was assigned a number to identify them by the computer. The questions were also numbered serially and responses to every question coded, some using alphabetic and others using numeric notations. These were later keyed into floppy disks, each segment separately. The entire data was verified on the machine for errors. In addition, the data was check listed and again manually checked to weed out possible omissions.

Later on the computer sorting techniques were employed to regroup the data in various combinations to enable development of the different tables. Every time the programs were tested on sample data and accuracy ensured before final tables were prepared. Thanks to the cross refering ability of the computer, it was possible to detect and rectify completely self-contradictory entries in the schedules, before the data was taken up for processing.

LIMITATIONS OF THE STUDY

Initial interviews were held in the hospital ward by the bed-side of women. Lack of privacy has been embarassing to many as they showed initial hesitation to answer. But once rapport was established there was no difficulty. Often women took the opportunity to ventilate their feelings of fear regarding operations, anxieties regarding the after-effects, doubts about the safety of method, etc. Some had evidently come not on their own choice but under pressure from others. They wept bitterly and there was difficulty in obtaining information from them. However, with the investigators' experience in family counselling and case work the situation could be managed without letting loss of information.

There were cases of six women who left the hospital without getting sterilised although they were included in the hospital list for undergoing sterilisation and were interviewed. Such cases were not taken for the study.

Second interviews were conducted in a more favourable environment in the waiting room of the nurses. As the hospital had two days a week set apart for follow-up visits, about 10 to 15 women would line up for check-up. Although two investigators were engaged to conduct

interviews women were faced with some unavoidable waiting, their hurry to get away was noticeable.

Women who turned up for the second follow-up interview after six months were less in number and consequently there was no queue. The investigators could take time over the respondents. Despite the larger number of questions to be covered and recorded the women were relaxed enough to spend half an hour or slightly more with the investigator.

REVIEW OF RESEARCH IN THE FIELD

Behavioural Science researches on population control originates in the country with the adoption of Family Planning as a part of the official policy of the Central Government in the year 1950. An authoritative evaluation of researches done in the field over two decades has been done by Udai Pareek and Venkateswara Rao.[29] Behavioural science researches picked up momentum in the 1960's with the maximum around 1966, 1967 and 1968 which may be considered as peak years.

There was a heavy concentration on knowledge, attitude and acceptance (KAP) studies during the initial stages. The background variables of acceptors have also been made available through numerous survey studies in

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[29] Udai Pareek & Venkateswara Rao, A Status Study on Population Research in India, Vol.I, Tata McGraw Hill Publishing Co., 1974.

various parts of the country.[30] The information provided by such data served as a basis to study the effectiveness of organised efforts for evaluation and guidance of the existing programme.

Studies on motivation strategies, influencing factors in family planning, community variations in contraceptive acceptance, effectiveness of programme promoters at various levels, etc. by private and official bodies steadily increased over the years. During the last one decade intensive researches have gone into the areas of method preferences of couples, their fertility behaviour, personality of acceptors, demographic effectiveness of methods, decision-making in family planning, communication and adoption of contraceptive practices and so on. Medical men have done intensive researches into methods and procedural techniques.

Most of the method studies done by medical men have been to analyze the biomedical effects and complications of contraceptive practices. The psychological and social consequences have also been subjected to verification to assess not only the immediate but also the long-term impact through follow-up studies. In comparison with other contraceptive methods, sterilisation, particularly tubectomy, has received the maximum attention of researchers.

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30 Ibid.

The present study is also a follow-up study of female sterilisation. However, the emphasis of enquiry was to assess the level of inter-personal relationships within the family of acceptors and to ascertain the losses or gains in the area after the operation. Although no prior exploration into this particular area has been done by researchers, information on varied aspects related to quality of family relationships is available from other studies on sterilisation.

Sexual complaints after tubectomy have been analysed in a follow-up study of 1936 patients for one to five years by Dr. Anklesaria in Ahmedabad, under the auspices of the Indian Council of Medical Research.[31]

Second international conference on Advances in Voluntary Sterilisation held in Geneva in 1973 suggested that sexual pattern following female sterilisation should be studied. Effort in this direction was made by Dr. Mehta[32] in the year 1974. In his sample of 500 women who were sterilised between 1968 and 1974, Dr. Mehta studied the psychological consequences of tubectomy

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31 Anklesaria, S.B., "Statistical Review of 500 Female Sterilisation", International Seminar on Maternal Mortality: Family Planning & Biology of Reproduction, (1969), Bombay.

32 Mehta V. Pravin, "Psychological and Sexual Influence of female surgical contraception", 2nd International Conference, 1975. Bombay

especially in terms of the sexual behaviour of couples, analysing it in the light of psycho-sexual growth from childhood.

Rajashri Das[33] study of maternal mortality following tubectomy has reported of psychological complaints such as weakness GIT disturbance, obesity and Dyspareunia. Lahiri's study[34] in Calcutta of 600 sterilised women has attempted to bring out the psychosomatic problems after female sterilisation in addition to gynaecologic.

Attitude of acceptors to operation and to security of children were subjected to scrutiny by Dr. Joshi Leela & Ghosal Bina.[35] They also analysed the benefits of sterilisation to couples, children and society.

In a study of 8,180 women who were sterilised at the Government Hospital Guntur, Dr. Subhadra Devi has reported of remote psychological complications[36] such

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33 Das Rajyashri, et. al., Maternal Morbidity following female sterilisation, 3rd International Seminar, New Delhi, 1980.

34 Lahiri, B.C., Gynaecologic and Psychosomatic Problems after Female Sterilisation, 3rd International Conference Proceedings, New Delhi, 1980.

35 Joshi Leela (Dr.), & Ghosal Bina, Post-Sterilisation Attitude to Operation and Security of Children - A Survey, 3rd International Conference, New Delhi, 1980.

36 Subhadra Devi, N. & Sakuntala Devi, I., A Study of 8180 Sterilisation Operations, International Seminar on Maternal and Perinatal mortality termination and Sterilisation, 1975, Bombay.

as vague pain in the abdomen, dragging pain in the lower limbs and menorrhagia.

Several published reports of follow-up studies of female sterilisation from six to sixty months are available.[37] Most of them have documented the immediate and late morbidity patterns following tubectomy. A six months follow up by Patel at Nowrosjee Wadia Maternity Hospital in Bombay; a 2 year follow up by Bhatt and team in Baroda; another 2 year follow-up of cases with complications by Engineer in K.G.Medical college, Lucknow Burkman's experience over three years at John's Hopkins; Bickaner follow-up study of 2,799 female sterilisation; and Mehra's follow up for four years of 666 women in New Delhi are some of them.

A prospective study done by Dr. Peter Cooper and others on the psychological sequelae to elective sterilisation of 201 women in England has been reported recently in the British Medical Journal.[38] The study was an attempt to verify findings of earlier studies that have reported of psychiatric disorders, psychosexual problems and regret at having been sterilised as post-operative experiences of women that have undergone

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[37] Proceedings of the 3rd International Conference, New Delhi, 1980.

[38] Peter Cooper, et. al., "Psychological sequelae to elective sterilisation: a prospective study", British Medical Journal, Vol.284, Feb. 13, 1982.

sterilisation. Cooper's study of a homogenous sample consisting of women receiving elective interval sterilisation, has not only disproved earlier findings but has confirmed that disorder after sterilisation was significantly more common in patients whose psychological and social functioning had been impaired before the operation. Cooper does refer to two other similar studies[39] done in Dunfermline and Dundee, that confirm his findings.

CONCEPTS DEFINED

1. RELATIONSHIP:

The definition given by Otto Pollak is accepted in this study.[40]

> "It seems helpful to define relationships between two persons not only in emotional but also in functional terms. Every relationship is the functioning of two persons as need satisfiers for one another. . . . .
>
> "Relationships can be evaluated in terms of functional efficiency for the satisfaction of the present needs of the individuals involved and in terms of impact which these relationships are likely to exercise on the ability of these individuals to form other relationships".

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39 Ibid.

40 Otto Pollak, "A Family Diagnosis Model", Social Work With Families, George Allen & Unwin, London, 1971.

2. FAMILY RELATIONSHIPS:

Otto Pollak's definition is again accepted.

"Family relationships designate the nature and the quality of the functioning of the members as resource persons for the needs of others".

Three levels of relationships in the family observed by Otto are:

(a) Relation between spouses;

(b) Between parents and children;

(c) Between siblings.

(a) Between Spouses: means meeting of the needs of each other through the performance of emotional, social, economic and ego-strengthening function.

In the emotional sphere, they give each other the opportunity for non-pathological regression; such as the security of receiving tenderness and consideration; provision of care; and the experience of a common spectrum of interests.

In the sexual sphere, freedom of enjoying sex, discharge of physiological tension, etc.

In the economic sphere, division of labour between the spouses as well as cooperation and interchangeability of functions, the manner of utilizing income, decision-making for family expenses, etc. are factors for consideration.

(b) Between Parents and Children: Refers to promoting the physical and emotional growth of children, by providing food, education, love, attention, discipline, etc.

(c) Between Siblings: Children's ability to get along with each other, absence of rivalry, fighting, etc.

3. FAMILY SIZE:

In this study family size denotes the number of living children an individual or a couple has.

4. FECUNDITY:

Fecundity is the capacity to have live-born children. The expression reproductive capacity is also used.

5. FERTILITY:

Fertility relates to the actual frequency of births and carries no overtones of ability to have children.

6. BIRTH CONTROL:

Birth control is used here as planned contraception.

7. FAMILY PLANNING PROGRAMME:

Refers to all the activities undertaken by the Government officially to check population growth and enhance the quality of living of the people.

8. FAMILY PLANNING:

Operational meaning of the word is used here. It implies:

(a) prevention of unwanted births;

(b) child spacing;

(c) reduction in the number of children;

(d) assistance to couples with infertility problems.

CHAPTERISATION

The report is divided into six chapters:

Chapter I Introduction: This is further divided into three parts:

Part I Global dimensions of population and the Indian scene.

Part II Background and importance of the study, objectives and hypothesis.

Part III Methodology and review of literature.

Chapter II Description of Respondents:

The social, economic and demographic profile of the women respondents are discussed in detail.

Chapter III Motivational Factors:

Demographic variables such as age, education, profession, age at marriage; number of children and sex preferences; timing of

sterilisation; popular beliefs about family planning; previous history of contraception; source of encouragement for operation; acceptor's efforts at motivating others etc., were analysed and reported.

Chapter IV **Relationship Between Spouses:**

A comparative analysis is attempted of the relationships before and after operation in terms of ability to get along in the home; the manner of decision making; the quality of sex life of couples; the social lives of husband and wife; and the expectations for future happiness in the home.

Chapter V **Parent-child Relations:**

A comparative analysis is made of pre and post operative experiences of parents' relationship with children in terms of: parent's attitude to children; what children mean to parents; problems in management; ways of disciplining; hopes about children; parent's degree of satisfaction in giving children what they want.

Chapter VI **Summary, findings and Conclusions:**

Summary of the study; findings; recommendations; and suggestions for further research are presented.

II
DESCRIPTION OF RESPONDENTS.

Age - Religion - Marital Status - Education - Economic status - Demographic profile - Parity - Age at marriage - Complications of child birth - Timing of sterilisation - History of contraception - Language and native place -

C H A P T E R - II

DESCRIPTION OF RESPONDENTS

A quantitative measurement of the quality of any experience is a difficult task. Much more so when the experience is the result of multifarious factors involving diverse people. The happy or unhappy experience of any member of a family cannot be considered in isolation to the exclusion of other family members.

The present study was undertaken to explore the losses or gains in relationships which take place between the spouses and between parents and children in the environment of the family as a result of the acceptance of permanent termination of pregnancy by the mother. Tools of direct measurement lacking, indirect indicators of resultant experiences were considered appropriate to ascertain the presence or absence of positive relationships within the families of 300 women studied.

While analysis of information gathered from the 300 women acceptors of sterilisation is presented in the following chapters, description of the women themselves is attempted in the present chapter. A clear

understanding of the women studied is very important before one can try to analyse the factors influencing women in accepting surgical sterilisation, the disparity between expectations from the procedure and real experiences, the benefits accruing from permanent pregnancy termination in terms of interpersonal relationships within the family, the health and monetary gains from the operation for the whole family, the scope for surgical procedure in contributing to the population control measures of the country and so on.

The age of women studied, their marital status, educational levels of the couples, religious and geographic distribution of the acceptors, employment status of husband and wife, economic well-being of the family, age at marriage and their demographic profile, and parity at sterilisation are described in detail in the present chapter.

AGE OF RESPONDENTS

The age of acceptors of sterilisation is an important factor in determining the demographic effectiveness of the programme. The younger the age at sterilisation, the better the chances for averting larger number of births. Invariably therefore, all studies of sterilisation have taken care to record the age-structure of acceptors so that basic trends can be observed.

The most frequent age of female acceptors in the country has been between the ages 25 and 35. The analysis of the age-distribution of sterilised women of the present study reveals that there is a definite trend of younger women choosing the permanent method of pregnancy termination.

Table - 9

Age distribution of women

Age Group	Number		Percentage	
18	1		.33	
19	2		.66	
20	5		1.67	
21	6		2	
22	13		4.33	
23	24	97	8	32.33
24	23		7.67	
25	31		10.33	
26 - 30	128		42.66	
31 - 35	47		15.56	
36 - 40	18		6.00	
41 and above	2		0.66	
	300		100.00	

The maximum number of acceptors belong to the 26-30 age group, constituting 42.66% of the sample. Examination of research reports of sterilisation done in Kerala over the years show a steady increase of acceptors of female sterilisation between the ages 25 and 30.[1]

[1] Government of Kerala, Population Research Centre, "A Study of the characteristics of sterilised persons in Kerala (1974-76)", Trivandrum.

Experiences of other States[2] in the country do show a similar trend, but not so marked as that of Kerala.

The second largest group of acceptors in the sample comprising 32.33%, belong to the 21 - 25 age group. The finding is different from the national patterns that have been observed. Although at the initial stages of the programme the largest number of females that opted for sterilisation came from the 35 - 39 group, persistent efforts at education and motivation of women by the Family Planning Department did succeed to draw larger number of women acceptors from the 30 - 34 age group. The age-specific probabilities of acceptance of sterilisation, I U D and conventional contraceptives in the country over the years estimated by the International Institute for Population Studies, Bombay, estimates that women between 30 - 40 will continue as the major target group for sterilisation for years to come.[3] Evidently, the possibility of attracting younger women was not thought of at that time. It was also pointed out simultaneously that if women in the most fertile period of age 25 - 30 are persuaded to accept sterilisation, 2.0 births per sterilisation would be prevented.[4]

[2] Mehta, P.V., "Effectiveness of Female Sterilisation in Greater Bombay", Proceedings of International Conference Maternal and prenatal mortality, Bombay, 1975.

[3] Srinivasan, K. & Mukerji, S. (Ed.), Dynamics of Population and Family Welfare in India, Bombay, 1979, p.135.

[4] Mehta, P.V., Op. cit.

The present study opens out the future possibilities of sterilisation gaining access among the younger women as other studies on sterilisation have shown.[5] Further analysis of the acceptors of 21 - 25 age-group was done to see at which particular age maximum number of women submitted themselves for sterilisation. Findings show that at the age of 25, 10.33% got sterilised while 24 and 23 year olds constituted 7.67 and 8 per cent respectively.

The third largest group of acceptors were between 31 and 35 years forming 15.56 per cent. This is a sizeable proportion of the sample. That tendency of women to undergo sterilisation after decline of active fertility still persists can be inferred from the data. There were 6 per cent of women who got sterilised after they were 35 years of age. The demographic effectiveness of sterilisation of these women between 31 - 40 is evidently less, as these mothers would already have produced four or more children before accepting permanent birth prevention.

A small proportion of 2.66 per cent of women between the ages 21 and 25 were found in the sample of acceptors studied. This indicates that probably age as such

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5 Das Rajyashri,"Maternal Morbidity following female Sterilisation", Proceedings of The Third International Seminar on Maternal and Perinatal Mortality, New Delhi, 1980.

is not a very important factor in decisions concerning permanent birth prevention. The tendency of couples may be to end pregnancy totally once the desired family size is reached. Gulati's study[6] of sterilisations in Trivandrum throws more light into this observation.

RELIGION OF RESPONDENTS

Available studies reveal that Hindus form the majority of acceptors of sterilisation. This is to be expected as they form majority of the population in India. The place where the study has been conducted (Ernakulam District in Kerala State) having a large proportion of Christians in the population, the sample of 300 women comprised of a significant number of christians also.

Table - 10

Religious distribution of sterilised women in the sample compared with that of the District, State and National proportions

Religion	Sample		District '76		State 1971		National '71	
	No.	%	Sterilised %	General %	Sterilised %	General %	Sterilised %	General %
Hindus	134	46.3	53.22	46	72.46	59.41	88.5	82.7
Christians	110	37.3	32.90	41.54	17.44	21.05	2.2	2.6
Muslims	49	16.3	13.88	12.33	10.10	19.50	6.9	11.2
Others	7	2.33	N.A.	0.13	N.A.	0.04	3.3	3.5

Source: Facts and figures of Family Planning, Oct., 1976.

6 Gulati Leela, Family Planning in a semi-rural Squatter Settlement in Kerala (1978), Centre for Development Studies, Trivandrum.

As the table shows, Hindus constitute the major proportion of the population nation-wise, state-wise and district-wise. The Hindu women in the sample studied is therefore naturally more in number than christians and muslims. It is noteworthy that as other findings[7] have shown the proportion of muslims in the sample is much lower than their proportion in the National or State population but higher than the District proportion. However, it is to be admitted that awareness of the values of family planning is becoming evident among moslem women as larger numbers of them are opting for it.

The proportion of Christians in the sample is much higher than their proportion in the District, State or National population. This points to the popularity which the family planning has received among the Christians despite restrictions placed upon them by Church against the use of artificial contraception. It is interesting to observe that among the Christian acceptors in the sample studied, the number of Catholics is much higher than non-catholic Christians, which provides contrary evidence to the common notion that Catholics are against family planning.[8]

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[7] Fatima Nikhat, "Moslem Women & Family Planning", Journal of Family Welfare, XXXIV (1), Sept. 1977, pp.23-29.

[8] Pariyaram Chacko, "Catholic Philosophy on Contraception", Journal of Family Welfare, XXII (4), June, 1976, pp. 29-35.

Certain studies[9] that have shown absence or small proportion of Christians in their sample do not necessarily indicate lack of awareness about the values of family planning among Christians. The proportion of Christians in the total population of the area should be taken into account in such situations. With a proportion of 2.2% in the total population of the country, some studies conducted in the northern regions do show significant number of christians opting for sterilisation.[10]

MARITAL STATUS

All the 300 women in the sample studied were married and living with their spouses. This indicates that sterilisation is resorted to by mothers who have had sufficient number of children and are in need of preventing future pregnancies. Sterilisation being a permanent contraceptive procedure will not naturally be acceptable to women who have not had a family of their choice. Absence of divorced, deserted, separated, widowed or unmarried women in the sample shows that they are not at the risk of pregnancy and hence the need for sterilisation does not arise.

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[9] Engineer Amy & Sanmival, "The sequelae of female sterilisation", Proceedings of 3rd International Conference, Bombay, 1980.

[10] (a) Subhadra Devi & Sakuntala Devi, "A Study of 8180 Sterilisation cases", Proceedings of 2nd International Conference, Bombay, 1975.
(b) Das Rajyashri, "Maternal Morbidity following female sterilisation", Proceedings of 3rd International Conference, Bombay, 1980.

EDUCATIONAL LEVELS OF COUPLES

Education is recognised as an important factor in parents' acceptance of family limitation. Several studies[11] are available to show the favourable impact of education on birth regulation by couples. Education seems to play a decisive role in influencing couples to favour a small family norm. Yadav and Shah have shown by a study in Karnataka that rates of family planning acceptance were found to be higher where number of educational institutions per lakh population were more.[12]

Although with increasing literacy levels, higher acceptance of family planning is observed, the likelihood of acceptance of tubal ligation was found to decline with higher levels of literacy.[13]

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11 (a) Pathak & Prasad, "Component Analysis of the correlations of some factors with family planning performance by methods in India during 1967-73", Journal of Family Welfare, XXIII (3), March, 1977.
(b) Ghosh, B., "Fertility - Social and Economic Determinants", Journal of Family Welfare, XXI (3), March, '75.
(c) Dixon, B.R., "Education & Employment: Keys to Smaller Families", Journal of Family Welfare, XXII (2), December, 1975.
(d) Kripalani B. Gul., "Education & its relation to Family Planning", Journal of Family Welfare, XVIII (2), December, 1971.
(e) Yousef H. Nadia, "Rural Women - Factors affecting fertility", DraperFund Report No.9, October, 1980.

12. Yadav, S.S. & Shah, J.M., "Factors Associated with High and Low Family Acceptance in Karnataka State", Journal of Family Welfare, XXXIV (2), December 1977, pp.3-19.

13 (a) Dass, A., "Female Sterilisation for Population Limitation", 2nd International Conference - Maternal Morbidity - 1975, Bombay.
(b) Population Research Centre, A Study of the Characteristics of Sterilised Persons in Kerala (1974-76), Trivandrum.

This indicates that the demand for sterilisation is more from the illiterate people. Illiterate or primary educated seem to constitute the majority of acceptors of sterilisation. According to Dr. Nayar[14] education has no effect on women's fertility up to high school.

Table - 11

Education level of women in the sample and their husbands

Education		Number of women	Percentage	Number of husbands	Percentage
Illiterate	-	49	16.33	30	10.00
Literate	-	--	-	1	0.33
Primary	-	113	37.60	99	33.00
Elementary	-	76	26.30	91	30.30
High School	-	62	20.60	71	23.60
College	-	--	-	3	1.00
Graduate	-	--	-	1	0.33
Post-graduate	-	--	-	1	0.33
Not known	-	--	-	3	1.00
		300		300	

Analysis of the levels of education of women studied show 49 out of 300 acceptors, i.e. 16.33 per cent, illiterate. When we consider that the literacy level of

[14] Nayar, P.K.B., "The Influence of Education on Fertility", Journal of Family Welfare, XX (3), March, 1974, pp.31-36.

women in the State is 60.42, and that of Ernakulam District 65.37 per cent,[15] the percentage of illiterate women in the sample is low. It should be therefore assumed that illiteracy is an obstacle to acceptance of sterilisation. However, the finding should encourage the promoters of family planning as it can also be inferred that illiteracy need not be a barrier to women in choosing sterilisation. The 16.33 per cent who have opted for surgical contraception suggests that a minimum level of education need not be considered necessary in persuading women to undergo tubal ligation. There is scope therefore in promoting sterilisation among illiterate couples. Proper motivation may be decisive.

The largest proportion of women acceptors in the sample had primary education. The observations of Nayar and Dass seem to be substantiated by the present findings. The absence of any acceptor beyond high school level education, with 26.3 per cent of elementary and 20.6 per cent of high school educated, shows that women with higher education levels are not drawn to sterilisation. Does the absence of college educated women suggest that as a group they do not respond to sterilisation? Can it be that the environment of a General Hospital is not attractive enough for educated women to undergo surgery or that it does not

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15 Statistics for Planning 1980, Government of Kerala, Trivandrum.

provide adequate secrecy to them? Do women in such category go to private hospitals and escape public notice? Or do they have recourse to other contraceptives? These are areas that need to be further investigated.

There are studies[16] that show that husband's educational level is positively related to wife's acceptance of tubectomy. However, contrary findings[17] have also been recorded that wife's educational level, and not that of the husband's which is substantially related to decisions regarding tubectomy.

There were 30 husbands (10 per cent) who were illiterate while 99 (33 per cent) had primary education. The percentage of wives in this group who got sterilised was much higher which indicates that the level of education of husband is not an important criterion. The proportion of husbands with college education was small with a mere 2.67 per cent. Considering the educational levels of men in the District, the proportion of educated husbands is less. This need not lead to the conclusion that sterilisation has not received popularity among wives of educated husbands. Most

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16 Sharma D., and Shukla, "Bacteriology of Fallopian Tubes and General Tract in Relation to Puerperal Sterilisation", 2nd International Conference, Maternal Morbidity, Bombay, 1980.

17 Joshi Leela & Ghoshal Bina, "Post Sterilisation attitude to operation and security of children", 3rd International Conferencem Maternal Morbidity, Bombay, 1980.

likely, they may have recourse to other family planning devices. The observations that have been made by the Kerala Study[18] supports the viewpoint.

The proportion of larger number of illiterate women than men in the sample is not significant as this is only a reflection of the disparity in the educational levels of women and men in the total population of Kerala.

Table - 12

Distribution of couples according to education and religion

Education	Total No.	Hindus	%	Chris-tians	%	Mus-lims	%	Others	%
Illiterate:									
Husbands	- 30	11(36.67)		4(13.33)		14(46.67)		1(3.33)	
Wives	- 49	13(26.53)		9(18.37)		23(46.94)		4(8.16)	
Literate:									
Husbands	- 1	1(100)		-	-	-	-	-	-
Wives	- -	-	-	-	-	-	-	-	-
Primary:									
Husbands	- 99	48(48.48)		32(32.32)		17(17.17)		3(3.00)	
Wives	-113	50(44.25)		49(43.36)		13(1.16)		2(1.77)	
Matriculates:									
Husbands	- 91	39(42.86)		44(48.35)		8(8.79)		-	-
Wives	- 76	39(51.32)		27(35.52)		9(11.84)		1(1.32)	
High School:									
Husbands	- 71	36(50.70)		24(33.80)		8(11.27)		3(4.23)	
Wives	- 62	31(50.00)		25(40.32)		5(8.06)		1(1.61)	
College:									
Husbands	- 3	2(66.67)		1(33.33)		-	-	-	-
Wives	- -	-	-	-	-	-	-	-	-
Graduates:									
Husbands	- 1	1(100.00)		-	-	-	-	-	-
Wives	- -	-	-	-	-	-	-	-	-
Post-Graduates:									
Husbands	- 1	-	-	1(100)		-	-	-	-
Wives	- -	-	-	-	-	-	-	-	-
Not known:									
Husbands	- 3	-	-	2(66.67)		1(33.33)		-	-
Wives	- -	-	-	-	-	-	-	-	-
		134		110		49		7	

18 Demographic Research Centre, Selected Studies on Population and Family Welfare Programme, Vol.II, Trivandrum.

The table reveals clearly that Muslim women in the sample and their husbands were the least educated. Majority of illiterate women in the sample, i.e. 49 out of 300 belonged to the Muslim community. 46.67% of the illiterate women were Muslims while 36.67% were Hindus and only 13.33% were Christians. Religion-wise analysis of the education level of husbands revealed more or less the same proportion. While 46.94% of a total of 30 illiterate husbands were Muslims, their Hindu and Christian counterparts were 26.53% and 18.37% respectively.

Analysis of the religion-wise distribution of primary educated couples in the sample exposes again the low percentages of Muslim women and men 1.16% and 17.17% in the sample when compared with the 44.25% and 48.48% of Hindus and 43.36% and 32.32% of Christians respectively.

Out of a total of 76 matriculate women 11.84% were Muslims compared with 51.32% of Hindu women and 35.53% of Christian women. Out of a total of 62 high school graduate women in the sample 50% were Hindus and 40.32% were Christians while only 8.06% were Muslims.

In a total of 71 high school graduate husbands in the sample, 50.70% were Hindus while 33.8% alone were Christians and Muslims a still lower percentage of 11.27% only. About 66.67% of the college-educated husbands belonged

to the Hindu community against only 33.33% belonging to the Christian community. While there was one graduate Hindu husband and one post-graduate Christian husband, there was no Muslim husband who had gone to college.

The data indicates greater popularity of sterilisation among Hindus with rising levels of education than among the Christians and Muslims where the trend is not so marked. At the State level, the educational status of Christians is higher. However, the lower percentage of educated women among the Christian women in the sample shows that the acceptance of sterilisation among the Christian women is lower than that of the Hindus. This inference need not be valid as findings show that sterilisation has no appeal to women with above high school education.

The Muslims in general have lower levels of education in the State. The low proportion of Muslim acceptors in the total sample reflects their poor educational standards. However, the response shown by Moslem women may be an indication of the positive impact which education had upon them.

The proportion of illiterate couples in the sample is convincing proof that illiteracy need not be a barrier in making couples accept family planning. Educating

illiterate couples on the values of family planning and helping them choose methods that would be acceptable to them is suggested. Education would create demand for family planning services among the illiterate masses in society.

ECONOMIC BACKGROUND OF RESPONDENTS

No attempt was made to quantify the income earned by families as figures given often do not reveal the real income. However, the occupation of women and their husbands were explored which it was felt could be a more reliable indicator of the economic status of the family.

Except 6 women who held jobs on salary basis (one T.T.C. trained teacher, one nurse, two sweepers and three working in fishing companies) most women in the sample were daily wage earners. Their income varied from Rs.3 to Rs.8 per day. 44 women did not go out for any work but were housewives. These women could manage staying home without going for outside labour as the family could depend on the incomes which husbands brought. Occupational distribution of women show that the women belonged to families with meagre income.

The occupational data of men confirmed the poor economic strata to which families of women belonged.

Table - 13

Occupation of Husbands

Occupation		Number of men	Percentage
Coolie	-	166	55.33
Fishing	-	11	3.67
Skilled labour	-	68	22.67
Farm labour	-	4	1.33
Trade	-	29	9.67
Clerical	-	4	1.33
Professional	-	4	1.33
Begging	-	1	0.33
No jobs	-	13	4.33

Except 4 men belonging to professions such as Police and Services and 13 with no jobs the rest of the husbands were engaged in skilled, semi-skilled or unskilled jobs. The skilled and semi-skilled jobs included carpentry, masonry, tailoring, driving, haircutting, milking cows, etc. The large majority of men (55.2%) were manual labourers. Out of the 13 men without jobs, 2 were chronically ill and disabled. There was one who earned by begging.

Kerala Study of the ' Characteristics of Sterilised Persons' by the Population Research Centre has revealed that unskilled workers form the highest proportion among sterilised persons. The present study also presents an

identical picture regardless of whether the husbands or wives were taken into consideration. There were only a small proportion of 44 women (14.67 per cent) who could afford to stay at home as housewives without having to do any work outside. For such women staying at home, the need to prevent conception may not be so strong as will be the case with women who take up outside work. The large proportion in the sample of women who do manual labour or other skilled job outside the home does indicate that employment prompts need for family planning. Several studies[19] conducted in our own country as well as in other countries testify to the fact that female employment does make conditions conducive to the greater acceptance of the small family norm. Researches in the field have found a systematic evidence that fertility declines as married women are engaged in non-familial activities especially work outside the home.

THE DEMOGRAPHIC PROFILE OF WOMEN STUDIED

The number of children women have and their sex-wise distribution were analysed. The size of the family ranged from 2 to 7 children among the 300 women studied.

The following table reveals the demographic profile of respondents.

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[19] Agarwal Serla, "Women's employment and fertility control", Centre Calling, Vol.XIII(9), Sept., 1978.

Table - 14

Age of mothers and distribution of children

Age of mother	No. of mothers	%	No. of children 1	2	3	4	5	6	7	Average No. of children
Less than 20	8	(2.67)	-	7	1	1	-	-	-	2.13
21 - 25	97	(32.33)	-	33	53	10	1	-	-	2.78
26 - 30	128	(42.67)	-	20	61	30	7	9	1	3.43
31 - 35	47	(15.67)	-	3	12	12	11	5	4	4.32
36 - 40	18	(6.00)	-	-	3	6	3	3	3	4.83
40 and above	2	(0.67)	-	-	-	-	-	-	2	7
Total	300		-	63 (21)	130 (14.33)	58 (19.33)	22 (7.33)	17 (5.67)	10 (3.33)	

Parity is considered to be an important variable in determining couples' decisions regarding acceptance of family planning especially sterilisation.[20] Although acceptance rate is found to increase with parity[21] varied factors such as the number of male children, desired family size, age of mother, etc. seem to be related with ultimate decisions in favour of sterilisation. "There is enough evidence to show that the acceptance of family planning (more in the case of terminal methods like vasectomy and

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20 Sidh, K.K., "Fertility values and Family Planning in two religious groups in a metropolitan town", Journal of Family Welfare, XX(4), June, 1974, pp.43-50.

21 Mehta, "Effectives of Female Sterilisation", 2nd International Conference on Maternal & Perinatal Mortality, Bombay, 1975.

tubectomy) has been greater among couples with 4 or more children, perhaps because each couple is interested in achieving a minimum family size with an assurance of its existence, with a bias for at least one or two sons".[22]

Earlier studies[23] of women show that the vast majority of acceptors of sterilisation were moving to para 5 at the time of acceptance. The present study shows a pattern that is slightly different from those studies.

A substantially large proportion of women, 130 out of 300 (43.33 per cent) had decided in favour of permanent termination of pregnancy after they had three children. Studies done during the second half of 1970s[24] reveal a more or less similar picture. A definite change in acceptance of sterilisation at an earlier period becomes evident. Studies of Dr. Bhatt and team in Baroda and Dr. Dass[25] Study in Delhi are examples. However there are regional variations which are to be expected in a large country like India. A study in Bombay by Mrs. Mehta[26] has

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22 Pathak, K.B., "Infant Mortality, Birth Order & Contraception in India", Journal of Family Welfare, XXV(3), March, 1979, pp.11-20.

23 (1) Gandotra, M.M., "Demographic Changes among Family Planning acceptors", Journal of Family Welfare, XIX(2), December, 1972, pp.63-69.
(2) Srivastava, V.C., "Demographic & Socio-Economic Characteristics of Females Sterilised in Camps", Journal of Family Welfare, XIX(4), June, 1973.

24 Bhatt Rohit, et.al., "Female Sterilisation Sequelae", Report of 3rd International Conference, 1980.

25 Dass, A., "Synopsis of the Paper on Female Sterilisation for Population Limitation", 2nd International Conference, (1975) on Maternal & Perinatal Mortality.

26 Mehta (Mrs.), "Laparascopic Sterilisation with Fallope ring", 3rd International Conference, (1980) on Maternal and Perinatal Mortality.

reported majority of women accepting sterilisation after they have had two children.

Further examination of the table reveals that 21% of the women had only 2 children and were moving to para 3 at the time of sterilisation. Earlier choice of sterilisation by larger proportion of mothers are definitely indicated by the data in contrast to prior studies[27] that show lower proportion of women of para 2.

The proportion of mothers accepting tubal ligation after they have had 4 or more children is smaller than what earlier studies[28] on sterilisation show. Mothers of para 5, 6 and 7 are small in number, their proportion in the sample being 7.33%, 5.67% and 3.33% respectively. The data definitely reveals that sterilisation is becoming an acceptable method of pregnancy termination among mothers of lower parity. The average parity of women studied is only 3.44.

Sterilisation being a permanent method of pregnancy prevention, and with easy reversibility lacking, advocating the procedure to women of younger age group is questioned. There is no agreement on an optimum age for sterilisation. However, analysis of age of acceptors and parity show

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27 Population Research Centre, A Study of the Characteristics of Sterilised Persons in Kerala 1974-76, Trivandrum.

28 Ibid.

that an average Indian woman would have 3 or more children by the time she is 26 years old.[29] In the present study, among the 105 (35%) women who belonged to the 18 - 25 age group, 63 (60%) already had 3 children or more. In this group of 105 women below 25, there were 8 who were below 20 years of age. In this group of young mothers, even the 18 year old mother had 2 children. Except one 20 year old mother who had 3 children, the rest of the six mothers had 2 children each. The average parity of this group is 2.7 showing that the mothers opted for sterilisation after they have had 2 children.

The largest number of 128 acceptors (42.67%) came from the 26 - 30 age group. The finding conforms with other recent studies[30] that show that women of younger age group are opting sterilisation. Within this group although the average parity was 3.34, majority (47.66%) were para 3 women, while 23.44% were para 4, 5.47% para 5, 7.03% para 6 and 0.78% para 7.

The percentage of women who were 31 and above were only 67 (22.33%). Out of this group, 15.67% were between 31 and 35, 6% were between 36 and 40, and only one woman who was over 40.

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29 Dr. Mehta, "Effectiveness of Female Sterilisation in Greater Bombay", 2nd International Conference, (1975) on Maternal and Perinatal Mortality.

30 Population Research Centre, A Study of the Characteristics of Sterilised Persons in Kerala, 1974-76, Trivandrum.

The age of women at sterilisation may be an important consideration for the acceptor. However, parity seems to be a more important factor. There are 105 women who were 25 and below when they got themselves sterilised. In the case of these women their young age did not pose a barrier. However, these young women already had 2 or more children, while 41 (39.05%) had only 2 children, 53 (50.48%) had 3, 9(8.57%) had 4 and 1 (0.95%) had 5 children already. The finding points to the concern of couples in completing the family before sterilisation is accepted.

As age is also a factor considered when decision in favour of sterilisation is made, a favourable combination of the two factors, i.e., age and parity of the acceptor can attract more women to accept the procedure. Spacing of children which would enable couples to postpone the reaching of their desirable family size may save them from the difficulty of having to accept an irreversible procedure of pregnancy termination at an early age. The need for spacing of births by women of low parity requires serious consideration as a part of the Family Planning Programme. Dr. Mehta has already made a similar observation based on a study conducted by him in Bombay.

It has been pointed out by Researchers that the demographic benefit of sterilisation is negligible unless women of lower parity are brought under the programme of

tubal ligation. According to Dr. Mehta, women in the fertile age group of 25 - 29 need to be brought under the programme in order to avert at least 2.00 births per sterilisation. Dr. Dass has also made similar observations. According to Dass, sterilisation to be of demographic significance a substantial proportion of the population must practise the method; timing of sterilisation, age of the acceptor, and number of living children would all contribute to demographic effectiveness.[31]

While emphasis is made here on the need of persuading women of lower parity to accept tubectomy the benefits of the surgical procedure to higher para mothers at personal level and to the family as a whole cannot be overlooked.

The women in the sample above 30 years of age were 67 in number, i.e. 35.67 per cent, which is not an insignificant or small figure. These 67 women had a total of 253 children from their fourth and subsequent births. These births could be prevented if these over-30-year-old women were brought under the cover of tubectomy before they moved on to para 4 and above. The importance of reaching higher para women in favour of sterilisation cannot therefore be overlooked.

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[31] Dass, A., "Synopsis of the Paper on Female Sterilisation for Population Limitation", <u>2nd International Conference</u>, (1975) on Maternal and Perinatal Mortality.

PARITY WITH EDUCATION AND RELIGION

The parity of women in relation to their education level and religion were analysed to estimate the relation which education and religion have on parity.

Table - 15

The Average Number of Children and the Education and religion of parents

Religion/ Education level	No. of wives	Average No. of children	No. of husbands	Average No. of children
1	2	3	4	5
Hindu				
Illiterate	14	3	11	4
Literate				
Primary	50	4	47	4
Matric	39	3	39	3
High school	31	3	36	3
College	--	-	2	3
Graduate	--	-	1	3
Post-graduate	--	-	-	-
Not known	--	-	-	-
Total	134	3.37	137	3.4
Muslims				
Illiterate	23	5	14	4
Literate				
Primary	12	4	17	4
Matric	9	3	8	3
High school	5	4	8	3
College	-	-	-	-
Graduate	-	-	-	-
Post-Graduate	-	-	-	--
Not known	-	-	1	6
Total	49	4.29	48	3.71

Contd....

1	2	3	4	5
Christian				
Illiterate	9	3	4	5
Literate				
Primary	49	4	32	4
Matric	27	3	44	3
High school	25	3	24	3
College	-	-	1	5
Graduate	-	-	-	-
Post-graduate	-	-	1	2
Not known	-	-	2	4
Total	110	3.45	108	3.4
Others				
Illiterate	3	4	1	6
Literate				
Primary	2	3	3	5
Matric	1	3	-	-
High school	1	2	3	3
College	-	-	-	-
Graduate	-	-	-	-
Post-graduate	-	-	-	-
Total	7	3.29	7	4.29

Examination of the table reveals that the average number of children of Hindu and Christian wives is 3.40. In the face of remarks frequently made against the Christians as a group that does not favour family planning practices, especially 'Artificial' contraception, the finding deserves attention.

The average child per moslem woman is 3.71 which is significantly higher than that of the Hindu and Christian woman. The frequently heard comment against muslims that they are against family planning seems to have some basis as the findings of the present study show.

According to Ehsanul Haq[32] high fertility level among Muslims as compared to other religious groups may be because of minority concept, misinterpretation of religious facts and their socio-economic backwardness.

Distinctly, regardless of religious differences, average number of children among the illiterate and primary educated women were high. While the illiterate Hindu and Moslem woman had an average of 4 children, Christian women had a higher rate of 5. With higher levels of education among women, religious differences aside, the average number of children seemed to decrease. The finding indicates the favourable impact which education has upon decisions concerning family limitation. The potential which education offers in breaking religious barriers against acceptance of family planning is brought to focus by the data.

Dr. Siddh's[33] comment that religious objections are only towards extreme steps such as abortion and

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32 Haq Ehsanul, "Social Stratification and Fertility", Indian Journal of Social Work, XXXVIII(3), Oct., '77.

33 Siddh, K.K., "Fertility values and family planning in two religious groups in a metropolitan town", The Journal of Family Welfare, XX (4), June, 1974, pp.43-50.

sterilisation and not to family planning in general provides hope to those that are unnerved by the strong religious sentiments existing in the country against sterilisation. Even where religious prejudices hinder acceptance of family planning, education can serve as an effective weapon to break the resistances. "There is no more potent machinery than education to persuade women to accept Family Planning".[34] "To spread the concept of small family norm it is time we embarked upon a crash programme of Women's Education".[35] Education according to Dixon[36] can

1. Delay marriage;
2. Increase probability of non-marriage;
3. Reduce desired family size by mating aspirations for higher level of living; and
4. By exposing women to knowledge, attitudes and practices favourable to birth control.

Regardless of varied religious backgrounds, education of husbands does not seem to exert much influence upon the number of children a couple has. This is especially true with higher levels of education. There were six women in the sample who had college-educated husbands. Among

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[34] Reddy, D. Jayaleksmi, "Age at Marriage and Fertility", Social Welfare, XXIV(7), October, 1977, pp.4-6.

[35] Luthra Prem Nath, "Family Planning via Women's Development", Social Welfare, XXIII (11), February, 1977, pp.10-12.

[36] Dixon, B. Ruth, "Education and Employment Keys to Smaller Families", Journal of Family Welfare, XXII(2), December, 1975, pp.38-50.

these six, three came from the Hindu community while two from the Christian. There was no college educated muslim husband. The average number of children the college-educated husbands had was higher than their less-educated counterparts.

Table - 16
Number of children according to educational levels of husbands and wives

Educational levels		Average Number of children per wife	per husband
1. Illiterate	-	4	4.2
2. Literate	-	-	1
3. Primary	-	3.98	4.03
4. Matric	-	3	3
5. High School	-	3.06	3
6. College	-	-	3.67
7. Graduate	-	-	3
8. Post-graduate	-	-	2

Examination of the table does not reveal that husbands' education considerably influences the number of children a couple has as Sharma and Shukla have brought out in their study at Banares.[37] While the average number of children according to illiterate mothers is only 4, that of illiterate husbands is a higher rate of 4.2. This

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37 Sharma, D. (Dr.) & Shukla, P.S. (Dr.), "Bacteriology of Fallopian tubes and general tract in relation to peurperal sterilisation", Proceedings of II International Seminar, Bombay, (1975) on Maternal and Perinatal Mortality.

raises several questions. Is wife's level of education more favourably related to acceptance of sterilisation than the education of husband? Are the wives of illiterate husbands illiterate too? If not, what are the levels of education of those wives whose husbands are illiterate? Similarly, what are the levels of education of those husbands whose wives are illiterate?

Although husband's higher education level does not seem to affect decisions concerning family size, the present study points towards the negative impact which illiteracy makes in having a large family.

RESPONDENT'S AGE AT MARRIAGE

Traditionally early marriage has always been the norm in India. However with improved facilities of education and employment open to women the trend has slowly changed. Legislations were got enacted banning child marriages. Raising the age of marriage for girls to 18 and 21 for boys by the Special Marriage Act of 1954 was a forward leap not only in the field of women's welfare but also in the history of family planning in the country helping with substantial reductions in birth.

Further raising of age for marriage is considered by the Government today. The objective is to postpone marriages of girls for two more years which it is hoped

would avert births considerably. World Fertility Survey's analysis of data from 14 developing countries has shown that raising of marriage age tends to limit family size.[38] Sterilization at the age of 25 and above will have desired demographic benefits only if the number of births are reduced to 2 or less before women submit themselves for sterilisation. Raising of age of marriage it is hoped will help to achieve the purpose of reducing population growth.

Analysis of the age at marriage of respondents in relation to their religion, educational level and number of children was done to see whether there is any meaningful relationship.

Table - 17

Religion of women and their age at marriage

Age at marriage	Religion				
	Hindu	Christian	Muslim	Others	Total
Less than 15	17(12.69)	10(9.09)	11(22.45)	1(14.29)	% 39(13.00)
16 - 20	89(66.42)	57(51.82)	29(59.18)	4(57.14)	179(59.67)
21 - 25	26(19.40)	39(35.45)	8(16.33)	1(14.29)	74(24.67)
26 - 30	2(1.49)	4(3.64)	1(2.04)	1(14.29)	8(2.67)
	134	110	49	7	300

As the above table shows marriage at 15 and below is more prevalent among Muslims than Hindus or Christians.

[38] UNFPA, Population News Letter, Vol.6, No.3, March, 1980.

While 22.45% of Muslim girls were married at this age, there were only 12.69% and 9.09% respectively of Hindus and Christian women who got married at such young ages.

Regardless of religious differences, the largest proportion of marriages according to the present study takes place among women between the ages 16 - 20. While 66.42% of Hindu women got married at this age, 51.82% of Christians and 59.18% of Muslims were married at this age. Marriage at higher age groups is found to be more prevalent among the Christians according to the study. While 35.45% of Christian women got married between the ages of 21 - 25, their Hindu and Muslim counterparts accounted only 19.40% and 16.33%. The percentage of marriages that took place between 26 and 30 years was again more among Christians (3.64%) than Hindus (1.49%) and Muslims (2.04%).

Table - 18

Respondent's age at marriage & education level

Age at marriage	Education				
	Illiterate	Primary	Matriculate	High School	Total
Less than 15	9(18.37)	19(16.81)	9(11.84)	2(3.23)	39(13.00)
16 - 20	30(61.22)	71(62.83)	47(61.84)	31(50.00)	179(59.67)
21 - 25	9(18.37)	20(17.70)	18(23.68)	27(43.55)	74(24.67)
26 - 30	1(2.04)	3(2.65)	2(2.63)	2(3.23)	8(2.67)
	49(16.33)	113(37.67)	76(25.33)	62(20.67)	300

Educational variations did not seem to have much effect upon age of marriage as most of the respondents got married while they were between 16 and 20 years of age. More or less equal proportions of women 61.22%, 62.83% and 61.84% of different educational levels namely illiterate, primary and matriculation respectively were married at this age.

However, more marriages at higher ages had taken place among the more educated category of women. Among the High School graduates there were 43.55% who had got married after they were 21 and below 25, while there were only 23.68% of matriculates belonging to the same age group. Among the primary and illiterate category, the percentages were still less, 17.70% and 18.37% respectively.

Percentage of late marriages after 26 years of age have taken place more among the High School graduates than at the lower levels of education. While there were 3.23% of High School graduates who got married after they were 26, the percentages of matriculates, primary and illiterates were 2.63%, 2.65% and 2.04% respectively.

Although the finding reveals that the most prevalent practice is to have girls married between the ages of 16 and 20, higher education definitely delays marriages considerably.

The average age of marriage of the women studied according to their religion and education has been found to be the following:

Table - 19

Average age at marriage of women, education-wise and religion-wise

Average age at marriage of	Illiterate	Primary	Matric	High school
Hindu	19.04	18.00	18.18	19.11
Christian	18.17	18.34	19.78	21.56
Muslim	17.63	16.67	18.33	19.90
Others	17.67	18.00	26.00	25.00

Among the matriculates and High school graduates, age at marriage was definitely higher. Remarkably higher ages are found among the high school educated women. When religious differences are considered, it is to be observed that the average age at marriage of Muslim women is much lower than the Hindu or the Christian women. However, with education, the age of marriage rises sharply. One of the ways in which education affects fertility is by delaying marriage enforced by schooling. A positive relation between education and age at marriage was found by Chauhan.[39]

[39] Chauhan, J.S., "Age at Marriage", Journal of Family Welfare, XX(4), June, 1974, pp. 54-61.

Table - 20

Duration of Marriage and Number of Children

Duration	No. of mothers	No. of children	Average No.
Less than 5	83	210	2.53
6 - 10	- 103	327	3.17
11 - 15	- 52	221	4.25
15 and above	- 30	155	5.17

Within five years of married life couples have an average of 2.53 children which means that the mothers would be moving to para 4. Analysis of age and parity has shown that the average number of children of respondents, at sterilisation was 3.44. Decisions to accept sterilisation were probably therefore made by a large proportion of women 34.33% - between 5 and 10 years of married life, when the couples had already 3 children and moving to para 4.

Early marriages will necessitate early sterilisation if births have to be averted and women are to be prevented from moving above para 2 and 3. It may be difficult and unwise to encourage very young mothers to undergo sterilisation. The solution for such categories of young mothers will be spacing which will postpone pregnancies and increase intervals between.

Spacing is not evidently practised by couples. With duration of married life increasing, the average number of children also is found to increases as the table shows. The finding points towards married people accepting conception, pregnancy and birth of children as a natural consequence of married life which they are unable to prevent or regulate. Whether the couples are aware of or in actual need of spacing are not brought out by the data. According to a study made by Khan[40] birth intervals are influenced by demographic and socio-economic factors such as age at marriage, sex and life span of the previous child, religion, education of mother and income.

COMPLICATIONS OF CHILD BIRTH

Enquiry into the kind of delivery woman had, lost pregnancies, still births and mortality among children were made. It was hoped that the information would throw light into factors surrounding child birth which would encourage or discourage women to go for further pregnancies or to decide in favour of sterilisation.

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40 Khan, M.E., "Factors affecting spacing of births", Journal of Family Welfare, XX(2), December, 1973, pp.54-68.

Table - 21

Number of living children and nature of child birth in a total of 1124 pregnancies

Age of women	No. of children	No. of ladies.	Normal delivery	Caesarian	Forceps	Child loss or lost pregnancies
1	2	3	4	5	6	7
Less than 25	1	1	1	-	-	1
	2	41	40	-	1	11
	3	53	52	-	1	7
	4	9	8	-	1	-
	5	1	1	-	-	-
	6	-	-	-	-	-
	7	-	-	-	-	-
Total		105	102	-	3	19
26 - 30	1	-	-	-	-	-
	2	20	20	-	-	-
	3	61	58	1	2	4
	4	30	30	-	-	9
	5	7	7	-	-	3
	6	9	9	-	-	4
	7	1	1	-	-	-
Total		128	125	1	2	38
31 - 35	1	-	-	-	-	-
	2	-	-	-	-	-
	3	3	2	1	-	1
	4	12	12	-	-	2
	5	12	12	-	-	6
	6	11	11	-	-	3
	7	5	5	-	-	2
	8	4	4	-	-	1
Total		47	46	1	-	15
36 - 40	1	-	-	-	-	-
	2	-	-	1	-	-
	3	3	3	-	-	4
	4	6	6	-	-	1
	5	3	3	-	-	3
	6	3	3	-	-	5
	7	3	3	-	-	1
Total		18	18	1	-	14

contd.....

1	2	3	4	5	6	7
40 and above	1	-	-	-	-	-
	2	-	-	-	-	-
	3	-	-	-	-	-
	4	-	-	-	-	-
	5	-	-	-	-	-
	6	-	-	-	-	-
	7	2	2	-	-	-
Total		2	2	-	-	-
GRAND TOTAL		300	293	2	5	86

Out of 300 women studied, 293 had natural births. Experience of Caesarian and forceps was had only by 2 and 5 women respectively. The number of lost pregnancies either by still birth or by abortion was only 86 out of a total of 1124 pregnancies which is 7.65%. The absence of women in the sample with complications at child birth except 7 confirms the observations made by researchers that experience of pregnancy or child loss is an obstacle to mothers' acceptance of terminal methods of birth prevention. Mother's age at birth, parity and spacing are found to influence the rate of abortion, still birth and infant mortality which in turn are related to acceptance of family planning by couples according to a study made by Jorapur.[41]

41 Jorapur, P.B., "Health of Women and Family Planning", Indian Journal of Social Welfare, XXXVI (2), Bombay, July, 1975, pp.139-145.

Experiences of other countries show that mortality declines, particularly infant mortality rates, have proceeded declines in fertility. Studies in India also confirm that high fertility is associated with higher infant and child mortality.

Observation of changes in society may not always make an impact upon parents about the better chances for survival of children. However personal experiences of couples can play more effective role in building perceptions regarding the future of children. Experiences of still birth, abortion, miscarriage and so on induce apprehensions about their ability to have healthy children which in turn diminishes their desire to accept permanent methods of pregnancy termination. It was thought that complications of pregnancy would intimidate the health of the mother thus motivating her to accept sterilisation. This is not found to be true.

Child mortality was negatively correlated with birth intervals by Gupta and Rao.[42] They have also found that women who had shorter closed birth intervals had greater child loss experience than those who had longer intervals. Srivastava[43] has found that infant mortality reduces the

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42 Gupta, K.C. & Rao, R.K.V., "Child loss experience", Journal of Family Welfare, XXIII(1), Sept., 1976, pp.27-35.

43 Srivastava & Pandey, "Infant Mortality and Fertility", Journal of Family Welfare, XXV(3), March, 1979, pp.57-64.

interval of the next birth considerably. "Infant death results in higher fertility irrespective of the parity, age of mother, proportion of children surviving, type of family and caste of the couple".[44]

The total number of lost pregnancies or loss of live children was 86 out of a total of 1,124 pregnancies which is 7.65 per cent. Infant mortality rate of Kerala was steadily brought down over the years from 120 in the 1950's to 50.1 during the 1970's.[45] The present study shows a higher infant death rate of 76 when compared with the State average. Regardless of such variations the most evident inference is that the proportion of women in the sample with experiences of loss of pregnancies or children is very low. This does not prove lower rates of infant mortality in the general population, but conversely, the non-acceptance of a terminal method of birth prevention by women with experiences of child loss. Presence of very few women in the sample (5) with experience of forceps or caesarian deliveries is convincing proof that such complications in pregnancy do not frighten away women in favour of terminating conception by tubectomy.

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44 Ibid.

45 The Directorate of Economics and Statistics, Government of Kerala, "Statistics for Planning 1980", Trivandrum, 1980.

TIMING OF STERILISATION

Post-partum sterilisation has been a popular method of pregnancy termination in India for the last two decades. A study done in the Nandanagar Maternity Hospital, Indore, observes the prevalence of a common notion among women that a woman could be sterilised only immediately after delivery.[46] While 7,092 were delivered between January 1970 and December, 1974, puerperal sterilisation was performed in 768 cases, whereas during the same period there was only 14 interval sterilisation. When women present themselves to the hospital for delivery doctors get direct access to them where women can be easily motivated to undergo sterilisation. Once they leave the hospital it will be difficult to get them back to the hospital and submit to be operated upon. Observations of medical men in the field of family planning have often emphasized upon the effectiveness of motivating women for sterilisation when they come to the hospital for confinement. Dr. Palaniappan made an attempt to see why women refuse to undergo puerperal sterilisation even when the mothers know that "they can have two birds at one stroke if they undergo the procedure during the unavoidable hospital stay".[47] Dass's study has

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46 Muley, S.D., "Termination of Pregnancy as a Motivating factor", <u>2nd International Conference</u>, (1975) on Maternal and Perinatal Mortality.

47 Palaniappan, "Non-acceptance of puerperal sterilisation", <u>2nd International Conference Proceedings</u>, Bombay, 1975.

shown that M. T. P. with tubectomy was seen more often among women of higher economic strata and that post-partum women were younger as compared with interval and M.T.P. sterilisations. Kochhar's[48] sample of women sterilised had a larger proportion of M.T.P. cases than interval sterilisation. Immediate post-partum cases were the smallest group.

It is quite reasonable to expect higher levels of motivation from women admitted in hospital for M.T.P. than for delivery. However, the number of M.T.P. cases opting for tubectomy is dependant on varied factors such as marital status, number of children, desire for pregnancy, moral values and so on.[49] Out of 120 cases of M.T.P. done by Domadia only 51 women underwent sterilisation whereas the rest opted for temporary methods, not interested in permanent termination.

In the present study of 300 acceptors of tubectomy, 78.67 per cent were post-partum, 19.67 per cent M.T.P. and a small percentage of 1.67 per cent interval.

HISTORY OF CONTRACEPTION

Among the 300 women studied, only a small proportion of women had previous experiences in contraception.

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48 Kochhar, M. et.al., "Laparoscopic Sterilisation", 2nd International Conference Proceedings, Bombay, 1975.

49 Domedia, et.al., "Psychological and Clinical Study of Medical Termination of Pregnancy Cases", 2nd International Conference Proceedings, Bombay, 1975.

Majority, i.e. 253 out of 300 (84.33 per cent) women did not have exposure to contraception of any kind.

Sterilisation evidently is not chosen often by women who practice family planning by other means. With knowledge of temporary methods of birth prevention lacking and faced with a situation of unpreventable and unwanted births, the women decide in favour of sterilisation when encouragement and motivation are provided. This would have been the case with 253 women in the sample who chose tubal ligation.

The analysis by Dass of contraception practices before sterilisation has similar findings. Vast majority of women, 69.1 per cent had no experience with contraception. Among those who were familiar with different methods of conception control, 20.7 per cent were Nirodh users. IUD was used by a smaller proportion of 8.8 per cent and other conventional methods by 1.4 per cent.

Dr. Mehta has emphasised upon the need to inject sufficient motivation to mothers who come for deliveries to accept temporary methods and eventually to go in for methods of permanent termination. Mehta has asserted that couples are favourably disposed to spacing between births of two children.[50]

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[50] Mehta, Ibid., p.317.

Table - 22

History of contraceptive use by 47 women

Types of contraceptives		Users Satisfied	Users Not satisfied	Total
1. Loop	-	7	9	16(34.04%)
2. Nirodh	-	13	11	24(51.06%)
3. Pills	-	2	4	6(12.77%)
4. Natural	-	1	-	1(2.13%)
Total		23(48.94%)	24(51.06%)	47

Among the 47 women who had used various contraceptive devices, the largest proportion was nirodh users (51.06%). In this group more than half were satisfied with the method whereas 45.83% were not. Second most popular method was loop, being used by 34.04% of women. While more than half of loop users (56.25%) were not happy with the device, less than half alone were satisfied. Pills were the third mostly used device, with only 12.77% using it. 75% of the pill users were not happy while only 25% were contented with the method. One woman who was using the natural rythm method expressed satisfaction with the method.

Whether satisfied or not, decision to get sterilised was made because of encouragement from either husband or the doctor who attended to the delivery in the hospital. The fact that worry about future pregnancy will be

permanently removed was the most attractive feature about sterilisation in contrast with other methods that are a 'constant headache' or 'nuisance' as some women remarked. Although some of the husbands wanted to get sterilised themselves the women did not approve as they feared adverse side effects such as loss of libido, decline of masculinity, etc. falling upon husbands as a consequence of vasectomy. Therefore the obvious choice was for the wife to undergo sterilisation.

LANGUAGE AND NATIVE PLACE OF RESPONDENTS

Analysis of the mother-tongue of respondents showed that all except three spoke Malayalam and belonged to Kerala. The three women who were Tamil speaking had husbands who were Keralites.

The ease with which women go for family planning without fear of being known is indicated by the data. Most of the women came from the District of Ernakulam itself. Their getting sterilised at the local Government Hospital is sufficient proof for the absence of the need to remain unidentified as acceptors of sterilisation. If such fears existed, they would have chosen to go to other neighbouring or distant hospitals for operation.

However, the generalisation may not hold true for all women that accept sterilisation. In the sample studied, most women belonged to the economically lower strata of day labourers and semi or unskilled workers. The more economically forward section of women are not at all found in the sample. This does not mean that women in such strata do not get themselves sterilised. Most likely, such women may not approach Government hospitals for family planning services either for fear of publicity or for lack of facilities which private hospitals alone provide. Studies of sterilisation done in private hospitals may impart data which can substantiate the observation.

III

MOTIVATIONAL FACTORS

Source of information - Encouragement for tubectomy - History of contraception - Preference for sterilisation - Pre-operative feelings, discouraging factors and expectations - Experience in motivating others - Sterilisation versus other methods - Popular attitudes - Ideal motivator - Indirect factors of motivation such as: religion, economic background, age and parity, duration of married life, sex preferences of couples - conclusion.

CHAPTER - III

MOTIVATIONAL FACTORS

The Government of India's resoluteness to pursue the Family Planning Programme with expanded vigour had often been made clear by official statements.[1] The fullest co-operation of the State Governments and the people were sought in order to make the nation accept "the concept of small family". Even while the urgency of the situation is pointed out the policy statements make it clear that in achieving this goal "there is no room for compulsion, coercion, or pressure of any sort. The approach is educational and wholly voluntary but there will be no slackening of the efforts in implementing the programme".[2]

As long as the programme remains voluntary in approach and its success dependent on the voluntary co-operation of the people the role of education and motivation in provoking the need for small family becomes crucial. The enormity of the task before the nation to provide adequate information and education to the millions to effectively activate them in becoming family planning

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[1] President's Address to Parliament in 19-2-1979 as reported in Family Welfare Programme in India Year Book - 1978-79.

[2] Ibid.

acceptors, is well recognized by planners and administrators of the country. The task becomes all the more difficult in a condition of mass illiteracy which the nation faces.

In a broad sense, motivation implies all activities and conditions that bring about changes in behaviour. These stimulating activities and conditions may be directly and consciously brought about; or they can be the result of other factors that are present within the person or outside, in the environment.

Adoption of family planning involves a change in the sex behaviour of couples. Any traditional behaviour is resistant to changes and more so when it affects the accustomed intimate personal lives of people. Different stages can be observed before a couple is motivated to become adopters of family planning. Initially, the person who is unaware of family planning has to be furnished information. The second stage is when the person is able to accept the idea of family planning on the basis of the information he has received. The third stage is reached when the couple, convinced of the values of family limitation seeks ways of doing it. Help with knowledge of methods of conception regulation is to be provided at this stage. It is not enough that knowledge of any one method is given as there is no one single perfect method yet

available which can meet the requirement of every couple. The 'method information' imparted should be such that the couple should be able to choose the method that will suit his individual need, personal preferences, mental outlook, religious and ethical values and so on. Decision-making on adoption of family limitation methods is dependent on:

1) The felt need for family limitation;
2) Knowledge about family limitation methods;
3) Perceived quality or value of methods available and
4) Availability of desired methods within easy reach",[3]

Inability of couples to make a responsible and conscious choice regarding the choice of a method can lead eventually to frustration, discontentment towards methods and even aversion to the concept of family regulation, psychological disturbances, unhappiness in family life, rejection of family planning practices and so on. The proof of an effective educational and motivational programme can be measured by the level of satisfaction of adopters and their continuous practice of family planning.

The Government of India is fully aware of the role which motivation activities play in attracting couples to become family planning users. The need of direct as well as indirect efforts of motivation is sufficiently recognised. The direct effort is the official family planning

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[3] Ghosh, B., "Fertility-Social & Economic Determinants of Family Welfare", Journal of Family Welfare, XXI (3), March, 1975, pp.38-46.

programme itself, planning, organising and implementing a policy of population for the nation. The most obvious and direct method of motivation is the propaganda machinery instituted by the government to disseminate information regarding the why and how of family planning. The goal is to communicate to the masses the message of a small family norm and the desirability of a small family particularly to the illiterate and the economically backward. For imparting this information mass media approach has been widely used. Through the films, radios, exhibitions, posters etc., the mass media communication has succeeded to a considerable extent in breeding familiarity with the concept of fertility control resulting in creation of awareness among the people. Siddh's study has shown that 62% of a sample of general population he studied were aware of family planning needs.[4] In addition to familiarity and awareness among the masses, the subsequent achievement of the mass media efforts has been the legitimisation of the programme by the people as 'good' and 'acceptable'.

Motivation efforts through mass media still go on as an important part of the implementation of the programme as this is necessary to sustain people's awareness and interest which will lead to creation of demand for family planning services. The need for continuance of mass media

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4 Siddh, K.K., "Fertility values & Family Planning in a metropolitan town", Journal of Family Welfare, XX (4). June, 1974, pp.43-50.

education is substantiated by findings that show that sizable proportion of people in the country still do not consider population explosion as a very serious problem "People have quite a narrow concept of family planning. They are not aware of the philosophy behind the programme like prevention of unwanted pregnancies, spacing between births, etc."[5]

A substantial amount of the budget allocation for population control measures goes towards motivational efforts. The equilateral red triangle which has been adopted as the family planning symbol is widely displayed all over the country in rural as well as urban areas. Bill Boards, wall posters, slides, puppet shows, dramas and news paper advertisements are means by which dissemination of information is made. Of the 172 mobile publicity units of the Directorate of Publicity, family planning is the major activity of 142 units while 30 are engaged exclusively in family planning.[6]

The camp approach was an experiment during 1971-72 to boost up vasectomy which was steadily declining in popularity from 1967 touching the lowest level in 1970. The success of the camps led to its incorporation into the normal programme during 1972-73.

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5 Family Planning Association of India, "People's perception about Family Planning", Population Research Bulletin, Bombay, 1970.

6 Government of India, "Family Welfare Programme in India", Year Book 1980-81, New Delhi.

The organization of camps helped in creating mass awareness and group acceptance of sterilisation to an unprecedented degree. High incentives offered during the camps generated a high level of acceptance, but as this high level of incentives could not be maintained by the Government for financial reasons, the incentives were withdrawn resulting in a drastic fall of vasectomy acceptors. "After trying camp approach for five years, counter-productive effects of mass camps were recognized. Motivational activities were neglected in the effort to shoot high and achieve numbers".[7]

Use of mass media for motivation has been often criticized by educators and motivators in the field. It was felt that mass appeal for acceptance of family planning will be repulsive to the common man as topics related to sex and married life in India are not matters for public discussion. Despite objections to mass approach in favour of individual approach, publicity through mass media was undertaken with more and more vigour with the hope of obtaining mass acceptance of the programme. Even if the number of acceptors of contraception has been far less than estimated targets of planners the need for regulating the country's population has come to be widely recognized today. The common

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[7] Jain, S.P., "The Indian Family Planning Programme an assessment of past performance", Journal of Family Welfare, XXI (4), June, 1975. pp.10-28.

man has also come to realise the need for limiting births contrary to the traditional attitudes of allowing unrestricted birth of children as gifts of God. Small family norm is undoubtedly gaining acceptance by couples in India.

Comparison of characteristics of sterilised women available from earlier and later periods substantiate this observation. In Anklesaria's study[8] of 5900 female sterilisations in Ahmedabad the largest number of acceptors belonged to para 5 and 6. A Kerala Study conducted by the Demographic Research Centre during the same period reports of parity of women acceptors of sterilisation as 4 and above. Later studies[10] (1 & 2) show a trend of women of lower parity accepting sterilisation.

Recent studies do indicate that more and more women of para 3 are volunteering for sterilisation. World Fertility Survey findings do reveal that demand for family planning is increasing all over the world especially in the developing countries.[11]

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8 Anklesaria, S.B., "Statistical Review of 5900 female sterilisation at the Civil Hospital, China Maternity Hospital and Lallubhai Hospital, Ahmedabad", 1st International Conference Proceedings, 1969.

9 Demographic Research Centre, "Selected Studies on Population and Family Welfare Programme, Vol.II, Trivandrum, 1978.

10 (1)Lahiri, "Gynaecologic and Psychosomatic problems after female sterilisation", 3rd International Conference Proceedings, 1980; (2) Population Research Centre, Characteristics of sterilised persons in Kerala 1974, Trivandrum, 1981.

11 ESCAP, Asian-Pacific Population Programme News, Vol.10, Nos.1&2, 1981, p.6.

In the present chapter, the different stages of motivation that led to acceptance of sterilisation by women are analysed. The source of information about family planning, the persons who have encouraged them to decide in favour of permanent pregnancy termination, previous experiences in contraception, values or benefits that have influenced their choice of sterilisation in preference to other methods, women's feelings about the operation, their fears regarding the future consequence of tubectomy, expectations from permanent pregnancy termination, their experiences in motivating others in favour of family planning practices etc. are analysed in depth to appreciate the effectiveness of the government's motivational efforts to elicit demand and ultimate acceptance of contraceptive practice.

Indirect conditions that have set the scene for women's acceptance of tubectomy have also been scrutinised. Influence of religion upon decisions of couples regarding conception regulation, the effect of education on couple's choice for family size, the economic background of the family in decisions concerning the number of children, the age of women and parity, timing of sterilisation, sex preferences of couples regarding children, duration of married life etc. are areas that have been subjected to verification in order to perceive those factors in the environment that may have exerted influence upon women's decisions in favour of sterilisation.

1. Source of information:

Mass media services are employed for diffusion of family planning information and advice so that all sections of the population are reached with the message of small family norm. The effectiveness of the propaganda may be measured in terms of the number of acceptors that accept fertility regulation voluntarily.

In the present study the sources of women's information on sterilisation were investigated with the purpose of finding out who can provide the most effective encouragement to women to undergo sterilisation. The knowledge, it was felt, would be of help in improving the propaganda techniqыes and fix the categories of people that can exert influence upon couples to accept family planning.

Table - 23

Source of information for sterilisation among women studied

Source		No.	% approximate
Husband	..	50	(16.66)
Parents	..	1	(0.33)
Relatives	..	43	(14.33)
Friends	..	130	(43.33)
Newspaper	..	1	(0.33)
Books	..	6	(2.00)
Radio	..	14	(4.66)
Govt. Officers	..	18	(6.00)
Doctors	..	37	(12.33)
		300	(100%)

Despite efforts to reach couples through health visitors and field workers employed by the Government hospitals in the District of Ernakulam, the women in the sample studied came to know of sterilisation mainly through friends (43.33%) husbands (16.67%), relatives (14.33%) and doctors (12.33%). The Governmental and medical officers provided information to 6% of women, while 4.66 per cent of women got informed through the radio, 2 per cent from books, 0.33 per cent each through parents and newspapers.

The ease with which women among themselves speak on matters such as sex, family life etc. is a familiar phenomenon in our culture. Such topics are not discussed usually in public and in company of persons belonging to the opposite sex. It is quite unlikely that friends with prejudices against sterilisation or with unhappy experiences following operation would have advised the respondents in favour of surgical sterilisation. Most likely, the friends who have provided the women with information on sterilisation may have been happy acceptors of sterilisation or they would have been adequately informed and strongly convinced of the values of conception termination.

The data clearly show that husbands that are well informed on surgical contraception can play an effective role in influencing their wives in favour of contraceptive practices. Doctors also seem to play an important role.

Doctors get the opportunity to meet the women when they come to the hospital for delivery and many of them hold the view that this is a very opportune time to persuade women to accept contraception. The influence of relatives upon women also show that information and education on family planning through mass media have successfully contributed to bring about changes of attitudes among the public who in turn act as motivators to couples that are in the reproductive age-group and are in need of family planning.

2. <u>Source of encouragement for sterilisation:</u>

Out of the 300 women studied, although the information on surgical contraception was obtained from different sources, the vast majority of women (238 i.e. 79.33%) had taken the decision to undergo sterilisation on their own without pressure from others. Husbands were responsible for decision in the case of 47 (15.6%) women; doctors for 9 women (3%) and in the case of 6 women, friends or relatives were responsible for the decision.

<u>Attitude of husband to operation:</u>

In majority of women, husband's attitude towards operation was favourable. Out of 300 women studied, in the case of 189 women (63%) husbands were encouraging. Of 95 women (31.67%) where no encouragement was given, they had no objection if the wife wanted to do so. For these women consent of the husband was sufficient although they

would not have been happy to undergo the operation without it. In the case of 9 women husbands were not in favour, still the women chose to do it. There were 3 women who had not informed the husbands of the operation for fear that he would object. However, they took the decision hoping that husbands would reconcile after they came to benefit from the operation. There were 4 women who decided in favour of the operation inspite of opposition by husbands. These women decided to risk the disfavour of husband for better benefits in future.

Table - 24

Husband's attitude to operation and fears about operation

Husband's attitude	Harmful effects	Psycho-logical effects	Sexual prob-lem	Wrath of God	Dis-rept	Oth-ers	Total %
1. Encoura-gement	78 41.26%	11 5.8%	4 2.11%	2 1.05%	0	94 49.73%	189 63%
2. Permi-tted	36 37.89%	2 2.10%	3 3.15%	2 2.10%	0	52 54.73%	95 31.67%
3. Not in favour	7 77.77%	0	0	0	0	2 22.22%	9 3%
4. Haven't told	1 33.33%	0	0	0	0	2 66.66%	3 1%
5. Opposi-tion	1 25%	0	0	0	0	3 75%	4 1.33%
	123	13	7	4	0	153	300 (100%)

Even among husbands who encouraged wives for operation, a sizable number (41.26%) were fearful of the harmful effects of operation. Those that gave their consent

also were anxious about the side effects of the operation on the spouse. The fears indicate the lack of adequate knowledge of husbands concerning the operation. The data warrants the need of educating husbands also on family planning methods successfully.

Among the 13 husbands who were either not in favour of the operation or expressed their opposition to it, most did so mainly because of undue fears regarding the harmful effects the operation might have on the woman. 3 husbands were eager to have one more male child and 1 husband longed to have a girl and consequently was not in favour of sterilisation. There were 2 husbands who felt that there would not be any one to care for the wife after operation in the hospital and later on at home while she convalesced.

There were 3 women who did not tell the husband about the operation. In the case of one, husband was away, and did not care for her; the second woman felt that she better not tell the husband, as he would oppose. She was certain that operation should better be done by women as men have got to work and hence their health should not be affected by operation. In the case of the third woman the husband was an alcoholic and he did not care for what she did.

In general, women were not concerned about the reaction of other people to their decision to undergo sterilisation. Opposition for operation was expected only from families of 35 women (11.66%). One woman had fears about opposition from neighbours and still another from the community. The data clearly shows that the community has come to accept sterilisation without inhibitions.

There were only 5 women out of 300 who were not happy about the possibility of others coming to know of the operation. 285 women (95%) were absolutely unconcerned as to what others would say.

Attitudes of others to operation:

Women's opinion regarding the outlook of others in the general community towards operation was looked into. The enquiry was to establish the extent of popularity which sterilisation has received among the public.

Table - 25

Out look of others to operation

Category of people	Happy	Not much opposition	Oppose	Not concerned	Others
1. Husband	281 (93.67%)	14 (4.67%)	4 (1.33%)	1 (0.67%)	-
2. Children	9 (3%)	1 (0.33%)	2 (0.67%)	-	-
3. Parents	205 (68.33%)	59 (19.66%)	25 (8.66%)	8 (2.67%)	3 (1%)
4. Neighbours	149 (63.33%)	10 (3.33%)	5 (1.66%)	134 (44.67%)	2 (0.67%)
5. Community	106 (35.33%)	18 (6.0%)	8 (2.66%)	164 (54.67%)	4 (1.33%)

Opposition to sterilisation is not so strong as is imagined to be. Parents of women who opposed the operation definitely belonged to the older generation, and they constituted only 8.33%. The majority of parents (68.33%) were in favour of their daughters getting sterilised while 19.66% were not so happy about the decision without of course raising any serious objection. Very few women expected unfavourable comments from either neighbours (1.66%) and the community (2.66%). The findings speak for itself the achievement which family planning propaganda has been able to attain in removing prejudices and traditional unhealthy attitudes in general and about sterilisation in particular.

3. History of Contraception:

Out of 300 acceptors of sterilisation only 47 (15.6%) had previous experiences with contraception.

Table - 26

Contraceptive History of 47 women prior to sterilisation

Methods used	Satisfied	Not satisfied	Total
Loop -	7(43.75%)	9(56.25%)	16(34.04%)
Nirodh -	13(54.16%)	11(45.8%)	24(51.06%)
Pills -	2(33.3%)	4(66.6%)	6(12.76%)
Natural method -	1	0	1(2.12%)
	23(48.93%)	24(51.06%)	47(100%)

Out of 300 couples in the reproductive group only 47 i.e. 15.6 per cent had attempted other methods of family planning. This means that vast majority of couples (84.4 per cent) had allowed pregnancies to take place at will. Sterilisation was therefore accepted by them in a situation where they were helpless in the face of repeated conceptions coupled with economic hardships. Their choice for sterilisation cannot, therefore, be considered fully voluntary and a welcome proposition. The decision would have been the result of environmental situation.

Those that had tried other temporary or semi-permanent methods of contraception and were satisfied or dissatisfied with them may be considered wilful and voluntary acceptors of sterilisation.

Nirodh users formed the major portion with 47 acceptors. While 24 out of 47 (51.06%) had experiences with Nirodh, 16 (34.04%) had used loop, 6 (12.76%) were using pills and only 1 (2.12%) person had tried natural method (Rythm).

The experience of Nirodh users opting for sterilisation later has been observed by other researchers.[12] The initial popularity which nirodh succeeds to obtain from users might be on account of its simplicity for use. However, use of nirodh for long periods of time may be

[12] Anand B. Khorania,"Acceptor Characteristics of women undergoing 'Tubectomy", Journal of Family Welfare, XXII (3), March, 1976, pp.33-39.

unpleasant to couples sexually and health-wise leading them to consideration of alternate methods. While majority of satisfied Nirodh users also opted for sterilisation, majority of loop and pill users were not happy. This may indicate that women who are happy with either loop or pill will be more reluctant to get sterilised, unlike satisfied nirodh users.

The one woman who was happy with the natural rhythm method chose sterilisation because of the permanent safety which the method offered instead of "waiting anxiously till the next menstural flow, to make sure that conception has not taken place".

Surveys done[13] on the characteristics of acceptors of sterilisation reveal that majority of them are without prior experiences in contraception. However, there are other studies that substantiate prevalence of family planning practices prior to acceptance of sterilisation. In a study done at by Gandhigram Population Research Centre, data shows that 90% of tubectomied women were previously using IUD.[14]

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[13] Anand B. Khorana, Ibid.

[14] Population Research Centre, Empirical Estimates of parameters for "Birth Averted Model", Population Research Bulletin, Gandhigram, 1979.

4. Preference for sterilisation:

Reasons for women's choice of sterilisation in place of other contraceptives were analysed. This was done in order to find out what were the most attractive features of tubectomy. Women with experiences of different contraceptives would be better evaluators of the various methods than women with no similar experience.

Table - 27

Previous history of contraception and feelings to operation

Feelings		Users	%	Nonusers	%	Total	%
Afraid	-	20	42.5	93	36.7	113	37.66
Feel nothing	-	20	42.5	110	43.47	130	43.33
Welcome	-	-	-	4	1.58	4	1.33
Courageous	-	7	14.8	46	18.18	53	17.6
Feel guilty	-	-	-	-	-	-	-
Feel shy	-	-	-	-	-	-	-
		47	15.6	253	84.4	300	100

Women with previous experiences in contraception were more fearful about the surgical procedure of permanent pregnancy termination than those who had not tried any method. The larger proportion of non-users of other contraception methods in the sample substantiate the point. These women could easily be persuaded for sterilisation as they

were unaware or inadequately informed of alternate procedures. The Cafeteria approach in the delivery of family planning services may therefore work against easy acceptance of sterilisation by women.

Those that have used various methods would have been most likely convinced about the benefits of small size family. Although women who were satisfied or non-satisfied were of rather equal proportion, they decided upon sterilisation as a more effective method which would bring results without having to undergo the problem of method or practice failure. In the words of several women themselves "once it is done, nothing to worry later".

Out of the 47 women who had tried various contraceptives only 7 expressed courage in undergoing operation and 6 out of this 7 were satisfied Nirodh users. Among the women with previous experiences in contraception, a large majority of them were apprehensive about the physical side-effects of operation. Compared with non-users, fear of physical ailments existed more among the users, 40.3 per cent and 44.6 per cent respectively. Despite the fears, the decision in favour of sterilisation was made because of the lack of reliability of other methods and the freedom from unwanted pregnancy which sterilisation would unmistakably and permanently offer.

A comparison of discouraging features about sterilisation between users and non-users of previous contraceptives was made.

Table - 28

Users of Non-surgical contraceptives and discouraging elements in operation

Disturbing factors	Users	%	Non-users	%	Total	%
1. Physical ailment	21	44.6	102	40.3	123	
2. Mental conflicts	3	6.38	10	3.95	13	
3. Sexual problem	2	4.25	5	1.97	7	
4. Wrath of God	1	2.12	3	1.18	4	
5. Disrupt marriage	0		0		0	
6. Others	20	42.55	133	52.5	153	
	47		253		300	

Fears about mental conflicts, sexual difficulties, punishment by God etc. loomed larger in the minds of users of non-surgical contraceptive methods than the non-users. This is to be expected as the users were familiar with the idea of contraception and had made a choice of a particular method. A revision of the earlier decision to choose a different method would have involved serious weighing of pros and cons of the new method under consideration. The choice here would have been more difficult with the possibilities of comparison at a later stage open before them.

These women needed to make sure that they were not making a wrong choice in opting for sterilisation. For non-users, such efforts at discriminating between methods were not called for and decisions would have been easier in the face of possible ignorance about other methods of contraception. As data on previous knowledge of respondents regarding various contraceptive devices were not obtained, the inference made is only a possibility.

Table - 29

Educational level of couples with previous history of contraception

Methods	Educational level				Total
	Illi-terate	Primary	Elementary	H.S.	
1. Loop:					
Husband	2	5	7	3	17
Wife	1	10	3	3	17
2. Pill:					
Husband	-	3	1	2	6
Wife	-	1	3	2	6
3. Nirodh:					
Husband	1	6	6	11	24
Wife	1	10	6	7	24
4. Natural method					
Husband	-	-	1	-	1
Wife	-	-	-	1	1
Total: Husband	3(6.25)	14(29.17)	14(29.17)	17(35.42)	48
Wife	2(4.17)	22(45.83)	12(25)	12(25)	

When the educational level of couples who had experience with previous contraception was examined it was found that in general most of these women (45.83%) had primary education. Illiterate women constituted just 4.17 per cent. Equal proportion of women (25% each) had elementary and high school education. There are other studies[15] that show that majority of acceptors of sterilisation are either illiterates or primary school educated; IUD users belong to the elementary educated; and other conventional contraceptive users have high school education. In the present study among the 6 pill users, 3 had elementary education and 2 high school. The only woman who had used the rhythm method had high school level education. This is not surprising as the calculation of safe period will not be easy to uneducated couples and the ability to practise the method successfully presupposes a higher educational level.

As far as expectations from sterilisation were concerned, the users of non-surgical contraceptives and non-users were not much different. Financial benefits formed the strongest incentive for both groups, 55.31 per cent for users and 61.66 per cent for non-users. Those that were using contraception earlier seemed to be more aware of

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[15] Hemalatha Rangachari, et.al., "Favoured methods of family planning in different socio-economic groups", _Journal of Family Welfare,_ XXIII, March, 1977, pp.53.57.

the benefits of family limitations in terms of peace in home, care of children and maternal health. Unless these values were strongly reinforced in them, it is unlikely that they would have opted for sterilisation which assured absolute safety.

5. Women's feelings about tubal surgery:

A day before the actual operation took place the way women felt towards the operation was explored. Whether the operation was frightening to the individual or whether she welcomed it, or whether she felt shy or reluctant to undergo the operation etc. were the questions for which answers were obtained. Feelings would indicate the obstacles which stood in the way of accepting sterilisation by women in general which it was hoped would provide clues to the kind of motivation measures that should be tailored to overcome resistances.

Table - 30

Feelings toward operation

Feelings		No. of women	Percentage
Afraid	-	113	37.66
Feel nothing	-	130	43.33
Welcome	-	4	1.33
Courageous	-	53	17.66
Feel guilty	-	0	-
Feel shy	-	0	-
		300	100.00

Looking into the table it is clear that majority of the women did not have negative feelings towards the operation. Except the 113 women (37.6 per cent) who were frightened of the operation all the others faced the operation without any anxiety or fear. While the proportion of this group in the sample is encouraging, the 37.66 per cent who were frightened of the operation merits the attention of programme implementers. Post-sterilisation experiences of this group is important to follow up, as for them, it will either substantiate and reinforce their anticipated fears or will discard their unrealistic fears. Those that belong to the latter with real favourable experiences are likely to make the best promoters of the programme later.

The feelings of women were analysed on the basis of their religious beliefs:-

Table - 31

Feelings toward operation and the religion of respondents

Feelings	Hindu	Christian	Muslim	Total
Afraid	57 (41%)	42 (37.5%)	14(28.5%)	113 (37.67%)
Feel nothing	56 (40.2%)	52 (46.4%)	23(46.9%)	130 (43.33%)
Welcome	3 (2.15%)	1(0.89%)	0	4 (1.33%)
Courageous	23 (16.5%)	17(15.17%)	12(24.4%)	53 (17.67%)
Feel shy	-	-	-	-
Feel guilty	-	-	-	-
	139	112	49	300

The findings of the religion-wise analysis of women's feelings to operation are significant. A remarkably smaller proportion of Christians and Muslims than Hindus have fear for the operation. While 41 per cent of the Hindus in a total of 139 have expressed fear of the operation, only 37.5 per cent of Christians and 28.5 per cent of Muslims are anxious about the operation. Equal proportion of Christians and Muslims (46.4 per cent and 46.9 per cent respectively) are unconcerned about the operation while only 40.2 per cent of Hindu women alone have exhibited lack of anxiety or fear.

There are 3 Hindu women (2.15 per cent) who have welcomed the operation while only 1 Christian woman (0.89 per cent) expressed similar intent. No Muslim women welcomed the operation. About equal number of Hindu and Christian women could face the operation bravely without any fear whatsoever. Although in comparison to the total District population the proportion of Muslim women were much smaller in the sample, those that opted for the operation were sure of their decision to get sterilised. The proportion of Moslem women who were courageous to face the experience, was significantly more (24.4 per cent) than the Hindus (16.5%) and the Christians (15.17%).

The findings may indicate that non-religious factors may be more responsible in influencing women to accept or reject sterilisation.

Illiteracy is deemed responsible for difficulties in implementing popular control measures more rapidly. Feelings of women toward operation in general, discouraging factors about the operation and expectations of women were put to scrutiny in relation to their educational background.

Table-32

Education level and feelings of women to operation

Feelings	Illiterate	Primary	Elementary	H.S.	Total
Afraid	11(22.4%)	42(37.16%)	32(42.1%)	28 (45.16%)	113 (37.6%)
Feel nothing	30(61.2%)	49(43.3%)	30(39.47%)	21 (33.8%)	130 (43.3%)
Welcome	-	1(0.88%)	1(1.3%)	2 (3.2%)	4 (1.33%)
Courageous	8(16.3%)	21(18.58%)	13(17.74%)	11 (17.74%)	53 (17.6%)
Feel guilty	-	-	-	-	-
	49	113	76	62	300

Contrary to common beliefs, educational level does not play a prominent role in decisions favouring sterilisation. The table clearly shows that fear of operation increases steadily with increasing educational levels. While only 22.4 per cent illiterate women were frightened of operation, primary educated were 37.16 per cent, elementary 42.1 per cent and high school educated women formed 45.16 per cent. Freedom from any fear regarding operation was also reported by maximum number of illiterate women

(61.2 per cent) while the number decreased with increasing levels of education. While 43.3 per cent of primary educated were fearless, the corresponding figure for elementary was only 39.47 per cent and for high school 33.8 per cent.

The finding may be indicative of the fact that educated women are more conscious of the dangers of operation than the less educated ones. Therefore sterilisation may not be as acceptable to educated women as to the less educated. The illiterate may easily be made acceptors of fertility termination unlike the educated whose fears offer resistance to acceptance of sterilisation. Perhaps this emphasises the positive prospects before the Family Planning Programme of the Government that has recognized sterilization as the most suitable method for the illiterate masses in the country. Sterilisation therefore may be expected to bring faster results.

However, there are certain negative aspects regarding the greater popularity which sterilisation has among the less educated. The table shows that women who have welcomed the operation with conviction are more among the educated than the less educated ones. While no one in the illiterate group welcomed the operation, there were two high school graduates who welcomed it. The finding is similar to an observation made in a study of vasectomy acceptors. "Semi-educated vasectomised respondents are

anxiety laden, while educated vasectomised respondents show a high personality factor of independence".[16]

That no woman felt shy or guilty of the operation is convincing proof that family planning has come to be accepted as a normal conduct by the community. The sense of shame and guilt attached to matters related to sex are no more present.

6. Discouraging factors about tubal ligation:

Specific fears of women about sterilisation operation were explored. Physical ailments were reported to be the most serious concern of women.

Table - 33

Education and discouraging factors about operation

	Illi-terate	Primary	Elemen-tary	High School	Total
				%	%
Physical ail-ments	15(30.6%)	45(39.8%)	35(46.05%)	28(45.16)	123(41)
Mental con-flicts	1(0.04)	5(4.42)	2(2.63)	5(8.06)	13(4.3)
Sexual pro-blems	1(0.04	3(2.65)	1(1.31)	2(3.2)	7(2.3)
Wrath of God	0	2(1.76)	2(2.63)	0	4(1.3)
Disrupt married life	-	-	-	-	-
Present illnesses	32	58	36	27	153
	49	113	76	62	300

16 Yashir Singh & Mahesh Bhargava, "Second-order personality factors of sterilised and non-sterilised persons", Journal of Family Welfare, XXIV (1), Sept., 1977.

The table shows again that women had fears regarding physical ailments as a consequence of operation. These fears increased with increasing levels of education. While 30.6 per cent of illiterate were anxious about harmful side effects 39.8 per cent of primary educated women 46 per cent of elementary educated and 45 per cent of high school educated mothers expressed anxiety.

Psychological problems were also feared by women in the higher educational category groups. Similarly anxieties regarding sexual difficulties and disfavour of God were increasingly found with higher levels of education.

Evidently with education ability to weigh the pros and cons of operation and its side effects are gained and adequate information to allay baseless fears are not made available. This may explain for the lack of popularity of sterilisation among the more educated. The fear about the surgical procedure is adequate reason to keep women away from it.

Analysis of the impact of favourable education upon expectations of women from the operation does not show significant relation except that the more educated mothers are better aware of the values of limiting family size, such as ability to give better care to children and improvement of mothers health by preventing frequent pregnancies. Only two mothers with high school education could see the

prospect of improving children's health as a result of ability in providing better care to them.

The data reveal that none of the respondents feared that the operation would bring about disruption of married life. This is contrary to apprehensions of many that marital infidelities may occur as a result of freedom from pregnancy which sterilisation brings to the couple. Evidently then, fear regarding loss of faithfullness between spouses does not stand in the way of accepting sterilisation by couples.

It is commonly believed that religious beliefs stand in the way of couples deciding in favour of birth control. Effort was made to probe deep into the negative feelings which religious beliefs and the like dissuade women from undergoing sterilisation.

Table - 34

Discouraging factors about operation and the religion-wise distribution of respondents

	Hindu	Christian	Muslims	Total
	%	%	%	
Physical ailments	62(44.6)	47(41.96)	15(30.6)	123(41.33%)
Mental conflicts	6(4.3)	6(5.35)	1(2.04)	13(4.33%)
Sexual problems	4(2.8)	1(0.89)	2(4.08)	7(2.33%)
Wrath of God	0	4(3.56)	0	4(1.33%)
Disrupt marital fidelity	0	0	0	0
Present illnesses	67(48.2)	54(48.2)	31(63.2)	153(50.67%)
Total:	139	112	49	300

An examination of the table reveals that regardless of religious differences large proportion of women in each group was concerned about the physical ailments which may follow operation. As far as fear of mental conflicts were concerned Christian women are more in number (5.35 per cent) than either Hindu (4.3 per cent) or Muslim (2.04 per cent) women. Fear of sexual difficulties caused concern in the case of 2.8 per cent of Hindus and 4.08 per cent of Muslims whereas the percentage of Christian women was only 0.89 per cent. The finding may indicate the level of psychological relief which women regardless of their religious differences were hoping for from sterilisation. At the same time, anxiety about physical side-effects has been disturbing to majority of women in all the religious groups.

The most significant observation in the analysis is that only Christian women (3.57 per cent) were disturbed over the wrath of God which they might incur as a result of sterilisation. No muslim or Hindu women entertained such fears. This gives credence to the common belief that fear of God's punishment may be a deterrent factor to many Christian women accepting sterilisation - an obstacle which does not seem to be present with women of other faiths. It is further interesting to note that all these 5 women were Catholics. The finding proves emphatically that the teaching of the Church against all artificial methods of

contraception does offer resistance to acceptance of sterilisation by Catholic women.

There were no fears in women regarding the erosion of marital fidelity as a result of fertility termination.

7. Expectations from sterilisation:

What women hope to obtain by terminating fertility will perhaps be the most important element on which decision to undergo the operation is taken. Religious beliefs may have little to do with expectations from operation. However, an analysis of expectation according to the religious grouping was attempted and the result is shown in the following table:

Table - 35

Religion and expectations from operation

	Hindu	Christian	Muslim	Total
	%	%	%	%
Prevent pregnancy	32(23.02)	30(26.7)	5(10.2)	67(22.3)
Peace at home	-	2(1.78)	-	2(0.67)
Better relations with husband	2(1.43)	2(1.78)	0	4(1.33)
Financial benefits	87(62.5)	58(51.78)	37(75.5)	182(60.6)
Better care to children	3(2.15)	8(7.14)	0	11(3.6)
Give stability to marriage	-	-	-	--
Improve mother's health	14(10.07)	7(6.2)	5(10.2)	26(8.6)
Better children's health	-	2(1.78)	-	2(0.67)
Less housing problems	-	-	-	-
Total	139	112	49	300

Religious beliefs do not seem to play any important role in decisions to undergo sterilisation since the strongest motivation is based on financial benefits. As the vast majority of respondents had low economic means, it is not surprising that economic benefits formed the biggest incentive to women (60.6 per cent). While it suggests the prospects of bettering population reduction programmes by increased monetary rewards it is also a signal that other values of family planning to family life are lost sight of in our motivational efforts. Improvement of mother's health by preventing too many pregnancies, devoting more time to children's care, lessening of problems of housing etc. are benefits which limiting of children can bring. It is a fact that only few women are conscious of such advantages of having a small family. These are values which need to be emphasised while motivating couples for family planning.

If financial benefits become the basic enticement in decisions to limit family size, family planning will fail to receive a wide base as a programme for all and not for the poor only. Programmes devised to motivate couples on values other than economic benefits can give greater acceptability to the programme as a national need.

No women thought that limiting births would lessen their problems of housing. No one also felt that

sterilisation would add stability to the marriage. Perhaps the fear of marital infidelity as a possible development may have been within the minds of all women, although none of the women when questioned expressed such fears.

A very small percentage of women (1.33 per cent) alone expected better relations with husband as a consequence of operation. Fear of pregnancy having been removed, one would expect improvement of relations between spouses as a consequence. Most women were not aware of such benefits. Findings do not speak well for the effectiveness of motivational efforts in family planning.

Financial benefits accruing from family limitation was found to be the strongest motivation of women who opted for sterilisation in the sample studied.

Table - 36

Education and expectation from operation

Expectations	Illit.	Primary	Elem.	H.S.	Total
1	2	3	4	5	6
	%	%	%	%	%
1. Prevent pregnancy	10(20.4)	28(24.7)	17(22.36)	12 (19.35)	67 (22.3)
2. Peace at home	-	2(1.76)	-	-	2(.66)
3. Improve Husb. wife relations	1(2.04)	-	2(2.63)	1	4 (1.33)
4. Better interest in children	-	3(2.65)	3(3.94)	5 (8.06)	11 (17.74)
5. Financial benefit	34(69.38)	66(58.4)	49(64.47)	33 (53.2)	182 (60.6)

1	2	3	4	5	6
6. Better health for mothers	4(8.16)	14(12.38)	2(2.63)	6(9.67)	26(8.6)
7. Better health for children	-	-	-	2(3.22)	2(.66)
8. Better education of children	-	-	-	-	-
9. Stability of marriage	-	-	-	-	-
10. Lessen housing problems	-	-	-	-	-
11. Others	0	0	3(3.94)	3(4.8)	6(2)
	49(16.3)	113(37.7)	76(25.3)	62(20.7)	300

It is portentious to note that financial benefits were the greatest motivating factor for over 60 per cent of the sterilised women. Permanent prevention of further pregnancy was the strongest inducement for only 22.3 per cent of acceptors. Over 17 per cent of women hoped that termination of fertility would enable them to give better care to children, instead of having to face problems of neglecting children when more arrive. Only 8 per cent of mothers were conscious of the health benefits which they would derive by preventing too many pregnancies.

The data clearly shows that the family welfare benefits accruing from sterilisation are not adequately perceived by couples. This speaks for the inadequacy of educational programmes in the field of family planning.

The fact that financial benefits constitute the greatest attraction for couples to undergo sterilisation means that monetary rewards can play an effective role to make couples accept sterilisation. This poses not only financial problems for the Government but also concern regarding the scope for making the programme family-welfare oriented. In the long-run, the effectiveness of the programme will depend on couples accepting family planning voluntarily as a way to achieving greater happiness and well-being in the family. If monetary benefits forms the major criterion for controlling births, motivation to limit family size may cease with increased economic well-being.

The educated mothers seem to be more aware of the benefits of family limitation in terms of giving better care to children. Education does not seem to make much difference as far as the health benefits of the mothers from limiting family size is concerned. Most likely, the doubts of educated mothers regarding health may be due to their fears about the physical ailments which may result from the operation.

Two high school graduate mothers were sure that children's health can improve with better care if further pregnancies were avoided. They also knew that subsequent pregnancies after the third and fourth were not in the interest of children's health.

The need for educating couples on the benefits of family planning in terms of health of the mother, the child, housing comforts etc. is revealed by the data. Housing problems of the poorer sections of the people cannot be over emphasized. Even the educated mothers were not conscious of the benefits which a small family can bring in terms of lessening housing problems. The data reveals the scope before us in making the family planning programme more effective by educating couples on the benefits of limiting family size in non-economic terms too. Economic gains alone do not ensure family welfare.

Experiences of women in motivating others:

The concept of acceptors functioning as motivators is not anything new. Findings of studies[17] revealing the scope of the Family Planning Programme using satisfied acceptors for educational and motivational work have already been made available. Recommendations have also been made[18] suggesting the feasibility of using acceptors for improving the effectiveness of the Family Planning Programme.

The Satisfied Sterilisation Acceptors Project (SSA Project) is an experiment to evaluate the effectiveness

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17 Government of India, Department of Family Welfare, Population Research Bulletin-Important findings, New Delhi, 1979.

18 Ibid.

of using acceptors of sterilisation as motivators. The project is being implemented in 3 Primary Health Centres in a rural set-up.[19] The project, launched during 1978-79 and 1979-80, has not yet brought out the final findings. However, interim evaluations show that such a programme is feasible. The experiment points to positive contributions which SSA's can make in motivational and educational activities for promoting the family planning programme. Population Research Centre, Bangalore, is evaluating the effectiveness of SSA Projects and the report is being awaited.[20]

The women studied were sterilised and sent home without being briefed on the scope or their responsibility in motivating other eligible women for tubal ligation. It was felt that the spontaneous and voluntary contribution of those women in doing so would give a clue to the possibilities that open itself to programme planners in making conscious and planned use of acceptors to involve themselves with motivational activities.

Personal satisfaction of motivators:

The respondents were asked whether they had encouraged other women for sterilisation. Out of 118 women, nearly half of them (49.15 per cent) had done so. However, when they were further asked to give the number of

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19 Ibid., findings of selected research studies.

20 Ibid., studies in progress during May to December, 1979.

women they had motivated, fewer number of women could alone claim of effective persuasion.

Table - 37

Experience of 58 acceptors as motivators

	No. of women motivated				
	1	2	3	4	0
No. of respondents	7	11	0	3	97

Out of the total of 58 women who had said that they had tried at motivating other women, evidently 21 alone had been successful effectively. The other 37 women did not succeed in convincing although they had tried. When the experiences of women that did succeed in motivating were examined, the picture is encouraging, and provides an insight into the potential which acceptors present in functioning as motivators.

The satisfied acceptors of sterilisation are likely to be the best motivators for sterilisation. Often times not knowledge, but experience is given greater credibility and persons with experience are taken more seriously than those without. When knowledge is combined with experience, the credibility as well as acceptability further increases. Women who have adequate knowledge about sterilisation can feed others with information where knowledge is lacking.

Where awareness is to be developed, the acceptor's conviction of its benefits from personal experience, will be doubly effective and convincing. Once awareness is brought about and necessary knowledge also is provided, the background for initiation of action is prepared. A satisfied acceptor without adequate knowledge of the procedure can not be effective. However, armed with basic information, a satisfied acceptor can function as an effective motivator, if she is prepared and motivated to do so.

The harm which dissatisfied acceptors of sterilisation can do in disuading eligible women from accepting the procedure needs serious consideration. Women who opt for the method on their own after consideration of its merits and demerits and after comparing it with other methods of contraception, are likely to have greater conviction of the method than others who do it by persuasion of others or for other less important consideration. The need therefore to make every acceptor of sterilisation not only a satisfied but a personally convinced acceptor becomes important. Only such women can be effective instruments in motivating other women to decide in favour of and accept sterilisation.

There were 3 women who had motivated 4 other women each to terminate pregnancy permanently. There were 11 women who were responsible to persuade 2 others each. With 7 acceptors bringing one other woman each in favour

of the permanent method of pregnancy termination the contribution of 21 women in motivating a total of 41 other women in favour of sterilisation is brought to light. Possibilities of successfully utilising acceptors as motivators are exposed by the data.

The women were asked how they could convince other women in favour of the method. According to 35 women out of the 58 who attempted to motivate, the reliability and dependability of the method as a sure one in comparison to other methods were the most attractive feature. Vasectomy did not have the same reliability as tubectomy according to these women.

Nineteen women pointed out the safety and absence of side effects of female sterilisation. These women were of the opinion that vasectomy brings with it undesirable physical and mental effects which will incapacitate husbands from their normal work. For women, the operation had negligible side effects and therefore they decided in favour of their getting sterilised instead of the husband.

Similar findings were obtained by other studies. Uppal[21] had shown that women did not favour vasectomy because of the inconvenience and pain it caused to husbands. Singh's,[22] Kothari and Kakar's[23] studies had exposed

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[21] Uppal Satinder, "A Study of women who have undergone tubal ligation", The Journal of Family Welfare, XX(2), December, 1973, pp.74-89.

[22] Singh Hanuman Rathore, "After Effects of Vasectomy and its social acceptance", Ibid., XIX (2), Dec., 1972, pp.20-25.

[23] Kothari Prakash, "Vasectomy-myths & realities", Ibid., XXXIV (4), June, 1978; Kakar, D.N.(Dr.), "Sexual problems related to vasectomy", Ibid., XXI (3), March, '75, pp.50-54.

fear of impotency as a serious concern of women in objecting to husbands getting sterilised.

The silent women were asked why they did not popularize the method. Thirtyfive of them reported that they did not get any chance to do so. There were 3 acceptors who said that they did not know how to do it. Most likely these 38 women were those who were not convinced acceptors with adequate knowledge to support their action in favour of sterilisation.

When the women were questioned whether they were satisfied with the knowledge they had about the operation prior to the procedure 68 (57.63 per cent) out of 118 women had no complaints. However a good proportion of them, 37.29 per cent felt that the knowledge they had was inadequate. It is not in the interest of the programme that so many accept the method without adequate prior information. Any dissatisfaction which may occur to these women after the operation can be used against the method which may deter those women who come into contact with these dissatisfied acceptors. There were 5 women (4.24 per cent) who said that they had no prior knowledge about sterilisation. It is rather unfair that women are allowed to undergo so major a procedure without their voluntary choice. In the absence of proper knowledge their decision to undergo sterilisation cannot be considered free and voluntary. These acceptors can do great harm to the programme if they become dissatisfied later on.

STERILISATION VERSUS OTHER METHODS

The women were asked to rate sterilisation in comparison to other methods about their suitability. While 66 women (55.93 per cent) were of the view that it is suitable for all women, 50 (42.37 per cent) were of the opinion that it is advisable only for some. Two women (1.69 per cent) held that the method is not good for anyone. Most likely, the first group of 66 women must have been happy acceptors without adequate knowledge concerning the operation. Their inability to appreciate the unsuitability and unacceptability of the method to some imposes difficulties on their functioning as effective motivators because of obvious lack of adequate knowledge.

The second group of women who had reservations about the suitability of the method to all were perhaps the adequately informed and convinced women who were in a position to strike confidence about the procedure in other eligible women and help them to make a responsible choice with due consideration of its merits and demerits that the method should not be advised for any are those who were unhappy after the operation.

To verify the women's responses, they were made to answer a direct but hypothetical question whether they would opt for the method again were they given another chance. All 118 women except 4 affirmed that they would,

voicing the absence of any regret for having got sterilised and thus prevented conception permanently. Out of the 4 women who did not respond possitively, 3 expressed regret while one did not answer.

It can reasonably be accepted that the 96.61 per cent of women who had no regrets and were certain about choosing sterilisation if they could make a choice again, are satisfied acceptors. These women if properly prepared and enthused can function effectively as motivators.

POPULAR ATTITUDES TO TUBAL LIGATION

Often what one accepts as good for oneself need not be considered good and acceptable for others. After the respondents were questioned about their personal attitudes and experiences towards sterilisation they were asked to comment about the general attitudes of women towards the various aspects of female sterilisation. It was felt that this information on popular prejudices would help in planning strategies for popularising the method.

The women were asked to state what were the reasons for their general reluctance to undergo sterilisation.

Table - 38

Reasons for popular reluctance to get sterilised according to 118 respondents

Reason		Number	Percentage
1. Fear of losing health	-	59	50.00
2. Fear of surgery	-	42	35.59
3. Superstitions	-	3	2.54
4. Lack of sufficient knowledge	-	20	16.95
5. Gain in weight	-	2	1.69
6. No answer	-	16	13.56

Fear of losing health was found to be the most serious concern of women in general about sterilisation. In the personal experiences of women also, this was the most disturbing factor. At the first post-operative interview, in contrast to 179 out of 203 women who had reported of either complete, significant, or hopeful recovery of lost health there were 8 women who felt deterioration of health. There were 12 women who were suspicious about the future possibilities of regaining full health. These 20 women will be unable to convince other women regarding the safety of sterilisation. Except the 133 women (65.52%) who have fully regained health the other 70 women (34.49%) were experiencing discomfort of the operation after one or two months at the time of the second interview. Prolonged experiences of physical ailments can develop prejudices against the operation among women which will be communicated to others.

The fear regarding the adverse effects on health can be allayed effectively by women who have undergone the operation devoid of such painful experiences. The post-operative follow-up that would monitor all complaints subsequent to operation giving prompt medical care would help in dissipating these anxieties.

Motivators will be doing injustice if they give false assurances about the side-effects of sterilisation and leave the women to find out later that real experiences are contrary to information given. Warning them beforehand about the possibilities of complications and the care that should be taken immediately will perhaps be better than encouraging women for operation without correct prior information and preparation.

The need to perfect the procedure without side-effects is also called for. The efforts of medical men in method research should make their contribution in this particular area. If fears regarding the irreversibility and side-effects can be overcome, sterilisation has the potential of receiving general acceptability.

Fear of the operation itself turns women away from sterilisation according to 31 women. This is not a surprising finding as hospitalisation and surgical procedures are usually dreaded by people. In a land where various systems of medicine such as the Ayurveda, Naturopathy,

Unani, Homeopathy etc. have wide popularity traditionally, surgical procedures of the Allopathy medicine are more avoided than sought for. Sterilisation being a surgical procedure involving hospitalisation will therefore be naturally avoided by people. It is to be noted that only 42 out of 118 women (35.59%) thought that fear of the operation itself would scare away women from accepting sterilisation. Although it is not as sizable a proportion as those with the fear of losing health, this remains an obstacle to the programme receiving popularity among women.

The need for developing non-surgical procedures that will give complete protection against unwanted conception is revealed by the data. The dependency on sterilisation as the one method that would bring sure results perhaps needs reconsideration in the country. The protection and reversibility which loop offers can be made attractive to women if proper efforts are made. The potential which loop has as a permanent method assuring reversibility needs to be explored. The experiences of China[24] confirm the values of IUD. It is estimated that about 60 million women all over the world are using IUD with over 40 million users in China alone. Sterilisation is the second most widely used method there.

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24 IUDs, "An Appropriate Contraceptive for many women", Population Reports Series B No.4, July, 1982.

When sterilisation is projected as the ideal method the need of couples to space births is not sufficiently appreciated. Sterilisation may be acceptable to couples that have completed their families. However, for couples that have got married and who want to postpone pregnancy; those who want to postpone the birth of a second child; those who want to wait and assure themselves against fears of child mortality before they go for sterilisation, etc. the need for easily reversible methods becomes obvious. For those categories of couples sterilisation will not definitely be acceptable and alternative methods will have to be offered. Failure to do so will lead to couples refusing to protect themselves by effective contraception leading to unwanted pregnancies and births.

Lack of adequate knowledge according to 20 women (9%) was responsible for their staying away from getting sterilised. When women were asked to state what kind of knowledges would be necessary to encourage women, 17 women (14.41%) were of the opinion that information on family planning in general and its benefits should be provided. There were 29 women (24.58%) who pointed to the need of instructing women on the operation itself. The experiences of women in presenting themselves for surgery without proper information about the procedure may have been responsible for this observation by women. Data collected from women at the one-month after operation interview

substantiate the point. There were 37 women (18.23%) out of 203 who had reported of unbearable pain during the operation. These women may not have anticipated discomfort. They were either not informed of the possibilities of temporary pain or they may have been fed with false information with the result that they were not prepared to face the suffering.

Table - 39

Memory of women's painful experiences about surgery

	Number	Percentage
Operation was very painful	37	18.23
Less than expected	26	12.81
More than expected	19	9.36
Just normal discomfort	50	24.63
No pain at all	71	34.98
	203	100.00

Most likely, 19 (9.36%) women who experienced greater pain than anticipated, may also have felt the need for correct information regarding the operation. There is therefore nothing unusual about these women asserting their right to have correct prior knowledge before the operation.

However, the report of a sizable number of 71 women (34.98%) about the absence of discomfort, 50 women (24.63%)

experiencing no unusual pain, and 26 women (12.81%) much less than what anticipated, indicate that these women may have had sufficient knowledge about what was to be expected.

While the absence of any or grave discomfort at operation may have also contributed to the general level of satisfaction of women regarding tubectomy in general, it is quite possible that those women who experienced severe discomfort and those who felt more pain than what was expected would spread scare about the operation among other women. This can affect the demand for sterilisation adversely. An effective way of guarding against such consequences will be to arm acceptors with adequate knowledge of the surgical procedure itself so that they are prepared to face the temporary distress without qualms.

Respondents could list the particular knowledges which women in general should have and which would persuade them effectively in favour of sterilisation.

Table - 40

Helpful knowledges for motivating in favour of sterilisation

Points that need emphasis in motivating	No.	Percentage
1. Safety - without complications	42	35.59
2. Small family will bring happiness	8	6.78
3. Reliability	53	44.92
4. Correct information	34	28.81

The assurance about the safety of sterilisation without side-effects according to a sizable proportion of 42 women (35.59%) will be effective in persuading. A very small number of 8 women (6.78%) held the view that the projection of a small family as healthy and happy would attract women to get sterilised. According to a large number of 53 women (44.92%) reliability which sterilisation offers will offer adequate motivation.

There were 34 out of 118 women (28.81%) who pointed out the need to give correct information regarding the method. This particular observation may perhaps be indicative of the incorrect knowledges which they themselves would have had and which experiences would have corrected. Correct information according to them will generate demand for the method. The comment points to the false information or misunderstandings which average women have against sterilisation. All 118 women except 2 who did not respond, substantiated the point by observing that more women will definitely volunteer for sterilisation if adequate and correct information is provided.

Acceptors were asked what were the popular fears and prejudices against sterilisation.

An examination of the table-41 reveals that fear of adverse effects on health is nurtured by women in general according to 84.75 per cent of acceptors. The concern

Table - 41

Popular fears against tubectomy

	Yes	No	No answer
	%	%	%
1. Will lose marital fidelity	27(22.89)	90(76.27)	1(0.83)
2. Affects health adversely	100(84.75)	15(12.71)	3(2.54)
3. Mental peace will be lost	6(5.08)	110(93.22)	2(1.69)
4. Fear of losing children	46(38.98)	71(60.17)	1(0.85)
5. God's curse will come upon the family	6(5.08)	111(94.07)	1(0.85)
6. Occasion for husbands to suspect wife	12(10.17)	103(87.29)	3(2.54)

of women regarding the side effects would be the most prominent factor that dissuades women from getting sterilised. The urgency to find ways of preventing physical ailments following operation and prompt attention to complications as they arise are indicated by the data.

The fear of losing marital fidelity according to 27 acceptors (22.89%) may deter women from undergoing sterilisation. Although in the real experiences of women only a small percentage entertained such fears a much larger percentage of women fear the prevalence of such thinking among women. This is perhaps one of the prejudices that has been built up in course of time in the country against sterilisation. That tubectomy will provoke

suspicions in husbands about wife's fidelity was also considered as a reason for women's reluctance to get sterilised. Contrary to personal experiences the acceptors here again may have been voicing the fears that exist among other women.

A sizable number of women (38.98 per cent) did think that women in general hesitate to accept sterilisation for fear that permanent termination of pregnancy by a method that is irriversible will place problems before a couple in the event of losing children by death. Although the number of respondents who had experience of child loss in the sample was negligible, the acceptors were expressing a genuine fear of women in accepting tubal ligation. Findings of studies and available literature in the field repeatedly emphasize the need of reducing child mortality as a condition that would create demand for sterilisation.[25]

Fear of God's wrath was advocated as a general cause for refusal of sterilisation by women. Although women in the sample with personal experiences of such fears were only few, 5.08 per cent of respondents considered this to be true among other eligible couples. However the assertion by 111 acceptors (94.07%) that such religious

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[25] Government of India, "Important findings", Population Research Bulletin, New Delhi, 1979.

sentiments do not provide a barrier in the way of women getting sterilised perhaps give an insight into the correct perspective which people have begun to develop about the teachings of religion in the matter of family planning.

Evidently prejudices built upon false understanding or interpretation of religious values surrounding birth and population control by ordinary masses are being eroded. Much more than resistances built up by religion, fear of side effects of the method, of losing children, of losing marital fidelity etc. seem to be greater obstaccles that need to be removed if family planning programme is to be made more popular among couples.

THE IDEAL MOTIVATOR

Apart from their personal experiences, the respondents were asked to comment who could be most effective in motivating women in favour of tubal ligation.

Table - 42

Who is the best motivator to persuade women for tubectomy

Category	Order of preference								Total	%
	1	2	3	4	5	6	7	8		
Doctor	0	25	23	4	12	11	4	1	80	67.8
Parents	10	45	19	5	0	0	1	-	80	67.8
Husband	80	9	6	-	-	-	-	-	95	80.51
Friends	22	13	6	-	-	-	-	-	41	34.75
Rel.heads	0	0	1	-	-	-	-	-	1	0.85
Health visitor	4	15	9	-	-	-	-	-	28	23.73
In-laws	1	10	36	-	-	-	-	-	47	39.83

The question could be answered evidently only from the personal experiences of women. The most effective motivator according to 80 out of 118 women is the husband. The second most effective motivator according to 45 women was parents. There were 36 women who gave the third place to in-laws as effective motivators.

While friends were considered to be the best motivators by 22 women , doctor was given second and third places by 25 and 23 women respectively. Effectiveness of doctors and friends in motivational activity is substantiated by the data.

The role of health visitors in motivation is not insignificant. However religious heads are not considered to be having any influence upon motivating women for sterilisation. Obviously, this is a field of work where religious leaders have not yet entered. As a result, their influence is not experienced by couples.

INDIRECT FACTORS OF MOTIVATION

Although not directly, religion of parents, their educational level, their economic background, age and parity of women, sex preferences regarding children, and duration of married life are conditions that would indirectly influence decisions concerning the acceptance of sterilisation to regulate family size. The influence of

these indirect factors upon decisions of respondents to get sterilised are analysed below.

Religion as a factor of motivation:

Contributions of religion towards family planning programme have not been helpful in the three decades of its history in the country. Mostly all the religious groups have kept themselves away from the field. Christians in general, and Catholics in particular, are considered to be not in favour of family planning as the Church opposes in principle all artificial means of contraception. As far as Muslims are concerned, it is contended that they oppose family planning for political reasons. The purpose of analysing the influence of religion upon motivation was to scientifically verify the role which it plays - positively or negatively -- in decisions to undergo sterilisation.

Of the three religious groups to which the respondents belonged to the largest number were Hindus, forming 46.3 per cent. The second largest group constituted the Christians (37.3 per cent) and Muslims only 16.3 per cent. The religion-wise composition of the population in the District of Ernakulam shows a higher percentage of Muslims. However, the sample studied comprised of a smaller proportion of Muslims than what is to be expected. The proportion of Christians in the sample is on the other hand

higher than the District average. In this background it was felt that an analysis of the feelings of acceptors, their fears and their expectations from the operation in relation to their religious beliefs would be worth probing. The positive and negative attitudes prevalent among the various religious groups would open up ways of breaking up prejudices wherever present and the positive factors made use of in encouraging others.

The influence of religious beliefs upon the feelings of the women towards sterilisation, discouraging features of the operation; and expectations from permanent termination of pregnancy are already presented earlier in Chapter II. The educational level of respondents and husbands has also been presented.

The method of sterilisation is found to have the greatest popularity among women with primary education as well as the illiterate: with higher levels of education, the method seems to steadily lose its popularity. The reasons for it have already been analysed.

The level of education of husbands does not seem to be related with women's decisions to get sterilised as explained in Chapter II. The observation is substantiated by findings of other studies that reveal the positive impact of education upon wives in decisions favouring family limitation.[26]

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[26] Government of India, "Study of Population Structure, behaviour and Demographic differentials: Waltair Study", _Population Research Bulletin_, 1979.

Economic Background:

Financial benefits accruing from family limitation was found to be the strongest motivation of respondents in getting sterilised.

Majority of respondents of the study having been drawn from the daily wage earning class of manual labourers, the low economic status of acceptors was evident. Although monetary emoluments were not received by acceptors as incentives, the assurance of financial gains that the family would receive evidently provided adequate motivation to women in getting sterilised. The finding points to the scope which financial rewards carry in attracting women to accept sterilisation. However, the value of monetary rewards in bringing about lasting changes in the sexual behaviour of couples in favour of accepting the values of a small family, is debatable.

For quick results in swelling the number of sterilisation acceptors and reaching targets faster, monetary incentives seem to derive significance.

Age and Parity:

While age as such is not much related to decisions concerning sterilisation, studies show that parity is closely linked with couple's decision to terminate fertility. Mehta has found that the lowest acceptance rate

for sterilisation is below age 20 and above 40. His analysis of parity revealed that the acceptance rate increases with parity till 5 and then it gradually declines. The decreasing trend of parity according to Mehta reveals the fact that the timing of sterilisation in relation to parity is becoming earlier which speaks well for the future prospects of the family planning programme.

In the present study, the age of women who underwent tubectomy ranged from 19 to 44. However, the maximum number of acceptors in the sample were between the ages of 21 and 30.

Table - 43

Age and Parity as factors in Tubectomy

Parity	Less than 21	21-25	26-30	31-35	36-40	40 & above	Total
		Age of mothers					
1.	--	1(.95%)	0	0	0	0	1
2.	--	41 (39.05%)	20 (15.63%)	3 (6.38%)	0	0	64 (21.33%)
3.	--	53 (50.48%)	61 (47.66%)	12 (25.53%)	3 (16.67%)	0	129 (43%)
4.	--	9 (8.57%)	30 (23.44%)	12 (25.53%)	6 (33.33%)	0	57 (19%)
5.	--	1 (0.95)	7 (5.47)	11 (23.40)	3 (16.67)	0	22 (7.33)
6.	--	0	9 (7.03)	5 (10.64%)	3 (16.67)	0 0	17 (5.67)
7.	--	0	1 (0.78)	4 (8.51)	3 (16.67)	2	10 (3.33)
		105 (35%)	128 (42.67%)	47 (15.67%)	18 (6%)	2 (0.67%)	

The age of women as such may not look significant when the table is scanned through. The average age of acceptors is 30.1. The level of acceptance increases from the age of 21 till 30 after which a steady decline is noticed. However, regardless of differences in age, it can be observed that the most popular timing for sterilisation is after the couple has reached a family size of 3 children. In every age group of women acceptors, maximum number of women had 3 children and were moving to para 4.

In the sample studied, maximum number of 128 women out of 300 (42.67 per cent) were between 26 and 30 years of age. The number of para 3 women in this group constituted 47.67 per cent. The next largest group in the 26-30 age category was para 4, women constituting 23.44 per cent. This is a sizeable proportion of women in the age group who have been moving beyond para 4. While there were 5.47 per cent of 20-30 and women who had 5 children, 7.03 per cent had 6 children each. With just one woman in the same age group having 7 children, the total number of children of mothers of para 4 and above were 216. There were births that could be prevented if women of 26-30 age group could be made acceptors of sterilisation before they moved to para 4. The 25-30 women who had only 2 children at the time of tubectomy constituted only 15.63 per cent. This is a pattern that

is not often seen since Indian women are usually found to have had 3 or 4 children by the time they are 25 years of age.[27]

Analysis of the 21-25 age group of women acceptors (35 per cent) reveals a trend of women of younger age group and of lower parity opting for permanent method of birth termination. Out of 105 women between ages 21 and 25, 39.05 per cent (41 in number) had only 2 children at the time of tubal ligation. Age is becoming a less important factor in decisions favouring sterilisation is indicated by the data. A large proportion (50.48 per cent) of 21-25 year old mothers however had made sure of 3 children before they decided to undergo sterilisation.

According to earlier research findings 3 to 4 children were the ideal family size.[28] Perhaps the present study shows a noticable trend among Indian couples for a 3 children family as the ideal. A similar trend is reported by Misra.[29] Although 3 children may be a well-planned family size for a couple, it is not in consonance with national goals that aim at persuading couples to limit to 2 children.

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27 Mehta, "Effectiveness of Sterilisation in Bombay", 2nd International Conference Proceedings, Bombay, 1975.

28 Lahiri Subrata, "Preference for sons and ideal family in Urban India", Indian Journal of Social Work, XXXIV January 1974, pp.323-336.

29 Misra, R.S. et.al., "Decision-making for tubectomy", Journal of Family Welfare, XXXII, July 1976, pp.50-63.

The presence of 9 women of para 4 and one of para 5 in the 21-25 age group confirms the trend in India especially Kerala where women complete their family in the first five years of marriage. According to Srivastava's estimates, within 1-4 years of marriage 25 per cent of children are born to couples.[30]

The proportion of 31-35 year old in the sample was slightly less than half the number of 21-25 aged mothers. While there were 35 per cent of women acceptors in their early twenties, the women between 31 and 35 were only 15.67 per cent. The data definitely reveals that lesser and lesser women wait for long to terminate pregnancy permanently.

Out of 47 women acceptors in the 31-35 age group 25.53 per cent had 3 and 4 children each. While 23.40 per cent accounted for 5 children each, those that had 6 and 7 children were 10.64 and 8.51 per cent respectively. If women of this age group were prevented from moving beyond para 3, a total of 161 births could have been averted.

In the 36-40 age group there were only 18 acceptors forming 6 per cent of the total sample. While 6 out of the 18 were of para 4, 3 each were of para 3, 5, 6 and 7.

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[30] Srivastava, S.C., "Birth and Death rates in India", Studies of Demography, Meerut, 1980.

There was only one woman over 40 years of age and she had 7 children. Sterilisation of this age group may not be demographically effective. However, personal benefits of sterilisation to these women cannot be ruled out.

Duration of Married Life:

If no effort is made to prevent conception, with increase in years of married life, there would be increase in the number of children.

Table - 44

Years of married life and number of children

Years	No. of women	No. of children	Average parity
Less than 5	- 92	232	2.52
6 - 10	- 115	364	3.17
11 - 15	- 57	237	4.16
15 and above	- 36	198	5.5
	300	1031	15.34

The average parity of women in the sample is 3.86. The average years of married life per couple is 8.8.

When parity is related with duration of married life, it can be observed that parity definitely increases with number of years of married life. While 5 year old couples had a parity of 2.522, 6-10 year olds had a

parity of 3.165. While couples with 11-15 years of family life had a parity of 476, those above 15 years had a parity of 5.5.

The maximum number of women who underwent sterilisation (38.33 per cent) had a duration of 1 - 10 years of married life. The 5 year term wives who got sterilised were only 30.67 per cent.

Women who got sterilised after 11-15 years of married life formed a smaller proportion of 19 per cent, but had a parity of 4.16. The smallest proportion of 12 per cent acceptors who had lived over 15 years of married life were moving to para 6 at the time of sterilisation.

If couples within 5 years of married life move to para 3, they should be approached sufficiently early if a third birth is to be prevented. As early marriages are the rule in India, preventing third order births by sterilisation means permanent termination of pregnancy at a very young age of 25 or lower which may not be advisable and acceptable. A study reported by Chen-Tien Hsu of Taipei Medical College, China[31] has pointed out that

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[31] Chien-Tieu Hsu, et.al., "The Incidence of uterine fibroids and uterine cervical cancer after tubal sterilisation", <u>2nd International Conference Proceedings</u>, 1975, Bombay.

there is overwhelming predominance of uterine cervical cancer in the younger sterilised women over the younger non-sterilised women. Motivation of couples during the early years of married life for spacing of births by contraception is called for if couples are to be saved from the prospect of having to undergo sterilisation at too young an age and at the same time to prevent third order births.

The proposal for further raising the age of marriage of girls and boys through legislation is a step contemplated by planners for bringing about later pregnancies and postponement of the age of permanent pregnancy termination.

An attempt to educate couples during the first years of marriage has been reported.[32] The study claims that the educational programme could initiate desire for small family size.

Timing of Sterilisation:

In the sample of 300 women acceptors the largest proportion of 78.67 per cent had undergone sterilisation as post-partum while 19.67 per cent with medical termination of pregnancy.

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[32] News and notes, The Journal of Family Welfare, XIX (2), December, 1972, pp. 69-74.

Whether post-partum procedure or with M.T.P., the large proportion of women submitting themselves for sterilisation bring out the fact that women are easily amenable to counselling and suggestions in favour of surgical contraception while they are hospitalised for either delivery or medical termination of pregnancy.

In the context of female sterilisation emphasized by the government as the most effective programme in reaching demographic goals, the importance of ensuring deliveries to take place in hospitals becomes evident. The urgent need to extend hospital facilities within easy reach of rural women is brought to light. Gulati has established the point convincingly in her paper "Sterilisation and Family Planning".

Cases of interval sterilisation among acceptors constituted only 1.67 per cent. The choice of these women to get sterilised would have been most likely the result of conscious and voluntary choice with conviction of the values of family limitation. According to Dr. Mehta's findings[33] psychological complications are relatively less among those who get sterilised voluntarily. The prospects of interval sterilisation for demographic effectiveness is however limited.

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[33] Dr. Mehta Pravin & Shastri, P.C., "Psychological and sexual influence of Female Surgical Contraception", Proceedings of 2nd International Seminar, Bombay,1979.

Sex Preferences of Couples:

The inability of man to determine the sex of his unborn children will cause families to be larger in communities where the sex of children is given importance. Sex preference will also affect the use of contraceptives.[34]

Several studies have been done in the country to establish the prevalence and extent of preference for sex of children. Bhatia has found that an average of 3 sons for every 2 daughters is the ideal.[35] According to Siddh, the question of family planning, more so sterilisation, does not arise in the case of couples with no male children, regardless of differences in religious beliefs. Pathak[36] in a recent study has observed that couples choose terminal methods of pregnancy termination who have 4 or more children with a bias for at least one or two sons.

No effort was made to collect data on sex preferences of couples from women directly. However with data on parity at the time of sterilisation available as well as the sex distribution of children, analysis was

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34 Waheed, M., "Family Size and sex preferences", Journal of Family Welfare, XIX (3), March,1973. pp.35-42.

35 Bhatia, C. Jagdish, "Ideal number and sex preference of children in India", Journal of Family Welfare, XXIV, No.4, June, 1978, pp.3-17.

36 Pathak, K.B., "Infant mortality, Birth order and contraception in India", Journal of Family Welfare, XXV (3), March, 1979, pp.11-20.

possible to ascertain the sexual considerations that may have gone into the achievement of the desired family size.

Table - 45
Sex-wise distribution of children according to order of birth

Fertility	Order of birth 1 F	1 M	2 F	2 M	3 F	3 M	4 F	4 M	5 F	5 M	6 F	6 M	7 F	7 M
1st	141	159	-	-	-	-	-	-	-	-	-	-	-	-
2nd	-	-	144	156	-	-	-	-	-	-	-	-	-	-
3rd	-	-	-	-	104	133	-	-	-	-	-	-	-	-
4th	-	-	-	-	-	-	52	56	-	-	-	-	-	-
5th	-	-	-	-	-	-	-	-	32	18	-	-	-	-
6th	-	-	-	-	-	-	-	-	-	-	16	11	-	-
7th	-	-	-	-	-	-	-	-	-	-	-	-	3	8

Examination of the table reveals that out of a total of 1033 children the female-male ratio is 492:541. Definitely more male than female children were born to couples who were covered by the study. The very motivation to end pregnancy permanently by surgical means would have been the result of couple's satisfaction regarding the male children they have.

There is predominance of male over female children in the first four order of births. The fifth and sixth order have more female children in contrast to the

seventh where the number of male again exceeds. The average number of male children per respondent was 1.80, while that of female was 1.64 showing respondents' decision to undergo sterilisation after they had the number of sons they wanted.

Infant mortality rate among male children is considered to be generally higher than female children. Despite survival rate of male children being less, the females per thousand males ratio in India as a whole is 935 according to 1981 figures.[37] Kerala state ratio for females is 1034 per 1000 males, higher than the rates of other states in the country. However, the ratio in the District is much less at 983. In this background of estimates, there is every likelihood that women that opted for sterilisation had assured themselves of the number of male children they wanted to have, prior to terminal procedure. A study by Bhatia[38] has shown that an average of three sons for every 2 daughters were found to be the ideal.

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37 Government of India, Census of India 1981 - Series 10, Kerala.

38 Jagdish Bhatia, "Ideal number and sex preference of Children in India", The Journal of Family Welfare, XXIV (4), June, 1978, pp.3-17.

CONCLUSION

While direct efforts to educate and motivate couples in favour of family planning practices are crucial in increasing demand for family planning services, the creation of favourable conditions that would influence decisions in favour of family limitation should be recognized important to bring the large number of fertile couples in the country under coverage of family planning programme. As the sixth joint conference of the Central Council of Health and Central Family Welfare Council recommended through a resolution, "Family Planning is not merely the use of contraceptive methods; it involves a behaviour change in the community which is linked with many aspects of overall social, economic and cultural factors".[39] According to a recommendation of the working group on Population Policy submitted to the Planning Commission in March 1979, the success of the family planning programme will depend on:-

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[39] Government of India, "Family Welfare Programme in India: 1978-79", Year Book.

1. "The involvement of the people and the various social, economic and political institutions especially at the local level in organisation of the programme, and

2. The successful implementation of the various programmes of social and economic change".

The changes recommended refer to those favourable factors that would indirectly influence decisions of couples in favour of contraceptive practices and family limitation.

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IV

HUSBAND-WIFE RELATIONS

Habits and behaviour of couples: kind of man husband is - Relatives and friends - Social life - Decision-making - How differences settled - Frequency of husband's coming home -- Physical well-being - Mental disposition - Self assessment of respondents: quality of relationship, sexual relations, future prospects - Conclusion.

C H A P T E R - IV

HUSBAND - WIFE RELATIONS

"Families are made up of human beings who love and hate, sin and forgive, are combatants and yet peace-makers. 'The home is a good training ground for the battle of life provided love conquers hate, forgiveness triumphs over sin, and peace overcomes war in the long run. . . . .'. Happy families are those which ensure affection and security to their members and are yet endearingly human".[1]

"Marriage has gradually shifted from being an institution to relationship",[2] "By relationship is meant an equality of status and value and a diminution of fixed roles. The wife is not merely the childbearer and housekeeper, nor is the husband the main source of authority and provision. A deeper and wider exchange of feelings is possible".[3]

To any family's welfare the quality of relationship between the husband and the wife is the most

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1 Bowley Agatha, The Problems of Family Life, Edinburg, 1948.

2 Dominian J., "Social Factors and Marital Pathology", British Medical Journal, 1 September, 1979.

3 Dominian, J., Ibid.

important determinant. Running of a home is the responsibility of parents and the mutual cooperation in sharing the responsibilities between them decide the quality of life of every one in the family. Discord or tension between husband and wife will disturb the harmony and well-being in the home bringing with it varying degrees of unhappiness to all family members.

"The corner-stone of the happy family is that mother should be on good terms with father, that their mutual companionship should be apparent, their loyalty to each other unquestioned, and their occasional arguments and disagreements good-humoured and transient".[4]

The ultimate objective of family limitation is family's welfare. If limiting of births fails to contribute to family's welfare, the very purpose of family planning will be defeated.

'Welfare' of a family is mainly an experience of the members that live in it. The sum total of the satisfying personal experiences of the couple in the various spheres of family living ultimately contributes to their feeling of well-being and happiness. Quality of the conjugal life of the couple, freedom from the fear of unwanted pregnancies, health of mother and children,

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[4] Bowley Agatha, Ibid.

freedom from financial strains, psychological well being of the couple etc. are all crucial aspects which finally determine the quality of welfare.

The major objective of the present study was to scientifically investigate whether family limitation through sterilisation achieves the purpose of enhancing family welfare. Lacking objective techniques of direct measurement the analysis of husband-wife relationship in this chapter is attempted through four different channels of enquiry into related areas.

1. The first stage presents the couple's habits and behaviour that would influence and determine their intimacy. The kind of man husband is; his habits; the company which he keeps; the couple's ability to get along; their manner of decision-making; the ways in which differences are settled; frequency of husbands coming home; and the social life of the couple; are examined in order to obtain insight into relationship.

2. Physical well-being of spouses constitutes the second stage of analysis as it is an important contributing factor to marital happiness.

"Sexual satisfaction is also an important part of marital happiness".[5] Poor bodily health can intrude and

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[5] Dominian, J., "First Phase of Marriage", British Medical Journal, 15 Sept., 1979.

leave little time for intimacy. In addition to bodily health, sexual life of couple is also therefore included in the analysis of couples' physical well-being.

3. The third stage analysis is the mental well-being of the couple. Post-operative experiences of women are compared with women's initial feelings toward sterilisation; discouraging elements about the surgical procedure; and their expectations about future gains from permanent termination of pregnancy.

4. The fourth and final analysis is based on the self-assessment made by acceptors themselves. The purpose of this appraisal was to verify the observations of the other three stages of enquiry.

In the absence of any effort to control other variables, it may be difficult to prove convincingly that it is sterilisation alone that has brought about change in relationships if any had taken place. However, assuming that the conditions within the family have not undergone signal changes physically, financially, and psychologically during the period of study, it is assumed that changes in the area of relationship if it has occured during this period, would have been the result of sterilisation which should be accepted, as a major event in the life of married couple in the reproductive period.

The analysis of inter-spouse relationship presented in the following pages should therefore be viewed from this perspective.

I. HABITS AND BEHAVIOUR OF COUPLES

i) The kind of Man Husband is: No claim is made that the personalities of husbands were assessed intensively with any reliable instruments of testing. For the purpose of investigation into the particular area of study it was enough to know from wives what types of men the husbands were. Even if a subjective assessment by wives may not be depended upon as the reality, the response it was felt would give a clue to the tone of relationship which exists between the couple. A wife's comment about the husband as a patient man throws insight into the woman's apprecia-tion of her husband and the presence of positive feelings of mutual acceptance, forbearance, tolerance etc. On the other hand, a woman who complaints about husband's bad temper points to the unhappy experiences that they are subjected to even if the wife accepts the situation as unavoidable.

Table - 46

Kind of man husband is

Nature	No. of husbands	Percentage
Very patient -	91	30.33
Patient -	153	51.00
Lack patience -	5	1.67
Lose temper quickly-	44	14.67
Friendly -	6	2.00
No answer -	1	0.33

Majority of women had no complaints about husbands lacking patience in behaviour. While 91 husbands (30.33 per cent) were reported to be extremely patient and forbearing, 153 of them (51 per cent) were considered to be patient without making the women concerned or unhappy about it. There were 6 husbands who were reportedly very friendly in nature, with a constant pleasing disposition. These three categories of husbands totalling 250 (83.33 per cent) would be men who are disposed to strike happy relationships with others.

There were 44 husbands (14.67 per cent) who according to wives were in the habit of losing temper quickly. According to 5 other women, their husbands lacked patience. These 49 husbands (16.34 per cent) evidently have dispositions that ignite unpleasant episodes in relationship between spouses.

However, 83.33 per cent women affirming to have positively disposed husbands bear testimony to the possible, pleasant, inter-spouse relationships that have been existent in majority of families.

It cannot be concluded that the quick-tempered husbands had families with marital tensions and conflicts. "It is most unnatural to hide one's ill-temper or irritation altogether. It is far better to express it openly

to some extent, though constant bickering and nagging are pernicious and harmful to parents and children alike......".[6] "Eruption of anger need not be a sign of unhappy marital relations".[7] No further information regarding the frequency of outbursts of anger was obtained. Therefore a definite classification of these families as having healthy or unhealthy relationships cannot be made.

To avoid exaggerations in analysis, the presence of positive and satisfying relationships in the case of 250 families can be safely assumed from the presence of husbands who are positively disposed to do so by their nature and behaviour. It may be presumed that wives could not testify to acceptable disposition in case of 16.34 per cent husbands. This is a comparatively small proportion in the sample.

2. RELATIVES AND FRIENDS

Enquiry into the husband's relationships with others; his drinking habits, manner of spending his leisure, couple's social life and their pattern of decision-makking at home etc. substantiated the women's assessment of their relations with husbands.

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[6] Bowley Agatha, Ibid.

[7] Dominian, J., "Second Phase of Marriage", British Medical Journal, 1979.

Table - 47

Women's attitude to habits of husbands

	No complaints	Not happy	No answer
1. Husbands relations with others -	287 (95.67%)	12(4%)	1(0.33%)
2. Drinkking habits of husbands -	279(93%)	19(6.33%)	2(0.67%)
3. Leisure time -	286(95.33%)	14(4.67%)	0

"Spouses bring to marriage their relatives and friends who may or may not be appreciated by the spouse".[8] Women's satisfaction or dissatisfaction about husband's relation with friends and relatives, it was hoped would give insight into interpersonal relationships between spouses. A happy husband is better disposed to strike pleasant relationships among non-family members than another man with unhappy family life. There can also be no meaningful relationship without interaction whether of a positive or a negative kind. It was therefore felt that husband's ability to interact with friends and relatives would be a manifestation of his general disposition that would bear upon his interpersonal relationships within the family.

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[8] Dominian, J., "First Phase of Marriage", British Medical Journal, 1979.

Large majority of women (95 per cent) did not have any complaints about the behaviour of husbands with relatives and other non-family members. This speaks in favour of husbands who have been able to impress upon wives about the ability to strike normal interpersonal relationships. However there were 12 per cent of women who were not happy about husband's relationships with members outside the family. The dissatisfaction which these women have about husband's behaviour is an indirect indication into the personality of the husband. Even if the objectivity of women's comments is questionable, their opinions can be considered as an expression of what women think of their husbands negatively. These women would have had difficulties to agree with husbands and their behaviour on this particular point.

3. ALCOHOLISM

The link between alcoholism and marital-problems is well established.[9] Women were asked whether the husbands were in the habit of taking excessive drinks about which they were not happy. A large proportion of women, 279 out of 300 (93 per cent) had no complaints at all. This is a pointer to the satisfying level of adjustment which these women were able to achieve in their married life.

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[9] Dominian, J., "Marriage and Psychiatric Illness", British Medical Journal, 1979.

The small proportion of women (6.33 per cent) who were concerned about husband's drinking habits gave expression to the unhappiness which it has brought to the families. All 4 women who decided in favour of sterilisation as a solution to marital problems[10] came from this group of 19 women.

4. LEISURE

On enquiry into women's opinion about the way husbands spend their free time, 95.33 per cent of women had nothing to say against spouses. This was a question that normally does not call for inhibitions in answering and the women answered them quite fairly and clearly. Most women expressed satisfaction about the interest which husbands show in spending the time with family and joining for leisure time activities.

Women were further questioned how husbands spent their time in the home. This information was obtained in order to verify the information given about the satisfying leisure life of couples. The querry revealed that 275 women out of 300 were pleased that husbands spent most of their free time either with children (57.33 per cent), or attending to household tasks (34.33 per cent). In the

[10] Refer table-35, Chapter-III.

case of other 25 husbands, 23 were reported to be spending time in reading. There were only 2 husbands who did not spend leisure at home.

5. SOCIAL LIFE OF COUPLES

Time together is important for sustained healthy relationships between spouses. Although interests need not be identical, some approximation of interests and shared activity, would cement relationships.[11]

Women's account of how husbands spend their leisure time in the house gave insight into the happy relations which existed in the case of majority of women studied. However, to further verify the observations, details regarding joint activities other than household tasks were explored.

Table - 48

Interests of the couple

Item		Number	Percentage
Cinema	-	194	64.67
Entertaining	-	28	9.33
Pets	-	57	19.00
Cultivation	-	32	10.67
Garden	-	44	14.67
Cultural activities	-	22	7.33
Nothing particular	-	31	10.33

11 Dominian, J., "First phase of marriage", British Medical Journal, 2, 1979, pp.654-656.

In families where couples have difficulties of getting along, joint activities outside the family are found to be rare.

In the case of women studied, excepting 31 women who could not be specific about joint activities the rest of the women were satisfied about husband's cooperation in joining wife for mutually interesting activities other than household tasks. This would not have been possible to couples if their relationships within the family were strained and unpleasant.

Cinema going couples were 194 out of 300. Data about the frequency of film-going was not obtained. Much more than the frequency, the fact of their going together or not is sufficient information in order to have insight into relationship. Except in 31 cases, the remaining couples engaged themselves in some joint activity other than household work, in or outside the family.

6. DECISION-MAKING IN THE HOME

The pattern of decision-making in the home need not be an indicator of the quality of relationship between spouses. However, it can definitely reveal the kind of interaction, that is present in the home between the husband and the wife. Higher levels of interaction may point to higher levels of satisfying relationships and not to unpleasant experiences between the couple.

Evidence exists that if social barriers are closed marital conflict increases.[12]

Decision-making in the family is a behaviour which is often determined by the culture to which the family belongs. The traditional Indian family enjoins upon the husband or the eldest male member, the responsibilities of decision-making. The wife accepts the decisions made by husband without resentment as a normal pattern and conflicts are thus avoided. Absence of interaction between the couple in the matter of decision-making in the home therefore need not indicate absence of positive or evidence of negative husband-wife relationships. However, presence of interaction can be a definite manifestation of positive interpersonal relations between spouses.

Table - 49

Manner of Decision-making in the family

Manner		Husband alone	Wife alone	Jointly
Financial	-	217(72.33%)	8(2.67%)	75(25%)
Educational	-	134(44.67%)	41(13.67%)	124(41.33%)
Dress	-	129(43%)	46(15.33%)	148(49.33%)
Religion	-	83(27.67%)	69(23%)	148(49.33%)
Sexual	-	187(62.33%)	3(1%)	108(36%)

12 Dominian, J., "Choice of Parther", British Medical Journal, 2, 1979, pp.594-596.

As the table reveals, in considerable number of families of women studied (nearly 50 per cent) joint decisions are taken by couples. In the matter of religious activities and clothes of family members, the husband and the wife discuss and decide. In the matter of children's education 41.33 per cent of couples decide jointly. The percentage of couples who take joint decisions in matters of finance are 25 per cent which is not an insignificant proportion. This is perhaps a higher percentage since usually in the traditional Indian home men handle money matters of the family independently. This may not hold true in families where women also earn. Majority of the respondents in the study were wage earners. In this context, the participation of 25 per cent women in decision-making is only understandable.

Even in sexual matters 36 per cent of couples seem to be sensitive about their mutual responsibility in coming to decisions. This is reflective of the positive relationships which existed among the 36 per cent of couples. In the case of 3 women who said that they took their own decisions in sex matters without consulting husbands, they had evidently accepted sterilisation without concurrence because of discord between them and with hopes of keeping one problem out of their family life namely "Further pregnancy and addition of one more member to the family".

Cases of women taking decisions on their own are not many. However, 23 per cent of women who decide on religious matters, 15.33 per cent on the attire of family members, 13.67 per cent on children's education, and 12 per cent on other domestic matters, reveal the trust which husbands have in their wives leaving them to themselves in decision-making without interference. In her traditional role, woman is expected to leave decisions to the husband which comes to her as normal behaviour. Women who decided on their own cannot therefore be interpreted as going against the husband's will bringing strained relationships between spouses. Most likely, in the case of these women, the trust which husbands had in wives is manifested.

The husband deciding by himself in family matters cannot be interpreted as absence of positive relationships. However it may indicate the inability of couples to function democratically, reflecting at the same time the traditional patterns of behaviour to which the family is accustomed to. In the context of more than 90 per cent of women affirming their satisfaction about husband's dealings with relatives and neighbours, and about the manner of his use of leisure, it is to be inferred that the instances of husband taking independent decisions cannot be taken as evidence of negative relationships between spouses.

7. HOW DIFFERENCES ARE SETTLED

The manner of settling differences between couples was enquired into. When women were asked how they managed to settle differences when occured, most women did not think that they had any considerable differences that posed difficulties for solution. However, upon further query whether they had not experienced difficulties of settling differences at any time during their long years of married life there were 31 women who reported there were few such instances. When these women were further questioned who among them were the first to start a fight; who took the initiative to come to a compromise, who among them was better capable of forgiving the other, the responses indicated that except for women who did not want to answer, others expressed happiness or relief that they were able to set things right between them without serious estrangement of their relations.

8. FREQUENCY OF HUSBAND'S COMING HOME

Out of 300 women studied, husbands of 137(45.47%) stayed with the family. While 106 husbands were home once a week, there were 48 husbands who went home only once a month. There were 7 husbands who were occasionally going home.

Although large majority of husbands stayed with the family which may be evidence for their satisfying relations with family members, it cannot be said that positive relationships did not exist where husband's frequency of staying with family was less. The type of work which they did away from home necessitated their staying away. The case of 106 husbands who were with the family once a week show their interest for family life. Those that were with the family once a month (48 - 16%) or occasionally (7-2.33 %) were probably husbands for whom family relations were not satisfying.

II. PHYSICAL WELL-BEING - POST-OPERATIVE

Fatigue of mothers was found to be a source of increased irritation between spouses.[13] Ill health of a spouse can lead to marital tensions and conflict. Lack of bodily health will reduce the availability of spouse for intimacy, sex and leisure, which are closely associated with marital happiness.

BODILY HEALTH:

Although physical well-being or bodily health of a person can be measured quantitatively it is still true that mental attitude of a person determines to a considerable extent his experience of general well-being. Clinically a person may be pronounced healthy, but his personal experience may be far from satisfying.

[13] Dominion, J., "First Phase of marriage", British Medical Journal, 2, 1979, pp.654-656.

Being a surgical procedure, sterilisation is not a welcome proposition to couples however urgent their need may be to control births and thus limit their family sizes. Even those that decide upon sterilisation have their own prejudices and fears about it. However, their choice for operation is based on various expectations such as freedom from unwanted pregnancies, preventing too many births, financial benefits for family and so on.

Experiences after operation may be more satisfying to couples than what they had expected; or the experiences may be less frightening than anticipated. In these cases, sterilisation may be considered as having beneficial effects contributing to the welfare of the family. If the real experiences fall short of expectations or if real experiences have found to bring harmful effects, the welfare objective of sterilisation will become questionable.

The feeling of physical well-being of the women after sterilisation was probed into and the data was related to initial feelings toward the operation. The object was to ascertain the level of healthy family relationships for which the physical well-being of the mother would be contributory.

Table - 50

Feelings of women before operation and their physical well-being after operation

Feelings	Before %	Improved	As before	Worsened	Worsened much	Total
1. Afraid	37.66	2 (4.44%)	27 (60%)	15 (33.33%)	1 (2.22%)	45 (38.13%)
2. Not concerned	43.33	6 (13.33%)	22 (48.88%)	16 (35.55%)	1 (2.22%)	45 (38.13%)
3. Welcomes	1.33	0	1	0	0	1 (0.84%)
4. Courageous	17.66	5 (18.51)	10 (37.03)	11 (40.74)	1 (3.70)	27 (22.88%)
		13 (11.01%)	60 (50.81%)	42 (35.59%)	3 (2.54%)	118

Out of the 118 women who reported to the hospital for check-up and interview, 45 (38.13 per cent) of them were initially fearful of the operation. Among this group only 2 (4.44%) could say that their health had improved after operation. A sizable number of them, 27 (60%) did not experience any significant change at all. However, there was a large number of women, 15 (33.33 per cent) who reported of worsened health. One woman (2.22 per cent) in the group complained of serious setback to health as a result of operation.

Out of 118 women 45 were not at all concerned initially about the consequence of operation either

negatively or positively. Sixteen women out of this group of 45 i.e. 35.55 per cent complained of deteriorated health. However, there were 6 (13.33 per cent) who experienced improvement in health and 22 (48.88 per cent) who did not experience any change.

There were 27 women (22.88 per cent) out of 118 who faced the operation with courage. In this group was found a large proportion of 11 out of 48 (40.74 per cent) who spoke of worsened health as a result of operation. However, there were 5 (18.51 per cent) who were happy with improved health and 10 (37.03 per cent) who could not notice any change.

Backache and abdominal pain were the most common complaints of women who reported worsened health. Presence or absence of these pains before operation were not ascertained. If such data were available, its relationship with operation could have been established. However, even if we accept that the women had abdominal pains or back-ache before operation, her personal experience of worsened health is real to her and it will have its negative impact upon the total welfare of the family. For such families the result of sterilisation is an unhappy sickly mother.

Table - 51

Health experiences after operations and prior expectations

Expectations	Physical well-being after				
	Improved	As before	Worsened	Much worsened	Total
a) Prevent pregnancy	5 (19.23%)	12 (46.15%)	8 (30.76%)	1 (3.84%)	26 (22.03%)
b) Peace in home	0	0	0	1 (100%)	1 (0.84%)
c) Improve husband wife relations	0	1 (100%)	0	0	1 (0.84%)
d) Financial benefits	8 (11.94%)	36 (53.73%)	22 (32.83%)	1 (1.49%)	67 (56.77%)
e) Better care to children	0	2 (50%)	2 (50%)	0	4 (3.38%)
f) Better childrens health	0	1 (100%)	0	0	1 (100%)
g) Better mothers health	0	6 (46.15%)	7 (53.84%)	0	13 (11.01%)
h) Others	0	2 (40%)	3 (60%)	0	5 (42.3%)
	13 (11.01%)	60 (50.84%)	42 (35.59%)	3 (2.54%)	118

There were 26 women (22.03 per cent) out of 118 who accepted sterilisation with the sole purpose of preventing pregnancy. Among this group of 26 only 5 (19.33 per cent) experienced improvement in health. While 12 of them (46.15 per cent) did not notice any change in health

8 of them (30.76 per cent) experienced adverse effects. There was one woman who reported of deterioration of health.

Sixtyseven women out of 118 i.e. 56.77 per cent had got sterilised with hopes of financial gains. In this large group of 67 there were 22 (32.83 per cent) who complained of worsened health and one woman had very painful experience of bad health. While 8(11.94 per cent) experienced gains in health, 36 (53.73 per cent) were not aware of any change subsequent to operation.

One woman who had decided in favour of sterilisation as a solution to unhappy relations with husband was dejected as post-sterilisation experiences were much worse than before. Mothers who accepted sterilisation in order to improve their health were 13. All in this group were disappointed. While 6 (46.15 per cent) did not experience any change in health, 7 (53.84 per cent) had disturbing experiences of worsened health.

On the whole real experiences of acceptors of sterilisation fell far short of their experiences in terms of physical well-being. Out of 118 women only 13 felt health gains. While 60 (50.84 per cent) did not experience any change at all, the negative experiences of 45 (38.13 per cent) is an eloquent figure.

Table - 52

Discouraging factors about operation and experiences of physical well-being later

Ex peri- ences before	Factors	Physical well-being				
		Impro- ved	As be- fore	Worse	Much worse	Total
41	1. Harm to health	7 (14.28%)	23 (46.93%)	17 (34.69%)	2 (4.08%)	49 (41.52%)
4.3	2. Psycholo- gical effects	1 (20%)	3 (60%)	1 (20%)	0	5 (4.23%)
2.3	3. Sexual pro- blems	1 (25%)	1 (25%)	2 (50%)	0	4 (3.38%)
1.3	4. Wrath of God	0	1 (100%)	0	0	1 (0.84%)
1.69	5. Disturb marriage	0	1 (50%)	1 (50%)	0	2 (1.69%)
51	6. Present ill- nesses	4 (7.01%)	31 (26.27%)	21 (36.84%)	1 (1.75%)	57 (48.31%)
		13 (11.02%)	60 (50.85%)	42 (35.59%)	3 (2.54%)	118

Out of a total of 118 women, 49 with normal health entertained fears regarding adverse health effects. There were 57 women who had already been suffering from ill- nesses such as oedema, obesity, giddiness, hook-worm in- fection, uterine swelling, general weakness etc., who opted for operation fearing adverse effects upon health. While more than half of them 31 (54.39 per cent) did not experience any change, a sizable number, 22 (38.6 per cent) complained of deterioration in health.

Medical check-up of women and treatment of complaints prior to sterilisation are called for to guarantee adequate health to the acceptor before operation. This would prevent women falling ill too easily after operation. Also it would serve as a precaution toward off insinuations against sterilisation. Sterilisation may not be responsible for worsened ill-health of the acceptor. Yet, it is often found that to sterilisation is attributed all ailments after operation.

SEXUAL LIFE OF COUPLES

As sexual satisfaction is important constituent of marital happiness, a continuing deprivation of sexual pleasure can gradually erode relationship between spouses. Difficulty to enjoy sex can be experienced by either spouses. Emotional problems, inability to relax because of anxiety, fear of pregnancy, complaint about excess sexual desire or indifference by spouse etc. are likely to develop disgust for sex. Dissatisfaction with intramarital sex can lead to extramarital relations which can eventually break up marriage.

Relation between marital happiness and sexual satisfaction has been brought out in an American study of 100,000 women.[14] The study revealed that women (53 per

[14] Dominian, J., "Second Phase of Marriage", British Medical Journal, 2, 1979, pp.720-722.

cent) who reported of poor sex relations were found unhappy in marriage and those who described the sexual side of marriage as good or very good (92 per cent) were found to be happily married couples.

Although there were only few women who decided in favour of sterilisation, with hopes of improving their relations with husband, a sizable number of women accepted sterilisation in order to prevent repeated pregnancies which they were anxious to avoid. To this group the proposition to get sterilised was welcome because of the opportunity it offered them to prevent conception. The women's experiences after operation regarding their freedom from fear of unwanted conception were explored to assess whether sexual life of the couple has improved after sterilisation.

Table - 53

Initial expectations and sex experiences later

Expectations	Freedom from pregnancy assured in sex life				
	Both agree	Both boopo se	Husband oppose	Wife oppose	Total
1	2	3	4	5	6
a) Prevent pregnancy	25	0	1	0	26 (22.03%)
b) Peace at home	1	0	0	0	1 (0.85%)
c) Husband-wife relation	1	0	0	0	1 (0.85%)

1	2	3	4	5	6
d) Financial	- 67	0	0	0	67(56.78%)
e) Care to children	4	0	0	0	4(3.39%)
f) Mother's health	12	0	1	0	13(11.02%)
g) Child's health	1	0	0	0	1(0.85%)
h) Better education to children	-	-	-	-	- -
i) Stability to man	-	-	-	-	- -
j) Accommodation easier	-	-	-	-	- -
k) Others	5	-	-	-	5(4.24%)
	116	0	2	0	118

It was observed that all the 118 women except 2 said that the operation has provided them the ability to enjoy sex better as they had no fear of pregnancy. "A gradual decrease in frequency and quality of sexual intercourse may simply reflect a relationship deteriorating in other ways".[15] Women's responses do indicate better sexual enjoyment post-operatively.

However, when they were asked to respond whether their sex life was happier after operation, in the case of 19 couples they did not agree about improvement in sex life. The finding shows that even after fear of pregnancy

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[15] Dominian, J., "Second Phase of Marriage", British Medical Journal, 2, 1979, pp.720-722.

being absent sex life of 19 couples had not improved with sterilisation.

Table - 54

Expectations and quality of sex life

Expectations	Sex life has improved				
	Both agree	Both oppose	Wife oppose	Husband oppose	Total
a) Prevent pregnancy	22 (84.6)	3	0	1	26
b) Peace at home	0	0	1	0	1
c) Husband wife relations	1 (100)	0	0	0	1
d) Financial	56 (83.58)	9	2	0	67
e) Care to children	4 (100)	0	0	0	4
f) Mother's health	11 (84.62)	1	0	1	13
g) Child's health	1 (100)	0	0	0	1
h) Child's education	-	-	-	-	-
i) Stability to M.L.	-	-	-	-	-
j) Accom. easier	-	-	-	-	-
k) Others	4 (80)	1	0	0	5
	99 (83.9%)	14 (11.86%)	3 (2.54%)	2 (1.69%)	118

Although 116 out of 118 women said that sterilisation has taken away fears of conception from sex life, there were only 99 couples (83.9 per cent) who enjoyed

happier sex life after the operation. Freedom from pregnancy is only one factor that contributes to satisfying conjugal relations. There are other factors in husband-wife relationship that sets the tone of their conjugal life. Sterilisation as such need not therefore bring about improvement in the interpersonal relation of the couples.

The findings are encouraging and speak in favour of sterilisation which for majority of couples have brought happier sex life although they did not have such expectations from operation initially. Even the women who entertained various kinds of fears about operation testified to improved sex life after sterilisation.

Table - 55

Fears of operation and quality of sex life later

Factors	Quality of sex life later				
	Both agree %	Both oppose	Husb. oppose	Wife oppose	Total
1. Harm to health	44(89.8)	3	1	1	49
2. Psych. effects	3(60)	2	0	0	5
3. Sexual effects	2(50)	1	0	1	4
4. Wrath of God	1(100)	0	0	0	1
5. Disrupt marriage	2(100)	0	0	0	2
6. Others	47(82.46)	8	1	1	57
	99(83.9)	14(11.86)	2(1.69)	3(2.54)	118

Out of 49 women who feared harm to health, 44 (89.8 per cent) had experienced improved sex relations. More enjoyable sex life had been the result in sizable proportions of women who had entertained initial fears of adverse effects of sterilisation such as psychological disturbances, sexual conflicts, marital infidelity, God's chastisement etc.

Effort was made to probe further into the sexual life of the coupbes realizing fully well the dependability of such information in assessing the quality of relationship between the couples.

The women were asked to comment whether they experienced difficulties in sex life. Out of 300 women, 24 had admitted of dissatisfaction. Among these 24, there were 16 who felt that the husband was overly demanding and the women had to oblige to avoid displeasure. They felt that the husbands had no concern for their mood, choice or physical well-being. As a result they tried to satisfy the husbands even if they felt reluctance for sexual relations.

However the case of 276 women out of 300 who reported of happy sexual relations with spouses speak in favour of the healthy family relationships women had had.

Further probing was done into the quality of respondent's sex life to verify their general statements, women were made to rate the desire of husband and wife for sex.

Table - 56

Desire of husband and wife for sex

	Very much interested	Moderate interest	Not much interested	Not at all interested	Dislikes
Wife	59(19.67)	203(67.67)	23(7.7)	2(0.67)	13(9.33) = 300
Husband	143(47.67)	134(44.67)	22(7.33)	0	1(.33) = 300

The table does not suggest considerable differences with findings of other studies. While women complain about their partner as being selfish, inconsiderate, cruel etc., men's most common complaint is about the women being 'cold'.[16] The commonest complaint of women according to Dominian is too frequent demand for sex on the part of the husband without consideration of the wife's feelings.

According to the respondent s, 59 were intensely interested in sex while there were reportedly 143 husbands

16 Dominian, J., "Second Phase of Marriage", British Medical Journal, 2, 1979, pp.720-722.

who belonged to this category. Incompatability experienced by these couples need not have developed anxiety and tension as most of the women who had demanding husbands satisfied their partners by obliging "to avoid displeasure".

There were 203 women (67.67 per cent) who claimed to be moderately interested in sex whereas there were only 134 men (44.67%) with same degree of desire. For many women of this category adjustment with husbands would have required repression of sexual desires. However, if the total number of intensely and moderately interested women (277 - 92.34 per cent) are considered, more or less equal number of husbands (262 numbers - 87.34 per cent) are found to belong to this group. It can reasonably be assumed that these couples would have been able to adjust themselves sexually without serious dissatisfaction.

There were more or less equal number of husbands and wives, 23 and 22 who were not much interested. While only 2 women expressed lack of interest there were 13 who had dislike for sex. There was only one husband who according to the wife disliked sex totally. The total of 15 women who evidently did not like sex may have been unable to enjoy intramarital sex. It may be inferred that the inability of these women to satisfy sexual demands

would have led to marital unhappiness. Even if presence of marital discord and conflicts in the case of these women is not indicated by the available data, it can safely be concluded that the absence of healthy sex life by couple would have handicapped happiness of their marital life.

In a recent study[17] done on conjugal relationships the difference in sex drives between husband and wife was pointed out as an important determinant of conjugal happiness. In the sample studied there were not considerable differences between the sex drives of spouses and this was accounted for their happy sex lives.

As further verification of information given by women of their sex experiences, women were asked to verify the areas where differences of opinion mostly occured in their married life. This question was put particularly to find out whether sexual matters contributed adequate ground for unhealthy relations between spouses. In the case of 37 couples women felt that quarrels arose from differences on sex matters. These 37 women may be those who were not compatible with husbands sexually causing frustration and anxiety in inter-spouse relationships.

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[17] Jain Sunitha and Dave Parul, "A Study of Conjugal relationships"; The Journal of Family Welfare, Vol. XXVIII (4), June, 1982.

At the close of the final interview women were asked to state whether according to their experiences sterilisation would lead to marital infidelity. Significantly large majority of them 114 out of 118 - 96.61 per cent denied such outcome, directly suggestive of the impact which sterilisation had in the personal lives of couples. Even the 37 sexually dissatisfied women therefore do not evidently think that sterilisation will have such consequences. The inference may be that the dissatisfaction of these 37 women would have sprung from other factors and not sterilisation.

Even if the cases of 37 women are rejected as evidence for unhealthy impact of sterilisation on sexual life of couples, the benefits which the rest of the 263 women (87.67 per cent) claim to have obtained speak in favour of the method.

III. MENTAL DISPOSITION

Although sexual deprivations in married life reflect deteriorating interspouse relationships there are other psychological and emotional factors that eventually cause sexual problems and result in marital unhappiness.

No attempt to identify the mental or emotional characteristics of women were made. However, women's initial feelings about sterilisation; discouraging features

of the procedure and their future expectations from it were analysed. Permanent termination of pregnancy by the surgical method is not a simple decision to make as far as couples are concerned. Serious prior thought and consideration are obvious arousing fears, conflicts, prejudices based on rumour and gossip, feelings of insecurity and so on. Therefore initial feelings, fears and hopes of women about sterilisation were probed in detail and they were compared with post operative experiences. This comparitive analysis it was hoped would bring to surface evidence of inter-spouse relationships subsequent to sterilisation.

1. INITIAL FEELINGS:

Women were asked on the day prior to operation what their feelings were towards it. Out of 300 women, while there were (see table-27) 43.33 per cent who were unconcerned and free of anxiety, 37.67 per cent who were frightened. There were 17-67 per cent who were ready to undergo the operation with courage when 1.33 per cent were gladly welcoming it. It was remarkable that no women said that they were shy about getting sterilised in spite of careful and tactful querry. The effectiveness of mass media efforts and other educational programmes in removing social prejudices against family planning is proven by the data. In a traditional society where sex and related

subjects are taboo it is p6ignant how women have come to accept sterilisation without any sense of embarassement or shame.

Apart from 37.67 per cent of women who were afraid of the surgical procedure the remaining 62.33 per cent were not disturbed at all about the operation the degree of readiness ranging from indifferent to enthusiastic.

The initial feelings of women were compared with their responses regarding post-operative experiences of mental well-being after six months. This comparison could be made of only 118 women who turned up for the second follow up interview and gave information.

Table - 57

Comparison of Pre and Post-operative feelings

Feelings before	Feelings after				
	Disturbed mentally		For God's punishment		Total
	Yes	No	Yes	No %	
1. Afraid	9(20%)	36(80%)	4(9.76%)	41(91.11)	45
2. Unconcerned	5(11.11%)	40(88.89%)	3(6.67%)	42(93.33)	45
3. Welcome	1(100%)	0	0	1(100)	1
4. Courageous	6(28.57%)	21(77.78)	1(3.70)	26(96.3)	27
5. Shy	0	0	0	0	0
Total	21(17.8)	97(82.2)	8(6.8)	110(93.22)	118
	118		118		

Out of 118 women who gave information on their post operative experiences regarding mental well-being there were 45 (38.14 per cent) who were initially afraid of the operation. Analysis of post-operative feelings disclosed that 36 out of these 45 women (80 per cent) did not any more feel disturbed about it. There were only 9 women (20 per cent) who owned mental conflicts as a result of the procedure. When these women were questioned whether they feared God's punishment befalling them 91.11 per cent affirmed that they did not. A very small proportion of 9.76 per cent alone were worried that they had offended God by undergoing sterilisation. The finding is significant as it is often said that religious beliefs present barriers in the acceptance of family planning by couples in India. The inference is that either the religious barriers against family planning are steadily disappearing or that those who accept family planning are irreligious, with the truly religious persons keeping away.

Of the 45 women (38.14 per cent) who were indifferent towards sterilisation, 88.89 per cent did not entertain any feelings of anxiety while 11.11 per cent expressed anxiety. However, significantly larger proportion had gone through the operation without any psychological trauma.

As for fear of God's chastisement 93.33 per cent of the 45 who felt indifferent were the least concerned about it. There were just 3 women (6.67 per cent) who were worried about the same.

The only one woman (0.85 per cent) who welcomed the operation was mentally disturbed after the operation. However fear of God's redress was not the reason for anxiety. Having just two children (one boy and one girl) the mother was disturbed over the possible loss of children.

There were 27 women who had accepted tubal ligation with courage. Significantly large proportion of these women (28.57 per cent) reported of mental conflict. However, for these women also, fear of God's reparation was shared by only 3.70 per cent of women. On the contrary 77.78 per cent of women were mentally satisfied and 96.3 per cent did not entertain fears about God's castigation.

A general glance of table-57 reveals that the initial fears which women harboured before tubectomy have been shed by some women giving place to a sense of relief and achievement. While there were 45 women (38.14 per cent) who were initially anxious and fearful of the operation, 29 alone were found to be disturbed mentally six months after sterilisation. The finding corresponds with other studies that have reported of similar observations. Coopers

study of sterilised women in England claims against any evidence of post-operative psychiatric disturbances attributable to sterilisation. According to Cooper's study psychiatric disorder after sterilisation was significantly more common in patients whose psychological and social functioning had been impaired before the operation. Six months post-operatively Cooper found improvement in terms of psychiatric health, returning to pre-operative figures eighteen months after.

The general mental state of tubectomy acceptors was not assessed in the present study unlike Cooper who collected such information six months prior to sterilisation. In the present study data was collected from women acceptors one day before the operation. The information received may not indicate the general mental well-being of respondents. Feelings toward the operation at the particular time of interview were alone collected and subjected to analysis.

Feelings of guilt and regret:

As far as feelings towards sterilisation is concerned there would be temporary fears which are normal with any unknown experience with possibilities of desirable and undesirable consequences. There can also be lasting fears which are difficult to get rid of. While the information collected pre-operatively on fears toward sterilisation,

might have been transient, which fade after the experience has been lived through, the lasting fears of respondents such as feelings of guilt and regret were explored six months post-operatively.

Table - 58

Initial feelings to operation and feelings of guilt after operation

Initial feelings	Feels guilty occasionally after operation				
	Husband & wife	Husband only	Wife only	No guilt feelings	Total
a) Afraid	4 (8.89%)	4 (8.89%)	0	37 (82.22%)	45 (38.14%)
b) Indifferent	6 (13.33%)	2 (4.44%)	2 (4.44%)	35 (77.78%)	45 (38.14%)
c) Courageous	5 (18.51%)	0	0	22 (81.49%)	27 (22.89%)
d) Welcomes	0	0	0	1 (100)	1 (0.85%)
	15 (12.71)	6 (5.08)	2 (1.69)	95 (80.51)	118

Initial feelings of women toward tubal ligation were varied between fearful, indifferent and courageous. Initial feelings did not seem to have much relation with later feelings of guilt.

While many women with initial fears seem to have got rid of them after operation, feelings of guilt were found to develop more among those that faced the operation

indifferently and with courage. Out of 45 women who were initially fearful, all except 8 got divested of all fears proving them to be temporal. However, in the case of 22 women who faced the operation fearlessly with express courage, 5 had developed mental conflicts. In all the 5 cases both husband and wife were sharing these guilt feelings.

While the need to look into the complaints of those who experience mental conflicts and provide counselling services emerges from the finding, the desirability of identifying such cases earlier in order to prepare them mentally or prevent them from undergoing sterilisation before assuring the acceptability of the method to the couple psychologically, ethically, spiritually and socially, is brought out. The relief and peace of mind which the vast majority of acceptors (80.51 per cent) have come to experience as a result of the procedure may be justification enough for persuading women for sterilisation. However, unhappy acceptors harbouring feelings of guilt and dissatisfaction can do harm by gossip against the particular procedure or even against family planning as a concept. It is also true that often happy acceptors do not give publicity to their experiences in order to motivate others as the present study itself shows.[18] The discontented

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[18] Motivational factors - Chapter IV, experience in motivating others.

ones are more likely to speak against the procedure or family planning in general which may form the basis for false propaganda against the Family Planning Programme itself.

The finding clearly shows the importance of helping acceptors make their decisions in favour of sterilisation out of free as well as conscious choice. From the point of view of family welfare goals the programme can prove detrimental if the method brings about dissatisfaction and mental conflict in couples. Any suspicion in either of the spouses about the acceptability of the method at any time after the operation can destroy their happiness and welfare of family life.

Table - 59

Feelings of regret of tubectomy acceptors

If given chance again	No	Percentage
Will opt again for sterilisation	114	96.61
Will not choose	3	2.54
No answer	1	0.85

In response to direct questioning 114 out of 118 women said that they would positively choose sterilisation if they were given another opportunity for choice of a method. Most likely these are women who are satisfied with

the method. However, it cannot be presumed that the husbands of all these 114 women would have the same attitude. If method acceptability is lacking in the husband, it can affect the inter-personal relationship between spouses and consequently, the family's welfare.

The sense of relief and satisfaction which sterilisation has brought to 114 out of the 118 women interviewed post-operatively is evident. If women who failed to turn up for the six month post-operative interview are also considered as happy acceptors, the benefits which permanent termination of pregnancy brings to women is clearly manifested.

In Cooper's study[19] while 10.9 per cent were not satisfied, the percentage of unhappy acceptors in the present study is only 2.54 per cent. It is to be observed here that 10.9 per cent of Cooper's dissatisfied acceptors were according to data collected at 18 months post-operatively. The six month after follow-up data gave a smaller figure of 7.9 per cent.

2. DISCOURAGING FACTORS:

In addition to information on general feelings of women initially a day prior to operation, further probing to get into their mental attitude was done by

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[19] Cooper, et.al., *Ibid.*

questioning about the discouraging factors about sterilisation. These factors were related with later feelings of guilt post-operatively.

Table - 60

Initial discouraging factors and factors of guilt after sterilisation

Discouraging factors	Feel guilty: Yes				No	Total
	Husband & wife	Wife only	Husband only	Total		
1. Harm to health	7	3	1	11	38	49 (41.53%)
2. Mental conflicts	1	0	0	1	4	05 (4.23%)
3. Sexual problems	0	1	0	1	3	04 (3.39%)
4. God's wrath	0	0	0	0	1	01 (0.85%)
5. Disrupt marriage	0	0	0	0	2	02 (1.69%)
6. Loss of children	4	1	1	6	31	37 (31.36%)
7. Desire for another child	2	0	2	4	9	13 (11.02%)
8. Others	0	1	1	2	5	7 (5.93%)
	14	7	4	25 (21.19)	93 (78.81)	118

The major apprehensions of women acceptors of sterilisation brought to surface and the data obtained are

presented in table- 60. Injury to health of the mother and fear of losing children were found to be the most common discouraging element in getting sterilised. Although sterilisation is not directly responsible for child mortality the fear of the women as expressed by them was, 'the inability to conceive again'.

The disadvantage of sterilisation is recognized as its irreversibility. This realisation has led to intensive researches of the method by medical men in perfecting tubectomy by making it easily reversible.[20]

Desire for another child by 13 women, fear of mental conflicts by 4, disturbance to sex life by 3, disruption of marriage by 2 and fear of God's wrath falling upon the family, were the other discouraging features of sterilisation.

Analysis of post-experiences of respondents proved that their apprehensions were unfounded in majority of cases. There were 49 women out of 118 who accepted sterilisation with fears of after effects on health. Among these 49 women, 38 (77.6 per cent) felt relaxed and happy post-operatively without experiences of ill health. Out of a total of 37 women who were fearful of child loss there were 27 who did not entertain such anxieties later. It is

[20] Pouru Bhiwandiwala, People, Vol.8, No.4, 1981, pp.14-16.

difficult to guess how they could free themselves from the anxiety. It is possible, that the experience of caring for children with greater determination and interest may have developed confidence in mothers about the possibilities of assuring better health of children.

Desire for another child was expressed by 13 women (11.02 per cent). Data on whether they wanted a male or a female child was not obtained. However this was mostly the consideration of mothers with 2 or 3 children. The inability to conceive in future would have been there in the case of these women who may also have been aware of the possibilities of losing children. The post-operative experiences of these mothers show that majority of them (9 out of 13) did not regret the operation. However, there were 4 women who were feeling guilty in undergoing tubal ligation, with possibilities of pregnancy denied completely.

A much smaller proportion of women alone, 11 (22.45 per cent), continued in anxious state of mind regarding health effects of operation. Of the 5 women (4.24 per cent) who feared psychological problems, the experience of 4 (80 per cent) were contrary to expectations. Only 1 (20 per cent) woman was anxious concerning her mental health later. While fear of sexual problems disturbed 4 women before operation only in the case of 1 woman, the

fear was found to subsist. In the case of one woman who feared God's punishment and two others who were anxious about the effect of operation on fidelity between spouses, none seemed to be disturbed by such considerations after operation.

The analysis of discouraging factors substantiate the observations which emerged from the analysis of initial fears. Acceptors of tubal ligation seem to have benefitted psychologically by the procedure. The initial prejudices held against sterilisation have been proved baseless in the case of vast majority of acceptors.

3. EXPECTATIONS:

Initial expectations from sterilisation were related with later feelings of guilt. The responses were revealing.

Table - 61

Showing initial expectations from operation and later feelings of guilt

Expectations	Both No	Both Yes	Wife Yes	Husband Yes	Total
1	2	3	4	5	6
a) Prevent pregnancy	23 (88.46)	2 (7.69)	1 (3.85)	0	26 (22.03)
b) Peace at home	0	1 (100)	0	0	1 (0.85)
c) Husband wife relations	1 (100)	0	0	0	1 (0.85)

1	2	3	4	5	6
d) Financial gains	63 (94.03)	1 (1.49)	3 (4.48)	0	67 (56.78)
e) Care to children	4 (100)	0	0	0	4 (3.39)
f) Mother's health	12 (92.31)	0	1 (7.68)	0	13 (11.02)
g) Child's health	1 (100)	0	0	0	1 (0.85)
h) Others	5 (100)	0	0	0	5 (4.24)
	109	4	5	0	118

Out of 26 women who got sterilised with the main objective of preventing future pregnancy, 23 (88.46 per cent) did not have any regrets. There were 3 cases of families where either both or one of the spouses regretted for terminating pregnancy permanently. These are probably the women who did not want to conceive immediately, but at the same time would have gone for another child later, if they could do so. However, without knowledge or accessibility to methods that allow spacing, these women could not but decide in favour of sterilisation which would assure them against an immediate unwanted pregnancy.

In the case of one woman who accepted tubal ligation with hopes of bringig peace and harmony in the home,

post-operative experiences were not encouraging. Both husband and wife harboured feelings of guilt perhaps adding to an existing marital problem. Another woman who underwent tubectomy with hopes of bettering relations with husband expressed absence of guilt feelings. This need not necessarily indicate improvement of relations. The woman may still be hopeful of later beneficial changes.

The decision to get sterilised on the basis of financial considerations has not proved to be disappointing to vast majority of women post-operatively. It is difficult to say, if the sterilised women have experienced direct financial gains as a result of sterilisation within six months. A longer experience over a period of years might be required to affirm the economic benefits of sterilisation to women acceptors. However, in the absence of any guilt, the hopes of financial benefits which may be experienced eventually by family members could add to the general welfare of the family.

There were 4 women who underwent sterilisation expecting to give better care to children. All these 4 women were found to be devoid of any sense of remorse or guilt subsequently.

Out of 13 women (11.01%) who got sterilised expecting gains in their own health, one alone expressed disappointment. The other 12 without complaints manifests

satisfaction of expectations. It may be pointed out here that 45 out of 118 women were initially apprehensive of the physical ill-effects of sterilisation. Post-operative experience of six months would have relieved many of them from anticipated undesirable effects on health.

One woman who expected improvement in child's health did not reveal any frustration for having got sterilised. There were 5 women who could not specify what their expectations were from permanent pregnancy termination. However none of them had any regrets, which affirms that the welfare of their families have not deteriorated even if no improvements were noticed.

Analysis of expectations before sterilisation and later experience speak in favour of the method in terms of gains in the mental well-being of husband and wife which would definitely enhance the family's total welfare.

IV. SELF ASSESSMENT BY RESPONDENTS

Inquiry into the physical and emotional well-being of women acceptors of sterilisation pre and post operatively and comparison between the two brought to light the presence of satisfying inter-spouse relations in vast majority of cases. In order to verify the findings reached through indirect querry into related factors of relationship, women were asked to make a self assessment of relationship with husband basing on their personal experiences.

1. QUALITY OF RELATIONSHIP:

Inquiry into the women's assessment of their relationships with husband revealed that a good majority of the families of women studied enjoyed harmony at home.

Table - 62

Quality of relationship with husband

Details of relation-ship		Number of respondents	Percentage
Very cordial	..	88	29.33
Cordial	-	173	57.67
Occasional conflicts	-	26	8.67
Frequent quarrels	-	4	1.33
Always discord	-	9	3.00
		300	100.00

While 29.33 per cent of women had very cordial relationships with no complaints whatsoever 57.67 per c were satisfied with their relationship although they classified it as just 'cordial' and not 'very cordial'. The occasional conflicts which 8.67 per cent reported, could not also be considered as pathological as the women were not disturbed over it. They considered it as natural and nothing to be taken seriously. While 4 women (1.33 per cent) complained of frequent quarrels, there were 9 (3 per cent) who were unhappy about their constant bicker-ings and disharmony.

The data suggests that the decision for sterilisation was a mutually agreed and accepted one in the vast majority of the cases (87 per cent). In the case of families of 13 women who reported of frequent quarrels and constant discord the decision for sterilisation have not probably been a joint decision.

Studies show that women acceptors of sterilisation come from families where high level of communication between husband and wife are present.[21] Communication between couples indicate greater interaction which is a sign of healthier relations.

2. PROGRESS OVER YEARS:

Women were asked to comment on the progress of marital relations from the time of marriage. The question was aimed to elicit a comparative evaluation between relationship before and after tubal ligation as women had experienced it.

Table - 63

Assessment of marital relations after marriage

Quality of relations		No. of respondents	Percentage
Steadily improved	-	121	40.33
Deteriorated	-	20	6.67
Not much change	-	150	50.00
Erratic	-	7	2.33
No answer	-	2	0.67

[21] Government of India, Findings of Research Studies, 1979.

Relationships between spouses in majority of cases were either improving over the years (40.33 per cent) or remaining steady without much change from the beginning of their married life. It can therefore be logically inferrêd that the decision to undergo sterilisation was not motivated by desire to end family discord, but for other reasons. However, lack of prospects of betterment of conjugal relations need not rule out the possibilities of later improvement.

The table reveals that 40.33 per cent of the women felt proud about their cordial relations which improved with years. Half of the women studied did not experience any major change and were equally satisfied with their marital life. There were 7 women who reported of ups and downs in their relations with excess of cordiality and discord alternating. Even those women were not unhappy or desperate about the situation. However, there were 20 women who complained about deterioration in relationships over the years. These women had expressed longing for betterment of relationships although they were not hopeful. Some of them at least had hopes that sterilisation would improve the situation.

Out of the 20 women who complained of steady deterioration in relations since marriage, 3 were desperate about their worsened relations which they did not expect

to improve. Among these three, one woman complained that the husband was away and did not care for her. Another woman's husband was remarried. The third woman had an alcoholic husband who lived a reckless life of infidelity which she could not accept.

3. SEXUAL RELATIONS:

Women were asked to respond specifically about their sexual relations during the six months of post-operative married life after pregnancy has been permanently stopped.

Table - 64

Ability to enjoy sex by couples

		Ability to enjoy sex has enhanced	
		Yes	No
Both spouses	-	99 (66%)	14 (11.86%)
Wife alone	-	2 (1.69%)	3 (2.54%)
Husband alone	-	3 (2.54%)	2 (1.69%)

Significantly, experience of sex life of 99 women out of 118 (66 per cent) gives evidence for improvement of sex life after sterilisation. These women reported that they could enjoy sex better post-operatively in comparison with their pre-operative experiences.

Experiences of 14 women (11.86%) were different. They were of opinion that there was deterioration in their sexual relationships. In the case of 5 couples or 3 wives and 2 husbands, they did not agree that happier sex life had resulted from permanent termination of pregnancy. The experiences of 19 women (16.10%) therefore were not in favour of sterilisation as a method which would enhance marital relations.

The evidence given by 66 per cent of women affirming their gains in sexual relationships speaks in support of sterilisation as a method that can enhance interspouse relations of many couples, although it may not be beneficial to all couples.

> "Sexual difficulties are commonly associated with marital pathology. . . . . . A couple experiencing conflict, hostility and indifference may have a poor sex life, but their relationship is the primary problem".[22]

If poor sex life reveals poor marital relations, healthy sex life would be a reflection of healthy marital relations. The ability of 66 per cent women to enjoy sex better post-operatively, in comparison with their experiences before testifies to the couple's freedom from conflicts, anxiety, hostility, depression, etc. the presence of which would have reduced their sexual happiness.

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[22] Dominian, J., "Management Sexual Counselling", British Medical Journal, 2, 1979, pp.1053-1054.

Absence of tensions and conflicts point to satisfying interspouse relations which made possible for the couples happier sex experiences.

Finding suggests that proper screening of couples is called for so that couples who can benefit by the procedure are alone permitted to accept the method while keeping the others away. The method being irriversible, wrong choice made by couples can bring them misery and unhappiness defeating the family welfare goals of sterilisation.

4. RELATIONSHIPS IN GENERAL:

Women made a general assessment of their relations with spouses.

Table - 65

Ability to get along with husband

Opinion		Number	Percentage
No difficulty	-	111	94.07
Occasional difficulty	-	6	5.08
Not possible	-	1	0.85

Out of 118 women, 111 (94.07%) did not experience difficulties. There were 6 (5.08 %) who had occasional difficulties and one who complained of constant disharmony. This one woman had opted for sterilisation hoping that her health would improve and problem of disharmony would be

solved. However, her experiences were contrary to expectations. Neither happened. It is difficult to say whether poor health was alone responsible for poor marital relations before sterilisation. However, health conditions not improving, relations with husband could not change for the better as expected by wife.

Among the other 6 women 4 underwent the operation to prevent pregnancy and 2 for financial benefits. Reasons for their dissatisfaction were not obtained. But they disclosed that relationships had not improved by sterilisation. Most likely these six dissatisfied women are those who had unhappy marital relations pre-operatively. Sterilisation could not improve the situation.

5. FUTURE PROSPECTS:

Women's expectations for future regarding relations with spouses were explored. The purpose of obtaining this information was to obtain an insight into the dissatisfactions about present relationship which they would like to be changed in future.

Table - 66

Desires of women for future

	Number	Percentage
1. If possible greater unity -	22	18.64
2. Wish for less unpleasantness	1	0.85
3. Greater harmony -	95	80.51
Total -	118	

Women who wished for greater harmony would most likely be those that had already been enjoying a reasonable level of marital happiness. The women who desired greater unity, 22 in number (18.64%) may be the women that were disturbed by occasional conflicts from which they wanted deliverence. The single woman who wished for less unpleasantness may have been in constant disharmony with husband. Her wish is only for a relief from unbearable misery.

The most cogent observation is the harmonious relationships between spouses present in 80 per cent of families. A smaller proportion of 18 per cent got along but were not happy and looked forward to greater unity between spouses. These couples cannot be considered as living in constant marital discord.

CONCLUSION

The major finding that has emerged from the analysis is that there is evidence of positive gains in inter-spouse relations after female sterilisation. Ability for happier sex relations post-operatively, devoid of risk of pregnancy was recognized as a contributing factor to the development.

Bodily health of a sizable number of women acceptors of sterilisation seems to have deteriorated after surgery. More than 60 per cent of acceptors however did not experience adverse effects on health. Most women who reported of deterioration in health surprisingly had no regrets for having got themselves sterilised. The hopes of eventual regaining of lost health gave them the psychological energy to go through the crisis, whether real or imaginary.

The analysis of the mental health of women acceptors of sterilisation reveals absence of grave psychological morbidity post operatively. Fears about sterilisation harboured by women were proved to be false in the experience of majority of women, bringing greater satisfaction and happiness to married life.

Self assessment made by women acceptors throw light into their personal experiences of gains in relationship with spouses post-operatively.

The findings correspond with observations made by other researchers. Cooper could not find any evidence for post-operative psychiatric disturbance as a result of sterilisation. Sexual relations after sterilisation were reported as more enjoyable by over half of Cooper's patients. Regret for undergoing sterilisation expressed by only few acceptors in the sample of the present study

also corresponded with Cooper's findings. Cooper also established that psychiatric disorder after sterilisation was significantly more common in patients whose psychological and social functioning had been impaired before the operation. The present study also gives evidence to the fact that sterilisation cannot solve problems of marital discord. Unhappy relations between spouses post-operatively point to the presence of inter-spouse conflict before sterilisation.

If the fundamental family relationships are good, family troubles can be dealt with by a united front and the crisis leaves the family stronger than before. The hopes of women to go through the post-operative anxieties and ill health without endangering future happiness is evidence for the positive relationships that were already present in the families of women studied.

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V

PARENT-CHILD RELATIONS

Husband-wife relationship - Environment in the home: money, food, house, education, comforts, clothes, toys, good conduct, discipline, health - Management of the household; efficiency; general ability - Management of children: discipline; feelings to children - Children's feelings for parents - Self assessment by women.

C H A P T E R - V

PARENT-CHILD RELATIONS

The bond between the husband and the wife is the basis for all family relationships. Parents who are secure in each other's affection and loyalty alone can bestow to the other members security and love.

The second most important relationship in a family is that between the parents and children. There can be no substitute for parental love. Taking upon themselves the responsibilities of parent-hood, the man and the woman, united by marriage, dedicate themselves to bring up a family which would serve the best interests of children.

The child needs a home which protects him. He needs to feel sure of his parents. The child also needs a stable environment. Disharmony in marital relations, family quarrels, ill-health, financial insecurity, poor living conditions, unhealthy neighbourhood etc. can upset the serenity of family life disturbing the growth of children physically and emotionally.

Family planning is a family welfare measure, with goals of assuring health and happiness of all members in it. A happy and well-adjusted couple only will be able to discharge their responsibilities as parents to children and manage the household. Benefits which family planning bring to parents in terms of better emotional and bodily health, will make them more competent to provide the security, love, attention and care which children require. Child welfare goals of family planning have to be understood in this perspective.

The present study was to assess the impact of sterilisation on family relationships. Although husband-wife relationships are strategically important in family's well-being, the welfare of children can be conceived as the primary goal. Society is eager about the health of children because its future well-being depends on them. This can be achieved through parents that live happy family lives. Family planning helps parents to achieve greater adjustment and satisfaction from married life by restricting the number and timing of births. Although it is difficult to affirm what is the ideal size of a family, the best families are those that are well-spaced and well-planned. If children arrive when parents are not prepared to receive and care for them injustice is done to children; parents feel guilty about their predicament of being helpless managers of the family they are responsible for.

The present chapter attempts an analysis of how children were beneficiaries by sterilisation of mothers, in terms of obtaining greater love, care and attention from parents. Information which mothers could provide about changes in their care and attitude to children, it was hoped, would give insight into changes of relationships that have accrued between parents and children. The quality of such changed relationships would indicate the losses or gains which sterilisation has brought about for children.

The analysis of parent-child relations is attempted from five different angles:

1. Relationships between the husband and the wife, being the most crucial factor in setting the tone for parent-child relations, the change in inter-spouse relations that have occured as a consequence of sterilisation is examined initially.

2. The environment in the home - physical, emotional and economic - is important for the healthy growth and development of the child. The quality of food, clothes, housing facilities, play things, discipline, education, etc. which children receive are important determinants in assessing children's prospects for healthy development. Therefore changes in parent's ability to provide care and adequate facilities to children subsequent to sterilisation are examined.

3. Mother's efficiency to manage the household is an indirect indicator of her ability to manage children. Changes in the area of household management after

sterilisation are appraised in order to perceive possible changes in care of children.

4. Mother's satisfaction about child care before sterilisation is compared with post-operative experiences. This is a self-appraisal by women themselves.

5. The final scrutiny is based on mother's evaluation of parent's relations with children post-operatively, contrasting it with pre-sterilisation experiences. Hopes of mothers for future are also examined.

I. HUSBAND-WIFE RELATIONSHIPS

Analysis of interspouse relations is given in Chapter IV. The findings point to the gains of parents in the area of relationships, subsequent to sterilisation of the mother.

Happy parents can alone give children what they want. If parents themselves are starved emotionally, physically and socially, it is difficult to expect them to meet children's needs adequately. When a mother attends to a child, the husband may feel neglected or resented. The daughter may seek her father rather than the mother. This preference may be resented by the mother. The children may feel neglected by parents who are in conflict and constantly bickering. These are problems which parents face in families, causing dissatisfaction, to themselves and children.

Despire all its failings the family remains the nucleus for the growing child. Therefore any measure to help parents to be happier and healthier can contribute to welfare of children.

Analysis of inter-spouse relations six months after sterilisation has shown that it has benefitted most couples in relieving them from fears of unwanted pregnancy thus paving the way for better adjustment between family members. Enhancement of sexual happiness meant freedom from tension and anxiety, healthy interaction between couples, more time for intimacy, and so on. These benefits will improve couples' ability to get along, cooperate in management of children and the household etc. Absence of prejudices against sterilisation as irreligious and unacceptable, injurious to marital fidelity and so on in majority of women acceptors is evidence for the benefits which women were sure of deriving from it. Post-experiences of sterilisation in most cases were convincing of the values of the method as against the fears they nurtured prior to acceptance.

If parents had benefitted emotionally owing to the mothers getting sterilised, parents will in turn be better able to meet the amotional needs of children. Freedom from emotional tensions will enable parents to give more time, care, attention and love to children which will help personality development of children.

Every gain in husband-wife relationship as a consequence of sterilisation can therefore be considered as contributing towards enhancement of parent-child relations.

II. ENVIRONMENT IN THE HOME

Home environment refers to the physical as well as the emotional. While children's need for parental love and emotional satisfaction is recognized, their need for comforts and bodily health cannot be ignored. A child who is exposed to frequent illnesses and deprivations will not grow normal, but will suffer lasting injuries to the personality.

Table - 67

Satisfaction of parents in giving children what they want before and after operation

Others	Satisfied		Not satisfied	
	Before	After	Before	After
a) Money	78(66.10)	76(64.41)	40(33.89)	42(35.59)
b) Food	83(70.33)	92(77.97)	35(29.66)	26(22.03)
c) House	101(85.59)	98(83.05)	17(14.41)	20(16.95)
d) Education	99(82.89)	97(82.20)	19(16.10)	21(17.79)
e) Comforts	56(47.46)	60(50.85)	62(52.54)	58(49.15)
f) Health	75(63.56)	87(73.72)	43(36.44)	31(26.27)
g) Discipline	114(96.61)	115(97.46)	4(3.39)	3(2.54)
h) Good conduct	115(97.46)	115(97.46)	3(2.54)	3(2.54)
i) Clothes	94(79.66)	98(83.05)	24(20.34)	20(16.95)
j) Toys	60(50.84)	51(43.22)	58(49.15)	67(56.78)

The purpose of the query was to estimate the degree of satisfaction the parents had about their ability to provide what they wanted to children. If parents were ambitious their desire would be to provide the maximum for their children. Inability to satisfy the recognized needs can develop tension among parents. On the other hand, if parents were not overly concerned and were satisfied with the minimum, they would not be disturbed about it.

MONEY: Parents were satisfied about their capacity to meet the money needs of children. Pre-operative experiences of couples were not materially varied from their post-operative experiences. While a majority of 66.10 per cent of parents were satisfied pre-operatively, a slightly lower percentage of 64.41 per cent only were satisfied post-operatively. The increase in number of non-satisfied parents may be due to their higher expectations from sterilisation. It is to be remembered that financial benefits formed the most powerful motive for women acceptors in the sample. In the absence of immediate gains economically, more parents were found to experience dissatisfaction.

It is important to forewarn women before tubectomy that the economic gains are a long range goal and not a proximate windfall. This would save parents from nourishing unrealistic hopes and ending up in frustration.

<u>FOOD:</u> Post-operatively, more women (77.97 per cent) claimed to the satisfied about their ability to provide adequate food to children. The proportion of satisfied parents preoperatively was only 70.33 per cent.

It is unlikely that parent's ability to buy more food for children has increased with sterilisation. However, the desire to give better food may have become more intense in the case of more parents post-operatively. As a result parents would have tried to feed children better with greater sense of responsibility arising from fear of losing them out of inadequate care.

Parents who felt pre-operatively that they were unable to meet the food needs of children adequately were proportionately more than those that had the same feelings post-operatively.

Children are the beneficiaries of parent's increased awareness to give better food to children. Resultant gains in health by children would add to the total welfare of all family members. A sick child can cause a lot of tension for all in the family. A healthy and happy child can alleviate parents of anxiety and tension thus helping to an environment of love, relaxation and contentment. Good food assures bodily health of children. Healthy children are happy children too. Therefore gains by children in obtaining better food and thereby

improving bodily health, indicate the possibilities of happier relations between parent and children.

The link between family planning and nutrition was established by the World Food and Nutrition Study[1] conducted by the U.S. National Academy of Sciences. The study recognized overcoming of malnutrition as a powerful instrument in lowering population growth rate. Adequate pre-natal nutrition and a viable family unit capable of sustaining the child would assure children's survival which would in turn influence parents' decisions in favour of limiting births. Undoubtedly parent's ability to provide better food to children would reduce mortality rate among children. The reduction of mortality would develop confidence in parents about child's chances for survival. Ultimately such confidence of parents will facilitate decisions in favour of accepting family limitation.

HOUSE: Change of housing conditions within six months after sterilisation would not have happened. The respondent's answer to the query whether housing conditions showed improvement after sterilisation, did not bring noteworthy data. Six months is too small a period for couples to bring about changes in living space in the home.

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1 IPPI, "Nutrition: a factor in family planning Acceptance" People, Vol.5, No.2, 1978.

However, a slightly bigger percentage of parents felt dissatisfaction about their inadequate housing post operatively when compared with pre-operative figures. Experience of dissatisfaction by larger proportion of parents indicate the awareness that has come to more parents of their inability to provide comfortable housing for children.

When the low economic condition of respondent's families are considered, it is quite unlikely that majority of parents had reasonably adequate houses. However, only a small percentage of parents were unhappy about their poor housing conditions, 17 and 20 per cent each pre and post operatively. The reason for dissatisfaction was their awareness about the need for proper housing when children would grow up.

The reason for satisfaction of a large proportion of parents regarding housing facilities may be their lack of awareness about the unfortunate psychological effects of crowded living in the home. Over-crowding in the home was found to be a factor causing delinquencing among children.[2]

It is to be remembered that initially when expectations of women from operation were scrutinised there

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[2] Bowley Agatha, Ibid.

were none who could see any benefits in terms of improved living conditions. Most of them were satisfied with the house they had. Evidently sterilisation had not brought notable changes in their attitude except in the case of a small proportion who had begun to feel dissatisfied about the houses they had.

EDUCATION: Initial query on women's expectations from operation in terms of children's education revealed that no women looked forward to any benefits accruing from it. None of them were aware of the possibilities of educating children better when further additions to family are prevented.

At the second post operative interview lack of awareness of women regarding the educational benefits of family limitation was again made obvious. While pre-operatively 83.89 per cent of women showed satisfaction about children's education, almost the same proportion (82.20 per cent) revealed satisfaction post-operatively.

The finding points to the ignorance of couples on values of family planning in terms of benefits to children. Indirectly this reflects upon the shortfall of the propaganda machinery of the Government in educating the masses and inculcating in them values in favour of limitation of family size.

The educational benefits from family limitation would be experienced by couples after several years when children reach higher classes and problems of finance face them.

COMFORTS: More number of parents could provide better comforts to children post-operatively. This was possible because parents became more conscious of the preciousness of the children they had in the context of their inability to have more. The natural consequence of this perception in parents was their eagerness to give the maximum care to children.

It is to be observed here that only 47.46 per cent of parents could say that they could give adequate comforts to children - before sterilisation. However after sterilisation count was slightly higher at 50.85 per cent. The number of dissatisfied parents were in majority pre-operatively (52.54 per cent) while post-operative experiences had brought the figure down to 49.15 per cent.

The data reveals that a large proportion of parents were disturbed about their inability to bestow reasonable comforts to children. This shows the higher aspirations which parents had come to cherish for children. Improved opportunity of attending to children's needs were expressed as parents expectations from sterilisation according to data

obtained at the pre-operation interview. These hopes would have led parents to initiate efforts in providing better care to children within six months of post-operative period. The level of satisfaction of these parents is reflected in the data indicating also the gains by children during the short after sterilisation interval. The greater concern shown by parents toward children reflects enhancement of positive relations between parents and children.

HEALTH: Out of 118 women who were interviewed six months after sterilisation, only two had got sterilised with hopes of health gains for children. None of the other women had such expectations. Most likely they may have been unaware of such benefits.

Post-operative query revealed that although parents had not expected gains in terms of children's health, apparent gains were experienced by parents. According to 63.56 per cent of parents, they were satisfied about the health care they could give children pre-operatively. The number had substantially increased to 73.72 per cent according to women's information based on their post-operative experiences.

The reason for the added generation of enthusiasm in parents was the fear of loss of children and the inability of further addition to family. In this context

parents would definitely take greater care of children's health to prevent unhappy situations arising from child mortality.

The ultimate beneficiary of improved parental care and concern is the child. Improvement in bodily health would easily be noticed by parents who would derive satisfaction and happiness from it. The happier parent would be able to give more, making the children healthier and happier.

The mutual give and take between parents and children adding to mutual joy and satisfaction indicate the healthy interactions that have developed between the two after tubal ligation. Increased interactions point to enhancement of relations.

The number of parents who were still dissatisfied about children's health were 36.44 per cent pre-operatively. The number was reduced to 26.27 per cent six months after sterilisation. The testimony of these parents about the inability to provide the health care they wanted reflects their genuine desire to do so. The admission of their inability reveals the sense of awareness that had come to them about the need for giving children adequate health care. These are positive signs of parents' efforts to prevent illness in children, give immediate attention when children fall ill and providing of better food.

The health gains by children would have been the result of these and not sterilisation directly. However, the indirect impact which sterilisation had in the change of attitude and behaviour of parents should be fully recognized.

The effectiveness of family planning in reducing infant mortality rates is widely recognized today.[3]

> "It is therefore crucial that the countries with such high growth rates take steps to reduce fertility, particularly through increasing the availability of family planning, which, providing the services are properly designed, could have a demographic impact even before modernization becomes a reality in the poorest countries".[4]

Lowering of infant mortality rates is considered to be important in encouraging mothers to accept family planning. While high mortality rates are usually associated with poverty, low mortality rates are found in poor countries also. Kerala provides an example as the poorest State in India having a low infant mortality of 55, less than the national average.[5]

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3 Jean Bovin, "Least Developed Countries", People, Vol.9, No.2, 1982.

4 Jean Bovin, Ibid.

5 Newland Kathleen, "Tackling the Scourge of Infant Mortality", People, Vol.9, No.2, 1982.

Table - 68

Infant mortality rates in selected low-income countries around 1978

Country		Infant mortality rate (Deaths per 1000 live births)	Per capita income (Dollars)
Sri Lanka	-	42	200
China	-	63	230
Madagaskar	-	102	250
Tanzania	-	125	240
Haiti	-	130	240
Bangladesh	-	139	90
Afghanistan	-	185	160
Nigeria	-	200	240

Source: Population Reference Bureau and World Bank - Adopted from People, Vol.9, No.2, 1982.

As the table shows experiences of other developing countries are there to show that poor countries need not wait for affluence to reduce infant mortality rates.

The experiences of couples in the present study have shown that with sterilisation parents' care of children improves and children benefit by gaining bodily health. The result will be subsequent reduction of infant and child mortality. Pathak in a study[6] has observed that family planning can help to bring about decline in infant mortality while it is at the same time responsible for

6 Pathak, K.B., "Infant Mortality, birth order and contraception in India", The Journal of Family Welfare, XXV (3) March, 1979, pp.12-21.

non-acceptance of family planning. Kerala experience shows that reduction of infant and child mortality rates result where acceptance of family planning is higher.[7]

DISCIPLINE: According to vast majority of mothers, they were happy about their ability to discipline children. Almost all women 114 and 115 out of 118 were satisfied pre and post operatively. Evidently sterilisation did not have much impact either negatively or positively on problems regarding children's discipline.

Absence of problems of discipline meant that the parents were not divided among themselves in disciplining children. They were able to manage children without undue tension, anxiety or unpleasantness. This is a reflection of the cordial relations that already existed between parents and children in the families of women studied. Sterilisation did not bring any significant change with one parent alone expressing that they could not clothe children to their satisfaction according to their pre-operative experiences. The percentage was slightly smaller post-operatively at 79.66 per cent. The increase of satisfied parents after sterilisation is indicative of increased parental efforts to look after children and not most likely the result of financial gains.

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[7] Krishnan T.N., The Demographic Transition in Kerala, Facts and Factors, Trivandrum.

Greater interest and efforts to clothe children better reveal parents' positive satisfaction post-operatively when compared with pre-sterilisation experiences.

Parents' satisfaction about their ability to control and manage children without problems of discipline expose the healthy relations of both parents towards children. While it speaks more for the unity and co-operation between spouses it also reveals how the parents unitedly handle problems of child management, indicating the positive and satisfying relationships which would have existed in the families before and after sterilisation.

GOOD CONDUCT: Sterilisation did not seem to have any effect in the conduct of children. Almost all women in the sample except 3 were happy about children's conduct and behaviour. The obvious inference is that the behaviour of children was not annoying to grown-ups and therefore the absence of tension and irritability among parents are indicated. Parents not only tolerated but enjoyed children and their behaviour revealed the presence of positive parent-child relations in families of women studied.

CLOTHES: There was a larger proportion to parents (83.05 per cent) who felt that they could not clothe children to their satisfaction preoperatively. The percentage was slightly smaller post-operatively at 79.66 per cent. The increase of satisfied parents after sterilisation is indicative of increased parental efforts to look after children

and not possibly the result of financial gains. As most women in the sample came from the wage-earning class, possible financial benefit could not have been spent on buying more and better clothes for children. Children would have become more precious to parents post-operatively as they faced the reality of having no more children in future. Their increased enthusiasm and sense of responsibility in providing adequate clothing to children were the result of permanent limiting of conception.

Greater interest and efforts to clothe children reveal the increased concern of parents for children and the subsequent improvement of interactions with children. In this interaction naturally children felt more wanted and cared contributing to their emotional security and general well-being.

<u>TOYS:</u> While 50.84 per cent of parents were satisfied about their ability to provide adequate playthings to children the percentage of satisfied were smaller (43.22 per cent) pre-operatively. Many more parents subsequent to sterilisation felt the need of providing better toys if they had the resources. In the absence of such resources they felt justified in not spending their meagre earnings on not so essential an item as toys. Many women said that if they had better resources they would have liked to buy toys for children.

Greater awareness about children's needs and parents' genuine interest to meet them are again reflected by the data. This is an indicator of more positive feelings that parents had begun to experience about children post-operatively.

Specific information on difficulties to give children what parents wanted to give was obtained.

Table - 69

Parents' difficulties in providing children necessary amenities

Difficulty		Number	Percentage
Poverty	-	38	32.20
No job	-	13	11.01
Children ill	-	13	11.01
No house	-	1	0.85
Too many children	-	6	5.08
Other reasons	-	3	2.54
No answer	-	44	37.29
		118	

The probe into parents' particular difficulties regarding the obstacles that stand in their way of caring for children was made in order to have further insight into the frustration and tensions parents are exposed to. Presence of frustration would definitely indicate absence of harmony and peaceful living.

According to the responses of women, economic difficulties were more common with inadequacy of income in 32.20 per cent of families and lack of job in 11.10 per cent cases. In 11.10 per cent families parents were worried over children's poor health. Lack of proper housing facilities was felt only by one family. In 6 cases (5.08 per cent) women felt that if not for too many children they could have provided better for them. There were 3 other women (2.54 per cent) who considered their own ill health as reason for inability to give adequate care to children.

The data gives insight into the physical and economic conditions from which the acceptors came. Most of the women were from economically backward families. The observation is corroborated by the analysis of parents' employment which had revealed (chapter-II) that most of them were manual labourers. Lack of physical amenities of living however did not seem to affect considerably parents' eagerness to meet children's emotional needs. Parents were found to be eager to give good care to children according to what their resources permitted. The emotional environment in the home appeared conducive to giving the needed emotional security to children, despite physical and economical handicaps.

Detailed information regarding parents' experiences in providing children the best and the maximum they could with their limited resources are exposed by the post-operative data. The pre-operative experiences are reflective of the minimum comforts parents were trying to give children due to their financial strains. The effort to give the maximum post-operatively indicate the greater concern and interest which had developed. The development of more positive relationships between parents and children was therefore a natural outcome.

MANAGEMENT OF THE HOUSEHOLD: "A child needs consistent, clear, reasonable discipline and adequate freedom. Above all, he needs one system of laws and one method of management which he can learn to accept from the beginning. Too many adults, too many rules, too much restriction or too much fussing play havoc with his upbringing, and a spoilt and discontented child is the result".[8]

"Home Management is planning, organizing, controlling and evaluating the use of resources available to the family for the purpose of attaining family goals. . . .. The use made of the family's resources and the extent to which family goals are realised depend in large measure on the managerial ability, interest and leadership of the two homemakers and their ability to motivate all members of the group".[9]

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[8] Bowley Agatha, Ibid.

[9] Nickel and Dorsey, Management in Family Living, Wiley Eastern Ltd., New Delhi, 1976.

Of the two home managers, the husband and the wife, wife's role is more crucial setting the tone for joint and co-operative action of family members through the building up of strong interpersonal relationships.

Inefficiency of wife to manage the household can increase conflicts in intrafamilial relationships especially that between parents and children. Children are often the victims of parent's frustrations and dissatisfactions in the home. It was felt that information on women's feelings about their ability to manage the household post-operatively and a comparison with pre-operative experiences will throw light into the pattern of parent-child relationships that have been emerging during the period after sterilisation.

EFFICIENCY IN HOME MANAGEMENT: Women were asked to assess upon their ability to do household tasks post-operatively as to whether they were aware of perceivable variations when compared to pre-operative experiences.

Table - 70

Women's comparative ability to do household tasks pre and post operatively

Changes	After experiences compared with former							
	Better		Worse		Same		N.A.	
	No.	%	No.	%	No.	%	No.	%
a) Interest	71	60.17	4	3.39	43	36.44	--	
b) Ability	29	24.58	14	11.86	74	62.71	1	0.85
c) Management of others in family	19	16.10	2	1.69	62	52.54	35	29.66

Majority of women acceptors as the table shows were not disturbed about their ability to run the household after sterilisation. Most of these women did not experience any changes proving that they continued their routine tasks after operation as they were before. A sizeable proportion of women had observed improvement which they identified as beneficial effects of sterilisation.

Interest of 60.17 per cent out of 118 women doing household tasks had appreciably increased. Freedom from unwanted pregnancy had given most of them relief and zest to work which was not there before sterilisation. With fear about the operation and its side effects having been removed most of these women were confident about their ability to do hard work in future. Arousal of fresh and greater interest in women about conscious fulfilment of their household responsibilities indicate more satisfied husbands and children who would ultimately be the beneficiaries of mother's enhanced interest in them. Improvement of intra familial relationships is surely indicated.

Although greater interest in household tasks were aroused in a large proportion of women, those who were satisfied about their ability to do the work well were fewer. There were 24.58 per cent of women alone who could claim competence. A large proportion of 62.71 per cent could not notice any change in performance.

When the ability to manage other members of the family was enquired into, majority (52.54 per cent) did not report of much change as compared to pre-operative functioning. However, there were a small proportion of 16.10 per cent women who claimed to have achieved greater efficiency. There were some women (29.66 per cent) who did not respond to the query as they did not have other persons staying with them.

Women who reported of deterioration of interest in running the household were smaller in proportion (3.39 per cent). Many of these dissatisfied women complained about ill health subsequent to sterilisation and to which they attributed their lack of interest to do work around the home. Although this group is considerably small when compared with the more contented and hopeful, these women can abuse their experiences in building up resistance in other women against sterilisation. The need to follow up women after sterilisation and to assist with complaints as and when they arise is brought out by the data.

Because of bodily ailments resulting from sterilisation, 11.86 per cent of women could not attend to household responsibilities although they wanted to. According to this category of women they were quite happy about their ability to discharge housework before sterilisation. The frustrating post-operative experiences of these women would be used by them to dissuade other women from

accepting tubal ligation. Serious efforts to follow up and help women who develop complications after sterilisation are called for.

Inability to manage other members in the household was experienced by only 1.69 per cent of women post-operatively. Coupled with bodily ailments, the extra burden of caring for old relatives was resented by these women as they were already experiencing difficulties in caring for "their own children", with poor health. Evidently these women had come to realise well their responsibility in caring for children's health.

GENERAL ABILITY AT HOUSEHOLD TASKS: Assessment of women's general ability to run the home was made by making women respond to certain statements.

Table - 71

Post-operative reaction of women to statements regarding ability to run the home

Statement	Yes		No	
1. Able to do better now	95	(80.51)	23	(19.50)
2. Don't feel healthy enough	36	(30.51)	82	(69.50)
3. Frequently ill	28	(23.73)	90	(76.27)
4. Doubts future health to work hard	34	(28.81)	84	(71.19)
5. Greater interest to work	95	(80.51)	23	(19.49)
6. Will require help at household tasks	27	(22.88)	91	(77.12)

As the table shows the information obtained through these responses were not entirely different from those obtained by women's comparative assessment of pre and post operative experiences. A counter check to verify the assessment was aimed at by observation of women's reactions.

A larger proportion of 80.51 per cent women agreed that women after sterilisation were able to run the household better. The figure was only 60.17 per cent when women were given the option to assess. This definitely speaks in favour of sterilisation which has benefitted so many women by creating an environment that has aroused in them greater interest in managing household responsibilities. The arousal of interest was the result of the sense of relaxation and comfort which prevention of future pregnancies brought to women. There were however 19.50 per cent of women who could not agree with the statement affirming their failure to gain emotionally by sterilisation. The small percentage of 3.39 per cent women who reported of deterioration in interest belonged to this group of 19.50 per cent of respondents who responded negatively to the statement.

When women were asked to react to the statement that after sterilisation women had greater interest to do household work, the same proportion of 80.51 per cent who affirmed of greater interest were found to agree. The

statement was put much later in the series as it was felt a fresh analysis would offer greater scope for truthfulness of the answer. Remarkably there was no variation in the number of women responding to greater interest from 'Ability'. This reveals that women not only felt greater interest to attend to household tasks after sterilisation but that they also experienced better ability in carrying out responsibilities in the home. The evidences obtained from women's experiences speak definitely the gains derived by the family in having a more efficient mother to run the household, post-operatively.

Those that responded to statements about ill health such as "Don't feel healthy enough to work"; "falls ill frequently"; and "doubts future health to work" were 30.51 per cent, 23.73 per cent and 28.81 per cent respectively. About 30 per cent of women were not happy about their health after sterilisation. These women fall in the category of those that call for close follow-up. If complaints of these women are not attended to, promptly, they can pose potential dangers to the programme of sterilisation developing fear and resentment among prospective acceptors.

Pre-operative check up and proper medical care extended to health complaints of acceptors can avoid possibilities of women attributing to sterilisation all signs of ill health. As information on the bodily health of

women was not collected before sterilisation it is not possible to ascertain whether the illness experienced by women after tubal ligation were a carry-over from pre-operation situation. Proper screening of acceptors to prove eligibility by assurance of sound health is required if later prejudices against the side-effects of sterilisation are to be prevented.

When mothers' opinion regarding the statement on need to obtain outside help was sought, there were 22.88 per cent who answered affirmatively. These were the women who had complaints of bodily ailments and who required medical care. According to many of them these were complaints that developed after sterilisation. Verification of the etiology of the disease was not very important as far as the woman acceptor was concerned or for the future of the programme of sterilisation. Availability of medical services to attend to post-operative complaints of acceptors thus establishes prominence in the fabric of family planning programme of the Government.

MANAGEMENT OF CHILDREN: "It has now become almost platitudinous to say that an anxious child reflects an anxious parent. Normal concern for and interest in the child's development are very different from unnatural worrying and fussing over every stage in his development. The over-solicitous parent may well hide an attitude of rejection

towards the child. The over-maternal mother may be far from having genuine maternal feelings. The obsessional type of parent will fuss about cleanliness and health and tidiness and make the child's life a burden. Over-emotional parents, who have unsatisfactory marital lives, may seek to gain their child's affection exclusively".[10]

Analysis of mother's ability to manage children and her feelings of satisfaction about children's behaviour were considered as correct indicators of parents' relationship with children. The tired, the busy, the worried, the exacting, the ailing, the unstable and the neglectful mother would find it difficult to provide a real home for children and the husband. Mother's inconsistent and inefficient management would result in behaviour difficulties in children. A mother who radiates calm and charm would reflect in her children happy and peaceful disposition. Unrest and insecurity would result from mother's inability to make harmonious living possible in the home.

The quality of parent's management of children was probed into in order to obtain insight into the gains or losses in relationships experienced by parents and children.

DISCIPLINE: The purpose of discipline is to help the child control himself in his own interest. Where children behave

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[10] Bowley Agatha, Ibid.

without causing annoyance to elders, father and mother working together in co-operation and unity of purpose is visible. Wherever it is lacking and divided discipline is the style of functioning, difficulties of managing children arise.[11]

Women were asked pre and post-operatively whether they had difficulties of managing children.

Table - 72

Difficulties of managing children

		Present		Not present		Total
		No.	%	No.	%	
Before sterilisation	-	113	37.67	187	62.33	300
After sterilisation	-	40	33.90	78	66.10	118

Evidently, as the table shows, mothers were aware of their problems of managing children.

While 62.33 per cent of women reported of having no difficulties pre-operatively, there were 66.10 per cent of mothers who had no problems. A sizable increase is noticed in the proportion of mothers who have been able to manage children smoothly without complaints. This reveals the healthy level of adjustment that was present in the case of 66.10 per cent of families post-operatively in contrast with 62.33 per cent pre-operatively.

11 Bowley Agatha, Ibid.

Post-operative experiences of problems in child management were present in 33.90 per cent women only whereas a higher proportion of women (37.67 per cent) had such pre-operative experiences. At the post-operative interview women were asked to explain about the frequency of difficult experiences with children. Only 2 out of 40 women (1.70 per cent) had constant difficulty while the remaining mothers' only occasional.

The kind of difficulties parents had with children was probed into. According to pre-operative information major difficulties were disobedience, quarrels between children, irresponsibility, lack of interest in studies, and bad company. Women were then asked how they handled children.

Table - 73

Ways of handling children

Method		Before No.	Before %	After No.	After %
Punishment	-	127		5	
Reprimand	-	57		3	
Report to father	-	3		0	
Don't interfere	-	1		2	
Threat	-	4		0	
Other	-	108		98	
		300		118	

The most poignant observation is that while 36 per cent women before sterilisations managed children by

friendliness and tact, there were 91.53 per cent who did so post-operatively. This points to the disappearance of frictions and conflicts between parents and children in many families after sterilisation. In addition to the relief and relaxation which parents have come to enjoy post-operatively with avoidance of future conception the realisation that they could not have children any more would have paved the way for many parents to start enjoying their children. From the traditional methods of punishing, threatening, reprimanding etc., parents' attitude to children in handling them has changed to friendliness. The result is reduction of tension in parents and feeling of security and acceptance by children, with ultimate experiences of satisfying relationships between parents and children.

While punishment was resorted to by 4.33 per cent of parents pre-operatively, the post-operative proportion was only 4.24 per cent. While 19 per cent reprimanded before operation only 2.54 per cent did so after. While only 0.33 per cent did not interfere with children's problems a bigger proportion took non-interfering attitude post-operatively. Most likely leniency towards children to the extent of reluctance to interfere had developed in few parents as a result of permanent pregnancy termination of the couple.

Table - 74

Initial expectations from operation and post-operative attitude of parents in child management

Initial Expectations	Friendly	Authoritative	Punishing	Lenient	Total
Children's health	1(1.20%)	-	-	-	1
Attention to children	4	-	-	-	4
Prevent pregnancy	24(30.12%)	1 (20%)	1	-	26
Peace in home	1(1.20%)	--	-	-	1
Husband-wife relations	1(1.20%)	--	-	-	1
Financial gains	59(71.08%)	2	4	2	67
Mother's health	13	--	-	-	13
Stability to marriage	--	--	-	-	--
Reduce housing problems	--	--	-	-	--
Others	5	--	-	-	5
Total	108(91.53%)	3(2.54%)	5(4.24%)	2(1.69%)	118

A pertinent observation to be made from the table is that except 5 out of 118 mothers (4.24 per cent) who had got sterilised with hopes of benefits for children, the rest of the mothers had no such expectations. Their interests were personal, financial, etc. However, in the experiences of mothers regardless of their varying expectations initially, vast majority of them had benefitted in terms of ability to manage children. As data

is not available it is not possible to say whether the acceptors of tubal ligation had become aware of these gains. Although child welfare is a goal of family planning, child welfare goals are not effectively used for persuading couples to accept family limitation. The scope for making use of child welfare values of sterilisation for motivating couples becomes thus evident.

FEELINGS TOWARD CHILDREN: In general children are always welcome in the Indian family. This is brought out in a study conducted by Sadashivaiah on the value and cost of children. According to the findings of his study, people aspire for children not as an economic security, but for other reasons. The non-economic values which parents ascribe to children were found to overweigh the cost of bringing them up in the long run. Parents were found to feel secure and rich in old age although they were poor financially.[12] Specific feelings experienced by mothers toward children before and after sterilisation were explored.

Table - 75

FEELINGS FOR CHILDREN

		Before operation		After operation	
		No.	Percentage	No.	Percentage
Joy	-	277	92.33	98	83.10
Pride	-	-		1	0.85
Nuisance	-	8	2.67	-	-
Burden	-	2	0.67	-	-
Help	-	-	-	8	6.78
Consolation	-	-	-	11	9.32
Nothing special	-	13	4.33	-	-
Total	-	300		118	

12. Sadashivaiah, K., "Contraceptive Research on the value and cost of children", The Journal of Family Welfare, Vol.XXVIII (4), June, 1982.

According to a large majority of women both pre and post operatively 92.33 per cent and 83.10 per cent respectively they enjoyed children. Although the post-operative proportion is smaller, there were others in the group for whom children were not only just a source of joy but their pride (0.85 per cent), help (6.78 per cent) and consolation (9.32 per cent). These sentiments were not expressed by women at the pre-operative interview. To the question whether they considered the children a nuisance or burden 2.67 and 0.67 per cent of women pre-operatively answered in the affirmative. No single woman had similar feelings post-operatively. There were 4.33 per cent of mothers who could not claim to have any particular sentiments toward children pre-operatively. Post-operative experiences were different. There was not a single woman who said post-operatively that she had no particular feelings for children. Evidently women started to appreciate and feel more for children after sterilisation. This is evidence for the favourable changes in relationship that had taken place in many of the families of women acceptors of the study. Development of mutually satisfying interactions between family members indicate definite gains in relationships subsequent to sterilisation.

Children's response to increased parental attention was analysed. Women were asked to comment what children's feelings were towards the father and the mother.

Table - 76

Children's feelings to parents

Feelings		Mother No.	Mother %	Father No.	Father %
Love	-	110	93.22	100	84.75
Fear	-	8	6.78	16	13.56
Hate	-	-	-	1	0.85
Indifferent	-	-	-	1	0.85
		118		118	

In the vast majority of cases, (93.22 per cent) children's feelings for mother was mainly love. Fear dominated in the case of children of 6.78 per cent of mothers. This according to mothers did not mean that children had no love for them. Children could be better controlled if they have fear towards any one parent in the words of mothers themselves.

Feelings of children towards father were slightly different. A smaller majority of 84.75 per cent families had children whose feelings to father was dominantly affection. While children of 13.56 per cent families were frightened of the father, there was the case of one family (0.85 per cent) where feelings to father were mainly hatred and one other (0.85 per cent) indifference.

Analysis of children's feelings for parents corroborates the earlier observation of the presence of harmonious relationships in majority of the families of women studied. Except in the case of two families where children felt indifferent or hateful towards the father, healthy and satisfying interactions were possible between family members in the environment of mutual love. Presence of cordial and harmonious intrafamilial relationships are therefore indicated in most families of respondents.

III. SELF ASSESSMENT BY WOMEN

Observations were made from data concerning objective evidences for parent-child relationships within families of acceptors before and after tubal ligation. In order to verify these observations women's own evaluation of their experiences in interpersonal relationships was made use of. Even if objective evidences show improvement of the quality of family life justifying sterilisation the subjective feelings of mothers about its outcome were considered important and relevant for substantiation of findings.

Mothers were asked to react to certain statements. Most statements required women to make a comparative evaluation of their pre and post operative experience.

Table - 77

Women's assessment of child care post-operatively

Statement	Reaction						Total
	Yes		No		N.A.		
	No.	%	No.	%	No.	%	
1) I find it less difficult to manage children now	104	88.14	14	11.86	---		118
2) I have more time to give to children.	115	97.46	3	2.54	---		118
3) I feel more affection for children now than before	115	97.46	3	2.54	---		118
4) I feel anxious when children fall ill	86	72.88	32	27.12	---		118
5) I feel guilty about sterilisation	30	25.42	88	74.58	---		118
6) I fear God's punishment	17	14.41	101	85.60	---		118
7) I feel ashamed about operation	113	95.76	15	12.71	---		118
8) Children are more loving to parents now	90	76.27	20	16.95	8	6.78	118

A large majority of women (88.14 per cent) were happy to say that they faced less problems in managing children than before. It is difficult to accept that children's behaviour underwent changes as a result of mother's sterilisation. Children become unmanageable when they are frustrated by unmet needs. They are dependent on

parents for meeting their needs failing which they show problems of behaviour. In the cases of women studied, the decrease of parental problems in child management reveals parents' ability to meet their needs rather than any other cause. Parents became capable of satisfactorily meeting children's needs because of freedom from tension, anxiety, marital frictions and so on. With no other major change taking place in the family, prevention of unwanted births by sterilisation would have been responsible for it.

To the statement "I have more time now to give to children" reactions of respondents were eloquent. It was emphatically affirmative that they could spend more time for children after sterilisation. When they were questioned why it was not possible for them before, some of them answered that they did not try much. According to some of the women even fathers were showing greater interest in children's care post-operatively and about which women were happy.

Evidently, sterilisation was not directly responsible for giving more free time to women in enabling them to look after children better. However, the operation would have made an indirect contribution by creating a favourable disposition in parents inducing them to be more concerned about children's well-being. With termination of pregnancy permanently, parents would have felt keenly

their responsibility in caring for children lest they would lose them by lack of attention on their part. Once the need for greater care of children was recognized by parents, they had to find time to devote for children. The women's responses only showed that parents succeeded to find more time to spend for children.

Benefitted by better parental care children felt greater security, emotional well-being and bodily health. The result of the increasing give and take between parents and children were mutual satisfaction and harmonious living. Except 3 women out of 118, the rest of the mothers (97.46 per cent) testified to their happy experiences of giving enhanced attention and care to children.

Mothers evidently started to feel greater affection for children, post-operatively. This did not mean that they had no love for children before. Majority of acceptors came from families where intra familial relationships were strong as findings have already shown. The post-operative experiences had given a new impetus to their feelings for children, making them precious and whom they could not afford to lose by any neglect on their part. These were the circumstances which disposed parents in favour of children and their care. Almost all women except 3 (2.54 per cent) had admitted that they felt more affection for children post-operatively.

To verify and confirm opinions expressed by women about their positive feelings to children, women were asked whether they felt anxious when children fell ill. A large majority of mothers (72.88 per cent) shared their fears with the investigator. The excess concern of these mothers in children's well-being was quite evident. The response does not prove that the remaining 27.12 per cent were unconcerned, but in the words of some women, they did not feel upset about it as "worry would not help; obtaining the best help possible is our only concern in such situations".

Even if women's post-operative experiences were happy with regard to children and their management, feelings of guilt about getting sterilized could blemish their experiences of satisfaction. The women were therefore asked to react to the statement "I feel guilty about having got sterilized". Large majority of women (74.58 per cent) were emphatic about absence of any guilt feelings. Some of the women expressed amazement about the statement itself as if it were an impossible outcome. However admission by 25.42 per cent of acceptors that they did feel guilty occasionally throws light into the ambivalent feelings which some women had towards sterilisation. It is quite likely that these women were subject to at least occasional anxiety and mental conflicts which would have reduced their ability to relate themselves positively to husband and children.

Fear of God's punishment was disturbing to a considerable proportion of women acceptors (14.41 per cent). Such feelings of fear and remorse would have marred women's capacity of positive interaction with family members, diminishing the happiness of all in the family. An unhappy, mentally disturbed mother could spread her inner misery into those that live with her. The husband and children would be the easy and natural victims.

The finding exposes the need to be convinced about the acceptability of sterilisation to the woman's religious and moral sentiments before she is encouraged to accept it. Neglect in doing so can lead the acceptor and her family into unnecessary unhappiness. Unhappy acceptors of this category could do harm to the programme of sterilisation itself by sharing their resentment towards the method with potential acceptors.

Feelings of shame about the operation were shared by five women (12.71 per cent) only. The rest were unconcerned proving the acceptability which the method has come to have in the community. These are feelings that would slowly wear off with time and when knowledge about more women opting for the method is brought to them. Feelings of shame of these acceptors cannot therefore be considered as serious hindrance affecting harmonious living in the family.

After obtaining an insight into how much more or less parents were able to give children post-operatively in comparison with pre-operative experiences women were asked to react to the statement "Now children are more loving to parents". The purpose was to assess whether children's responses to parents had undergone changes. This would verify the information given by parents about their giving themselves to children. While 6.78 per cent of acceptors could not make a specific comment, a large percentage (76.27 per cent) of women responded positively. This confirmed the claims of majority of acceptors about their greater affection for children and devotion to their care. The children responded to parents' increased attention and care by more lovable and less annoying behaviour.

In the case of 16.95 per cent acceptors they could not speak of any change in behaviour or attitude of children. These were the mothers who could not free themselves entirely of feelings of tension and anxiety regarding their decision to get sterilised. The need for helping women to make willing, voluntary and conscious choice of sterilisation on their own without pressure from outside is emphasized by the finding.

Women were finally asked to comment about the value of sterilisation as a family welfare measure.

Table - 78

Women's evaluation of family welfare goals of sterilisation

	Yes No.	Yes %	No No.	No %	N.A. No.	N.A. %
a) Helps family's general well-being	116	98.31	1	0.85	1	0.85
b) Financial improvement	113	95.76	4	3.39	1	0.85
c) Improve mother's health	101	85.60	16	13.56	1	0.85
d) Better children's health	117	99.15	--	-	1	0.85
e) Peace in family	113	95.76	4	3.39	1	0.85
f) Better marital relations	114	96.61	3	2.54	1	0.85
g) Destroy family happiness	4	3.39	114	96.61	-	-
h) Bring suspicion between husband and wife	3	2.54	115	97.46	-	-
i) Bring shame to children	-	-	118	100.00	-	-
j) Bring God's wrath	3	2.54	115	97.46	-	-

Almost all women (98.31 per cent) were convinced that sterilisation is helpful for family's general well-being. A general comment was felt to be inadequate since specific benefits accruing from sterilisation as method of family planning constituted partly the objective of the present investigation.

Women who gave favourable responses about benefits of sterilisation were a sizable proportion. While 95.76 per cent each acknowledged financial gains and harmony in family respectively as benefits of permanent pregnancy termination, 99.15 per cent, 96.61 per cent and 85.60 per cent vouched for gains in children's health, marital relations and mother's health.

Although initially women were unaware of gains of sterilisation in terms of children's health (with about 5 per cent of women alone deciding in favour of sterilisation with hopes of benefits for children) the post-operative experiences of women were convincing enough to make large majority of acceptors (99.15 per cent) vouch for its benefits.

The findings of studies that have shown that sterilisation would reduce child mortality rates are confirmed by the present finding. The health gains due to better care of children which sterilisation is instrumental in bringing about, can be accounted for such reductions in mortality. Sterilisation can therefore achieve not only reductions in birth rate but also mortality rates of children.

Further verification of women's responses was made by querying on the negative outcome of female sterilisation. They were asked to comment whether sterilisation

would lead to loss of marital happiness. There were only 4 women out of 118 (3.39 per cent) who were of the view that it would. The opinion was evidently based on the personal experiences of these women. However, the larger majority of acceptors (96.61 per cent) testified to contrary convictions.

One common complaint against sterilisation is the risk of suspicion between husband and wife and endangering of marital fidelity. The testimony of 96.61 acceptors confirm that such fears are without ground and contrary to experiences. It is to be observed here that most of the acceptors came from families where harmony between spouses was present. Husbands formed the major influence and encouragement for most women deciding in favour of sterilisation. Those women that were happy and well adjusted with husbands could go on happily without sterilisation affecting their marital relations adversely. Women who did not enjoy harmonious relations with husbands failed to achieve it after getting sterilised showing that sterilisation is not a solution to marital disharmony. To couples in conflict sterilisation may aggravate matters by adding to frustrations that come with the realization that sterilisation cannot solve problems of marital discord.

Not one woman felt that shame would be brought to children because mothers had undergone sterilisation.

Many women commented that children were not old enough to understand. When they were asked to respond to such a hypothetical situation, they denied the possibility. For the younger, growing generation, the concept of family planning, sterilisation etc. may be familiar and nothing to feel shameful about. This may be the reason for women being unconcerned about children coming to know about it and their consequent feelings.

According to 2.54 per cent of women religious sentiments would be disturbed by accepting sterilisation. This is a factor which cannot be ignored while encouraging women for sterilisation. Neglect to respect religious and moral sentiments which prospective acceptors of sterilisation hold can develop anxiety and conflict which will adversely affect family happiness. A mother in mental conflict cannot do justice to the family in her roles as wife, mother and manager of the household.

The need for ascertaining the wilful voluntariness of woman's decision to accept sterilisation is thus indicated. Compulsion from any quarter can prove detrimental to the cause of family's welfare, which is the oft-emphasized goal of sterilisation.

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VI

SUMMARY
FINDINGS
&
CONCLUSIONS

Summary of the study - Arrangement of the Report - Findings: Husband-wife Relationship - Parent-child Relations - Motivation to tubectomy - Characteristics of tubectomy acceptors studied -- Conclusion: analysis of hypothesis - suggestions - areas for further research.

CHAPTER - VI

SUMMARY, FINDINGS AND CONCLUSIONS

As the final and concluding part of the research study report, Chapter-VI contains a summary of the previous chapters in brief, the researcher's findings and conclusions. In addition, suggestions arising from the study and indications for possible areas of further research efforts, which are felt to be relevent to policy makers are also included.

SUMMARY

How female sterilisation affects interfamilial relationships was the object of the present study. Relationships between spouses and between parents and children were the major areas of scrutiny.

Three hundred women who got sterilised at the Ernakulam District General Hospital in Kerala State between July 1, 1979 and November 8, 1979 formed the sample.

Data was collected at three stages, the first a day prior to operation, the second and third at one and six months post-operatively. Interview schedules were used for interviewing.

OBJECTIVES OF THE STUDY:

The major objective was to assess the gains or losses in relationship between spouses after sterilisation of the wife. The second objective was to gauge the impact of sterilisation upon parent-child relationships.

Factors that were responsible in motivating women to accept sterilisation were subjected to enquiry with the conviction that the information would give insight into the inadequacies of the official Family Planning Programme, offering prospects for feasible and salutary changes.

HYPOTHESIS FOR VERIFICATION:

The study was initiated on the basis of the following assumptions:

a) People have not come to accept sterilisation as the ideal method of contraception, although the programme has been officially projected as such for the illiterate masses.
b) The programme of sterilisation has not yet made an impact on people as one that promotes happiness of family life.
c) The fear of extra-marital indulgences lead to loss of respectability for the method.
d) Couples who feel that their family lives have been affected by sterilisation are those whose family lives have not been happy pre-operatively.
e) Well-adjusted couples undergo sterilisation without adverse effects on future family lives.
f) Sterilisation is resisted by people because it is a surgical procedure requiring hospitalisation.
g) Fear of infant and child mortality stands in the way of early sterilisation by couples.

h) Psychological and religious barriers present serious hurdles in persuading couples to get sterilised.

ARRANGEMENT OF THE REPORT

The report is arranged under six chapters.

The first chapter, Introduction, has three parts. The global and natural dimension of the problem of population is considered in Part I; The Importance of the topic studied namely sterilisation is discussed in the second Part; and Part III explains the background and methodology of the study.

The second chapter is a description of tubectomized women who were the respondents. Their personal and family data, economic, social, educational and demographic profile; form its contents.

The direct and indirect influences that were responsible to make women decide in favour of sterilisation are dealt with in the Third chapter.

The Fourth Chapter is an analysis of the interspouse relations pre and post-operatively and an assessment of gains and losses in the area subsequent to sterilisation.

How children have benefitted physically and emotionally as a consequence of improved care/and attention from parents post-operatively constitutes the analysis attempted in the Fifth chapter.

The Sixth and final Chapter contains the summary of the study, major findings, conclusions based on the assumptions of the research, suggestions for revamping the Family Planning Programme, and proposals of areas for further research.

FINDINGS

The most important finding disintered by the study is that large majority of women acceptors of sterilisation had come from families where satisfying interfamilial relationships were present. The decision to get sterilised was taken by most women either with the encouragement obtained from husband or his concurrence. This points to the difficulty of eliciting favourable response to sterilisation from couples that are faced with marital problems.

The augmentation of mutual adjustment and relationship between spouses was a predominent post-operative experience of most of the women who underwent tubal ligation. They were not anticipating such gains prior to operation, gains in relationship was not a motivational factor.

Although women were unaware of the benefits of sterilisation accruing to children, the post-operative experiences of women confirmed the gains by children in obtaining greater love, care and attention from parents.

Success which parents achieve in the family is determined by the success they have in their relationship with one another. Improved parent-child relationship is the out-pouring of the relationship between parents. The gains in relationship between spouses indicate therefore the gains in relationships between parent and children. As parenting is the work of integrating children into the interpersonal love-relationship of parents, it should be accepted that sterilisation had contributed to help the families of women studied in achieving greater levels of happiness and satisfaction from family living through enhancement of interpersonal relationships.

Analysis of pre and post-operative experiences in intrafamilial relationships has brought to light the following:

I. HUSBAND-WIFE RELATIONSHIP:

1. A large majority of women - 83.33 per cent - had spouses who had pleasant disposition, arousing no complaints against them by wives.

2. According to 95.67 per cent of respondents they had no complaints about husband's relationship with relatives and friends.

3. A large majority of women - 93 per cent - did not have complaints about husbands being alcoholics.

4. With few exceptions, 95.33 per cent of women had nothing against the way husbands spent leisure. However, men who spent the time with the family were a slightly smaller proportion of 91.67 per cent.

5. Husbands joined wives in household tasks and recreational activities in the case of 89.66 per cent of acceptors.

6. In nearly 50 per cent of women's families husband and wife jointly took decisions in religious matters and dress. Financial decisions were taken by husbands alone in 72.33 per cent cases, and wives alone in 2.67 per cent of cases. While 44.67 per cent of husbands decided educational matters there were 41.33 per cent who took independent decisions. A higher percentage of husbands 62.33 per cent decided sex issues independently while there was one per cent of women who did so. In 36 per cent cases in matters of sex decisions were joint.

7. Excepting 4 women out of the sample of 300 women, all were happy about the ways in which they settled differences of opinion without disturbing harmony between them.

8. In the case of 44.33 per cent of women husbands stayed with the family. While 35.33 per cent were home once a week, 16 per cent were home once a month. Occasional and irregular home coming was experienced by 2.33 per cent of women.

The above findings expose the background of families from which women acceptors of sterilisation came, indicating the presence of satisfying inter-spouse relationships within their families.

The physical and mental well-being of mothers after sterilisation were analysed and comparisons between pre and post-operative of 118 women who were interviewed six months post-operatively were made. The physical and mental health gains or losses were considered as dependable indicators of losses or gains in relationship between spouses. Findings were the following:

1. While about half of the women (50.84 per cent) did not experience any change in bodily health, 35.59 per cent reported of adverse health post-operatively and 2.54 per cent disheartening experiences of ill health. There were only 11.01 per cent of women who claimed of health gains post-operatively.

2. The proportion of women who underwent sterilisation to improve relations with husband was only 0.85 per cent. The rest had accepted tubectomy with other expectations such as preventing pregnancy (22.03 per cent), peace at home (0.85 per cent), financial gains (56.78 per cent), improvement of mother's health (11.02 per cent), child's health (0.85 per cent). However, post-operative experiences of women revealed gains in sexual life of the couple. Except 19 women (16.10 per cent), 83.89 per cent of women had experienced greater ability to enjoy sex after chances for conception were permanently removed. Increased sexual satisfaction by large number of women indicate achievement of greater marital happiness. This points to absence of conflicts, anxiety, hostility, depression, etc. in couples. Improved conjugal relationships suggest couples' increased ability to relax which definitely indicates post-operative gains in mental health by respondents and husbands.

3. According to the vast majority of acceptors (96.61 per cent) sterilisation of the wife will not lead to marital infidelity and destroy marital happiness.

4. Including 36 acceptors out of 45 (38.14 per cent) who were emotionally disturbed about sterilisation pre-operatively, 82.20 per cent of acceptors have given evidence by their post-operative experiences that sterilisation does not affect the mental well-being of couples adversely.

5. Feelings of guilt about sterilisation were experienced by 19.45 per cent of acceptors in contrast to 80.51 per cent who were devoid of any.

6. Excepting 2.54 per cent of acceptors of tubal ligation 96.61 per cent of women not only felt no regret for getting sterilised but asserted that they would opt for sterilisation if they were given another chance to choose.

7. Initial fears harboured by women about sterilisation such as harm to health of mother (41.53 per cent), loss of child (31.36 per cent), emotional (4.23 per

cent) and sexual (3.39 per cent) conflicts, etc. were got rid of by sizable proportion of women. There were only 21.19 per cent of respondents who were fearful of the consequences of operation at six months post-operatively.

8. When women's initial expectations from sterilisation such as preventing pregnancy (22.03 per cent) bringing peace to family (0.85 per cent), improving relation with spouse (0.85 per cent), financial gains (56.78 per cent), giving better care to children (3.39 per cent), improving mothers' health (11.02 per cent) and children's health (0.85 per cent) are matched against real experiences of operation a large majority (92.37 per cent) of women revealed absence of any frustration or disappointment about their decisions to get sterilised.

9. According to women's own assessment, 87 per cent of acceptors acknowledged cordiality in their relationship with spouse, proving the satisfying level of adjustment the couples were enjoying pre-operatively. There were 6.67 per cent of acceptors who were concerned about deterioration in relationship with husband. The finding points to happily adjusted couples going on, without sterilisation affecting their marital relations adversely; and couples with problems of adjustment continuing in their unhappiness with sterilisation offering no solution to marital conflicts.

10. According to women's assessment of inter-spouse relationships six months post-operatively, except 7 women (5.93 per cent) the vast majority of 94.07 per cent of acceptors acknowledged absence of any difficulty, to adjust with spouses.

11. Acceptors who were enjoying harmonious relationship with husbands (80.51 per cent) expressed their hopes for enhanced marital happiness in future.

II. <u>PARENT-CHILD RELATIONS</u>:

1. Parents are children's environment and neighbourhood. Evidence of improvement in inter-spouse relationships post-operatively, indicated therefore possible gains of relationship between parents and children.

2. The physical environment of the home had post-operatively become more conducive to favourable interactions between parents and children.

More women were satisfied about their ability to meet children's need for food, clothes, toys, comforts, health and discipline after tubal ligation.

More women showed concern about inability to satisfy children's needs for money, housing facilities, education and good conduct indicating the awareness that had developed in women subsequent to sterilisation.

3. Appreciable increase post-operatively of 60.17 per cent acceptors' interest to do household tasks was reflective of the benefits obtained by families in terms of better management. Children would be definite beneficiaries of mothers' improved efficiency in running the family.

4. A higher percentage of respondents, 66.10 per cent, reported of successful management of children post-operatively in comparison with 62.33 per cent who had similar experiences before undergoing sterilisation.

5. While there were 3.34 per cent of parents for whom children were either burden or nuisance pre-operatively, post-operative experiences of no single acceptor could subscribe to such feelings.

6. In women's own assessment of their ability to manage children post-operatively when compared with pre-operative experiences:

   88.14 per cent could manage children better;
   97.47 per cent found more time for children's care;
   97.47 per cent felt greater affection for children;
   72.88 per cent felt more anxious when children fell ill; and
   76.27 per cent felt children were more loving to parents.

7. In women's final evaluation of family welfare goals of sterilisation post-operatively, 99.15 per cent of them subscribed to the view that the procedure would help in improving the health of children. (It is to be observed here that 5 per cent of mothers were alone conscious of the child welfare goals of sterilisation pre-operatively.)

III. MOTIVATION TO TUBECTOMY:

Direct and indirect factors that influenced women in favour of tubal ligation were found to be the following:-

1. Efforts of the Government to reach couples with Family Planning information through field workers and health visitors (6 per cent) were less effective than the roles played by husbands (16.66 per cent), friends (43.33 per cent), relatives (14.33 per cent) and doctors (12.33 per cent).

2. The husbands, friends and relatives of respondents who had provided information to women on sterilisation speak in favour of the propaganda efforts of the Government to successfully impart information to the general public.

3. The vast majority of respondents (79.33 per cent) had decided to get sterilised voluntarily without pressure from others. The voluntariness of the programme of family planning is thus maintained considerably, as the Government of India wants it to be.

4. In majority of cases (63 per cent) encouragement for surgical procedure of contraception came from husbands.

5. Majority of respondents were unconcerned about the reactions of others within and outside the family about their decision to get sterilised, showing the acceptability which the programme has come to receive in society.

   The respondents who expected objections in their getting sterilised were from husbands (1.33 per cent), children (0.67 per cent), parents (8.66 per cent), neighbours (1.66 percent) and community (2.66 per cent), revealing that the community prejudices and inhibitions against sterilisation are negligible.

6. The proportion of acceptors with previous history of contraception was small (15.67 per cent) which exposes the inadequacy of official propaganda to reach couples with information on methods of spacing children. The large majority of 84.33 per cent of women deciding in favour of permanent pregnancy termination emphasize at the same time the dire need of family planning, regardless of the nature of the method. Women who had previous experiences in contraception

were more concerned and anxious about the consequences of sterilisation than others who had none. Choice of sterilisation after weighing the pros and cons of various methods were possible for them making their choice voluntary. Women for whom Tubectomy was the first experience of contraception, voluntariness of their choice cannot be certain. When knowledge of or experience with other methods is lacking, the choice of the first method they came to know cannot be called a choice at all. However, the decision to choose a permanent method, without adequate knowledge about alternatives, point to the extreme need of women for family limitation.

7. In addition to the reliability of the method, freedom from the future worries of continuing a method was the most attractive feature of sterilisation for acceptors.

8. Religious differences of women did not seem to vary significantly women's feelings towards sterilisation. Remarkably smaller proportions of Christians and Muslims expressed fear of the operation. Larger proportion of Moslem Women (24.4 per cent) welcomed the operation with courage than their Hindu (16.5 per cent) or Christian (15.17 per cent) counterparts.

9. One of the most significant factor that is decisive in the acceptance of tubectomy is the educational level of the respondent. While educational level of husband did not seem to have much relationship with women's decisions to get sterilised, the level of women's education did. While the acceptors of tubectomy were mainly drawn from the illiterate and the least educated women, convinced acceptors came from the more highly educated. Illiterate women may therefore be easier targets to be won over in favour of sterilisation than the educated. The Government's recognition of sterilisation as the ideal method for illiterate masses in the country, is therefore relevant.

10. The most discouraging factor about tubal ligation for acceptors in the sample was fear of physical morbidity following operation which increased with increasing levels of education. Psychological and sexual morbidity following tubal ligation was feared by the higher educated acceptors. Contrary to an assumption of the study, fear of disruption to marital relations was not entertained by any woman acceptors of sterilisation.

Religious differences did not significantly vary women's fears regarding the physical and psychological implications of the operation.

11. The strongest motivation for sterilisation was financial benefits for 75.5 per cent of women. The non-economic values of family planning such as prevention of pregnancy, better care of children and improvement of mothers' health were known to only 26.7 per cent, 7.14 per cent and 6.2 per cent of acceptors respectively.

12. Not a single woman in the sample had realised that problems of housing would be lessened by limiting family size.

13. Satisfied acceptors could not be effective motivators of other eligible women as they did not possess adequate knowledge which could be used in addition to personal experiences. Out of a total of 118 women, 58 had tried to motivate others. However only 21 could claim to have succeeded in their attempt. In the experience of successful motivators, the reliability and dependability (requiring no care once done) were the most favourable features that could win acceptors in favour of sterilisation.

14. A sizable proportion (37.29 per cent) of women felt that they did not have adequate knowledge of sterilisation prior to operation.

    The large proportion of women (55.93 per cent) who held the view that sterilisation is the ideal method for all women, evidently were not properly enlightened on the method, indicating further the inadequacy of the educational efforts of the Government.

15. According to women acceptors reasons for women's general reluctance to undergo sterilisation are post-operative physical complications (50.00 per cent), fear of surgery (35.59 per cent) and lack of sufficient knowledge (16.95 per cent). Popular fears prevalent among women according to acceptors studied were loss of marital fidelity (22.89 per cent), adverse effects on health (84.75 per cent), losing mental peace (5.08 per cent), fear of losing children (38.98 per cent), God's chastisement (5.08 per cent) and occasion for husbands to suspect wives (10.17 per cent).

16. The ideal motivator according to 67.80 per cent of respondents is the husband.

17. Regardless of the age of the acceptor parity was more related to their decision to get sterilised. Out of 300 women in the sample, 129 (43.00 per cent) were of para 3, while 64 (21.33 per cent) were of para 2, 57 (19 per cent) of para 4, 22 (7.33 per cent) of para 5, 17 (5.67 per cent) of para 6, and 10 (3.33 per cent) of para 7. Except women of 36 - 40 age group, para 3 women were more in all other age groups. Although a sizable number of 105 women (35 per cent) in the sample were between 21 and 25 years of age, 50 per cent of them had 3 children at the time of sterilisation.

18. The average duration of married life of respondents was 8.8 years and the average parity was 3.86. Parity was found to increase with years of married life pointing to the need for birth spacing methods if sterilisation at young age is to be prevented.

19. The large proportion of 76.67 per cent of women who underwent tubectomy as post partum procedure shows that the most favourable time to persuade women in favour of family planning is when they are hospitalised for delivery. While 19.67 per cent underwent tubal ligation after medical termination of pregnancy, there were only 1.60 per cent who accepted it as an interval procedure.

IV. CHARACTERISTICS OF TUBECTOMY ACCEPTORS STUDIED:

Significant social, demographic, religious, economic and educational characteristics of respondents were the following:-

1. The maximum number of acceptors belonged to the 26-30 age group (42.66 per cent), while the others belonged to age groups 21-25 (32.33 per cent), 31-35 (15.56 per cent), 36-40 (6.00 per cent) below 20 (2.67 per cent) and above 41 (0.66 per cent).

2. All respondents were married and living with their spouses.

3. Hindus constituted 46.3 per cent of the sample of women studied whereas Christians and Muslims were 37.3 per cent and 16.3 per cent respectively.

While the proportion of Muslims in the sample was much lower than their proportion in the general population at the State and National level, it was higher than the District level. The proportion of Christians in the sample was much higher than their proportion in the District, State, or National proportion.

4. The largest number of acceptors (54.00 per cent) in the sample was drawn from the illiterate (16.33 per cent) and Primary school educated (37.60 per cent). While there were 26.30 per cent with elementary education, high school graduates were 20.60 per cent.

   Among husbands, while 10 per cent were illiterate, primary educated were 33 per cent, elementary 30.30 per cent, high school 23.60 per cent and college educated 1.66 per cent.

   Moslem women and their spouses predominated the illiterates in the sample studied. Proportion of Hindus in the sample increased with higher levels of education, while the proportion of Christians and Moslems did not show such marked relationship.

5. Most women in the sample (83.33 per cent) were earning daily wages from Rs.3 to Rs.8 per day. While 2 per cent held salaried jobs, 14.67 per cent were housewives.

   Majority of husbands (55.33 per cent) of women studied were manual labourers earning daily wages. While 22.67 per cent did skilled jobs, the rest were involved in fishing and trade. There were 1.33 per cent who were professional men. While 4.33 per cent of husbands had no jobs, one husband (0.33 per cent) lived by begging.

   The occupational analysis reveals the poor financial conditions from which acceptors of tubectomy came.

6. The largest proportion of women (43.33 per cent) had decided in favour of sterilisation after they had three children. The next largest group of 21 per cent women were of para 2. There were 19.33 per cent of women belonging to para 4, 7.33 per cent of para 5, 5.67 per cent of 6, and 3.33 per cent of para 7.

7. Number of children increased with lower levels of education. Religion of respondents did not show significant relationship with parity. The finding points to the potential which education has in breaking religious barriers against limiting of births.

8. At higher levels of education the education of husbands did not exert conspicuous impact upon family size, revealing the favourable impact which women's education has upon decisions to reduce births.

9. Marriage at 15 years and below had taken place among more Moslem women (22.45 per cent) than the Hindu (12.69 per cent) and the Christian (9.09 per cent). Higher ages at marriage were found more among Christian women than Hindu or Moslem women.

   Regardless of religion or educational differences, the largest proportion of respondents had got married between 16 and 20 years of age. However, higher education definitely had delayed marriages of respondents.

10. The number of lost pregnancies either by abortion or still birth was only 86 out of a total of 1,194 pregnancies which is 7.65 per cent. This shows that experience of child loss is an obstacle to women in accepting terminal methods of birth prevention.

11. Majority of acceptors (84.33 per cent) had no previous experiences in contraception. Among the 16.73 per cent that had, 51.06 were Nirodh users while 34.04 per cent were using loop and 12.77 per cent pills and 2.13 per cent natural methods.

C O N C L U S I O N

Findings of the study were examined in the light of the basic assumptions of the study, and they also formed the basis for specific suggestions in the interest of the official family planning programme.

HYPOTHESIS:

1. The hypothesis of the investigator that people have not come to accept sterilisation as the ideal method for family limitation has been disproved by the findings of the present study. The projection of sterilisation by Government as the ideal method for masses is also justified in the light of the greater popularity which the programme has succeeded to obtain among the illiterate and the semi-educated women than among the better educated.

2. The hypothesis that the programme of sterilisation has not yet made an impact on people as one that promotes happiness of family life is substantiated by the data. Although tubectomised women did benefit in terms of healthier and happier inter-familial relationships they were not aware of such values pre-operatively. Therefore it is unlikely that sterilisation has come to receive people's acceptance as a family welfare measure.

3. The acceptors of tubectomy were not victims of the fear of extra-marital indulgences as it was originally assumed in the study. Although in the personal experience of acceptors they had no such fears, they were of the opinion that such fears do stand in the way of women accepting tubectomy.

4. The findings have confirmed the initial assumption that couples who have complaints of post-operative psychologic morbidity are those whose family lives have not been happy pre-operatively.

Women who had accepted sterilisation in order to reduce marital conflict with husband was disappointed as no significant change was brought about.

5. The assumption that well-adjusted couples undergo sterilisation without adverse effects on future family lives has been substantiated by the data. The finding affirms that not only couples go on without unpleasant consequences, but enhancement of interfamilial relationships was the experience of tubectomized women.

6. Being a surgical procedure sterilisation was feared by a sizable proportion (35.5 per cent) of tubectomized women studied as was assumed in the study. However in real experience 18.22 per cent of acceptors alone considered the operation as very painful, and 9.36 per cent worse than expected, showing a still smaller proportion who subscribed to such fears. The findings does not indicate a considerably alarming situation as was assumed by the researcher.

7. Psychological and religious barriers do not pose serious obstacles to acceptance of sterilisation according to the findings of the present study.

S U G G E S T I O N S

1. The finding that acceptance of family planning and its favourable outcome were pronounced in families where good interfamilial relationships existed calls for a new approach to the entire Family Planning Programme that would give emphasis to favourable family

relationships as a condition precedent to successful implementation of the Family Planning Programme.

The need for family counselling services to build up and enhance good family relationships are called for.

2. The ineffectiveness of our educational efforts in motivating couples to accept family limitation as a means for its personal benefits to family members especially that for the mother and the child is evident from the findings.

Economic benefits are attractive inducements for family planning acceptance by the economically backward sections of people. However, failure to improve financial conditions of the family in future can eventually destroy faith in the method accepted. Non-monetary gains which family limitation brings are personally experienced by couples and therefore can contribute to the building up of confidence about the method in acceptors. The convinced acceptors with personal experience will be the most effective campaigners for family planning in society.

The Programme would gain popularity if non-economic values of sterilisation are emphasised by motivators and educators that are involved in family planning.

The use of satisfied and happy acceptors of sterilisation in motivational work needs serious consideration.

3. With adequate education and motivation even illiterates and semi-educated can be encouraged to become family planning acceptors. Illiteracy is not a barrier that need to be eradicated before family planning education can be imparted.

However, the effect of improving women's educational levels, and employment opportunities upon family planning acceptance cannot be overlooked.

4. Fear of physical morbidity following tubectomy being the most serious deterrent to its acceptance by women, pre and post-operative attention to physical complaints of acceptors will be absolutely necessary to remove such fears.

5. In order to make the programme of sterilisation demographically effective, the need to cover younger acceptors is urgent. Advocating a terminal method such as sterilisation to younger age groups will not be fair. In spite of its irreversibility, the readiness of younger age groups to accept sterilisation shows the fervent need of women to prevent unwanted pregnancies.

Information on spacing methods and making available such services to women of younger age groups can alone make younger women acceptors of family planning. Acceptance of spacing methods can effectively help women to postpone pregnancies and reduce birth rates faster and more substantially.

Women's choice of sterilisation for its reliability and dependability as a method that does not require any continuing attention of the consumer, is provided by the semi-permanent method 'Loop' which while being reversible, offers protection without need of constant attention. The overall continuation rate of loop is reported to be 50 to 80 per cent after 12 months.* The experience of China where 40 million women are satisfied acceptors of loop opens up the potential and scope for advocating loop in the country as a method for spacing births.

6. Acceptors of tubectomy should be properly screened so that women undergo the procedure with personal conviction of its acceptability emotionally, socially and ethically. This will not only guarantee voluntary choice of the method but would safeguard against much of unfavourable publicity for the programme by acceptors.

7. Fear of child loss is a serious deterrent to couples in accepting sterilisation. Provision of adequate

* IUDs : Population Reports: Series B, No.4, July 1982.

health care to children will alone release couples from the fear of infant and child mortality and encourage them to accept the small family norm.

8. Adequate counselling of women during hospital stay for confinement can be very effective in persuading them to accept family planning practices according to their individual needs.

9. Programmes to extend medical facilities in rural areas can be very effective in reaching rural women at confinement and persuading them in favour of accepting contraception.

AREAS FOR FURTHER RESEARCH:

1. Follow-up of acceptors of tubectomy to assess the long-term impact of tubal ligation upon interfamilial relationships will make the findings of the study more reliable.

2. Religious and moral barriers that stand in the way of acceptance of tubal ligation can be investigated by studying samples of the general population.

3. Barriers against acceptance of I U D should be subjected to scientific investigation.

4. Need by newly married couples for spacing methods should be established by scientific studies.

APPENDIX-A

INTERVIEW SCHEDULE No.I

(Translation from Malayalam)

IMPACT OF STERILISATION ON FAMILY RELATIONSHIPS

Date of Interview:

I PERSONAL DATA:

Name :

Address :

1. Age: (2) Mother Tongue:

3. Religion : Hindu Muslim Christian Other

Community ____ ____ ____ ____

4. Education : Illiterate Literate Primary Elementary High School College Graduate Post-graduate

5. Marriage : First Second Third

How long married: ____ ____ ____

6. Children living: No.deceased

Boys: ____ ____ ____ ____

Girls: ____ ____ ____ ____

7. Kind of delivery: No.

Normal -

Forceps -

Caesarean -

8. Lost Pregnancy: No.

   Still birth -

   Abortion -

   Miscarriage -

9. Occupation : Household work________

   Outside work ________

10. Income : Rs.________/day Rs.________/month

II. DATA OF HUSBAND:

1. Age: (2) Mother tongue:

3. Religion : Hindu Muslim Christian Other

   Community : ______ ______ ______ ______

4. Education: Illiterate Literate Primary

   Elementary High School College

   Graduate Post-graduate

5. Occupation: Coolie Trade Agriculture Fishing

   Professional Clerical Other

III. FAMILY DATA:

Children's order of birth	Male	Fe-male	Age	Education	Occupa-tion	Living with parents
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						

IV. MOTIVATION TO STERILISATION:

1. Experience in contraception : Yes____ No____

   If yes;

	Methods used	Satisfied	Not satisfied
1.			
2.			
3.			
4.			

2. Reasons for satisfaction or dissatisfaction:

Method	Satisfaction	Dissatisfaction

3. Source of knowledge about sterilisation:

   a) Husband
   b) Parents
   c) In-laws
   d) Relatives
   e) Friends
   f) Newspaper
   (g) Books
   (h) Radio
   (i) Cinema
   (j) Government officials
   (k) Doctor
   (l) Para-medical personnel

4. Source of encouragement for operation:

   Own ______ Husband ______ Parents ______

   In-laws______ Relatives______ Friends ______

   Doctor ______ Others________

5. If own decision, husband's attitude?

   Encouragement________ Consented________

   Not agreeable______ Have not informed ______

   Opposes __________.

6. Reasons for not informing husband:

7. Reasons for husband's objection:

8. If husband's encouragement, your reasons for submitting to sterilisation?

   a) To please husband ________________
   b) To avoid husband's displeasure ________
   c) For peace in the home ____________
   d) Other ______________________________

9. Your feelings toward sterilisation:

(a) Fear	(d) courageous
(b) Indifferent	(e) Feel guilty
(c) Welcomes	(f) Feel ashamed

10. Who may oppose your getting sterilised?

Family members : ________

Community people : ________

Neighbours : ________

V. EXPECTATIONS FROM OPERATION:

1. Encouraging features of operation:
   (a) Avoid future pregnancy
   (b) Peace in the home
   (c) Improve husband-wife relations
   (d) Economic benefits
   (e) Better care of children
   (f) Benefit mother's health
   (g) Improve children's health
   (h) Better education to children
   (i) Stability to married life
   (j) Reduce housing problems
   (k) Others

2. Discouraging factors:
   (a) Will affect bodily health
   (b) Mental disturbances
   (c) Sexual problems
   (d) God's wrath
   (e) Marital infidelity
   (f) Others

VI. OUTLOOK TOWARD OPERATION:

(a) Disturbed about others coming to know of your getting sterilised:

Yes ______ No ______

(b) Likely reactions of others should they come to know:

	Happy	No objection	Will oppose	Unconcerned
1) Husband -				
2) Children -				
3) Parents -				
4) Neighbours-				
5) Community -				
6) Religious heads -				

VII. RELATIONSHIP WITH HUSBAND:

1. Quality of inter-spouse relations:

   Very cordial _____ Cordial ______ Occasional ____

   Differences _______ Frequent quarrels _______

   Always conflicts ____________

2. Kind of man husband is:

   Very patient ________ Quite forbearing _______

   Lose temper quickly__________ Friendly _______

3. Husband's relations with others:

   Very well-mannered _________ Polite _______

   Tolerably polite _________ Impolite ______

4. Where does husband spend time after work?

	Always	Most of the time	Little time
In the home -			
Outside -			

5. Manner of spending time at home by husband:

   With children : ____________

   Attending to household: ________

   Helping spouse : ____________

   Reading : ____________

   Other : ____________

6. Decision making in the home:

	Husband	Wife	Jointly
a) Finance -			
b) Household -			
c) Children's education -			
d) Children's clothes -			
e) Religious affairs -			
f) Sexual matters-			

7. Relations with husband from the time of marriage:

   a) Steadily improved
   b) Steady deterioration
   c) No considerable change
   d) Extremes of love and discord.

8. Difficulties in sexual life: Yes ____ No ____

Quality of sex-life:

	Very much interested	Not much interest	Not at all interested	Indifferent
Wife -				
Husband -				

9. How differences on sex matters settled?

	Yield	Suppress desire	Show dissatisfaction	End in Quarrel
Husband -				
Wife -				

10. Joint activities of the couple:

Cinema & other entertainments : ________

Social activities : ________

Entertaining : ________

Pets and domestic animals : ________

Agriculture : ________

Gardening : ________

Music & other arts : ________

Others : ________

11. Habits of husband: Drinking/Smoking/gambling/other

VIII. PARENT-CHILD RELATIONSHIP:

1. Problems of managing children: Yes ____ No ____

Disobedient ________ Irresponsible ________

Not interested in studies ______ No love ______

Quarrelling ________ Lacks cooperation ______

2. How problems are settled?

Punishment ________ Reprimand ________

Report to father ______ Won't interfere ______

Threat ________ Other ________

3. Kinds of punishment?

	Beating	Withdraw	Advice	Deny Food	Lock up
Wife -					
Husband -					

4. What do children mean to you?

		Father	Mother
Joy	-		
Nuisance	-		
Burden	-		
Nothing particular	-		

5. Children's feelings to you?

	Love	Fear	Respect	Contempt	Pity	Disgust	Gratitude	Nothing
Mother -								
Father -								

6. How children help parents?

		Sons	Daughters
1. Economically	-		
2. Household work	-		
3. Work outside home	-		
4. Father's work	-		
5. Mother's work	-		

7. Level of parent's satisfaction in giving children what they want?

	Yes	No		Yes	No
a) Money -			(f) Health -		
b) Food -			(g) Discipline-		
c) Accommoda-tion -			(h) Character-		
d) Education -			(i) Clothes		
e) Comforts -			(j) Toys		

8. Reasons for inability to give children what parents want:

Area	Reason

IX. MEDICAL REPORT ON PATIENT:

Admitted for
(1) Delivery
(2) M.T.P.
(3) P.P.S.
(4) Interval sterilisation.

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APPENDIX-B

INTERVIEW SCHEDULE No. 2.

(Translation from Malayalam)

IMPACT OF STERILISATION ON FAMILY RELATIONSHIPS

Date: ____________

Name :

Address :

I. Experiences of operation and after:

1. Operation painful?

   Very painful/no pain at all/not painful as expected/ more painful than expected/normal pain

2. Place of stay after operation?

   With husband ________ With parents ________
   In-laws ____________ Others ________

3. Has normal health been regained?

   Fully ______ More or less ______ Being recovered ______ No considerable recovery ________ Deteriorated ________

4. Signs of incomplete recovery of health?

   (a) (b)
   (c) (d)

5. Mental well-being after operation?

   Satisfied ____________ Not satisfied _____

6. Reasons for dissatisfaction?

   (a) Concerned about bodily health
   (b) Fears operation has damaged physical well-being.
   (c) Should not have done the operation.
   (d) Did a mistake in getting sterilised.
   (e) Fear God's wrath
   (f) Fears sexual difficulties.

7. Hopes of future recovery?

	Comple-tely	Not Sure	Indiffe-rent	Not po-ssible	Will dete-rio-rate
a) Bodily health-					
b) Mental "					

II. Husband-Wife Relations

a) Husband's attitude in the last one month after operation?

Very happy/kind/more affectionate/as before/ indifferent/not pleasant.

b) When compared with pre-operative relations?

Has improved ______ Deteriorated __________

No change ________

III. Parent-Child Relations

a) Your feelings to children after operation?

As before/more affectionate/more concerned/ less care.

b) Children's attitude to you?

Sympathy/helpful/unconcerned/as before/more affectionate/less concerned/not old enough.

IV. Expectations for future

	Will improve	Not sure	Will not improve
a) Husband-wife relations -			
b) Sexual relations -			
c) Financial condition-			
d) Care of children -			
e) Children's health -			
f) Mother's health -			

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APPENDIX - C

INTERVIEW SCHEDULE No.III

(Translation from Malayalam)

IMPACT OF STERILISATION ON FAMILY RELATIONSHIPS

Date of interview:________

Name :

Address :

I. PHYSICAL WELL-BEING:

(a) Bodily health after operation?
improved/as before/slightly deteriorated/very bad.

(b) Signs of deterioration in health?

II. MENTAL WELL-BEING:

React to following statements:

	Yes	No
(a) It was useful to have undergone the operation -		
(b) Should have done it earlier -		
(c) Feel relieved after operation -		
(d) Feel fearful whether operation would harm bodily health -		
(e) No peace of mind after operation-		
(f) Fears God's punishment for getting sterilised -		

III. HUSBAND-WIFE RELATIONS:

1. Respond to the following:	Husband	Wife
a) More mentally relieved than before -		
b) More relaxed for sexual relations -		
c) Feel occasionally guilty for undergoing sterilisation -		
d) Fear adverse effect on mental health -		

	Husband	Wife
e) Fear marital infidelity -		
f) Should not have done the operation -		

2. Getting along with husband post-operatively.
   a) No difficulty at all/occasional difficulties/ always discord.
   b) I wish for greater harmony/less disharmony/ always harmony.

3. Decision making: Husband, wife or jointly?

	Al-ways	Of-ten	Occa-sional	Sel-dom	Never
a) Money matters -					
b) Household works -					
c) Outside tasks -					
d) Children's edu-cation -					
e) Children's clo-thes					
f) Children's disci-pline					
g) Husband's attire					
h) Wife's attire					
i) Sexual matters					
j) Health problem of members					

4. The following statements are applicable to whom?

	Husband	Wife
a) Loses temper quickly -		
b) Forgives easily -		
c) Firm in any situation -		
d) Loses courage easily -		
e) Persevering -		
f) Lasting grudges -		
g) Accommodative -		

5. Satisfied sexually?

Yes _____ More or less _____ Not much _______

Not at all _______

6. Complaints about husband sexually?

a) Not interested in sex at all
b) No considerable interest
c) Inordinate interest
d) Normal interest only

7. Expectations for future sex life?

	As Before	Will improve	Deterioration possible	Not certain
a) Husband's interest -				
b) Wife's -				

8. Household responsibilities - Husband, wife or jointly?

	Husband	Wife	Jointly
a) Household work -			
b) Care of children -			
c) Children's discipline -			
d) Social functions -			
e) Financial affairs -			
f) Religious activities -			

IV. PARENT-CHILD RELATIONS:

1. Problems in managing children?

Yes _____ Occasionally _____ Often _____

Always _______

2. Children are:

Obedient _______ Submissive _____ Indisciplined _______ unruly _________

3. What do children mean to you?

Joy _____ Pride _____ Help _____ consolation ____

Nuisance _____ Burden _______

4. Parents' relation to children?

	Friendly	Authoritative	Punishing	Liberal
Father -				
Mother -				

5. Respond to following statements:

	Yes	No
a) Less difficulty to manage children after operation -		
b) More time now to care for children -		
c) Feel more affectionate to children after operation -		
d) More anxious now when children fall ill -		
e) Feel guilty when children become sick -		
f) God's wrath is felt when children take ill -		
g) Children get along better after operation -		

6. Children's attitude to parents?

	To Father	To Mother
a) Respect -		
b) Love -		
c) Sympathy -		
d) Confidence -		
e) Pride -		
f) Admiration -		
g) Indifferent -		
h) Rivalry -		
i) Contempt -		

7. Able to give children what you want to?

		Yes	No
a) Money	-		
b) Food	-		
c) Education	-		
d) Comforts	-		
e) Health care	-		
f) Discipline	-		
g) Character	-		
h) Clothes	-		
i) Reescation facilities	-		

8. Reasons for inability to give?

V. ABILITY TO RUN THE HOUSEHOLD:

1. How will you rate your post-operative ability?

		Improved	Deteriorated	As before
a) Interest	-			
b) Efficiency	-			
c) Health to work	-			
d) Ability for hard work	-			

2. React to following statements:

		Yes	No
a) Better able to do household tasks after operation	-		
b) Don't feel healthy enough to attend to household work	-		
c) Feel sick to do work post-operatively	-		
d) I don't feel household work a burden	-		
e) More interested to do work in the home	-		
f) Will need assistance with household work for some more time	-		

VI. EXPERIENCE IN MOTIVATING OTHERS:

1. Encouraged other women for sterilisation: Yes ____
No ____

2. Reasons given to convince?

(a)

(b)

(c)

3. Your opinion about the acceptability of sterilisation?

To all ____ To some ____ To none ________

4. If given another chance, would you opt for sterilisation?

Yes ______ No ______

If no, what other method?

5. Why women in general object to sterilisation?

(a)

(b)

(c)

6. Was your knowledge about sterilisation adequate?

Yes ______ No ______

If no, what knowledges would you recommend for imparting?

(a)

(b)

(c)

With better knowledge will more women volunteer for sterilisation?

Yes ______ No ______ Don't know ______

7. Why do women fear sterilisation?

	Yes	No
a) Marital fidelity can be lost -		
b) Bodily health will be affected adversely -		
c) Peace of mind of couples will be lost -		

	Yes	No
d) Fear of losing children	-	
e) Fear of God's punishment fall upon the family	-	

8. Who will be the most effective motivator to persuade women to accept tubectomy. (mark preferences)

Husband	Nurse	Government officials
Doctor	Friends	Religious heads
Parents	In-laws	

9. Will sterilisation contribute to family welfare? (React to following statements)

	Yes	No
a) Will improve family's general welfare	-	
b) Financial gains will accrue	-	
c) Enhance mother's health	-	
d) Children's health will improve	-	
e) Will bring peace in the family	-	
f) Improve inter-spouse relations	-	
g) Will destroy marital fidelity	-	
h) Bring shame to children	-	
i) Invite God's punishment to family	-	

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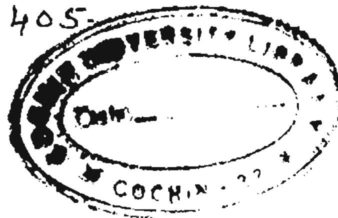
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The new twenty-point programme formulated and published by the Central Government of India highlights the issue of family planning as a programme to be promoted on a voluntary basis as a "People's movement". The urgency in the matter is brought to focus with realism and unambiguity.

> "The population of India has doubled itself since Independence, from 34.2 crores in 1947 to 68.4 crores in 1981. It is obvious that a further increase in population at the present rapid rate will nullify all the gains of our development effort. Reduction of death rate has been brought about through improvement in public health and medical aid. But we have not been able to make any appreciable curb on fertility. The birth rate per thousand population is estimated to be about 37 for the mid-census period of 1971-81. At the current growth rate the population will cross the 100 crore mark by A.D. 2000. The sixth Plan document has laid down the goal of reducing the birth rate to 21, the death rate to 9 and the infant mortality rate below 50. This target will require that the percentage of couples practising family planning should go up from 22.5 per cent to 36.5 per cent by 1984 - 85".[8]

The adoption of a small family norm does not imply birth prevention alone, but spacing of births too. Education in family planning will bring about "Conception by choice" it is hoped.

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[8] Government of India, Directorate of Advertising and Visual Publicity, The new 20 point programme, Information and Broadcasting, New Delhi, 1982.