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Child Survival and Family Planning Acceptance

Introduction

FAMILY planning improves the health of women by limiting the number of cycles of pregnancy and lactation. A woman with a large number of children increases her own and her children's risk of illness or death.

There are economic, social and biological reasons for parents to depend on children and to have children. Children are more than the object of their parents' attention and love and they are also a biological and social necessity. The human species perpetuates itself through children; cultural, religious, and national groups transmit their values and traditions through children; families maintain their lineage through children; and individuals pass on their genetic and social heritage through children. The ultimate value of children is the continuity of humanity. But the social imperatives reflected in the thoughts, feelings, and behaviour of those who produce children, the parents, differ.

Why people want children is a very difficult question to answer because it involves economic, social and psychological dimensions which cannot be easily disentangled and which vary tremendously among societies and among individuals within societies.

The links between birth rates and death rates are many and complex. But the bottom line is that there has never been a significant and sustained fall in birth rates which have not been preceded by a significant and sustained fall in child death rates (UNICEF 1987: 12). One reason for this is when parents become more confident that their children will survive, they tend to have only the number of children they actually want, rather than 'compensating' for likely deaths by extra births. Another related reason is that the parents of a child who dies in infancy tend to have another child soon. This is what is called child ensurement and replacement effect.

Micro-level studies regarding the impact of child death in a family on the parents' subsequent fertility indicate that there is more fertility response to a child death but that most families are unable or unmotivated to replace a deceased child with another live birth, in addition to those that would be expected in the absence of child death (Preston 1975:191).

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As most families would not replace the deceased child, the fertility reduction owing to 'replacement effect' is likely to be smaller in magnitude than the mortality reduction.

Objective

The objective of this paper is to analyse the relationship between child survival and acceptance of family planning.

Methodology

This study is conducted in Prakasam district of Andhra Pradesh. Ongole taluk of Prakasam district is selected for actual sample survey. The sampling technique used in this study is 'Cluster Random Sampling Technique'. In the first stage, the taluk is divided into two groups, i.e., urban and rural to facilitate comparison. For the urban area, the Ongole town is chosen and it is the only town under urban area in this taluk. With the help of the field map of Ongole town, the 58 wards of the town are divided geographically into four divisions and from each division one ward is chosen at random for collecting the data. From the selected wards of each division, 50 currently married women in the reproductive age group with or without children are selected for the study. Thus, the total sample in the urban area is two hundred (200). According to 1981 census, Ongole taluk comprises 48 villages. For the rural area, these 48 villages of Ongole taluk are divided into four geographical sectors with the help of the taluk map of the census. One village is selected at random from each geographical sector. Thus, four villages are selected from the rural area of Ongole taluk for rural study based on geographical stratification. From each village, one hundred (100) currently married women in the reproductive age group with or without children are selected at random for the study. The list of currently married women is available with the ANM and the same is used as a sampling frame. The sample size in the rural area is four hundred (400). Thus, the total sample size is 600 in this study. With the help of a scoring technique, the respondents are classified into three categories: 1) not responsible parents, 2) moderately responsible parents, and 3) responsible parents.

Different variables are considered to determine the status of responsible parenthood separately for the women with children and without children. The variables that are considered to determine the status of responsible parenthood for the women without children are ideal age at marriage for boys, ideal age at marriage for girls, ideal interval between marriage and first conception, desired number of children to have, continuing pregnancies till a son is born, favourable attitude towards sex education to children, necessity of family life education, knowledge of birth spacing that leads to better health and reduction of infant mortality; ideal interval between one pregnancy and another pregnancy, knowledge of nutritious food during pregnancy and lactation. And the variables considered for the women with children are the above said ten variables plus another fourteen variables, namely, educational aspirations for sons, educational aspirations for daughters, occupational aspirations for son, occupational aspirations for daughters, favourable attitudes to extra curricular activities of children, encouragement to participate in sports and games; special diet given for children, regular health check up at the time of pregnancy, period of breastfeeding,

services utilized at the time of morbidity of children, services utilized at the time of morbidity of mother, immunization to children, family planning adoption, thinking of using any family planning method at present.

The minimum and maximum score for each variable/item is zero (0) and two (2) respectively. The score value is assigned depending upon the answers provided by the respondents for each twenty-four questions concerned. This can be explained clearly in the following way with an example. The question posed to the respondent is "what is the ideal interval between marriage and the first conception"?. The answers may be, less than one year, one year, two years, three years and so on. The score values given to these answers are as given below:

Ideal Interval	Score value
< 2 years	0
2 years	1
3 years and more	2

Thus, for each question there are different score values. Since only ten questions (items) are considered for the respondents with no children, the minimum and maximum score values for these ten items are zero and 20, respectively. Similarly, for the 24 items that are considered for the respondents with at least one child, the range of score values is from zero to forty-eight. Based on these score values, the respondents are classified into: 1) not responsible parents, 2) moderately responsible parents and 3) responsible parents. The procedure for classifying the parents is as follows:

- 1) Not responsible parents: Women whose score value is equal to or less than forty nine per cent (49%) of the total score.
- 2) Moderately responsible parents: Women whose score value lies between 50 per cent and 59 percent.
- 3) Responsible parents: Women whose score value is equal to 60 per cent and above.

This status of responsible parenthood is cross-classified with demographic, social stratification variables, health variables and family planning variables. Similar type of scoring technique is also followed by Population Crisis Committee, Washington, to classify the country ranking of status of women into excellent, very good, good, fair, poor, very poor, and extremely poor covering 99 countries representing 92 per cent of the world's female population (Population Crisis Committee 1988).

Results and Discussion

Child Ensurement

In this study, women were asked whether it is necessary to have more children for ensuring the survival of the required number and also the necessity of replacement of the

babies lost. From Table 1, it is observed that about 89 per cent of the respondents with children felt that it was not necessary to have more children for ensuring the survival of a few of them. This attitude is expressed by 92 per cent of responsible women, 89 per cent of moderately responsible women and 88 per cent of not responsible women in the study area.

TABLE 1 : NUMBER AND PERCENTAGE DISTRIBUTION OF RESPONDENTS BY STATUS OF PARENTHOOD ACCORDING TO THE ATTITUDE WHETHER TO HAVE MORE CHILDREN FOR ENSURING THE SURVIVAL OF DESIRED NUMBER

<i>Status of parenthood</i>	<i>With children</i>		<i>Without children</i>	
	<i>Not necessary</i>	<i>Total</i>	<i>Not necessary</i>	<i>Total</i>
Urban				
1.	42 (89.9)	47 (100.0)	7 (77.8)	9 (100.0)
2.	59 (90.8)	65 (100.0)	11 (91.7)	12 (100.0)
3.	57 (89.1)	64 (100.0)	3 (100.0)	3 (100.0)
Total	158 (89.8)	176 (100.0)	21 (87.5)	24 (100.0)
Rural				
			+	
1.	146 (87.4)	167 (100.0)	29 (72.5)	40 (100.0)
2.	115 (88.5)	130 (100.0)	15 (88.2)	17 (100.0)
3.	36 (97.3)	37 (100.0)	9 (100.0)	9 (100.0)
Total	297 (88.9)	334 (100.0)	53 (80.3)	66 (100.0)
Total				
1.	188 (87.9)	214 (100.0)	36 (73.5)	49 (100.0)
2.	174 (89.2)	195 (100.0)	26 (89.7)	29 (100.0)
3.	93 (92.1)	101 (100.0)	12 (100.0)	12 (100.0)
Total	455 (89.2)	510 (100.0)	74 (82.2)	90 (100.0)

1. Not responsible parents. 2. Moderately responsible parents. 3. Responsible parents.

In urban area, about 90 per cent of respondents with children expressed that there was no need for more children for ensuring the survival of a few of them. About 91 per cent of moderately responsible women, and about 90 per cent each of responsible and not responsible women in urban area held this opinion.

In rural area, 89 per cent of respondents were against having more children for child ensurement. And this opinion was expressed by 97 per cent of responsible women, 88 per cent of moderately responsible women and 87 per cent of not responsible women.

It is interesting to note that even among the respondents without children, this attitude was held by 82 per cent; it was highest among responsible women (100%), followed by moderately responsible women (90%) and not responsible women (74%). Similar trend is observed among urban and rural childless respondents. So, on the whole, there is a negative attitude to large number of children for ensuring the survival of required number of children.

Child Replacement

Respondents were asked whether it is necessary to replace the child loss or not. About 96 per cent of the respondents with children were not eager for child replacement. This attitude was held by highest proportion of responsible women (98%), followed by moderately responsible women (96%) and not responsible women (95%) (Table 2).

In the urban area, about 95 per cent of women with children said 'No' to child replacement, and it was expressed by 97 per cent of responsible women, and 94 per cent each of moderately responsible and not responsible women in the urban area.

In the rural area also, about 97 per cent of the respondents with children were not in favour of child replacement. And this opinion was held by cent-per-cent of the responsible women, followed by moderately responsible women (98%) and not responsible women (96%). As explained regarding child ensurement, attitude towards child replacement was also similar among childless women (Table 2).

This negative attitude towards child ensurement and child replacement in this study is due to different factors like cost of bearing and rearing of children, uncertain trend of old age security because of social changes and increasing trend towards small family norm, etc.

Cain (1981) found that the functioning of credit co-operative and public relief employment schemes in the villages of the Indian states, Maharashtra and Andhra Pradesh, along with relatively greater access of women to productive activities made their inhabitants, particularly widows, less vulnerable to risk from natural disaster (e.g. flood and drought) and consequently less dependent on children as risk insurance than the villages in Bangladesh. It seems reasonable to infer from the above discussion that introduction of old age social security programmes (as in developed countries) and other appropriate institutional changes (as in Maharashtra and Andhra Pradesh states of India) may contribute to a decline in the fertility level of less developed countries.

TABLE 2 : NUMBER AND PERCENTAGE DISTRIBUTION OF RESPONDENTS BY STATUS OF PARENTHOOD ACCORDING TO THE ATTITUDE ON REPLACEMENT OF BABIES LOST

<i>Status of parenthood</i>	<i>With children</i>		<i>Without children</i>	
	<i>No.</i>	<i>Total</i>	<i>No.</i>	<i>Total</i>
Urban				
1.	44 (93.6)	47 (100.0)	8 (88.9)	9 (100.0)
2.	61 (93.8)	65 (100.0)	11 (91.7)	12 (100.0)
3.	62 (96.9)	64 (100.0)	3 (100.0)	3 (100.0)
Total	167 (94.9)	176 (100.0)	22 (91.7)	24 (100.0)
Rural				
1.	160 (95.8)	167 (100.0)	34 (85.0)	40 (100.0)
2.	127 (97.7)	130 (100.0)	17 (100.0)	17 (100.0)
3.	37 (100.0)	37 (100.0)	9 (100.0)	9 (100.0)
Total	324 (97.0)	334 (100.0)	60 (100.0)	66 (100.0)
Total				
1.	204 (95.3)	214 (100.0)	42 (85.7)	49 (100.0)
2.	188 (96.4)	195 (100.0)	28 (96.6)	29 (100.0)
3.	99 (98.0)	101 (100.0)	12 (100.0)	12 (100.0)
Total	491 (96.3)	510 (100.0)	82 (91.1)	90 (100.0)

1. Not responsible parents. 2. Moderately responsible parents. 3. Responsible parents.

Opinion Regarding Possible Lowering of Fertility if Child Mortality Declined

It has been generally accepted that a decline in infant and child mortality is an important factor in fertility decline. The World Population Plan of Action states that "Sustained reductions in fertility have generally been preceded by reductions in mortality. Although

this relationship is complex, mortality reduction may be a prerequisite to a decline in fertility". The level of infant and child mortality may affect the demand for births because of the desire to replace children who have died and the desire to ensure the survival of a certain number of somewhat older children. Potentially the most important is the desire for insurance against future uncertainty because it is the only one that affects desired family size and is therefore seen to increase the motivation for fertility control as mortality declines. The strength of this effect, which is difficult to measure statistically, will depend on parents' perception of a general decline in mortality and the relative importance of children as a source of old age support. More generally, an environment of greater certainty about the future, which accompanies a decline in mortality will increase parents' motivation for fertility control as they recognise the opportunity to chart their own future and make greater commitments through education and other investments in their living children. In a cross-cultural regression analysis, Heer (1966) found infant mortality level to be one of the strongest and most consistent predictors of fertility level.

In this study parents were asked whether they think that if less children died, young couple would choose to have fewer children. May be due to the long experience with high infant and child mortality, the respondents, particularly in the rural area, put blank faces at first to this question. After some explanation they understood the concept and gave their indefinite answer at least.

About 93 per cent of the respondents in the study area said 'don't know' and 'not definite' to this question. Only four per cent of respondents said 'yes' to this question. This indefinite opinion is expressed by about 97 per cent of not responsible women, 96 per cent of moderately responsible women and 79 per cent of responsible women in this study. From Table 3 we can say that there is a decline in the ignorance with the increase in status of parenthood. There is a significant association between status of parenthood and desire for fewer children, if infant mortality is lower ($\chi^2 = 38.8$, for 2 d.f., significant at 1 per cent level).

In the urban area, only 8.5 per cent of the respondents said 'yes' to this question. But about 85 per cent of the respondents were in dilemma to say 'yes' or 'no' and said 'don't know' or 'not definite' to this question. Perhaps because they have long observed high infant mortality and child mortality, they were not in a position to give definite opinion. The proportion holding this indefinite opinion was higher among not responsible women (92%) than among moderately responsible women (91%) and responsible women (73.5%).

But the proportion answering the question in the affirmative was higher among responsible women (16%) than moderately responsible women (5%) and not responsible women (4%) in the urban area.

In the rural area, as high as 98 per cent of the respondents did not have a definite answer to the question. The proportion of such respondents was higher in the rural than in the urban area. The variation is significant at 1 per cent level ($Z = 5.4$). And also, this opinion was expressed by higher percentage of not responsible and moderately responsible women (about 99%) than responsible women (89%) in the rural area.

So, responsible women were in a comparatively better position to understand and analyse the things and gave a definite opinion. The same trend is observed among childless women also.

TABLE 3: NUMBER AND PERCENTAGE DISTRIBUTION OF RESPONDENTS BY STATUS OF PARENTHOOD ACCORDING TO THE OPINION ON RELATION BETWEEN LOW CHILD MORTALITY AND LOW FERTILITY

<i>Status of</i>	<i>With children</i>				<i>Without children</i>			
	<i>Yes</i>	<i>No</i>	<i>Not definite</i>	<i>Total</i>	<i>Yes</i>	<i>No</i>	<i>Not definite</i>	<i>Total</i>
<i>(1)</i>	<i>(2)</i>	<i>(3)</i>	<i>(4)</i>	<i>(5)</i>	<i>(6)</i>	<i>(7)</i>	<i>(8)</i>	<i>(9)</i>
Urban								
1.	2 (4.2)	2 (4.3)	43 (91.5)	47 (100.0)	-	2 (22.2)	7 (77.8)	9 (100.0)
2.	3 (4.6)	3 (4.6)	59 (90.8)	65 (100.0)	1 (8.3)	1 (8.3)	10 (83.3)	12 (100.0)
3.	10 (15.6)	7 (10.9)	47 (73.5)	64 (100.0)	-	-	3 (100.0)	3 (100.0)
Total	15 (8.5)	12 (6.8)	149 (84.7)	176 (100.0)	1 (4.2)	3 (12.5)	20 (83.3)	24 (100.0)
Rural								
1.	2 (1.2)	-	165 (98.8)	167 (100.0)	1 (2.5)	1 (2.5)	38 (95.0)	40 (100.0)
2.	2 (1.5)	-	128 (98.5)	130 (100.0)		1 (5.9)	16 (94.1)	17 (100.0)
3.	3 (8.1)	1 (2.7)	33 (89.2)	37 (100.0)		-	9 (100.0)	9 (100.0)
Total	7 (2.1)	1 (0.3)	326 (97.6)	334 (100.0)	1 (1.5)	2 (3.0)	63 (95.5)	66 (100.0)

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(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Total								+
1.	4	1	208	214	1	3	45	49
	(1.9)	(0.9)	(97.2)	(100.0)	(2.0)	(6.1)	(91.8)	(100.0)
2.	5	3	187	195	1	2	26	29
	(2.6)	(1.5)	(95.9)	(100.0)	(3.4)	(6.9)	(89.7)	(100.0)
3.	13	8	80	101	-	-	12	12
	(12.9)	(7.9)	(79.2)	(100.0)			(100.0)	(100.0)
Total	22	13	475	510	2	5	83	90
	(4.31)	(2.5)	(93.1)	(100.0)	(2.2)	(5.6)	(92.2)	(100.0)

1. Not Responsible parents. 2. Moderately responsible parents. 3. Responsible parents.

TABLE 4: NUMBER AND PERCENTAGE DISTRIBUTION OF RESPONDENTS BY EDUCATION AND THEIR ATTITUDE (YES/NO/NOT DEFINITE) ON CHILD ENSUREMENT, CHILD REPLACEMENT AND THE DESIRE FOR LESS NUMBER OF CHILDREN IF THERE WILL BE LESS INFANT MORTALITY

Education	Child Ensurement 'No'			Child Replacement 'No'			Less infant mortality, less children desire (Not definite)		
	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
Illiterate	37 (94.0)	219 (84.6)	256 (84.8)	41 (95.3)	244 (94.2)	285 (94.4)	42 (97.7)	255 (93.5)	297 (98.3)
Primary	26 (89.7)	73 (94.8)	99 (93.4)	28 (96.6)	76 (98.7)	104 (98.1)	28 (96.6)	75 (97.4)	103 (97.2)
Secondary	68 (91.9)	50 (92.6)	118 (92.2)	68 (91.9)	54 (100.0)	122 (95.3)	66 (89.2)	52 (96.3)	118 (92.2)
College and others	50 (92.6)	8 (80.0)	58 (90.6)	52 (81.3)	10 (100.0)	62 (96.9)	48 (88.9)	10 (100.0)	58 (90.6)
Total	181 (89.5)	350 (87.5)	531 (87.8)	189 (94.5)	384 (96.0)	573 (95.5)	184 (92.0)	392 (98.0)	576 (96.0)

According to Omran (1976), about 45 per cent of the women believed that a decline in child mortality would result in fewer children being born; 28 per cent believed that it would not; and, the rest could not give an opinion.

Conclusions

Generally speaking, the empowering of mothers with today's knowledge about ways and means of improving their children's health can generate the confidence—the feeling of having control over their own life and the acceptance of family planning. In this sense, life saving techniques involving parental action— such as oral rehydration therapy and ensuring a full course of immunizations—can be linked directly to attitudes more conducive to smaller families. As the Director-General of the WHO has said, "the curative action can give her confidence that her child will survive. And it convinces her that she can take action to stop herself from having more".

In general, mortality decline has not always been necessary for fertility decline. In both France and the USA, fertility decline began before or simultaneously with mortality decline. This may have resulted from massive economic and social changes which shifted the demand for children downward. In many currently developing countries there may be massive changes which would lead parents to want fewer children than they could have with unrestricted fertility and existing mortality rates. This would lead to a demand to restrict fertility through contraceptives or to changes in age at marriage.

Though highest proportion of respondents were unwilling for child ensurement and child replacement, the proportion unwilling was a little higher among educated respondents than among illiterate or uneducated women (Table 4).

But indefinite answer was expressed by a higher proportion of uneducated women than educated women both in urban and rural areas.

References

- Cain, M., 1981, Risk and insurance: Perspectives on fertility and agrarian changes in India and Bangladesh, *Population and Development Review*, 7 (3), 435-475.
- Heer, David M., 1966, Economic development and fertility, *Demography*, 3 (2), 423-444. Omran, A. R. and Standley, C. C. (eds.), 1976, *Family Formation Patterns and Health, An International Collaborative Study, in India, Iran, Lebanon, Philippines, and Turkey*, WHO, Geneva. Population Crisis Committee, 1988, Population Briefing paper, No. 20, June, 1988, Washington, D.C. 20036. Preston, S. H., 1975, Health programmes and population growth, *Population and Development Review*, 1 (2), 139-199.
- Preston, S. H., 1978, *The Effects of Infant Mortality on Fertility*.
- UNICEF, 1987, *The State of World's Children*, New York.