

# Perceived reasons of rural mothers regarding family size at Cherlapally, India

Suguna Dumpala<sup>1</sup>, Guru Prasad Venna<sup>2</sup>, Nagaraj Konagunta<sup>2</sup>

<sup>1</sup>Department of Community Medicine, Mallareddy Medical College for Women, Suraram, Rangareddy District, Telangana, India.

<sup>2</sup>Department of Community Medicine, Kamineni Institute of Medical Sciences, Narketpally, Nalgonda, Telangana, India.

Correspondence to: Suguna Dumpala, E-mail: reachsuguna.dumpala@gmail.com

Received April 3, 2015. Accepted April 10, 2015

## Abstract

**Background:** In India, despite the availability of family planning (FP) methods since 1951, the use of FP remains low. It is not well-established how people make family decisions on the use of FP. Their perceptions about family size are not well-documented. These are important issues to be addressed to enhance the contraceptive use and lower fertility levels in India.

**Objective:** To identify the perceived reasons among rural mothers regarding family size.

**Materials and Methods:** A cross-sectional study was carried out at Rural Health Training Centre (RHTC), Cherlapally, Nalgonda, Telangana, India. RHTC covers a population of 1,700 spread out in 11 villages. The study subjects comprised all married women in the reproductive age group who limited their family by using permanent FP method. Data were collected from January to June 2014. Descriptive statistics were reported as percentages. A  $\chi^2$ -test was used to compare the family size with different demographic and socioeconomic categories. All statistical analysis was performed using Statistical Package for Social Sciences (SPSS, Inc., Chicago, IL, version 19);  $p < 0.05$  was considered as significant.

**Result:** Total subjects with  $\geq 3$  children were 184 (61.3%), and those with  $\leq 2$  children were 116 (38.7%). There was an association between larger families and age, education, and type of family groups, which were statistically significant ( $p < 0.05$ ). However, other variables such as larger family size and age at marriage did not show any association. The most common perceived reason for a larger family size was a desire for a male child or second male child (44%), followed by pressure from husband/mother-in-law (27%) and afraid of FP operation (11%).

**Conclusion:** Limitation of family was influenced by the interaction of family members/decision-makers about the family size and sex preferences at family level. Hence, effective intervention and attention of policymakers and researchers should be directed to meet the needs of rural women in India.

**KEY WORDS:** Family planning, family size, perceived reasons

## Introduction

In developing countries like India, the contraceptive use is low. It is still a male dominated society with patriarchal

values. Family planning (FP) has long been acknowledged as an effective public health intervention. Since the 1950s, India has been a leading country to voluntary FP programs. These programs provide health services and supplies that enable men and women to “decide freely and responsibly the number and spacing of their children and to have the information, education, and means to do so.” This is a fundamental human right, which was reaffirmed at the International Conference on Population and Development, Cairo, in 1994.<sup>[1,2]</sup> These programs have been effective in decreasing maternal mortality, child mortality, and promoting social and economic developments.<sup>[3]</sup> In developing nations, especially in south Asia, including Nepal, India, and Bangladesh,

Access this article online	
Website: <a href="http://www.ijmsph.com">http://www.ijmsph.com</a>	Quick Response Code: 
DOI: 10.5455/ijmsph.2015.03042015265	

International Journal of Medical Science and Public Health Online 2015. © 2015 Suguna Dumpala. This is an Open Access article distributed under the terms of the Creative Commons Attribution 4.0 International License (<http://creativecommons.org/licenses/by/4.0/>), allowing third parties to copy and redistribute the material in any medium or format and to remix, transform, and build upon the material for any purpose, even commercially, provided the original work is properly cited and states its license.

a strong cultural preference for sons is exhibited, which may influence the fertility desires and contraceptive use. Early child bearing and short birth intervals are common in India. The use of modern contraceptive methods is characterized by the predominance of female sterilization. The lack of understanding surrounding what influence FP use and how decision-making takes place in families has led to the inability of policy and programs to focus on the factors that are most important to help people control their fertility.<sup>[4]</sup> Various studies around the world showed that the fear of side-effects of FP is the most commonly cited reason for nonuse.<sup>[4–8]</sup> Diamond-Smith et al.<sup>[9]</sup> identified the fear of FP side-effects among women and men from India, Nepal, and Nigeria. Although contraceptive methods and services are frequently geared toward women, men are often the primary decision-makers on family size and their partner's use of FP methods.<sup>[10–12]</sup> Despite the ready availability of FP methods, the use of FP remains low in India. It is not well-established how people make family decisions on the use of FP. Their perceptions are also not well-documented. These are the important issues to be addressed to enhance the contraceptive use and lower fertility levels in India. This study, therefore, explored the family size decisions and perceptions among the mothers in the rural area of Nalgonda district, Telangana, India.

## Materials and Methods

This cross-sectional community-based study was conducted to assess the perceived reasons among the mothers about family size in the Rural Health Training Centre (RHTC), Cherlapally, which is the field practice area of the Department of Community Medicine, Kamineni Institute of Medical Sciences, Narketpally, Nalgonda, Telangana, which is in the southern part of India. RHTC covers a population of 1,700 spread out in 11 villages. The study subjects comprised all married women in the reproductive age group, who limited their family by using permanent FP method. Data were collected from January to June 2014. Assuming that 50% of population to be women (i.e.,  $1,700/2 = 850$ ) and 40% of them in the reproductive age (15–49 years;  $850/40 \times 100 = 340$ ), of whom 10% infertile ( $340 \times 10/100 = 34$ ), the sample size of 306 ( $340 - 34$ ) was rounded off to 300. Inclusion criteria were as follows: women between the ages of 15 and 49 years, married and completed their family by a permanent FP method, either tubectomy or husband underwent vasectomy. Those who were not willing to participate in the study were excluded. The operational definition of perceived reasons on family size was defined and characterized, which coincides with the individual's behavior with regard to the use of FP to limit the family. The trained medical students of semester VI interviewed the study subjects in local languages (i.e., Telugu and Hindi). A pretested structured questionnaire was used to record the data. Responses from surrogates were not permitted. A total of 300 subjects participated in the study. The social class of caste was assessed as

per the Social Welfare Department, Government of Andhra Pradesh. They were coded as open category (OC), backward class (BC), scheduled caste (SC), and scheduled tribe (ST). Occupation was assessed following the standard Indian classification system and coded as follows: skilled workers, unskilled workers, and professionals.<sup>[13]</sup> Additional category was “dependents,” which included housewives. The education level was classified as illiterate and literate. Data on the age, type of family, total number of children, number of girls and boys, FP methods used, and reasons for having two or less children and three or more children were collected. The primary outcome reflected on fertility decision, whether the desired family size had been achieved or not. This outcome reflected on the individual control over fertility and the ability to achieve the desired number of children. The perceived reasons of the study subjects with regard to the family size were analyzed. All the data presented as tables.

## Statistics

Descriptive statistics are reported as percentages. A  $\chi^2$ -test was used to compare the family size with different demographic and socioeconomic categories. All the statistical analysis was performed using Statistical Package for Social Sciences (SPSS, Inc., Chicago, IL; version 19);  $p < 0.05$  was considered as significant.

## Result

The sociodemographic characteristics of the study population are shown in Table 1. Their age ranged from 15 to 49 years. The maximum number of participants [184 (around 61%)] had  $\geq 3$  children; 102 (34%) of them were aged between 25 and 34 years, 41 (13.7%) of them between 35 and 44 years, and 27 (9%) of them between 15 and 24 years. Only 116 (38.7%) of the total study population limited their family with  $\leq 2$  children; most of them [46 (15.3%)] were aged between 35 and 44 years and 39 (13%) of them between 25 and 34 years. Illiterates were more [221 (73.7%)], of whom 125 (41.7%) had a larger family. Of the 219 (73%) unskilled workers, (133 (44.3%) of them completed their family with  $\geq 3$  children, followed by dependents/housewives [52 (17.3%)], of which 34 (11.3%) were with a larger family, and skilled professionals were only 29 (9.7%) in total. The Hindus were 282 (94%) in total; 167 (55.6%) belonged to BC, followed by SC and ST together [94 (31.4%)]. The subjects from nuclear family were 214 (71.3%), but still preferred a larger family were 142 (47.3%), and those with an extended family were 42 (14%). Many of the participants [144 (48%)] revealed a per capita income between Rs. 500 and 1,245, and 125 (41.7%) of them had larger families whose income was between less than Rs. 500 and 1,245. However, there was an association between the family size and age, education and type of family groups, which was statistically significant ( $p < 0.05$ ).

**Table 1:** Sociodemographic characteristics of the study population

Demographic characteristics	3 or more children, N = 184 (61.3%), n (%)	Up to 2 children, N = 116 (38.7%), n (%)	Total number = 300 (100%), n (%)	$\chi^2$
Age (years)				
15–24	27 (9)	07 (2.3)	34 (11.3)	28.904*
25–34	102 (34)	39 (13)	141 (47)	
35–44	41 (13.7)	46 (15.3)	87 (29)	
≥40	14 (4.6)	24 (8.1)	38 (12.7)	
Education				
Illiterate	125 (41.7)	96 (32)	221 (73.7)	7.313*
Literate	59 (19.6)	20 (6.7)	79 (26.3)	
Occupation				
Dependent	34 (11.3)	18 (6)	52 (17.3)	0.483
Unskilled	133 (44.3)	86 (28.7)	219 (73)	
Skilled	17 (5.7)	12 (4)	29 (9.7)	
Religion				
Hindus	171 (57)	111 (37)	282 (94)	0.531
Others	13 (4.3)	5 (1.7)	18 (6)	
Caste				
Other caste	24 (8)	15 (5)	39 (13)	2.027
BC	97 (32.3)	70 (23.3)	167 (55.6)	
SC and ST	63 (21)	31 (10.4)	94 (31.4)	
Type of family				
Nuclear	142 (47.3)	72 (24)	214 (71.3)	7.217*
Extended	42 (14)	44 (14.7)	86 (28.7)	
Per capita income (Rs)				
<500	41 (13.7)	28 (9.3)	69 (23)	3.130
500–1,245	84 (28)	60 (20)	144 (48)	
1,246–2,489	32 (10.7)	16 (5.2)	48 (15.9)	
2,490–4,149	18 (6)	6 (2.1)	24 (8.1)	
>4,150	9 (2.9)	6 (2.1)	15 (5)	

\*Significant at  $p < 0.05$ .

**Table 2:** Preference for number of children in relation to age at marriage of the study subjects

Age at marriage (years)	Preference for number of children		$\chi^2$
	≥3, n (%)	≤2, n (%)	
15–24	138 (46.0)	78 (26.0)	1.757
≥25	46 (15.4)	38 (12.6)	
Total (n = 300)	184 (61.4)	116 (38.6)	

The preference for the number of children in relation to age at marriage of the study subjects is shown in Table 2. Most of them [216 (72%)] got married between 15 and 24 years, of which 138 (46%) of them limited their family only after ≥3 children, but it was not statistically significant.

The perceived reasons of participants regarding the family size are shown in Table 3. In those with ≥3 children, the main reason for the family size was because of the pressure given by husband/mother-in-law [49 (27%)], followed by the desire for a male child [44 (24%)] or a second male child [36 (20%)], afraid of FP operation [21 (11%)], did not know

**Table 3:** Perceived reasons of study subjects regarding family size

Perceived reasons about family size	N (%)
<b>3 or more children (n = 184)</b>	
Preference of a huge family by husband/mother-in-law	49 (27)
Desire for a male child	44 (24)
Second male child	36 (20)
Afraid of FP/scared to get operated	21 (11)
Do not know about FP/nonavailability of FP services	14 (8)
Death of one child/one child has health problem	11 (6)
Desire for a girl child	6 (3)
Unaware of third pregnancy	3 (1)
<b>2 or less children (n = 116)</b>	
Low socioeconomic status	29 (25)
Benefitted by Bangaru Thalli Pathakam program (monetary benefits for two girl children)	20 (17)

about FP/nonavailability of FP services [14 (8%)], death of one child/one child with a health problem [11 (6%)], desire for a girl child [6 (3%)], and unaware of the third pregnancy [3 (1%)].

The participants with ≤2 children stated that a low socioeconomic status forced them to go for a small family

[29 (25%)]; other reasons were benefitted by Bangaru Thalli Pathakam (monetary benefits for two girls) [20 (17%)], delivered both the children by cesarean sections [18 (16%)], satisfied/wanted a small family/can take better care of children/husband does not like more children [15 (13%)], abortions/maternal problems/health issues [12 (10.5%)], conceived late [12 (10.5%)], husband died [6 (5%)], and hysterectomy was done [4 (3%)].

## Discussion

The study examined the perception of women and local notions regarding the couple/family dynamics in FP in a rural setting. The family size of the study subjects ranged from one to seven children. Among them, 17 subjects had four children, five subjects had five, one subject had six, and three subjects had seven. Overall, 61% of them preferred a family size of  $\geq 3$  children, which was similar to the National Family Health Survey (NFHS)-3, Government of India, report released on October 11, 2007, for united Andhra Pradesh state, which was 3.9. In 27% of them, it was because of the family pressure given by husband/mother-in-law, which shows a lack of autonomy and an unequal social status of women to decide about the family size. In many societies, there is often a pronounced preference for sons over daughters, although the desire for at least one child of each sex is also common.<sup>[14–16]</sup> Even though son preference over daughter is a common phenomenon in many countries, it is more pronounced in patriarchal setting. Studies from Bangladesh, India, Nepal, Pakistan, and Sri Lanka have confirmed the widespread presence of son preference in south Asia and its impact on reproductive attitudes.<sup>[14,17–19]</sup> This was similar to the findings of this study, wherein 44% of the subjects desired to have one or two sons and went for a bigger family. About 11% of them were afraid of FP/scared to get operated, which was similar to the studies conducted by Diamond-Smith et al.<sup>[9]</sup> Only 3% of them with a larger family wanted to have a daughter, which was similar to the study conducted by Stash,<sup>[20]</sup> which revealed the preference for at least one daughter, although, for the majority of respondents, the birth of more than one daughter was seen as undesirable. Around 39% of them preferred a smaller family with  $\leq 2$  children. This pattern suggests that, after two children, the desire to have a small family is that they had at least a son; 17% of study subjects limited the family after two girls to benefit from *Bangaru Thalli Scheme*. This is a welfare scheme for girls launched by the Government of Andhra Pradesh launched in 2013. The scheme supports the family of a girl from her birth till her graduation. All the below poverty line white card holders were eligible under the scheme.

## Conclusion

Limitation of a family was influenced by the interaction of family members/decision-makers about the family size and

sex preferences at the family level. Hence, an effective intervention and attention of policymakers and researchers should be directed to meet the needs of rural women in India.

## References

1. Programme of Action. Presented at the International Conference on Population and Development, Principle 8; 1994; Cairo, Egypt.
2. Proclamation of Tehran. Presented at the International Conference on Human Rights; 1968; Tehran, Iran.
3. US Agency for International Development. *Saving Women's Lives, Protecting Women's Health [Fact Sheet]*. Available at: [http://www.usaid.gov/pop\\_health/pop/popfactsheet.htm](http://www.usaid.gov/pop_health/pop/popfactsheet.htm) (last accessed on January 12, 2015).
4. Campbell M, Sahin-Hodoglugil NN, Potts M. Barriers to fertility regulation: A review of the literature. *Stud Fam Plann* 2006;37(Suppl 2):87–98.
5. Darroch JE, Sedgh G, Ball H. *Contraceptive Technologies: Responding to Women's Needs*. New York, NY: Guttmacher Institute; 2011.
6. Colombia Demographic and Health Survey; Profamilia; Macro International, Inc. *Colombia Demographic and Health Survey 2004–2005*. Calverton, MD: Macro International, Inc., 2005.
7. Uganda Bureau of Statistics (UBOS); ORC Macro. *Uganda Demographic and Health Survey 2000–2001*. Calverton, MD: Macro International, Inc., 2001.
8. Sedgh G, Hussain R, Bankole A, Singh S. *Women With an Unmet Need for Contraception in Developing Countries and Their Reasons for Not Using a Method*. Occasional Report No. 37. New York, NY: Guttmacher Institute, 2007.
9. Diamond-Smith N, Campbell M, Madan S. Misinformation and fear of side-effects of family planning. *Cult Health Sex* 2012;14(4):421–33.
10. Nzioka C. *Programming for Male Involvement in Reproductive Health*. Report of the meeting of WHO Regional Advisors in Reproductive Health. Geneva: WHO/PAHO, 2002.
11. Oyediran K, Isiugo-Abanihe UC. Husband-wife communication and couple's fertility desires among the Yoruba of Nigeria. *Afr Popul Stud* 2002;17(2):61–80.
12. Paz Soldan VA. How family planning ideas are spread within social groups in rural Malawi. *Stud Fam Plann* 2004;35(4): 275–90.
13. *National Classification of Occupations, NCO Divisions*. New Delhi, India: Directorate General of Employment and Training, Ministry of Labour, 2004.
14. Kamal SMM. The effect of son preference on contraceptive use in rural Bangladesh. *Pak J Women's Stud* 2008;15:47–59.
15. Arokiasamy P. Gender preference, contraceptive use and fertility in India: Regional and development influences. *Int J Popul Geogr* 2002;8(1):49–67.
16. Rajaretnam T, Deshpande RV. The effect of sex preference on contraceptive use and fertility in rural south India. *Int Fam Plann Perspect* 1994;20(3):88–95.
17. Jayaraman A, Mishra V, Arnold F. The relationship of family size and composition to fertility desires, contraceptive adoption and method choice in south Asia. *Int Perspect Sex Reprod Health* 2009;35(1):29–38.
18. Arnold F. Son preference in South Asia. In: *Fertility Transition in South Asia*, Sathar ZA, Phillips JF (Eds.). London: Oxford University Press, 2001.

19. Varma GR, Babu BV. Son preference and desired family size in a rural community of west Godavari district, Andhra Pradesh, India. *J Soc Sci* 2007;15(1):59–64.
20. Stash S. Ideal-family-size and sex-composition preferences among wives and husbands in Nepal. *Stud Fam Plann* 1996;27(2):107–18.

**How to cite this article:** Dumpala S, Venna GP, Konagunta N. Perceived reasons of rural mothers regarding family size at Cherlapally, India. *Int J Med Sci Public Health* 2015;4:1260-1264

**Source of Support:** Nil, **Conflict of Interest:** None declared.