

THE KHASIS OF SHILLONG, MEGHALAYA: A STUDY ON FAMILY PLANNING

BY

MARIAMMA K.K

DISSERTATION SUBMITTED IN PART-FULFILMENT FOR
THE DEGREE OF MASTER OF PHILOSOPHY
IN ANTHROPOLOGY

NORTH-EASTERN HILL UNIVERSITY
DEPARTMENT OF ANTHROPOLOGY

SHILLONG

(1991)





PHONE :
GRAMS : NEHU

North-Eastern Hill University

Mayurbhanj Complex, Nongthymmai, Shillong-793014

Head, Department of Anthropology

CERTIFICATE

I certify that the Dissertation entitled "The Khasis of Shillong, Meghalaya: A study on Family Planning" submitted by Miss Mariamma, K.K. for the degree of Master of Philosophy in Anthropology of the North-Eastern Hill University embodies the record of the original investigation carried out by her under my supervision. She has been duly registered and the Dissertation presented is worthy of being considered for the M.Phil degree. The work has not been submitted for any degree of any other University.

Dated Shillong.
The 30th December, 1991.

A.K. Ghosh
(A. K. Ghosh)
Supervisor of Research.
Department of Anthropology
North-Eastern Hill University
Shillong

ACKNOWLEDGEMENT

I take this privilege to acknowledge my indebtedness to my supervisor, Dr.A.K.Ghosh, Head of the Department of Anthropology, North Eastern Hill University, Shillong who initiated, helped and encouraged me through out this study. His kind patronage, keen interest, generous help and meaningful suggestions have only enabled me to complete my work but have also considerably enriched my understanding.

I am very grateful to Dr.S Barua and Dr.S.B Nandi for their help and valuable suggestions in writing the thesis. I express my thanks also to Dr (Mrs) Debroy, for her help in collecting the information from the Meghalaya record. I am also grateful to Mrs.L.Hungyo for typing out the manuscripts and Mr.S Paul for preparing the diagrams.

I owe my perennial debt to the people of P.Chowdhury, V.Syiemlieh, Umdon,W.R, Shangtir,Helinson,Thomas and Molykutty for their help and cooperation to the present work.

Last but not the least,my deep gratitude goes to my friends who have been helpful to me in writing this thesis.

Dated Shillong,
The 30th December,1991.


(MARIAMMA.K.K)

CONTENTS

ACKNOWLEDGEMENTS
LIST OF TABLES
LIST OF FIGURES

CHAPTER I - INTRODUCTION

1.1 History of Family Planning movement in India	I
1.2 Family Planning Programmes in Meghalaya	8
1.3 Area of study	10
Location and Topography,	10
Climate,	11
Flora and Fauna,	12
Geological Composition,	12
1.4 The People	14
Division and Distribution,	14
Rule of Inheritance,	14
Religion,	15
1.5 The Problem	15
1.6 A brief Review	17

CHAPTER II MATERIALS AND METHODS

CHAPTER III

RESULTS

3.1 Demography,	28
Present age,	28
Age at marriage,	29
Pregnancies,	30

Economic
Occupation

- Live-births, 31
- Surviving children, 32
- Infant mortality rate, 33
- Reproductive wastage, 34
- Age - Specific fertility, 35
- Duration of marriage, 37
- Preference for a female child, 40
- Reasons for preferring a female child, 41

3.2 Adoption of Family Planning

42

- Age at adoption, 41
- Methods adopted, 42
- Attitude towards adoption and non-adoption, 44
- Prenatal and Infant Mortality, 47
- Reasons for discontinuation, 48
- Source of Information, 47

3.3 Social Proximates

50

- Education, 50
- Income, 54
- Correlation between children ever born and selected variables, 57
- Religion, 59
- Education of wife, 60
- Education of Husband, 62
- Income, 63
- Economic condition, 64

Economic condition and educational level,66

Occupational of wife,67

Occupation of Husband,68

3.4 Hospital Records of Family Planning 70

Methods adopted,70

Adoption by Christian and Non-Christian,72

Adoption by different ethnic group,73

Age at adoption and number of surviving children,74

CHAPTER IV DISCUSSION AND SUMMARY 76

REFERENCES 87

APPENDIX 97

LIST OF TABLES

<u>Table</u>	<u>Title</u>
1.	Acceptance of family planning measures in Meghalaya since 1989 (Meghalaya record: 1989-'91)
2.	The area and population of Shillong agglomeration (according to 1981 census)
3.	Present mean age of the couples by religion
4.	Mean age at marriage of the women.
5.	Mean number of pregnancies by religion.
6.	Mean number of live-birth by religion.
7.	Mean number of surviving children by religion.
8.	Infant mortality rate by religion.
9.	Reproductive wastages by religion.
10.	Age-specific fertility of the women by religion.
11.	Fertility of the women by duration of conjugal period.
12.	Actual and desired family size by religion.
13.	Preference for a female child.
14.	Reasons for preferring female child
15.	Mean age at adoption of family planning by religion.
16.	Methods adopted.
17.	Attitude towards adoption and non-adoption of family planning measures
18.	Prenatal and infant mortality by family planning status.

19. Value of d Binomial test of equality of proportion of prenatal mortality rate and infant mortality rate.
20. Reasons for discontinuation of Family Planning practice.
21. Source of information regarding Family Planning
22. Fertility of the women by educational level.
23. t-values.
24. Fertility of the women by income level.
25. t-values.
26. Correlation between children ever born (CEB) and selected explanatory variables.
27. Adoption of family planning measures by religion.
28. Adoption of family planning of women by educational level.
29. Adoption of family planning of men by educational level.
30. Adoption of family planning measures by level of income.
31. Adoption of family planning by economic position and educational level of the couples by religion.
32. Adoption of family planning measure by occupational status of the women.
33. Adoption of family planning measure by occupational status of the men.
34. Methods adopted.
35. Adoption of different methods of family planning by christian and non-christian Khasi.
36. Family planning measures adopted by different ethnic groups.
37. Mean age at adoption and mean number of surviving children.

LIST OF FIGURES

Figure	Title
1.	Map of Meghalaya
2.	Map of Shillong
3.	A comparative graphic representation of actual and desired family size.

CHAPTER-I

INTRODUCTION

HISTORY OF FAMILY PLANNING IN INDIA

Even before the independence of India the family planning movement, though in small scales through the efforts of some individual workers, started during mid-1920s (Agarwala, 1972; Danda, 1984). The family planning movement in India started with the idea of adopting a policy of population control as a measure to protect health of the mothers.

In 1925 Karve was the first person, who opened a family planning clinic in India. By doing so he had to pay a penalty and was forced to resign from his teaching position. A few years later the Neo-Malthusian league was set up in Madras. In 1930 a family planning clinic was opened by the then Mysore Government. Subsequently, in 1932 some birth control clinics came into existence in Madras. In the same year an All Indian Women's conference was held in Lucknow. A resolution was passed in that conference, recommending that men and women should be given proper instructions in methods of birth control in recognised clinics.

In 1935 under the chairmanship of Shri Jawaharlal Nehru, the National Planning Committee of the Indian National Congress strongly supported the family planning movement in India. In the same year Pillai conducted a course on family

planning. In 1939 some birth control clinics were opened in Utter Pradesh and Madhya Pradesh. In 1940 Sapru moved a resolution in the council of states for establishment of birth control clinics in the country. In 1943 under the Chairmanship of Sir. Joseph Bhore of the Health Survey and Development Committee, appointed by the then Government of India, recommended that there should be provisions of birth control service in hospitals with a view to protecting health of the mothers.

In 1947 India attained her independence. In 1949 under the presidentship of Smti. Dhanranthi Rama Rao the Family Planning Association came into existence in Bombay.

With the introduction of First Five-Year plan in 1951, the Government of India declared family planning as one of the official programmes and adopted it as a National Programme in 1952 (Rele, 1982). The central objective of planning in India was to raise the standard of living of the people and to provide them with adequate opportunities for a richer and more varied life (Alok, 1990). It may be stated that India was the first country in the world to make family planning a part of the national programmes. In the first five-year plan the Government of India included family planning and population control under the Medical and Public Health plan and allocated a sum of rupees 65 lakhs. The entire emphasis was given to find out the factors responsible

for rapid increase of population, to gain means of regulating it, to devise ways of educating public and to make family planning advise and service as an integral part of the service in hospitals.

In the second five-year plan (1956-61) the Government of India retained the earlier optimistic view of the first five-year plan and laid emphasis on use of mass communication media, provision for clinical services in both rural and urban areas, training of personnel and research and provision for supplies of family planning devices. For successful implementation of family planning programmes in this five-year plan the Government of India allotted Rs.497 lakhs, out of which only Rs.216 lakhs were actually spent. In fact, the planner's reliance on family planning clinics, following the Anglo-saxan tradition, was proved to be a mistake.

With advent of the third Five-Year Plan (1961-66) the Government of India supplemented the earlier clinical approach of the first and second five year plans by the extension approach through the network of primary health centres and sub-centres in the rural areas and hospitals and family welfare planning centres in the urban areas. It envisaged the utilisation of interested and influential local leaders in villages for promoting a small family norm and carrying the message of family planning to the people. The entire objectives of such an extension approach was

to create a norm of small family size in every community by educating and involving interested and influential local leaders, to provide information on family planning methods to every individual couples and to offer contraceptive services and facilities in socially acceptable manner. The entire idea of the extension approach was to take all family planning information at the doorsteps of the eligible couples and "in respect of advocacy on methods on family planning, the "cafeteria approach" was adopted, leaving the choice of the method to the acceptor"(Alok,1990). During the third five year plan the Government of India further increased the allotment of fund. In fact, Rs.27 crores were allotted, out of which Rs.24.86 crores were actually spend. During the plan period the Government of India introduced the system of giving incentives to the acceptors of terminal methods, i.e., sterilization and to motivators who could influence a couple to accept the terminal method, In 1962 i.e., during the third five year plan period, the symbol of inverted red-triangle was introduced to represent the message of family planning. Alok (1990) says, "The family planning programme was viewed not simply as a social welfare measure for improving the status of women in the country, their health, helping couples to space and limit their children according to their desires, but mainly as positive policy instrument for achieving the demographic goal for the country as a whole".

During
The period between 1966 and 1969 was known as "plan-holiday". During this period the earlier programmes continued. The annual budget was sanctioned for family planning programmes and the new target was set out. In this period of time the expenditure increased to about Rs.70.46 crores. The entire emphasis was given on IUD and sterilization, though all other methods were made available to the couples, and choice of selecting any method was entirely left to the eligible couples.

During the Fourth Five-Year Plan (1969-74) the Government of India declared family planning as one of the highest priority programmes. Consequently, a sum of Rs.330 crores was allotted, though, in reality, a sum of Rs.288 crores was spent. During this period a target was set to bring down the crude birth rate from 39 per 1000 to 32 per 1000 by the end of the plan period and by 1979 to 25 per 1000. During this plan period the emphasis was laid on (i) to secure social acceptability for a small family norm, (ii) to disseminate information and knowledge of family planning devices among the people and (iii) to make all necessary family planning devices available to the people. In 1971 the act, entitled medical termination of pregnancies, was approved by the parliament and the act became effective from 1st of April, 1972. This act helped the pregnant women to have legal abortion under certain specific conditions.

During the Fifth Five-Year Plan (1974-78) there was a dramatic rise and fall in family planning movement throughout the country. It was realised during this plan that the target set in the earlier plan failed to bring down the crude birth rate to the desired level. It was further realised that the family planning programmes, that were being implemented in this country, had only limited success, and it was felt necessary to intensify the implementation of family planning programmes in the country. During this five-year plan it was decided that the crude birth rate should be brought down to 25 per 1000 by 1984. In this plan a sum of Rs.408.98 crores was allotted for family planning programmes. In 1976 the Government of India proposed a comprehensive policy for the first time in the history of the country. During this period all sorts of coercive methods were applied which resulted in a disastrous consequences of the future of all family planning programmes. However, during the year 1976-77, the performance of the family planning programme was the best in the history of the country. About 8.26 million sterilizations were done. But, this programme suffered a severe setback, and a revised policy was announced in 1977. The term family planning was changed to family welfare planning with a view to including maternal and child health programme as an integral part of the whole family planning programme (Chandra, 1987).

On 2nd October 1978, a new law was enacted raising the age at marriage for the girls to 18 years and for the boys to 21 years. However, this recommendation was actually made in 1976, though it was finally implemented in 1978.

The Sixth Five-Year Plan came into existence in 1980-'85. The chief goal in this plan was to reduce the net reproduction rate to unity by 1995 for the country as a whole and by 2001 A.D. in all states from the level of 1.67. This plan envisaged that it could make possible only to reduce the birth rate to 21 and death rate to 9 and by increasing the number of adoptors of family planning to 60% of the eligible couples.

During this plan a sum of Rs.1,010 crores was allotted for family planning programmes, out of which Rs.688 crores use for promoting services and supplies, 250 crores for maternal and child health and Rs.72 crores for training, course evaluation, etc.

The Seventh Five-Year Plan covered the period 1985-'91. It adopted a demographic policy of reaching a net reproduction rate of one by 2000 A.D. During this plan the target was set into bring down the crude birth rate to 29.1, crude death rate to 10.4, infant mortality to 90 per 1000 of live births, universal immunization of children and also antinatal care for about 75% of all pregnant women. In this plan a sum of Rs.325.60 crores was allotted for family welfare programme.

During the 7th plan period the oral pill distribution programme was intensified.

This is the brief history of family planning movement in India.

1.2. Family Planning Programmes in Meghalaya

Now let us look at how the family planning programmes are being implemented in Meghalaya.

Meghalaya is predominantly a tribal state. The density of population is approximately 78 persons per sq.km. In the Meghalaya there is a State Family Welfare Bureau as well as an Urban Family Welfare Centre, which are situated in the capital city Shillong. Besides, a Family Welfare Bureau has been established in each of the 5 districts in the State.

The family welfare programmes in Meghalaya started in 1973, with a view to looking after mother's and child's health status and reducing infant and child mortality. However, such family welfare programmes in Meghalaya are voluntary and consequently, no incentive, in cash or in kind, is paid to the acceptors, motivators, or the doctors. Generally to popularise such family welfare programmes time to time exhibitions are made, camps are organised and speeches are broadcast over radio in both rural and urban areas.

It has been found from the official records that the Government of Meghalaya has been increasing the allotment

of fund for implementation of family welfare programme in the state. In 1972-73 the Government allotted merely 10 lakhs of rupees for Family Welfare Programme, but in 1991 the Government of Meghalaya allotted a sum of Rs.205.40 lakh for the implementation of such programmes. It shows that the State Government is very much concerned about the implementation of such programmes throughout the State.

Table 1.

Acceptance of Family Planning measures in Meghalaya since 1989 (Meghalaya record : 1989-'91)

SL.NO. Method	1989-'90 (Apr.1989- March'90)	1990-'91 (Apr.'90- March'90)	April '91 June '91
1. Sterilization	538	538	204
2. Vasectomy	18	20	4
3. Tubectomy	520	518	200
4. I.U.D. (Intra Uterine Devices)	1,610	2,015	372
5. Conventional contraceptives	2,343	1,732	459
6. Oral Pills	1,200	1,100	300
Total :	5,691	5,385	1,335

From the above Table 1 it is seen that the number of sterilisations is found to be same for both years 1989-90 and 1990-91. The number of IUD has increased tremendously from the year 1989-'90 to 1990-'91 (1,610 to 2,015). In contrast the number of conventional contraceptive users has dropped from 2,343 to 1,732 from 1989-90 to 1990-91. The same trend has been seen in case of Oral Pills, though the difference is not so high. The number of Oral Pill users in the year 1989-90 is 1,200 and in 1990-91 1,100.

Area of Study

Location and Topography

Meghalaya is one of the autonomous States in India. The word 'Meghalaya' means 'abode of clouds'. The State of Meghalaya is fairly a new state which was formed out of the erstwhile State of Assam on 21st January, 1972.

There are five districts in the State viz. East Khasi Hills, West Khasi Hills, East Garo Hills, West Garo Hills and Jaintia Hills, and the respective headquarters are Shillong, Nongstoin, Tura, William Nagar and Jowai. Shillong is also the capital of this State. (1991 census)

Meghalaya is situated in North-Eastern region of India, which lies between $25^{\circ}47'$ and $26^{\circ}10'$ North latitudes and $89^{\circ}45'$ and $92^{\circ}47'$ East longitude (Fig.1). It covers an area

of 17,60,625 sq.kms. It is a hilly region bounded by Assam in North-East and North-West and by Bangladesh in South and South West. (Bareh,1967)

According to 1991 census, the total population of the State is 17,60,626, of which 9,04,300 are males and 8,56,318 females. The decennial population growth between 1981 and 1991 is 31.80%. The density of population per square kilometer is 78 and the overall sex ratio is 947 females per 1000 males. The literacy rate in Meghalaya is 39.16%. (1991 census)

In Meghalaya about 80.6% of the total population belong to one or the other tribal group. The major tribes in the State are the Khasi, Garo and Jaintia (1991 census). Besides, some other tribal populations, residing in this State, are the Hajong, Koch, Chakma, Cacharis, Kukis, Mizo and Naga (according to 1981 census). Besides those tribal populations, there are some non-tribal populations who have permanently settled here. They are the Bengalis (9.29%), Nepali (4.39%), Assamese (2.31%), Hindi speaking people (1.70%), etc. according to 1971 census (Marwein:1987).

Climate:

The climate is salubrious. The world's heaviest rain fall is recorded in Cherrapunji and Mawsynram with an average annual rainfall of 1270 centimetres. In summer i.e. May to September, the temperature goes upto as high as 26° and

in winter at times goes down as low as the freezing point (Marwein, 1987).

Flora and fauna

The State is very rich in flora. The flowering plants include orchids, ferns and profusion of mosses, fungi lichens, etc. The hill portion is fully covered with pine forest.

The fauna includes wild animals, birds reptiles. Various types of amphibians and fish species and insects are seen. The wild animals include elephants, buffaloes, bears, jackles, mithun, wild pigs, wild dogs, jungle cats, etc.

Geological Composition

Meghalaya is rich in mineral resources. Coal is found in the Khasi Hills, ^{Garo Hills and Jaintia Hills.} It occurs in various parts of the Khasi Hills viz. Cherrapunji, Laitryngew, Mawlong, Mustoh, Mawsynram, Mawdon and Thanjinath. The total estimated workable coal in Meghalaya is about 3,883 lakh tonnes (Lamin: 1986). Limestone is plenty in the State, especially in the southern part.

Shillong

Shillong is the capital of Meghalaya. It is situated at an elevation of approximately 1,496 metres with $23^{\circ}34'$ N latitude and $91^{\circ}53'$ E longitude. The total population of Shillong is 11,31,38 of which 61,38,7 are males and

51,75,1 females (1991 census). The literacy rate in Shillong is 77.26% (1991 census).

The name 'Shillong' was given by the British after the Shillong peak, the highest peak in Meghalaya (Marwein, 1987). Shillong is the only one urban agglomeration in Meghalaya. It consists of Shillong Municipality, Shillong Cantonment, Mawlai, Nongthymmai, Pynthormukhrah and Madanriting.

The area and population of Shillong agglomeration according to 1981 census is given in Table-2.

Table 2

The area and population of Shillong agglomeration (according to 1981 census).

Localities	Area in Sq.Km.	Population
Shillong Municipality	10.36	10,545
Shillong Cantonment	1.84	3,598
Mawlai	6.14	3,223
Nongthymmai	2.93	7,358
Pynthorumkhrah	2.02	5,302
Madanriting	2.11	2,922
Total	25.40	6,878

According to 1981 census, in Shillong there are 1,063 scheduled castes, out of which 658 are males and 405 females. Total number ^{of} scheduled tribe individuals in Shillong are 85,833 out of which 40,886 are males and 44,947 females.

The people

The present study has been carried out among the Khasi, who constitute 44% of the total population. Their language belongs to the Monkhmer group of the Austroasiatic family (Das, 1987). The Khasis are mainly divided into five groups namely 'Khyrnriam', 'War', 'Bhoi', 'Lyngangam', and 'Pnar' (Sen, 1985)

The Khasi society is characterised by matriliney. According to Nakane (1967) the central core of ^{the} family comprises two persons - the maternal uncle holds the authority and the youngest daughter owns the property. The rule of succession is strictly matrilineal. The children adopt the mother's clan. The descent goes through mother and the property is inherited from one generation to other in the female line. The youngest daughter 'Ka khadduh' (keeper of the house) is the custodian of the property. She obtains the ancestral property, including ancestral house in order to perform the religious rites. If there is no female successor to the property, a daughter may be adopted from the mother's kin group (Natarajan, 1977). The acquired property is being equally divided among the other sisters and all of them branch off after their marriage.

The maternal uncle has the authority on the family and enjoys a high position in the family. The ancestral property (nongthynmen) cannot be disposed of even by the Khadduh without the consent of her maternal uncle and other clan elders. The traditional rule of residence is 'matrilocal'.

Religion

The Khasis are monotheistic. The traditional religion of the Khasi may be described as 'animism' or 'spiritual worship'. Many authors (Marwein, 1987; Mowrie, 1979) call the Khasi religion animistic or theistic. The Khasis believe in one supreme God or creator called 'U blei' (Marwein, 1987).

The Khasis perform various types of rituals and ceremonies to propitiate their ancestors. Sacrificing animals such as fowls, pigs, cows, goats and breaking eggs are the part of the rituals to offer thanks giving to God (Marwein, 1987). The rituals are performed by the priest (u sohblei). The Khasi traditional religion has neither fixed days of worship nor any organised church.

1.5 The Problem

Meghalaya is popularly known as 'Khasi land' since the Khasi is the most dominant tribal population of the state. It constitutes 44% of the total population of the state (Marwein, 1987). Nearly (52.62%) of the total Khasi population



in the state are Christian by faith (Das Gupta, 1984). As mentioned earlier in Meghalaya the family planning programmes have started as early as 1973. Since the Khasi is the major population of the state and Shillong is the Capital of the state, one may reasonably ask (i) how and to what extent the Khasi of Shillong have been adopting family planning methods; (ii) Whether or not there is any religious and or any social stigma against adoption of family planning methods among them. With a view to finding out answers to the above questions we have undertaken a study on family planning among the Khasi of Shillong. The objectives of the present study are as follows:-

1. To find out how far the Khasi people, belonging to various religious groups/sects have been responding to family planning methods;
2. To estimate their attitude towards and knowledge of family planning;
3. To find out the relationship between various social proximates like education, economic condition, etc, and adoption of family planning.

1.6 A brief Review.

Several factors, such as religion, economic condition, education etc. have a very close association with fertility and adoption of family planning. Many authors have studied about the impact of various socio-cultural factors on fertility (Lorimer et al, 1954; Freedman, 1967; Mandani, 1972; Mandelbaum, 1974; Kaur, 1976; Nag 1981, and others).

Religion is considered to be an important factor, affecting fertility. Several studies have been carried out by many researches (Driver, 1963; Agarwala, 1964; Kirk, 1966; Srinivasan, 1967; Rele, 1982; and others).

Kirk (1966) says that, the Muslims have higher fertility than the non-Muslims. Jones and Nortman's (1968) study in the United States of America, clearly showed a higher fertility rate among the Catholics and a lower fertility rate among the Jews in comparison with the Protestants. Raj (1978) is of the opinion that, fertility among the Muslim, is higher, as compared with that of the Hindus. Rele (1982) has observed that the fertility rate in India is higher among the Muslims than among the Hindus, since adoption of family planning among the Muslim is lower in comparison to the other religious groups. However, Agarwala (1972) is of the opinion that the reasons of this difference may be due to the fact that the Muslim do not impose restrictions on widow remarriage like their Hindu counterparts.

Several studies have been carried out to find out the effect of education on fertility (Driver, 1963; Anand, 1966; Camargo et al, 1970; Husain, 1970; Agarwala, 1972; Chatterjee et al, 1980; and others).

Driver (1963) has suggested that, there is a positive relationship between women's fertility and education and there is a sharp decline of fertility among the highly educated women. Husain (1970) has reported that there is a steady decline in the general fertility rate with the increase in rate of female education.

Barua and Das (1982) in their study of Khasis have observed that, fertility rate decreases with the increase in the level of education of the couples.

Many authors have suggested that, there is an inverse relationship between economic condition and fertility (Anand, 1966; Mitra, 1966; Agarwala, 1972; Caldwell, 1977; Bharati, 1981; Mouli and Mouli, 1981; Ghosh et al, 1983; and others).

Sinha (1957) has concluded that, families belonging to the high income class, have a lower fertility rate than those belonging to the lower income class.

Khan (1979) in his study of Muslims in Kanpur, has stated that, there is no bar in Islam against the adoption of family planning methods. He further states that, it may

not be the religious prejudices restricts the adoption of family planning methods by the Muslims of Kanpur city.

Kamitkar (1980) has suggested that, the parsees practise family planning more than the other religions communities, since they have on an average higher level of educational attainment. Kamitkar and Murthy (1983) have observed that adoption of family planning measures is better among the Hindus than among the Muslims.

Sinha (1991) has studied the attitude of Hindu and Muslim, toward adoption of family planning and reported that the Hindu students of Bihar have more positive attitude toward adoption of family planning than the Muslim students.

David and Bhas (1973) in their study in Utter Pradesh have observed that education has a significant association with the practise of family planning but, they have failed to find any association between religion and practise of family planning.

The effect of education on adoption of family planning measures has generally come out quite conclusively in various studies by Agarwala, 1960; Morrison, 1961; Taneja, 1972; Mukherjee, 1973; Danda, 1984; and others.

Morrison (1961) in his study in Bombay, has found out that education is positively related to the acceptance of family planning. Danda (1984) has suggested that, people who

are unaware of family planning methods are mostly illiterate and the educated ones have no reservations about discussing on family planning methods publically.

Sunder (1990) concludes that, female education is a key determinant of contraceptive use. It promotes the adoption of different family planning methods. She further stated that educated women have more knowledge about various family planning methods and also know how to acquire them, since they have adequate familiarity with modern ways of life and the availability of the different methods.

Various authors have reported that, the percapita income has a direct relationship with family planning practices (Rao, 1976; Mouli and Mouli, 1981; Danda, 1984; Piplai et al, 1990, and others.

Jha et al (1969) have concluded that, women with white-collar jobs have better knowledge about family planning methods and have more favourable attitude towards it than the others.

Khan (1979), in his study of Muslims in Kanpur city, has observed that, the economic condition is negatively associated with the adoption of family planning, in case of Muslims with hereditary occupations and positively, in case of Muslims with non-hereditary occupations.

Piplai et al, (1990) have reported that, the employed women adopt family planning measures more than those who are only house wives. They have further observed that, the women who are engaged in technical jobs are more infavour of adoption of family planning methods than those who are employed in non-technical jobs.

Many studies have been carried out to evaluate the magnitude and impact of the family planning programmes among various communities in India (Bhatnagar, 1964; Nair, 1970; Misra et al, 1972; Poffenberger, 1973, Mandelbaum, 1974; Jain, 1975; Khan, 1977; Khan et al 1980; Mecarthy, 1990; and others.

Nag (1965) in his study of Khasis has observed that 85% of the Khasi women are unfavourable towards adoption of family planning measures. He further writes that, women of the age of 45 years and above are opposed to family planning in a large proportion and the catholics are found to be more reluctant toward acceptance of family planning methods.

Jain (1975) finds that, birth spacing is lightly higher in rural areas because of the increased length of post-partum ammenorrhea, a high incidence of reproductive wastages, prolonged breast-feeding, taboos and customs pertaining to post-partum sex between spouses.

Khan et al (1980) in their study of perception of the individuals about family planning in India have stated that,

people have a very narrow concept of family planning. They have further stated that non-accessibility of the methods and knowledge of the various methods is one of the most important reasons for non-acceptance.

Lakshamma and Reddy (1991) in their study of family planning in Ongole Taluk of Andhra Pradesh have observed that, Tubectomy is the most satisfactory permanent birth-control method accepted by the rural and urban people, while Nirodh is chosen as a most satisfactory method by the urban respondents and the oral contraceptives by the rural women.

Various studies have been carried out, in order to find out, the sex preference in different societies (Devi, 1972; Park, 1978, Mauli and Mauli, 1981; verma, 1987; Karki, 1988, and campbell, 1991, etc.)

In the context of the Hindu Society, Mamdani (1973) has stated that, the first duty of a married woman is to bear children and to become a mother especially sons. These are the duties (dharma) of a Hindu woman, in his study he also opines that the ultimate goal of having sons is to have economic prosperity and therefore it is preferred.

Ghosh et al, (1983) in their study which was conducted in Ranchi found that, the preference for male children is to be found to greater extent among the lower castes. They further conclude that, the preference for male children is

is not very strong among the Muslims they studied. However, the conclusion drawn by them in respect of the Muslim may not be very much true as they had taken a small sample size of the Muslim population.

Varma (1987), in his study of a Bihar village, observed that, the women like to have atleast one son or more. He further writes that, desire for a male child is very commonly found amongst other Indian communities, too.

Kark's (1988) study of sex preference in Nepal, finds that among the current adoptors of family planning, the mean number of living sons was higher than that of the mean number of living daughters. He further states that, most couples have at least one son before they adopted any contraceptives or other such methods.

Campbell (1991) has observed that, the preference for sons do exist in the western areas. The men wish to have equal number of sons and daughters among their surviving children, but the balance is more in favour of sons than daughters.

The review of literature presented above is not an exhaustive as a large number of important works are available in India and abroad on family planning and related topics. In the next chapter, we shall discuss the materials and methods used for the present study.