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REVIEW OF LITERATURE

NEED/IMPORTANCE OF THE STUDY

STATEMENT OF THE PROBLEM

OBJECTIVES

HYPOTHESES

RESEARCH METHODOLOGY

RESULTS & DISCUSSION

FINDINGS

RECOMMENDATIONS/SUGGESTIONS

CONCLUSIONS

SCOPE FOR FURTHER RESEARCH

ACKNOWLEDGMENTS

REFERENCES

APPENDIX/ANNEXURE

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CONTRIBUTIONS TO BOOKS

- Sharma T., Kwatra, G. (2008) Effectiveness of Social Advertising: A Study of Selected Campaigns, Corporate Social Responsibility, Edited by David Crowther & Nicholas Capaldi, Ashgate Research Companion to Corporate Social Responsibility, Chapter 15, pp 287-303.

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- Schemenner, R.W., Huber, J.C. and Cook, R.L. (1987), "Geographic Differences and the Location of New Manufacturing Facilities," Journal of Urban Economics, Vol. 21, No. 1, pp. 83-104.

CONFERENCE PAPERS

- Garg, Sambhav (2011): "Business Ethics" Paper presented at the Annual International Conference for the All India Management Association, New Delhi, India, 19–22 June.

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- Kumar S. (2011): "Customer Value: A Comparative Study of Rural and Urban Customers," Thesis, Kurukshetra University, Kurukshetra.

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- Garg, Bhavet (2011): Towards a New Natural Gas Policy, Political Weekly, Viewed on January 01, 2012 http://epw.in/user/viewabstract.jsp

SMALL FAMILY NORMS IN INDIA AND ITS QUALITATIVE IMPLICATIONS ON CHILD CARE: A MULTIVARIATE ANALYSIS

RITWIKA MUKHERJEE
RESEARCH SCHOLAR
CENTRE FOR THE STUDY OF REGIONAL DEVELOPMENT
SCHOOL OF SOCIAL SCIENCES
JAWAHARLAL NEHRU UNIVERSITY
NEW DELHI

ABSTRACT

The present paper seeks to investigate the association between changing family norms and levels of child care with its necessary socio-economic correlates across regions with reference to National Family Health Survey I, II and III unit level data. Appropriate bivariate and multivariate analysis such as binary logistic regression models have been worked to show the net effect of the selected demographic and socio-economic predictor variables impacting the probability of the betterment of children's post natal care. Analyses show a remarkable decrease in family size and the growth of nucleated household structure over the periods. A distinct rural/urban differential could also be observed in access to child health care facilities where the urban households have fared much better even though the gap is narrowing over the periods with rural-urban convergence. This is a typical situation of the southern states which have mostly achieved the replacement level fertility. On the contrary, some of the Northern states like Bihar, Chattisgarh, Orissa, Madhya Pradesh their family size mostly ranges from medium to high with bulk of the population being rural and inefficient grass root family planning implementations at the village level. In some of the economically developed pockets of the North, like Punjab and Haryana, the small family norm actually translated to the intensification effect of strong son preference with increasing performance of sex selective abortions along with a skewed sex ratio at birth.

KEYWORDS

small family norm, child post-natal care, rural-urban convergence, multivariate model.

INTRODUCTION

The size of the family is of great importance not only for the country as a whole but also for the welfare and health of the individual. India adopted the goal of universalizing the 'two child family norm' lately by the end of this century which has consequences both at the micro (individual) as well as the macro (community) level. A norm in relation to family size, according to sociologists, implies a pattern which sets limits for any community's fertility behaviour. The size of the family affects greatly the quality of life of human beings. Recently, the decline in family size in most parts of India is controlled not only by the family planning initiatives such as contraceptive use and sterilization of young foetus, the disintegration of the joint family system assumes an another important mechanism in explaining the decline in family size. Generally the size of the family has direct and indirect implications on the quality of child care. In this paper an attempt has been made to employ a causative association between the decline in family size and its impact on child health care at a disaggregated level with an idea to search clues if the linear relationship actually holds.

STATEMENT OF PROBLEM

Inequity in child care is a composite outcome of a number of social, economic, cultural and environmental factors. In most cases it is controlled by all these factors wherein the change in family size acts as a catalyst to differentiation in child care. The main research enquiry in the present study is therefore to examine how much and to what extent the change in family size have *intensified* the inequity in child care across India.

The principle aims of the study conform to:

1. To highlight the transition of family size and the twin process of family planning and disintegration of families conjointly operating to cause the decline in family size.
2. To trace out the implications of small families on child care both in terms of curative and non-curative child care across the socio-economic dimensions.

ANALYTICAL FRAMEWORK

In India, the recent National Family Health Survey (NFHS) depicts that 12 out of 29 states have achieved the replacement level or below replacement level of fertility. The decline in fertility is often associated with the 'desire for small families'. The decline in fertility calls for the underlying mechanisms operating for which contraceptive usage has been used to check the desired result. One cannot merely overlook the modernisation factors possibly the increasing prevalence of nuclear families which often acts as a positive impetus on the overall development of the child. Excluding endogenous genetic factors at the individual level, it is assumed that the chances of infant survival depend upon the degree of care in which the infant is brought up. Broadly visualized, care, starting from conception to the first birthday, i.e. during 21 months of life, is important for an understanding of the determinants of child's health status. The two dimensions of individual level factors which have a direct bearing on child care are:

a. Timing
b. Type of care

Timing may be divided into three categories namely,

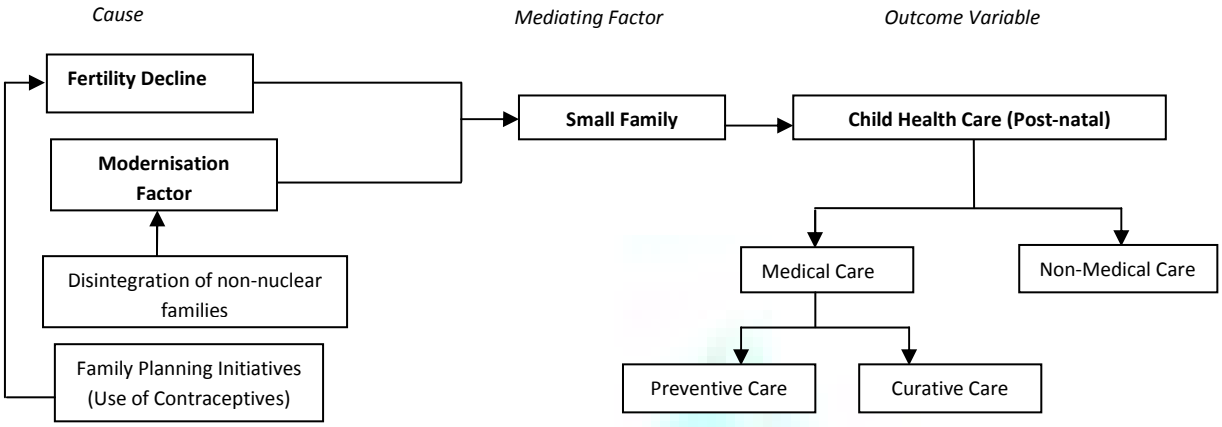
a. Pre-natal
b. Peri-natal
c. Post-natal

Type of care accrues to

a. Medical
b. Non-medical care.

Medical care includes immunization, treatment of illness and medical attention at birth. Non-medical care includes feeding practices, protection from environmental insults and general cleanliness. However, in the present analysis, only the post-natal care of the child has been considered since the aim is to enquire how family size affect child care after the child is born. Thus, the two main dimensions of care yield the following two main individual-level factors:

a. Post-natal non-medical child care- infant feeding practices, for example breastfeeding for at least six months.
b. Post-natal preventive medical child care- immunization.



RESEARCH METHODOLOGY

The database for the present study has been taken from National Family Health Survey (NFHS III, unit level) published in 2005-'06. Data source for different socio-economic developmental indicators have been taken from Census of India for the years 1991, 2001 and 2011.

SELECTION OF INDICATORS

TABLE 1: SELECTED INDICATORS FOR ANALYZING FAMILY SIZE AND CHILD HEALTH CARE

FAMILY SIZE		SOURCE	YEAR	LEVEL OF CONSULTATION
MODERNISATION	Percentage of households by structure (nuclear/non-nuclear)	NFHS III	2005-06	Unit Level (T-R-U)
FAMILY PLANNING	Percentage of Families having two or less than two living children	NFHS I, II, III	1998-99, 2002-03, 2005-06	Unit Level (T-R-U)
	Share of currently married women who want no more children by number of living children			
	Percentage of currently married women (age 15-49) who are currently using any kind/method of contraceptives			
CHILD CARE				
MEDICAL CARE	**Post Natal Preventive Child Care**			
	% children 12-23 months universally immunized	NFHS III	2005-06	Unit Level (T-R-U)
NON-MEDICAL CARE	**Post-Natal Non Medical Care**			
	% children 0-12 months currently breastfeeding	NFHS III	2005-06	Unit Level (T-R-U)

Appropriate Bi-Variate analyses are worked out to see the gross effect of different level factors over child care. However, the net or independent effects of all the factors have been captured by the binary logistic regression models. Two separate models have been used according to each of the dimensions of child care as described above, i.e. Medical care and Non-medical care.

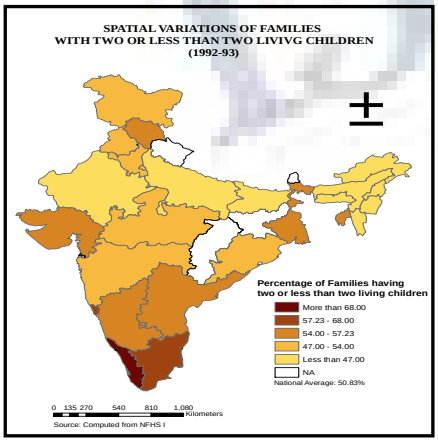
RESULTS AND DISCUSSION

FAMILY SIZE TRANSITION IN INDIA: EMERGING TREND OF SMALL FAMILIES

FAMILY PLANNING INITIATIVES

Indian families are shrinking and the prevalence of small family norms with an ideal number of two children incepted in the wake of rapid population increase is becoming stronger and stronger. A close look will verify (Figures 1-9) an existence of a north-south divide in terms of number of children born, the southern states reporting greater possibilities of two or less than two living children and has been strengthened over the years with a clear jump from 1998-99 to 2005-06 in terms of percentage of families having two or less than two living children. The northern counterparts except Himachal Pradesh and some of the economically developed pockets like Punjab and Haryana show a persistence of large families with the fertility preferences towards a son coupled with the widespread unmet needs to fulfil the target. However, this discrepancy is somewhat diluted in the urban context with a gentle gradient from the south to the north where most of the families having achieved the replacement level fertility with greater levels of awareness and attitudes of maximizing wellbeing of children welfare and minimizing costs of additional childbearing.

Figure 1



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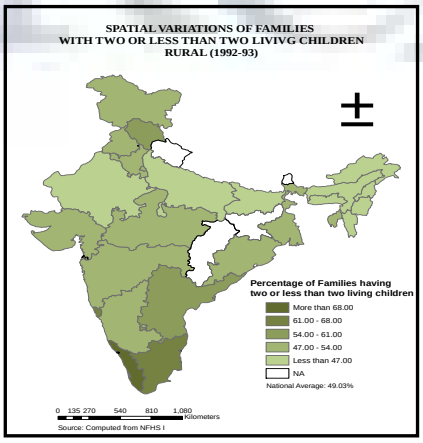

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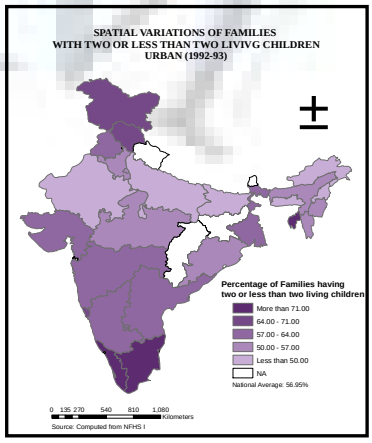

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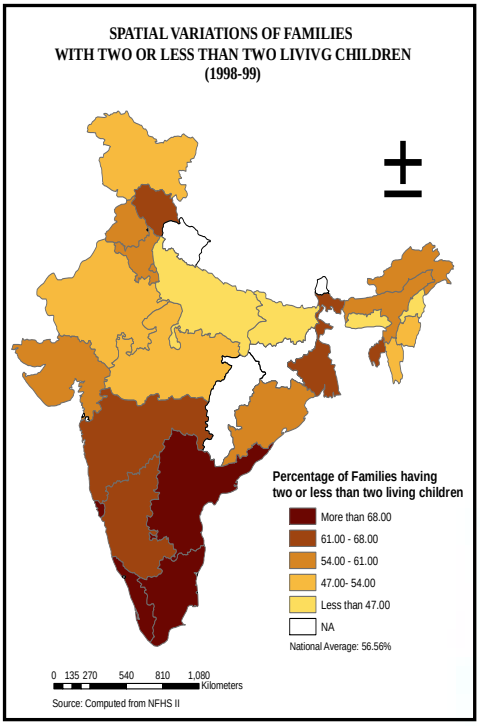

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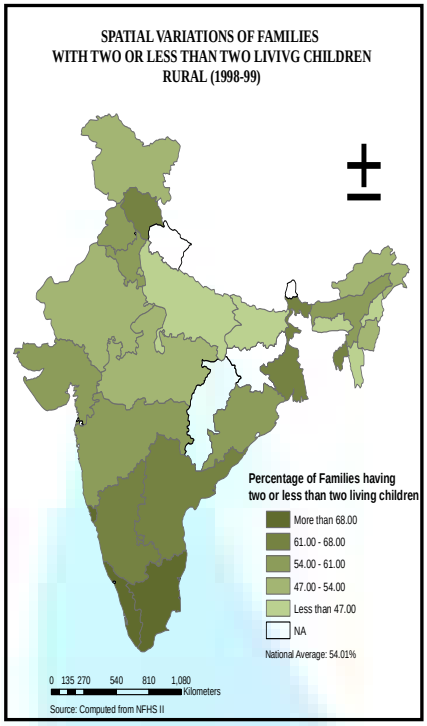

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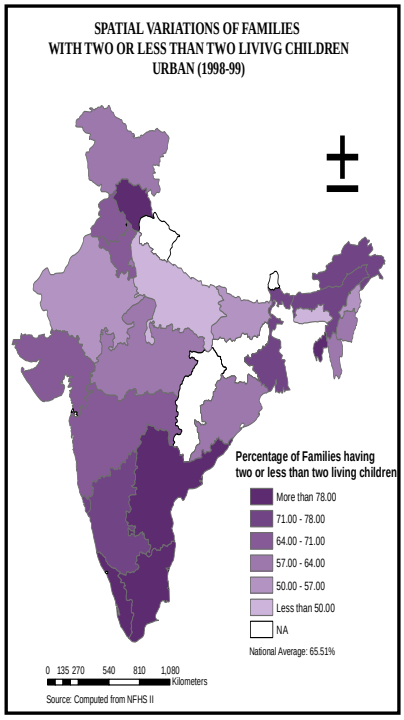

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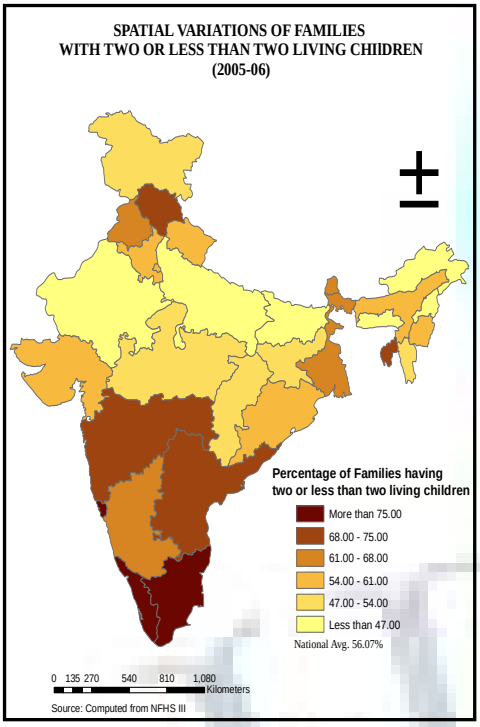

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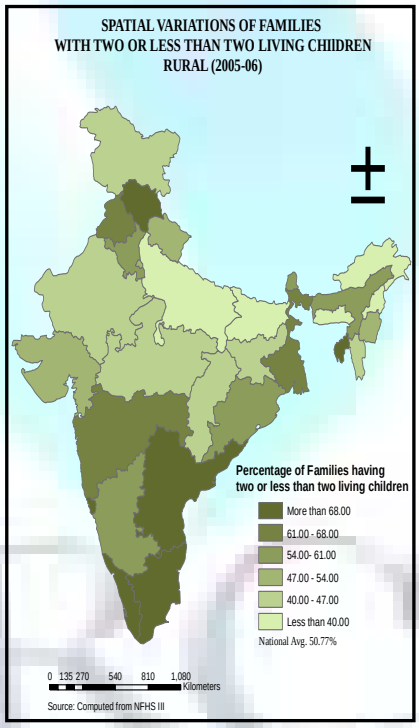

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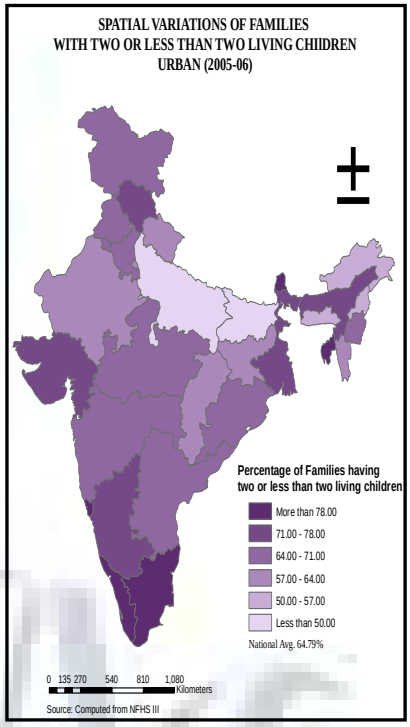

FAMILY PLANNING METHODS: CONTRACEPTIVE USE

Clearly, contraceptive use is now a happening issue in India; the rural areas have shown a remarkable improvement in 2005-06[1] (40.61%) jumping to almost its double as it was in 1998-99 (Table 2). A more steady progress could be found in urban areas covering to almost 56% of the currently married women in their reproductive age group who avail any kind of contraceptives. The National Rural Health Mission adopted to cater the unmet needs of the rural areas have worked significantly in this case, even though some states like Uttar Pradesh, Bihar, Rajasthan, Orissa, Madhya Pradesh etc still record values lower than the national average. Kerala long having achieved the replacement level fertility sweeping itself into the second stage of demographic transition share common issues as many as socially developed states of the world. West Bengal's case is more of spending quality time and cost of a few children rather than a whole lot to fulfil their middle class needs. Punjab is a more gendered motivation to stop childbearing after securing the advantages of a boy child.

TABLE 2: PERCENTAGE OF CURRENTLY MARRIED WOMEN (AGE 15-49) WHO ARE CURRENTLY USING ANY KIND/METHOD OF CONTRACEPTIVES (NFHS I, II AND III)

Percentage of currently married women (age 15-49) who are currently using any kind/method of contraceptives									
States	Total			Rural			Urban		
	NFHS I	NFHS II	NFHS III	NFHS I	NFHS II	NFHS III	NFHS I	NFHS II	NFHS III
Jammu and Kashmir	35.58	29.66	43.11	32.02	25.00	37.18	58.62	54.35	67.27
Himachal Pradesh	43.21	39.49	58.70	41.73	37.93	57.90	63.64	58.33	66.67
Punjab	43.58	50.00	56.65	41.24	45.80	56.57	51.02	64.08	56.89
Uttaranchal			48.07			43.58			62.42
Haryana	32.95	38.33	49.66	29.34	35.43	45.89	45.75	47.59	61.45
Delhi	52.46	53.66	59.85	52.00	45.95	50.51	52.60	54.52	56.47
Rajasthan	16.29	20.46	35.84	13.93	17.93	30.62	28.88	30.39	56.09
Uttar Pradesh	10.37	15.46	37.51	8.38	12.37	34.17	20.09	31.51	53.31
Bihar	12.58	9.84	25.02	10.58	8.98	23.09	25.76	18.77	39.66
Sikkim		37.50	48.00		35.71	45.03		50.00	56.63
Arunachal Pradesh	15.38	15.63	33.33	14.04	14.29	30.83	33.33	25.00	38.67
Nagaland	7.14	14.93	19.35	6.67	14.29	15.51	10.00	20.00	34.48
Manipur	22.73	25.33	50.00	18.99	25.45	45.90	31.25	28.57	60.64
Mizoram	40.00	37.04	50.00	35.71	28.57	43.87	43.75	46.15	55.26
Tripura	45.52	39.51	64.74	41.60	37.14	63.08	70.00	63.64	74.22
Meghalaya	10.00	14.74	17.54	7.87	9.76	14.03	22.73	46.15	36.51
Assam	28.38	28.37	49.75	26.35	27.57	47.39	49.26	41.46	67.94
West Bengal	46.77	50.98	64.35	43.37	47.40	61.32	58.34	66.91	77.58
Jharkhand			24.62			19.16			48.16
Orissa	21.40	23.94	36.60	20.26	22.74	34.29	28.13	34.23	51.28
Chhattisgarh			38.30			35.67			51.52
Madhya Pradesh	20.37	21.24	40.70	17.56	18.40	39.29	31.65	31.58	54.08
Gujarat	28.70	36.18	55.22	25.19	31.19	52.78	36.51	44.81	59.36
Maharashtra	36.40	36.63	51.61	36.52	37.04	48.86	36.20	35.90	57.15
Andhra Pradesh	36.26	43.57	60.18	32.94	42.28	59.25	46.37	47.41	57.07
Karnataka	34.40	37.19	53.61	31.91	34.47	52.99	40.56	43.22	54.64
Goa	40.00	39.29	48.15	37.50	38.89	42.27	40.56	45.45	51.31
Kerala	51.21	52.61	64.98	49.58	51.29	62.59	55.78	58.22	70.03
Tamil Nadu	44.89	37.89	56.36	41.88	31.06	53.85	50.33	50.83	66.44
All India	**26.18**	**28.41**	**44.25**	**22.72**	**24.78**	**40.61**	**38.00**	**41.13**	**55.95**

Source: Computed from NFHS I, II and III.

ROLE OF MODERNISATION FACTORS: NUCLEARISATION OF FAMILIES

The nuclear families (a proxy for small families) are not only an urban phenomenon; they too reflect strong assistance with the southern and north eastern states, Delhi and West Bengal being two exceptions of the Northern and Eastern regions respectively (Table 3). All the northern, western and central states have reported lower than national average values showing strong traits of their traditional cultures of extended families more prominently in the rural areas. Incidentally, some of these states have already achieved replacement level fertility (Punjab, Haryana, Himachal Pradesh etc) and show an alarming use of contraception, so the issue of modernisation impacted small families is a big question, trends merely succumb to a need based approach towards fulfilling the target goal of two child families.

TABLE 3: PROPORTION OF HOUSEHOLDS BY TYPE (NFHS III)

Percentage of households by Structure						
States	Total		Rural		Urban	
	Nuclear	Non-Nuclear	Nuclear	Non-Nuclear	Nuclear	Non-Nuclear
Jammu and Kashmir	37.19	54.73	37.09	55.32	37.55	52.71
Himachal Pradesh	32.06	64.02	28.30	67.79	43.08	52.96
Punjab	30.91	62.51	28.84	63.77	34.80	60.13
Uttaranchal	39.98	55.54	39.54	55.64	41.27	55.24
Haryana	35.91	53.58	34.68	54.54	40.53	50.00
Delhi	50.76	44.52	53.00	42.00	50.56	44.74
Rajasthan	42.71	47.70	42.88	47.30	42.21	48.92
Uttar Pradesh	43.41	48.22	42.31	48.16	45.57	48.34
Bihar	40.00	46.90	40.16	48.13	39.64	44.12
Sikkim	48.70	47.47	49.12	46.49	47.72	49.75
Arunachal Pradesh	49.66	48.28	52.61	46.08	42.64	53.49
Nagaland	64.33	34.49	65.11	33.44	63.21	35.99
Manipur	50.58	47.59	53.96	44.34	45.18	52.78
Mizoram	51.65	47.64	60.00	39.79	41.27	57.41
Tripura	52.90	40.53	54.15	40.32	48.12	41.35
Meghalaya	64.50	35.32	66.02	33.85	60.87	38.82
Assam	57.18	39.56	55.47	42.06	63.72	29.97
West Bengal	46.75	45.65	52.05	40.74	38.51	53.29
Jharkhand	41.64	52.75	43.69	51.94	36.46	54.80
Orissa	45.54	45.59	46.39	44.98	42.89	47.48
Chhattisgarh	40.95	52.95	40.66	53.28	41.83	51.98
Madhya Pradesh	48.14	44.06	49.89	42.15	45.71	46.74
Gujarat	41.76	51.88	42.34	50.65	40.73	54.02
Maharashtra	38.91	55.60	33.55	58.48	41.81	54.03
Andhra Pradesh	48.91	43.28	43.65	43.88	52.01	42.93
Karnataka	35.19	53.56	31.15	55.96	42.90	49.00
Goa	41.19	49.80	37.35	51.22	44.98	48.39
Kerala	23.40	64.31	24.24	62.12	21.65	68.90
Tamil Nadu	60.40	34.12	59.64	33.41	61.11	34.78
All India	**44.95**	**48.21**	**44.47**	**48.15**	**45.73**	**48.32**

Source: Computed from NFHS III.

IMPLICATIONS OF SMALL FAMILIES ON CHILD HEALTH CARE

CHILD MEDICAL (PROTECTIVE) CARE

Universal Immunisation captured through the measures of six vaccine preventable diseases during 12 to 23 months of a child show a marked difference according to household type. The protective efforts of the child is no doubt better among the non-nuclear or joint families excepting some southern states like Andhra Pradesh and Tamil Nadu wherein the nuclear families show a better performance than the non-nuclear counterparts (Table 4). This points the benefits of extended families where the child is under the surveillance of a number of vigilants apart from their parents. By and large child immunisation is on the decline when the number of living children is more than two. The protective care is highest with two living children barring a few cases like Assam, West Bengal, and Goa etc. More than the regional variations, the structural variations in terms of household type and family size assume a greater weightage.

TABLE 4: PERCENT OF CHILDREN (12-23 MONTHS) WHO ARE UNIVERSALLY IMMUNISED ACCORDING TO HOUSEHOLD TYPE AND NO. OF LIVING CHILDREN (NFHS III)

States	% children 12-23 months universally immunized						
	HH Structure		No. of Living Children				
	Nuclear	Non-Nuclear	1	2	3	4	5+
North							
Jammu & Kashmir	35.92	64.08	27.27	35.71	23.05	7.79	6.17
Himachal Pradesh	27.34	72.66	34.00	48.00	11.33	4.67	2.00
Punjab	24.91	75.09	30.36	44.29	20.00	3.93	1.43
Uttarakhand	33.33	66.67	25.45	42.29	20.07	7.89	4.30
Haryana	29.59	70.41	25.08	46.78	16.95	7.46	3.73
Delhi	47.72	52.28	28.76	38.13	20.07	7.02	6.02
Rajasthan	41.62	58.38	26.57	38.65	17.87	9.18	7.73
Central							
Chhattisgarh	35.96	64.04	32.98	29.08	20.92	8.16	8.87
MP	42.91	57.09	29.75	38.35	17.03	7.53	7.35
UP	31.01	68.99	25.38	35.25	18.38	11.93	9.05
East							
Bihar	27.47	72.53	23.36	32.89	23.68	10.86	9.21
West Bengal	44.28	55.72	39.10	36.68	13.32	7.09	3.81
Jharkhand	36.89	63.11	29.11	35.68	18.31	8.92	7.98
Orissa	42.51	57.49	40.53	34.32	14.50	8.28	2.37
North-East							
Arunachal Pradesh	50.00	50.00	35.62	36.99	12.33	6.85	8.22
Assam	71.00	94.00	44.12	37.65	8.24	5.88	4.12
Manipur	40.87	59.13	35.13	39.74	15.64	6.41	3.08
Mizoram	44.37	55.63	23.84	38.41	23.84	7.28	6.62
Nagaland	69.85	30.15	18.91	35.82	15.92	12.94	16.42
Tripura	51.82	48.18	47.52	37.59	9.93	3.55	1.42
Meghalaya	64.71	35.29	18.95	25.49	18.30	10.46	26.80
Sikkim	50.27	49.73	40.00	31.79	13.85	8.21	6.15
West							
Goa	44.74	55.26	43.79	39.13	11.80	3.42	1.86
Gujarat	36.92	63.08	73.00	112.00	45.00	23.00	16.00
Maharashtra	40.28	59.72	35.78	41.26	16.15	3.47	3.34
South							
Andhra Pradesh	53.33	46.67	31.44	47.99	13.00	4.96	2.60
Karnataka	35.09	64.91	32.33	42.03	17.09	5.77	2.77
Kerala	27.21	72.79	40.00	43.94	10.00	4.24	1.82
Tamilnadu	65.30	34.70	35.60	45.44	13.95	3.22	1.79
All India	**41.44**	**58.56**	**32.21**	**39.31**	**16.31**	**6.91**	**5.27**

Source: Computed from NFHS III

CHILD NON-MEDICAL CARE

Breastfeeding constitutes an important part of the intensive care of the child. Unlike universal immunisation, nuclear families show a better response in breastfeeding barring a few states like Tamil Nadu, West Bengal, Tripura, Assam, etc (Table 5). The northern and western regions show the widest difference between nuclear and non-nuclear households, southern states apart from Kerala as well as north-eastern and eastern region the values remain back to back. The entire central region, a few hilly pockets in the north like Jammu and Kashmir and Uttarakhand and high fertility states of Bihar and Jharkhand in the east have their children breastfed lower than the national average figures for the first child. Like immunisation, the intensive care is higher for first and the second child, keeps on decreasing as birth order increases.

TABLE 5: PERCENT OF CHILDREN LESS THAN 1 YEAR CURRENTLY BREASTFED ACCORDING TO HOUSEHOLD TYPE AND NO. OF LIVING CHILDREN (NFHS III)

States	% children 0-12 months currently breastfeeding						
	HH Structure		No. of Living Children				
	Nuclear	Non-Nuclear	1	2	3	4	5+
North							
Jammu & Kashmir	65.65	34.35	29.45	29.45	22.60	9.59	8.90
Himachal Pradesh	76.92	23.08	35.37	42.68	13.41	4.88	3.66
Punjab	73.40	26.60	37.57	34.91	18.34	5.03	4.14
Uttarakhand	68.15	31.85	29.66	31.72	21.38	8.97	8.28
Haryana	67.62	32.38	33.33	34.56	14.37	7.95	9.79
Delhi	54.23	45.77	32.89	33.55	19.08	9.21	5.26
Rajasthan	63.37	36.63	30.99	26.98	15.12	12.95	13.95
Central							
Chhattisgarh	58.09	41.91	31.13	26.89	20.52	11.08	10.38
MP	61.06	38.94	28.48	26.20	20.14	12.59	12.59
UP	52.41	47.59	23.24	24.97	20.09	13.64	18.07
East							
Bihar	58.20	41.80	28.73	22.55	16.10	14.04	18.57
West Bengal	49.40	50.60	37.29	35.53	15.03	6.60	5.55
Jharkhand	57.55	42.45	26.77	27.87	16.06	13.23	16.06
Orissa	54.01	45.99	38.74	30.56	14.78	10.04	5.88
North-East							
Arunachal Pradesh	52.17	47.83	31.82	22.73	13.64	13.64	18.18
Assam	48.80	51.20	38.42	27.61	16.22	8.11	9.65
Manipur	53.66	46.34	31.71	29.27	19.51	9.76	9.76
Mizoram	56.25	43.75	29.41	29.41	17.65	11.76	11.76
Nagaland	40.00	60.00	16.67	23.33	20.00	13.33	26.67
Tripura	48.15	51.85	50.88	29.82	8.77	5.26	5.26
Meghalaya	38.71	61.29	22.58	24.19	16.13	14.52	22.58
Sikkim	55.56	44.44	36.36	27.27	18.18	9.09	9.09
West							
Goa	61.54	38.46	43.75	37.50	12.50	6.25	0.00
Gujarat	57.94	42.06	30.92	32.64	19.63	9.33	7.48
Maharashtra	68.03	31.97	38.82	36.52	15.18	4.80	4.68
South							
Andhra Pradesh	52.37	47.63	37.45	41.31	15.02	3.43	2.79
Karnataka	65.83	34.17	34.88	36.77	17.79	6.76	3.80
Kerala	79.55	20.45	47.24	35.64	12.43	2.76	1.93
Tamilnadu	39.72	60.28	42.50	39.78	13.20	2.71	1.81
All India	**58.25**	**41.75**	**31.81**	**30.04**	**17.14**	**9.95**	**11.06**

Source: Computed from NFHS III

THE MULTIVARIATE MODEL

In order to trace out the differentials in child care in terms of the desired family size and a number of socio-demographic factors, binary logistic regression analysis has been attempted. Two separate models (Table 6) have been worked out to show differentials in child care in terms of medical and non-medical terms. The dependent variable in the case of medical care is the percentage of children 12-23 months who have received universal immunization, whereas in the other case, it is the percentage of children below 1 year who are currently breastfed. The main objective of this exercise to show the differences in probable outcomes in terms of child care according to different family sizes and household structure as well as to identify the other proximate determinants that in turn affect the quality of child care other than family size. The models depict different results with considerable variations among the rural and urban counterparts for which separate models have been worked out individually for immunisation and breastfeeding.

TABLE 6: SUMMARY OF BINARY LOGISTIC REGRESSION

Independent Variable	% children 12-23 years universally immunized Odds Ratio			% children below 1 yrs. Who are currently breastfed Odds Ratio		
	Total	Rural	Urban	Total	Rural	Urban
HH Structure (Ref Nuclear)						
Non-Nuclear	-0.021	0.038	0.067***	0.198*	0.167***	0.201***
No. of Living Children (Ref. Less than or equal to 2)						
3	0.0654*	0.564*	0.801*	0.110	0.179	0.219
4	0.405*	0.320**	0.619*	0.204	0.192	0.117
5+	0.170***	0.150	0.268***	0.075	0.075	0.405
Sex of Child (Ref. Male)						
Female	0.50***	0.023*	0.096***	0.129***	0.129***	0.123***
Caste of the HH Head (Ref. General)						
OBC	0.098**	0.012	0.021	0.235**	0.213	0.295***
ST	-0.109**	0.215*	0.125***	0.058	0.069	0.059
SC	-0.259*	0.283*	0.239***	0.093	0.047	0.365
Birth Order (ref. 1)						
2	0.302**	0.339**	0.199	0.757*	0.565***	1.370**
3	0.101	0.125	0.011	0.221	0.045	0.810*
4	0.092	0.134	0.095	0.30	0.012	0.305
5+	0.196**	0.265**	0.021	0.074	0.156	0.361
Desire for more children (ref. doesn't want)						
Want	0.020***	0.092	0.187***	0.866*	0.105*	0.560***
Undecided	-0.184	0.234	0.033	1.698*	1.831*	1.394*
Wealth Index (ref. Poorest)						
Poorer	1.196*	1.411*	1.971*	1.118*	0.751*	1.092*
Middle	0.906*	1.085*	1.788*	0.887*	0.510*	1.221*
Richer	0.518*	0.628*	1.511*	0.781*	0.453*	0.924*
Richest	0.453*	0.547*	1.409*	0.528*	0.210*	0.639*
Mother's Educational attainment (ref. No Education)						
Primary	1.731*	1.351*	1.211*	0.175	0.034	0.213
Secondary	1.223*	0.860*	0.848*	0.294**	0.174	0.286
Higher	0.741*	0.482*	0.577*	0.325*	0.197	0.306***
Mother's Working Status (ref. Doesn't Work)						
Worked Last Year	0.238	0.775***	1.008*	0.822	1.764	0.420
Currently Working	0.123***	0.248**	1.205*	0.553*	0.442**	0.128**
Partner's Educational Attainment (ref. No Education)						
Below or up to Primary	1.481*	1.001	1.430*	0.009	0.055	0.223
Below or up to Secondary	1.197***	1.263***	1.255**	0.053	0.048	0.290
Higher	0.073	1.144***	0.022	0.124	0.161	0.114
Mother's Nature of Employment (ref. Not Working)						
Skilled Work other than Agriculture	1.097***	0.814**	1.043	0.710	0.587	1.095
Agricultural	0.085	0.022***	0.030	1.459*	1.402*	0.166
Unpaid Household Worker	0.950***	0.801***	0.046			0.921***
Region (ref. North)						
Central	-0.034	0.295*	0.048	0.406*	0.377*	0.439*
East	1.622*	1.744*	1.294*	1.483*	1.558*	1.418*
North-East	0.105***	0.004	0.035	1.833*	0.909*	0.690*
West	1.709*	1.882*	1.540*	1.331*	1.328*	1.393*
South	1.093*	1.331*	0.071	0.526*	0.533*	0.548*
Constant	1.201*	1.423*	0.876**	0.474**	0.721**	0.202
-2 log likelihood	19853.163	11878.981	7902.935	10740.136	6793.296	3899.976

Significance Levels: *1%, **5%, ***10%

ref. is Reference Category

The nuclear households taken as the proxy for small families have performed better in terms of both immunisation and breastfeeding compared to non-nuclear counterparts and is stronger for breastfeeding where the results are statistically significant at 1 and 10% levels (Table 6). Considerable levels of discrimination occurs in large families where the chances of immunizing a child is less with three or more living children as compared to families which have two or less than two living children with significant observations. The levels of this discrimination between two or less than two living children (sought as the reference category) and the third child becomes all the very stronger in urban areas which is statistically significant at 1% level of significance. Even in case of breastfeeding the same tendency of benefits of small families are noticed even though the results are not statistically significant. A substantial discrimination in care occurs across the sex of the child and the female child is at a very disadvantageous position across all levels, be it rural or urban. However, the magnitudes of discrimination in urban areas are higher for immunisation and reverse the case for rural areas. That the first child is a blessed child is evident from the relative survival opportunities it gets as compared to the next children. From the birth order wise analysis it is clearly noticeable that the second and subsequent birth orders are so much at a grave situation in comparison to the first, the values of some being statistically significant barring the second birth order of likelihood of immunisation. Parent's desire for small families indirectly indicates appropriating existing resources in a sustainable manner and meeting quality care of the child. The chances of both immunization and breastfeeding are higher for those children whose parents do not want any more children irrespective of the place of residence though the phenomenon is stronger in urban areas.

In terms of structural variations across the socio-cultural dimensions too are the evidences quite interesting. In all types of care, it is the general castes which are on the brighter side in comparison to the marginalised and vulnerable social segments of the population (Table 6). The result is statistically significant and perhaps ascribed to the lower socio-economic status and social opportunities granted to these marginalized groups in comparison to general households. From the perspective of wealth standards of the population, the poorer have greater probabilities of immunising and breastfeeding the child in comparison to the poorest which on the other hand have higher chances of child care as compared to medium, rich and richest stratum of the population. This indeed points out the fact that child care is no longer confined to the richer and wealthy people of the country; it has been rapidly diffused to the lower segments in the modern period. More than that child care which here has been captured through universal immunisation (excluding breastfeeding) is longer costly and with the diligent efforts made by the Government to make it universal across space and people, little variations do little remain with child care and economic constraints of the

families. Moreover, the richer and wealthier occupants have other business in their life apart from actively taking part in child care all day long, hence might lose some of the important timings of vaccinations which the poor and home working mothers keep a close eye at.

The education of mother is an important controlling variable of child care so as revealed in the binary logistic regression model where uneducated mothers show lesser chance of immunising the child as compared to those who have attained primary or secondary schooling. The results are not statistically significant for breastfeeding where the argument is irrelevant from the perspective of mother's educational attainment (Table 6). Mothers who do not work have higher chances of breastfeeding and immunising the child than those who are working which is quite natural of the greater opportunity costs of time of employed mothers where child care often has to be sacrificed in the name of an outside burdened work. Herein calls an elaborate understanding of the nature of work. If the work is more efficient, less labour intensive and less time consuming like in case of skilled work, it is more advantageous or rather has a greater chance of immunisation unlike agriculture employed mothers statistically significant at 10% level.

The spatial dimensions of child care needs a broader elaboration given the regional diversity of the country inhabited by an ever demanding heterogeneous population. The Northern region has greater likelihood of both immunisation and breastfeeding of the child compared to the central region which is still at a backward stage of socio-cultural dispositions. Except the eastern region, all the other regions comprising of the South, East and the West have higher chances of immunising the child than the North (Table 6). So in case of breastfeeding where all the regions excepting central and south display greater chances of breastfeeding in comparison to the traditional value holders of the north.

FINDINGS

- The family size transition in India evokes out of the desire for small families operating jointly through the mechanism of fertility decline and increasing trend of nuclearisation of families which could be taken as a proxy for small families. This process of nuclearisation is more an urban phenomenon.
- A distinct rural/urban differential could also be observed in access to child health care facilities where the urban households have fared much better even though the gap is narrowing over the periods with rural-urban convergence. This is a typical situation of the southern states which have mostly achieved the replacement level fertility by prioritizing reproductive and child health at every level of the family planning programme.
- On the contrary, some of the Northern states like Bihar, Chattisgarh, Orissa, Madhya Pradesh their family size mostly ranges from medium to high with bulk of the population being rural and inefficient grass root family planning implementations at the village level for which the National Rural Health Mission was launched as a landmark event.
- The factors of modernization have different effects in terms of levels and quality of child care. Small or nuclear households are reported to have performed better in terms of both medical and non-medical care as compared to the non-nuclear households.
- In terms of structural variations, socially vulnerable and marginalised communities are at a higher risk of poor health condition of the child. The economic situation of the family is little valid to explain the observed differentials on child health care. Poorer consider an upper hand than the richer.
- The other proximate determinants of child care like mothers' occupational structure or their educational attainment are also seen to have considerable effects where mothers' having atleast some level of education or those who are employed in skilled occupations are reported to perform better in terms of medical protective care like complete immunisation.

CONCLUSION

Thus the small family norms incepted as an exception to the usual discourse of socio-economic development is seen to have diverging results in terms of the specificities of quality child care. The western, eastern and the southern regions have shown better performances in the protective efforts of the child while breastfeeding which demands an intensive care of the child show differences particularly pertaining to the working status of the mother. Education of both the parents and the modern demographic ideologies are essentially crucial for meeting the desired outcomes of medical care which has little to do with the income profile of the household. In some of the economically developed pockets of the North, like Punjab and Haryana, the small family norm actually translated to the "intensification effect" of strong son preference with increasing performance of sex selective abortions with a skewed sex ratio at birth.

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NOTES

[1] Years of NFHS I, II and III are 1998-99, 2002-03 and 2005-06.

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