CHAPTER – II
REVIEW OF LITERATURE: UNMET NEEDS AND FAMILY NORMS

FAMILY NORM

The Indian Family Planning Programme depends for its success on voluntary acceptance of the people, through a process of motivation and education, of the good that accrues to individuals practicing the small family norm. The decision of family size and acceptance of contraceptive is an individual’s (couple) act, which are reinforced by members, peer group and society.

The size of the family is a matter of great importance not only for the country as a whole but also for the welfare and health of the individual, the family and the community. India has adopted the goal of universalizing the two-child family norm by the end of this century. The achievement of this goal has consequences both at the micro level i.e. level of individuals and family, and at the micro level i.e. for the nation as a whole.

Although India has made significant progress in various development sectors since Independence, the fruits of these developments have not reached major segments of the poor. One important reason is that many of the gains have been neutralised by the rapid growth of the population. India does not have the resources to bring about a radical qualitative improvement in the lives of hundred of millions and at the same time to provide to million more. A slower increase in population would enable qualitative changes to take places.

The size of the family affects the quality of life of human beings. The quality of life does not only pertain to economic standards of living; rather it has a much wider horizon. Family size affects: i) basic human need, (ii)
income and growth of the economy and savings, (iii) food and nutrition-quality and quality, (iv) used of land and urban public system, (v) health, especially that of mother and child, (vi) education, particularly that of children.

In any society, other things being equal, the larger the size of the family, the relatively smaller will be the per capita share of basic needs for individuals and the family. Similarly, declining size and fewer members of the family results in bigger per capita shared required for existence and development.

Preference for a large family size eventually leads to fragmentation of land holdings, especially in rural communities which has its effect on low per capita productivity. This results in migration of the population from rural to urban areas which in turn, exerts pressure on urban public systems, leading to poor social and economic development.

Various studies have shown higher morbidity among mothers and children in large families. Early marriage, followed by too early pregnancy, too many children, too frequently till the advance reproductive age of the mother, affect the health of the mother as well as that of the child.

Family size is seen to be related to education, where the mother’s education is high, family size is usually smaller and infant mortality is also relatively lower. The level of the mother’s education and its impact on family size is evident in the State of Kerala, where female literacy is the highest, and it has the lowest birth rate, and the child mortality rate is also the lowest in the country.

The Centre (15 February, 2000) gave the nod of to a new national population policy that seeks to hasten the process of population stabilization through a series of socio-economic measures. The approval came at a meeting of the Union Cabinet. The promotional and motivational measures under the
policy include linking of the disbursement of the cash awards under the Rural Development Department’s maternity scheme to compliance with the antenatal check-up, institutional delivery by trained attendant, registration of birth and BCG immunization; provision of health insurance scheme for couples below the poverty line, who undergo sterilization with not more than two living children; and a special reward for those who marry after the legal age of marriage, register their marriage, have the first child after the mother reaches the age of 21, accept the small family norm and adopt a terminal method after the birth of the second child. The policy envisages the setting up of a high-powered ‘national commission’ on population, chaired by the Prime Minister, to monitor and guide planning and implementing of the policy. The panel would consist of chief ministers of all States and Union Territories as members, besides Central ministers in charge of the Department of Family Welfare and other concerned Central ministers and departments, and reputed demographers, public health professionals and the representatives of NGO (www.uwmc.uwc.edu).

The small family norm is widely accepted and general awareness of contraception is universal (Santhya, 2004). However, awareness of reversible (modern or natural) methods is relatively limited among both women and men. Nationally, for example, only 71% of the currently married women were aware of condoms (IIPS and ORC Macro, 2000). In some major states including Andhra Pradesh, Karnataka, Madhya Pradesh and Orissa, fewer than three in five currently married women were aware of condom (Santhya, 2004). For example, only three fourth of married adolescents were aware of condom, compared to nearly three fourths of women between 20-34 years (Santhya and Jejeebhoy, 2003). Small-scale studies show that a substantial proportion of unmarried boys and girls also lack contraceptive knowledge (Bhende, 1994; Kumar et al., 2000). Inadequate knowledge of contraceptive method, and incomplete or erroneous information about where to obtain...
methods, and how to use them are the main reasons for not accepting family planning (Levin et al., 1992; Roy et al., 1991; Viswanathan et al., 1998).

Studies assessing correct, adequate and timely knowledge suggest that only a small proportion have complete knowledge of various contraceptive methods (Balaiah et al., 1999; Rajaratnam and Deshpande, 1994; Sharma et al., 1997). In many cases, men and women who were otherwise aware of contraceptive methods did not have timely knowledge. Studies shows that if these couples had such knowledge during the initial years of their married life, they might have delayed the first pregnancy (Haberland et al. 2001; Levin et al., 1992).

**SMALL SIZE FAMILY NORM**

Demographic research over the past two decades has confirmed that preference for sons over daughters remains entrenched in many countries throughout the world. In such settings, religious traditions and social norms coupled with economic discrimination against women and girls conspire to ensure that young boys have greater access to education, health care, and even food than do their sisters. Such neglect leads to markedly higher rates of illiteracy, malnutrition, and poor health among girls. In the worst cases, discrimination against girls takes the form of female infanticide, in which girl children are killed outright immediately after birth. These practices have evolved in recent years to include the use of modern technologies to determine the sex of children in the womb and the subsequent use of sex-selection abortion to avoid the birth of a girl child altogether. The result of such practices is evident in the growing imbalance in the survival of girls relative to boys in some countries today. Such is the case in India, where the combined effects of historical discrimination against girl children and the use of advanced technology for sex selection are now clear. Data collected in the 2001 Census of India reveal that the juvenile sex ratio has declined steadily
over the past decade, from 945 girls per 1,000 boys ages 0-6 years old in 1991 to 927 girls per 1,000 boys in 2001. This decline has been attributed both to excess neo-natal female mortality due to the spread of female infanticide, and to the rapidly expanding use of prenatal diagnostic technology for the purposes of sex determination (SD) followed by use of sex-selection abortion (SSA).

It is now indisputable that, as India enters the 21st century, SD and SSA have been integrated into the range of family building strategies used by couples to ensure a desired imbalance in the number of male and female offsprings. What is less well understood are the ways in which population policies supported by both the government and international donor agencies have fueled the insidious use of modern technology to eliminate girl children even before they are born.

The roots of son preference in India lie in deeply entrenched social, cultural, and economic discrimination against women and girls. The predominant system of patrilineal descent and inheritance legitimizes and propels the desire for sons. Sons, for example, traditionally perform the last rites after the death of a parent. Indeed, a strict interpretation of Hindu tradition holds that salvation in the afterlife can only be achieved if a son lights his parent.s funeral pyre (Mutharayappa, et al.; 1997). As a result, many religious Hindus strive to ensure they have at least one son.

Economic calculations are increasingly a factor in the perpetuation of son preference. In much of the country, men and boys are more likely to work for cash wages than are women and girls. Although women often work longer hours than men, they are more likely to be engaged in unpaid subsistence and domestic work that, while critical to family survival, is ironically perceived to be less valuable. At marriage, daughters leave their natal homes and must bring a dowry to their husband.s family, to which they are also expected to contribute economically, whether in the form of paid or unpaid work. Sons
are expected to support their parents in old age, and, therefore, are viewed as a source of social security. In fact, the desire to accumulate wealth has become an increasingly important factor in son preference in recent years, in part as a result of the desire among the growing middle class for upward mobility. The spread of consumerism and the associated increase in the cost of dowry and marriage, plus the desire to maintain landholdings within a family all have contributed to an environment that is extremely hostile to women and girl children, even among the educated middle and upper classes. Indeed, contrary to what might be expected, the most dramatic declines in the sex ratio over the past decade were found in Punjab, Haryana and Maharashtra, among the richest states in India (Census of India, 2001).

Average family size in India has been declining over the past two decades, in response to a number of economic and social changes, including rising aspirations for children coupled with the increased costs of rearing them, and the entry of large numbers of women into the formal labor force. Such changes have taken root more quickly among some segments of the population than others, and families of three children remain the norm in a number of states, including Andhra Pradesh, Bihar, and Uttar Pradesh. The Government of India has attempted to hasten the transition to small families among every segment of the population through population policies and programs implemented largely through the Indian Family Welfare program. These strategies have ranged from the heavy-handed approaches of the seventies and eighties which relied on social pressure and outright coercion to increase contraceptive use and reduce family size to the Target-Free Approach adopted in the mid-nineties, which was intended to eliminate the coercive tactics that had become common place in the rush to raise contraceptive prevalence rates.

Over the past three years, however, political pressure has once again been mounting for the government to redouble its efforts on population
control. Today, national and state population policies focus variously on building voluntary support for small families through a variety of strategies to the outright imposition of two-child families through the use of social and economic incentives and disincentives. In Andhra Pradesh and Rajasthan, for example, preferred access to housing, education, and other needed social resources is now given to couples that have no more than two children. In Andhra Pradesh, Rajasthan, Madhya Pradesh, Haryana and several other states, laws also prohibit individuals with more than two children from contesting local government elections.

The shift to smaller families now evident in India has not, however, been accompanied by a concurrent shift in the social and economic pressures that underlie the preference for sons over daughters. Indeed, if anything, the pressure to have sons has intensified as couples strive simultaneously to reduce family size and ensure the birth of the desired number of sons, leading to increased acceptance of and reliance on the use of sex-selection strategies to achieve these results. Evidence of these trends has been clear for a number of years, but neither the national nor the state governments in India have effectively addressed the root causes of pervasive son preference. Population and health policies have focused on building pressure for smaller families through a variety of means, but largely have failed to address the social norms that simultaneously privilege sons over daughters, and tacitly support the epidemic of gender violence that afflicts women and girls throughout their lifecycle. The government has failed to effectively address persistent gender gaps in education, employment and access to productive resources such as land and property. Even existing laws, such as the Child Marriage Restraint Act and the Dowry Prevention Act, have been poorly implemented, if at all. Family is that group of people who live under one roof and share a common kitchen. In terms of their composition different types of families are distinguished.
The Indian Family Planning Programme depends for its success on voluntary acceptance of the people, through a process of motivation and education, of the good that accrues to individuals practicing the small family norm. According to Govind Narain (1968) the philosophy behind the programmes is as follows:

The community must be prepared to feel the need of the services in order that those may be accepted when provided.

- Parents alone must decide the number of children they wish to have.
- People should be approached through the media they respect and through their recognized and trusted leaders.
- The services should be made available to the people as near to their homes as possible.
- The services will have greater relevance and effectiveness if they are made an integral part of medical and public health services, especially of the mother and child health programme.

To adopt family planning it depends on the extent of the degree of motivation to limit family size. However, ideal family size, as expressed by couples can be considered as crude proxies of the motivation to limit the family size.

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Our country has adopted the goal of universalizing the two-child family norm by the end of this century. The achievement of this goal has consequences both at the micro level i.e. level of individuals and family; and at the macro level i.e. for the nation as whole.

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capita productivity. This results in migration of the population from rural to urban areas which, in turn, exerts pressures on urban public system, leading to poor social and economic development.

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Every increased in family size results in decrease in per capita food and nutrition availability and this slows down the quality of nutrition and improvement of health standards, this, in turn, has its effect on productivity of labour, which ultimately affects the overall economic development.

There are certain hazards of large and unplanned families about which people need to be aware. These hazards are going to affect not only the
mother’s and children, but also the family as a whole, and subsequently, the community and the nation.

The size of the family affects the quality of life of human beings. The quality of life does not only pertain to economic standards of living; rather it has a much wider horizon.

For adopting family planning it depends to a large extent on the degree of motivation in order to limit the size, space the children and the knowledge among the couples of contraceptive methods.

At the level of individual decisions, the family size and its composition are strongly influenced by the class to which they belong. The consumption utility is same for all the classes. Regarding family composition, desire to have at least one male child in the family emerges from social belief and compulsion. The number of children born to a family and ultimately their survival is dependent upon three factors. They are (i) demographic factor, (ii) developmental factor, and (iii) factors related with health and medical care facilities. These three factors operate in a complex manner and exert diverse influence on one’s family.

Various studies have shown higher morbidity among mothers and children in large size families. Early marriage, followed by too early pregnancy, too many children, too frequently till the advance reproductive age of the mother, affect the health of the mother as swell as that of the child.

While it may appear self-evident that two-child family is a happy family, widespread acceptance of the two-child norms has not yet taken place in the country due to various religious, cultural and socio-economic factors. Concerted efforts therefore, need to be made to provide the necessary information and education of to the people, especially in rural areas and urban slums to motivate them to accept the two-child family norm. It is indeed imperative on the part of each one of us to advocate and adopt the two-child

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family norm and constructively contribute our share in our own work settings and in the developmental efforts aimed at achieving the quality of life and physical, mental and socio-economic well-being of the people, and the family and the community at large.

Several studies conducted in India has proved that there is a positive association between the economic status of a person (couples) and use of contraceptives (Agarwal, 1962; Kaur, 1974; Singh and Gupta, 1983). Muleitha and Kaur (1962) in their Chetla Urban Health Centre study, noticed that among the higher income group, 57% of wives were practicing family planning, while the percentage was very low among the lower income group (20%). A highly positive and significant association was observed between the income and the level of family planning adoption by Kaur (1974) in two industrial units near Delhi and also by Khan (1979) among the Muslim of Kanpur City.

Higher educational status increases the knowledge and changes the attitudes towards family planning which leads to the use of contraceptives. Sarupriya (1964) found that in a district town near Jaipur, the percentage in favour of family planning among illiterates was 38, while it was 62 among those with primary education. For those who have secondary and college education, the percentage in favour of family planning were 57 and 70 respectively.

In the 16th round of National Sample Survey (NSS, 1967) conducted during 1960-61 in the urban areas of the States, questions were put to husbands about the number of children considered ideal and whether they desired to have children in addition to those they already had. In the urban areas of Karnataka during 1960-61 the average number of children considered ideal was 3.5 as compared to the actual family size of 4.1 (NSS, 1967).
During 1960-61 the proportion of husbands (with wife under 45 years of age) in the urban areas of Karnataka who did not desire additional children was 36.5 per cent in the combined sample (NSS, 1967).

The decision of family size and acceptance of contraceptive is an individual’s (couple) act, which are reinforced members, peer group and society. Dubey (1969) suggests that the decision making can be conceptualised at three level: (i) the total society, (ii) the family members and the peer group, and (iii) the couple itself. These levels have been conceptualised in the fertility models forwarded by different scholars. For example, the structural model of Davis and Blake (1956) provided an exhaustive list of societal and institutional variables affecting fertility. They called them as intermediate variables as any change in fertility must be effected only through modifications of one or more of them.

Ideal family size as expressed by couples and the proportion of couples not desiring additional children can be considered as crude proxies of the motivation to limit family size (Rao, 1976). One should note that an ideal family size need not necessarily refer to the respondent’s own (ideal) family size. The proportion of couples who do not wish to have additional children (over those they have) is a better indicator of the desire to limit the family size. Ideal family size varied from 2.9 in Assam, Madhya Pradesh and West Bengal to 3.6 in Uttar Pradesh. In all the States, ideal family size was smaller than the actual family size (Rao, 1976).

To measure the socio-economic status occupation is an indicator with higher occupational status, higher education and income, in turn leads to higher rate of adoption of family planning methods. In Greater Mumbai, according to fertility and family planning survey, Rele and Kanitkar (1980) observed that the highest use of contraceptives was noticed among wives working in administrative, professional and technical cadres (53%) followed
by clerical (38%) and sales professionals (38%), whereas the lowest rates were observed among the housewives (23%) and also among the women who were engaged in other skilled or unskilled work and primary sector.

The first requisite formulated of motivation for small families refers to the socio-psychological approach to life as expressed by generally held values and implies from the standpoint of fertility norms, a rational approach to reproductive decision-making. The second precondition is directly derived from the social and economic value attributed by parents and family to large numbers of children. Models attempting to account for the factors that create demand for children and give children their value (Caldwell, 1982) as well as for the conditions under which motivation for smaller families arises (Easterlin, 1975), have been proposed and are invaluable for understanding, the theoretically both the desire for fewer children and the obstacles to resort to birth control to achieve that end.

Singh and Gupta (1983) in their case study of Patna observed that education is significantly related to sterilisation. For example, the percentage of adoptors were more (79%) among those educated up to matriculation and above as compared to those educated below matriculation level (21%).

Demographic evidence suggests that the accurate determination expected family size of a given population involves conceptual and methodological problems (McClelland, 1983). In most societies, before becoming parents, few couples plan the exact size of their families. This is based on the costs and benefits of children and their economic and personal resources.

The successful limitation of family size by the couples depends not only on their small family ideals but also their psychological acceptance of family limitation, knowledge of birth control methods, availability of contraceptives, psychological and economic costs, and more important, an
environment favourable to the practice of birth control. The decision to limit the family size rests with the individual or the family, although the government strongly advocated that couples not to bear more than three children in their own nation’s interest, and to this end has instituted a well-structured family planning method. The extent to which the couples make use of these government sponsored facilities depends on their motivation to limit family size, attitude towards government facilities, and their socio-economic conditions (Ramu, 1988).

Extensive country-level surveys show that many women as having “unmet need” for family planning. In some countries unmet need is as high as 36 per cent of all married women. It is estimated that up to 120 million women of reproductive age have an unmet need for family planning in all developing regions of the world. These estimates do not include sexually active adolescents and unmarried women…groups that have been excluded from surveys that inquire about reproductive health and family planning. Meeting the remaining unmet need from contraception may be difficult, specially if the “easiest” group of women have already been served….namely those who were inclined to use contraceptives and who enjoyed relatively easy access to organized programme (Ashford and Noble, 1996).

UNMET NEEDS

Millions of women in developing countries who would prefer to postpone or avoid pregnancy do not use contraceptives. These women have an "unmet need" for contraception. By reducing obstacles to the use of contraception, family planning programs have been successful in addressing unmet need. Programs’ principal methods for addressing this need have included emphasizing voluntary acceptance of contraception, educating couples about the range of methods and their possible health risks, and subsidizing the cost of contraceptives.
Unmet need is a disconnection between a woman's fertility preferences and what she does about them: She wants to avoid conceiving but fails to do what is needed to prevent pregnancy. The concept is usually applied to married women but also can apply to sexually active unmarried women and to those whose current method is inappropriate or inadequate. Survey research in developing countries estimates that more than 150 million married women of reproductive age have an unmet need for contraception. India has the highest number at about 31 million women (20 percent). In the majority of African and Middle Eastern countries studied and in a large number of countries in Asia, Latin America, and the Caribbean, at least 20 percent of married women of reproductive age had an unmet need for contraception. The countries with the highest percentage of women with unmet need are in Sub-Saharan Africa: Rwanda (37 percent), Malawi (36 percent), and Kenya (36 percent).

Inadequate attention to alarmingly rising population and its deleterious effect on developmental effort and food situation, has led us to a disastrous situation. Contraception is the best development (Singh, 1992). Many women who are sexually active would prefer to avoid becoming pregnant but are not using any method of contraception. These women are considered to have an unmet need for family planning. The concept of unmet need points to the gap between some women’s reproductive intentions and their contraceptive behaviours. Even where the proportion of women with unmet need is declining, the absolute number with unmet need may be growing because the population is growing. Among the common reasons for unmet need for family planning are inconvenient, unsatisfactory services, lack of information, fears about contraceptive side effects and opposition from husbands, relatives or others (Population Reports, 1997). In developing countries, average level of unmet need is about 20% (Westoff and Bankole, 1995). By responding to the concerns of women with unmet needs, programme can serve more people and in a better way. In view of the above, the present study was carried out with
the objectives to estimate the magnitude of unmet need for family planning among married women of reproductive age to identify socio demographic factors associated with unmet need for family planning and contraceptive users, and to explore common reasons for unmet need for family planning.

According to Demographic and Health Surveys (DHS) definition, the unmet need group includes all fecund women who are married or living in union, and thus presumed to be sexually active, who either do not want any more children or who wish to postpone the birth of their next child for at least two more years but are not using any method of contraception.

Women who have recently given birth and are not yet at risk of becoming pregnant because they are amenorrheic have an unmet need if their pregnancies were unintended. In this formulation, women who became pregnant unintentionally because of contraceptive method failure are not considered to have an unmet need for family planning (Westoff and Ochoa, 1991; Westoff and Bankole, 1995).

There were criticism in the definition as pointed out by Ruth Dixon-Mueller and Adrienne Germain (1992). According to them, the concept of unmet need can apply to all sexually active people, whether married or not. Further, even contraceptive users themselves may have an unmet need if they are using an ineffective method, using a method incorrectly, or using a method that is unsafe or unsuitable for them. They argued that the concept of unmet need should not be restricted to women, but also should be applied to men. Sinding and et al. (1994) argued that family planning programmes, should attempt to meet unmet need rather than pursue government targets reflecting demographic considerations. The concept of unmet need could be used by programme planners to develop better-focused new programmes and to fine-tune existing programmes to address people’s specific needs. Roughly one-fifth to one-quarter of births in the developing world are unwanted, as
measured by women’s direct responses in surveys to a question about the wantedness of their most recent pregnancy (Bongaarts, 1997). The most direct evidence that unmet need is real is the high incidence of births that are reported as unwanted. With all the attention given to unmet need during the past decade, it is easy to forget that it is desirability of preventing unintended pregnancies that justifies the focus on unmet need (Yinger, 1998). Furthermore, a substantial fraction of pregnancies are terminated through induced abortion (Alan Guttmacher Institute, 1999) and therefore the fraction of pregnancies that are unwanted must be even higher than the fraction of births that are unwanted.

Unmet need for family planning, which refers to the condition of wanting to avoid or postpone childbearing, but not using any method of contraception has been a core concept in international population for more than three decades. Under the label “KAP-gap”. The concept has its origin in the first fertility and family planning surveys carried out during the 1960s; and from the outset it was recognized as a pre-eminent rationale for investments in family planning programmes because of its casual link to unwanted child bearing. Its central role as a justification for programmatic effort and, more fundamentally, as an organizing concept in international population has if anything solidified during the 1990s (Casterline and Sinding, 2000).

Unmet need for family planning identifies the group of women who wanted to avoid or postpone childbearing but are not using contraception. Women with unmet need for family planning constitute a significant fraction of married women of reproductive age in India. According to the National Family Health survey-I (NFHS-1) conducted during 1992-93 total unmet need for family planning was 19.5 per cent with unmet need for spacing of 11.0 per cent and limiting of 8.55 per cent (IIPS, 1995). The second round of NFHS collected data for the period 1998-99. According to NFHS-2, unmet need
declined to 15.8 per cent and unmet need for spacing and limiting was 7.5 and 8.3 per cent respectively (IIPS, 2000).

Unmet need for family planning has generated considerable interest as both national government and non-governmental agencies use it as a yardstick for indicating the extent of intervention required by a programme to improve contraceptive usage. In fact, justification for public and private investment in family planning programme is based on unmet need (Casterline and Sinding, 2000).

The concept of unmet need can apply to all sexually active, fecund women and perhaps even to men. Its measurement has been limited largely to married women, however, because for most countries the survey data necessary to measure unmet need have been available only for married women (Westoff and Bankole, 1995; Westoff and Ochoa, 1991). Various attempts have been made to measure the unmet need. Since 1984, the main information source for measuring unmet need has been the Demographic Health Surveys (DHS). In addition, the Family Planning and Reproductive Health Survey (FP/RHS) have estimated unmet need in national surveys since 1985. While the FP / RHS formulation of unmet need is not strictly comparable with that used in the DHS, these surveys provide estimates of unmet need for some countries, principally in Latin America and the Caribbean, that have not been surveyed the DHS (Robey and et al., 1992). The formulation of unmet need that has become their standard and is used most widely to measures unmet need was developed partially by Charles Westoff. In this formulation the unmet need group includes all fecund women who are married or living in union – and thus presumed to be sexually active – who are not using any method of contraception and who either do not want to have any more children or want to postpone their next birth for at least two more years.
Levels of unmet need vary substantially according to women’s demographic and social characteristics such as their age and education. Also, there are important differences among women with unmet need. For example, whether their interest is in limiting or spacing births, and whether or not they intend to use contraception. Around the world, many sexually active young people who want to avoid pregnancy are not using modern contraceptive methods for various reasons, including a lack of access to services or disapproval by health providers. Evidence of the “unmet need” for family planning services is often indirect, particularly for unmarried adolescents, making it difficult to quantify.

The concept and measurement of unmet need have evolved considerably in the last two decades. Nortman (1982) introduced measures of unmet need for spacing to supplement the measure of unmet need for limiting births. He included pregnant women and amenorrheic women for consideration because they would soon need contraception again. Similarly, the NFHS identified unmet need in currently married women in the productive age groups. In addition, World Fertility Survey (WFS) excluded questions for spacing births as a result of exclusion of pregnant and amenorrheic women by Westoff as they were temporarily at least not in need of contraception (Westoff, 1978). Subsequently, DHS included additional questions that allowed for the inclusion of pregnant and amenorrheic women among those for whom unmet need for spacing and limiting could be measured (Westoff, 1988; Westoff and Ochoa, 1991; Westoff and Bankole, 1995, 1996). Further FP/RHS on a more limited scale were conducted which provides estimates of unmet need, with the inclusion of unmarried women too (Robey et al., 1992).

In the developing world as a whole, excluding China, about 20 per cent of married women of reproductive age have unmet needs. This percentage is highest in Sub-Saharan Africa, where in some countries one married woman
in every three has unmet need. In most of these countries more married
women have unmet need that are using contraception. In developing countries
over 1000 million women who are married or in union have unmet need for
spacing or limiting births. India has the most, at about 31 million women.

A primary cause of unmet need for family planning is the desire
women have for additional children (Westoff and Bankole, 1995). Unmet
need was lower where the knowledge about family planning method was
higher (Bongaarts and Bruce, 1995). It is also reported that family planning
methods were perceived to be less accessible to women with unmet need.
Women in several countries have discontinued contraception because of side
effects and these women form a sizeable fraction of the unmet need groups
(Bhusan, 1996). Various studies indicate that along with other reasons, lack of
sufficient knowledge may contribute to more than two-thirds of all unmet
need (Ross et al., 1996). Other surveyed countries where large numbers of
women have an unmet need are Pakistan at 5.7 million, Indonesia and
Bangladesh at 4.4 million each, Nigeria at 3.9 million, Mexico at 3.1 million,
Brazil at 3.0 million and the Philippines at 2.5 million. Among surveyed
countries, levels of unmet need, as a percentage of all married women of
reproductive age, range from 11% in Thailand and Turkey to 36% in Kenya.
The developing countries average is about 20% (Population Reports, 1977).

Religious opposition is the main reason for unmet need among women
in Bangladesh, Pakistan, Senegal and Nigeria (Westoff and Bankole, 1995).

In the Chitwin District, where access to top services is better than in
many parts of Nepal, many women with unmet need said that they did not use
contraception because they received or expected poor treatment at clinics, or
they feared side effect of contraceptive use that would affect their working
capacity and capability (Stash, 1995).
In rural Nyanza province of Kenya, women’s decision to use family planning were taken tentatively following exploratory conversations with friends and then “more strategic conversations” with contraceptive users (Ruttenberg and Watkins, 1996). Most women expressed concerns about side effect of contraceptives. Also, their husbands had considerable power over them. After beginning contraceptive use, women remained ready to discontinue, should they change their minds, experience effects or face their husband’s opposition.

Women in several countries have discontinued contraception because of side effects and these women form a sizeable fraction of the unmet need groups (Bhusan, 1996). It is also reported that family planning method were perceived to be less accessible to women with unmet need (Bhushan, 1996). In Dang District where family planning is not accessible some women were not using contraception because they did not know who would provide information and supplies (Valley Research Group, 1996).

Following the evidence of unmet need from large scale surveys in many countries of the world – DHS, WFS and BHFS – there had been some attempts to stuffy the reasons for unmet need in diverse population. It is found that in Manila and several rural areas, women with unmet need were more likely than contraceptive users to think that the health risks of contraception outweigh the risks of pregnancy (Casterline and et al., 1997).

Over the years from 1992-93 to 1997-98 the quantum of unmet need has increased from 15 to 20 per cent (Forthcoming NFHS Report). According to the sources the unmet need is slightly greater for spacing births than for limiting births. To make the family planning services accessible to people in the reproductive age group. It is quite important to enlarge the scope so that effective rate of protection from unnecessary risks to births can be increased. However, keeping in view the increasing proportion of unmet need in family
planning it is estimated that the number of such currently married women in Himachal Pradesh is to be little more than 150,000 women.

Nag (1984) noted that a woman may have unmet need for family planning because of high social cost of challenging the opposition from spouse or anyone else in her social influence group. In India, studies show that men will also accept vasectomy when conditions for service and delivery are favourable despite poverty, patriarchal traditions, and preference for sons (Gulati, 1986). Increased involvement of men in reproductive health of the family is appreciated by their partners and a large number of women are motivated to control fertility (Gallen et al., 1986; Zachariah, 1990). In India desired family size of most couples is 3 or more children (Khan and Gupta, 1987; Rajaretnam and Deshpande, 1994). In two communities of Tamil Nadu, one peri-urban, the other rural, unmet need often resulted from the lack of contraceptive choices; sterilization was the only method available (Ravindran, 1993). In Sri Lanka, the principal reasons cited by women with unmet need for non-use of contraception included: (a) health concerns (19.3 per cent); (b) husband’s disapproval (14.6 per cent); (c) infrequent sex (13.3 per cent); (d) lack of knowledge (10.4 per cent); (e) religion (3.6 per cent); and (f) lack of access (3.2 per cent) (Bongaarts and Bruce, 1994).

Mitra and Simmons (1995) in their article “Diffusion of the culture of contraception: Programme effect on young women in Bangladesh” describes a process of diffusion of family planning information, ideas and technology among an unanticipated audience of young, unmarried women in rural Bangladesh. The data have been derived from a focus-group study conducted in 1987-88 in the Maternal Child Health and Family Planning Project in Matlab, Bangladesh. The discussion showed that many young, unmarried women learn about family planning from an early age from the community-based family planning worker, from female relatives, peers and the media. The findings of this exploratory study suggest that greater attention be paid to
the contraceptive needs of young women and that continued research be conducted with this population of women.

Loaiza (1995) in his article “Sterilization regret in the Dominican Republic : Looking for quality-of-care issues”, shows that the concept of quality of care by looking at the covariates of sterilization regret in the Dominican Republic according to the results from the 1991 Demographic and Health Survey. The main variables observed are the women’ satisfaction with sterilization, the decision making process, sterilization experience, use of family planning, and socioeconomic characteristics. The more detailed measurement and analysis of the outcomes of care point to a need for improvement the public programmes effort with regard to sterilization. Substantial proportions of women were sterilized who were younger than 30, who had three or fewer living children and who had the operation before they had used any other method of contraception. Because a greater proportion of sterilisation regret is observed among these groups, women must be enabled to make a free and informed decision about sterilisation by means of programmes that offer a more balanced choice of methods, as well as better counseling, education, and to high quality services.

Gaje (1995) explore the linkages between various indicators of women’s position and spousal communication about family planning and contraceptive use by using the data from the 1998 Togo Demographic and Health Survey. The results highlight the importance to their contraceptive behaviour of women’s economic power and individual control over choice of partners. The likelihood of spousal communication about family planning and modern contraceptive use is significantly higher among women who exercised complete control over selection of partner than among those with arranged marriages. Women who work for cash are significantly more likely than those who do not communicate with their spouses about family planning, particularly if they participate in rotating credit or saving schemes. Such
participation also increases significantly the likelihood of every using traditional and modern methods of contraception’s.

In their comparison of unmet need among countries that conducted Demographic and Health Survey showed that the most common reason for women not to use contraception was lack of knowledge of family planning methods (Westoff and Bankole, 1995). Unmet need was lower where the knowledge about family planning methods was higher (Bongaarts and Bruce, 1995).

Another study in Tamil Nadu found that few women were even aware of methods other than sterilization (Dharmalingams, 1995). In this case, most wives felt that sterilization entailed to many risks, while most husbands were opposed to sterilization.

In Uttar Pradesh a study found that little interest in contraception was being met because the family welfare programme gave little attention to temporary methods such as oral contraceptives (Devi et al., 1996).

Another contributing factor for unmet need is the general health condition of women. Women do not use contraception as they believe they do not need it. When a woman believes that she is unlikely to become pregnant, she is disinterested in contraception. Women with unmet need are much less likely than contraceptive users to accept that they can ever become pregnant (Casterline et al., 1997).

A 1997 survey in the province of Punjab, Pakistan revealed that among the eight possible barriers to contraceptive use, the most prevalent was disapproval by the husband, followed by fear of side effects (Population Council, 1977).

In Phillipines, women with unmet need are more likely to consider using contraception to be socially acceptable (Casterline et al., 1997).
Women with unmet need in Uttar Pradesh reported that their husbands were opposed to contraception: for 87 per cent of the women interviewed, the decision to use family planning ultimately depended on the husband (Vishawanathan, et al., 1998). Women also describe the inconvenience of and dislike for the contraceptives that are available in the family planning programme. In Bangladesh and Pakistan, religion and the partner’s opposition were cited as the principal reason for not using contraception by women with unmet need in the 1990/1991 and 1993 DHSs (Macro International, 1998). Opposition by the husband was also identified as a major reason for non-use of contraception in India (Viswanathan et al., 1998).

Several recent studies have shown that barriers to individual use are part of larger social and cultural patterns. Using in-depth interviews and focus group discussion along with survey data, studies in Ghana, India, Pakistan, the Philippines and Zambia, as well as Guatemala, consistently found that lack of knowledge, fear of side effect and husband’s support are the major factors accounting for unmet need (Finger, 1999).

Despite improved availability and access to contraceptive services, a substantial proportion of pregnancies (21% of all pregnancies that resulted in live births nationally were unplanned (mistimed or unwanted) (IIPS and ORC Macro, 2000). It is estimated that if all unwanted births could be eliminated, the total fertility rate would drop to the replacement level of fertility data from NHFS-2, for example, show that 21 per cent of all pregnancies that resulted in live births in three years preceding the survey (including current pregnancies) were unplanned – 12 per cent mistimed and 9 per cent definitely unwanted (IIPS and ORC Macro, 2000). Moreover, a substantial proportion of unintended pregnancies may be terminated through induced abortions. Estimates show that about 6.7 million induced abortions take place annually in India (National Commission on Population, 2002). Several studies report that the desire to limit family size and to space the next birth are the main
reasons for abortion mentioned by the majority of abortion seekers (Ganatra, 2000) clearly highlighting that there is a substantial unmet need for contraception among women in India.

There are pronounced regional differences in the proportion of women with an unmet need for contraception. NFHS-2 data show that the level of unmet need was higher in the northern and north-eastern states than in the southern state – 19 per cent versus 11 per cent. There are substantial differences in unmet need within each region as well. In the southern states, for example, 8 per cent of married women in Andhra Pradesh had an unmet need for contraception, compared to 17 per cent in Goa. Similarly, the level of unmet need in the northern states ranged from 7 per cent in Punjab to 25 per cent in Bihar and Uttar Pradesh. In the north-eastern states, unmet need ranged from 16 per cent in Mizoram to 36 per cent in Meghalaya (IIPS and ORC Macro, 2000). Rama et al, noted in 12% of mothers, the reasons for unmet need was opposition from husband, families and communities (Rama et al., 2000). The NFHS-2 reports that 16% of currently married women have an unmet contraceptive need, which translates into one fourth of women who wish to space or limit births (IIPS and ORC Macro, 2000).

Casterline et al (1997) in his article “Factors underlying unmet need for family planning in the Philippines” investigates four explanations for unmet need: (a) as an artifact of inaccurate measurement of fertility preferences and contraceptive practice, (b) as a reflection of weakly held fertility preferences, (c) as a result of women’s perceiving themselves to be at low risk of conceiving, and (d) as due to excessive costs of contraception. The explanations are examined using quantitative and qualitative data collected in 1993 from currently married women and their husbands in two provinces in Philippines. The results indicate that the preference–behaviour discrepancy commonly termed “unmet need” is not an artifact of survey measurement. The most important factors accounting for this discrepancy are the strength of
women’s reproductive preferences, husbands’ fertility preferences, and the perceived detrimental side effect of contraception. Inaccessible family planning services appear to carry little weight in this setting. Modification of services to make them more attentive to other obstacles to contraceptive use would improve their effectiveness in reducing unmet need.

Every use of condom is relative high in the northeastern states (except Rajasthan), as well as in Kerala, IUDs have been used more in Delhi and Punjab than in any other part of India. The pill is popular among the women in Tripura and West Bengal.

The report by Okun (1997) described trends and differentials in contraceptive practices among Israeli Jews. Data from two fertility surveys show a heavy reliance on the IUD, little use of sterilization, and declining, but still significant use of withdrawal. The factors associated with the practice of withdrawal are explored. Evidence is found in support of Santow’s hypothesis that the degree of sex–role differentiation with in marriage and the belief that men hold the authority in reproductive decision making are both positively related to the practice of withdrawal. Fear of oral contraceptives, a dislike of sterilization, and a reliance on the IUD only at greater parities imply a continuing role for withdrawal, especially among Israeli Jews couples in which wives are less educated and have more traditional sex roles than the wives in other couples.

Stash (2000) explores the reasons why women in rural Nepal who say they do not want to become pregnant do not necessarily use contraception. According to her, many women with an unmet need for family planning were waiting for a later time and better circumstances in which to undergo sterilization operations. In Nepal, efforts to promote family planning have encountered severe barriers, among them the lack of a rural health–care infrastructure, modest government budgetary allocation, and a terrain that
hinders conventional delivery of services and supplies. Stash interviewed 98 men and women in Chitwan, a rural poor predominantly agrarian region of Nepal. In the interviews, respondents showed a tendency to equate contraceptive use the sterilization, long the mainstay of the country’s family planning programme. Strategies employed to lower contraceptive risk include altering the method of choice, manipulating relationships with spouses, timing the adoption of contraceptives and managing the context of service provision. Some of the strategies results in apparent discrepancy between people’s expressed desire to limit additional births and their use of contraception. For example, because children are desired as a means to secure the future social and economic welfare of households, couples balance their future needs against their present economic hardship. Because decisions regarding the birth of children affect other extended family members, couples sometimes must choose between satisfying their own desires and those of powerful kin. In addition, a strong cultural preference for the birth of two sons leads to a tendency for women and men to exhibit contradictory fertility motivations. Some couples who had one or more sons said that they wanted no more children, yet were reluctant to use a family planning method. Stash found that such couples feared both the death of their son or sons and the side effects of using temporary methods. According to Stash, people’s apprehensions about side effects were on the experiences of their friends and neighbours. Her findings underscore the extent to which women who have been identified by commonly used survey definitions as having an unmet need for family planning have other requirements, ones that are more important to them than contraception.

Ram (2000) made a study on the “Improvement of Quality of Care in Health and Family Welfare – Experiences in Andhra Pradesh, India”. He made an attempt to examine the issue relating to quality care in both private and public sector in the state of Andhra Pradesh to identify the unmet needs
and suggest policy options to be addressed for improving the health and family welfare services. The information provided is based on the results of recently conducted National Family Health Survey-2 (NFHS-2) in Andhra Pradesh and other action oriented and operational research studies carried out in selected pockets of the state.

In 2000, health concerns were still cited (11 per cent) as the single most important non-biological reason for not using contraception, followed by husband’s disapproval (3.9 per cent and religious opposition (3 per cent), among married non-pregnant women who were not currently using a method of contraception and who reported being unhappy if they became pregnant too soon (Department of Census and Statistics, 2001).

A study conducted in Sitapur district of Uttar Pradesh found that a quarter of the surveyed women with unmet need for contraception considered. The available method was inconvenient to use (Kaushik and Vemuri, 2003).

While the needs of the vast majority of women who wish to stop childbearing are being satisfied, the needs of women who wish to delay or space children remain largely unsatisfied. For example, it is estimated that the need of 86% of women who wish to stop childbearing are addressed by the existing services, compared to the needs of 30% of women who wish to delay their next pregnancy (Santhya, 2004).

Puri et al (2005) made a study on ‘assessment of unmet need for contraception in an urban slum of Delhi’. Their study reveals that 34.6% of the subjects were users, where tubectomy accounted for 58.3%. Vasectomy as a method was not found accepted by any of subject’s partner. 49.8% women had unmet need for contraception. In majority of women opposition from husband’s/families (30.6%) and male child preference was cited as the main reason for non use of contraception. 60.3% of women had knowledge index of 3 or more i.e. despite sufficient knowledge, study subjects had a high level of unmet need.
An unmet need for family planning can be indicated in other ways than through comparisons of fertility desires with contraceptive practice, lack of knowledge of contraceptive method or of a place to obtain it, and incorrect beliefs about methods, for instance, represent needs for information and services. Unmet need for family planning may also manifest less directly, through high rates of unplanned and unwanted pregnancies and abortions (World Population Monitoring, 1996).

In surveys of reproductive health attitudes and practice, those with an unmet need for family planning are women and men who say they want no more children or want to delay their next birth by more than two years, but are not practicing contraception. Those who want no more children have unmet need for limiting; those who want to delay their next birth have unmet need for spacing (Casterline and Sinding, 2000; Westoff and Bankole, 1995).

The above observations are based on preliminary examinations of data being collected by some agencies like NFHS, Directorate of Health and Family Welfare etc. However, not much attention has been given to undertake the systematic studies for the pattern of unmet need is family planning by socio-economic background of the people in reproductive ages and also reasons for such patterns. It is, therefore, proposed that a study would be undertaken in Himachal Pradesh on the suggested theme to fill the gap in literature and also our understanding of the problems related to unmet needs in family planning.

When questions on the reasons for not using contraception have been asked to women, the responses have often been vague or women have been reluctant to respond (Robey and et al., 1996). Therefore, it is felt that a study should be made that focus on the factors leading to unmet need.

In India there are more married women with unmet need, about 31 million than in any other countries. In 1992 The International Planned
Parenthood Federation (IPPF) has estimated that in developing countries among the 172 million women estimated that in developing

Women using withdrawal or periodical abstinence as their contraceptive method often face substantial risk of an unintended pregnancy (Ross and Frankenberg, 1993). To estimate unmet need among young adult, Westoff and Bankole reported on all women ages 15 to 19, whether married or not. Under the criterion of sexual activity during the month before the survey, in this group more women have unmet need than use contraceptives in 15 to 19 countries (Westoff and Bankole, 1995).

Demographic and Health Surveys (DHS) in 45 countries in the last five years indicate the proportion of young people using family planning and their levels of unmet need (www.measuredhs.com). Surveys in sub-Saharan Africa, Central Asia and Latin America often include all women 15-19 years of age. In other regions, nearly all countries have only conducted surveys of ever-married women. This makes the results not strictly comparable, but the overall finding of high levels of unmet need is clear. (www.unfpa.org).

In Latin American and the Caribbean an average of 35 percent of sexually active teens over age 15 use family planning, in sub-Saharan Africa fewer than one fifth do so. As expected, both demand for and use of spacing methods exceed those of limiting births. The proportion of total demand (i.e. unmet need plus use) being met varies significantly, ranging from 71 percent in Central Asia to less than one third in sub-Saharan Africa, with other reasons between 45 and 55 per cent. In Sub-Saharan Africa, on average, 35.7 per cent of teenage women want to delay their next birth; in a few countries (Garbon, South Africa, Togo and Zimbabwe), more than half want to delay next birth. The regional average of meeting their spacing desires is only 30 per cent. In North Africa, West Asia and Europe, roughly half of the demand
for spacing and more than 55 per cent of all demand is being made. (www.unfpa.org).

Data from National Family health Survey-II show that almost half of currently married women (48 per cent) are using some method of contraception. Modern contraceptive use among currently married women has risen from 36 per cent in 1992-93 to 43 per cent in 1998-99. Despite the increased emphasis on contraceptive choice, female sterilisation is still the most used method. Most sterilisation users (82 per cent) never used any other method before sterilisation. The use of modern temporary or spacing methods, Pill, IUD, or Condom has remained nearly unchanged since 1992-93.

The current use of any modern method varies widely from 16 per cent in Mehhglaya to 61 per cent in Himachal Pradesh. Among major states, UP and Bihar have the lowest level of use, followed by Rajasthan, the Northeastern states except Mizoram also have rates of modern method use below the national average. Temporary modern methods of contraception are more prevalent in Delhi, Punjab, J & K, Haryana, the Northeastern states and West Bengal. The vast majority of sterilization users did not receive the information necessary for making an informed decision about their method choice. In most major states, fewer than 20 per cent of sterilization users reported receiving information about potential side effects or problems at the time of acceptance.

Among major states, unmet need varies from 7 per cent in Punjab to 25 per cent in UP and Bihar. Approximately half of the unmet need in the most populous states is for birth spacing. In better performing states in the South and Maharashtra, 50 to 72 per cent of unmet needs is for spacing. Some studies have shown that fertility rates especially in India’s most populous states would decline if women could achieve the family size that they desire.
The public medical sector, consisting of government/municipal hospitals, government dispensaries, PHCs and other outlets, provides methods for 76 per cent of current users. Compared with 79 per cent in NFHS-1. Slightly more users (17 per cent) than in 1992-93 (15 per cent) are relying on the private medical sector for contraception. The private medical sector is particularly important contraceptive supplies in Delhi, Punjab, Assam, Kerala, Goa, west Bengal, Meghalaya and Nagaland. Nearly all users (85-92 per cent) obtain method from governmental sources in HP, Rajasthan, MP, Orissa and Karnataka.

India was the first country to evolve a Government backed family planning programmes in 1950s. It was a modest beginning of the National Family Planning Programme with the establishment of a few clinics and distribution of educational materials, training and research. Family planning was declared as the very centre of the planned development during the Third Five Year Plan (1961-66). The emphasis was shifted from “Clinic Approach” to “Extension Approach” for motivating the people for acceptance of the “Small Family Norm”.

For adopting family planning it depends to a large extent on the degree of motivation in order to limit the size, space the children and the knowledge among the couples of contraceptive methods.

Various cultural and religious beliefs and traditions are generally involved in shaping individuals reproductive behaviour. In fact, the rational approach to procreation is often rational only within the upper and lower limits of reproductive norms established by the society (Freedman, 1966; Caldwell, 1980). Hence, the motivation for smaller families and that of used of birth regulation methods are not always linked, and family planning programmes need to adopt the view that gaps between the expressed desire
not to have children and the lack of contraceptive use can be accounted for, at least in part, by both normative and rational behaviour.

As a strategy for improving family planning services, the health infrastructure (e.g., Primary Health Centre, District and State Bureaus) was strengthened. The primary objective of the Fourth Five Year Plan (1969-74) was to reduce the annual birth rate to 32 by 1974 and “top priority” was given to family planning. Later, the targets to achieve zero population growth were reset in 90s, to be achieved by 2016. The programme was made an integral part of MCH (Maternal and Child Health) activities of PHCs (Primary Health Centres) and their subcentres. Since 1996 there is a major shift in family planning programme with emphasis on community need based assessment approach under the comprehensive concept of Reproductive and Child Health Programmes.

The above observations are based on preliminary examinations of data being collected by some agencies like NFHS, Directorate of Health and Family Welfare etc. However, not much attention has been given to undertake the systematic studies for the pattern of unmet need is family planning by socio-economic background of the people in reproductive ages and also reasons for such patterns. It is therefore proposed that a study would be undertaken in Himachal Pradesh on the suggested theme to fill the gap in literature and also our understanding of the problems related to unmet needs in family planning.

**NATIONAL POPULATION POLICY**

A policy is a plan of action, statement of aims and ideals, especially one made by a Government, political party, business company etc. According to U.N.O. (1973) population policy is “an effort to affect the size, structure and distribution or characteristics of population”. In its broader range, it includes efforts to regulate economic and social conditions which are likely to
have demographic consequences. Once the need for the Population Policy is realized, it has to be framed by appointing various committees and commissions for studying and advising and consulting experts. Then it has to be implemented through various programmes and then to evaluate from time to time.

The overriding objective of economic and social development is to improve the quality of lives that people lead, to enhance their well-being, and to provide them with opportunities and choices to become a productive asset in the society. In 1952, India was the first country in the world to launch a national programme, emphasizing family planning to the extent necessary for reducing birth rates “to stabilize the population at a level consistent with the requirement of national economy.” After 1952 sharp declines in death rates were, however, not accompanied by a similar drop in birth rates. The National Health Policy, 1983 stated that replacement levels of total fertility rate (TFR) should be achieved by the year 2000 (www.populationcommission.nic.in).

On 11th May 2000, India is projected to have 1 billion (100 crore) people i.e. 16 per cent of the world’s population on 2.4 per cent of the globes land area. If current trends continue, India may overtake China in 2045, to become the most populous country in the world. While global population has increased threefold during this century, from 2 billion to 6 billion, the population of India has increased nearly five times from 238 million (23 crores) to 1 billion in the same period. India’s current annual increase in population of 15.5 million is large enough to neutralize efforts to conserve the resource endowment and environment (Ibid).

The National Population policy, adopted in February 2000, further legitimized the paradigm shift to client-based services. The National Population Commission was set up in May 2000 to guide the translation of policy rhetoric into programmes. In March 2001, an Empowered Action Group was set up by the government of India to facilitate focused efforts to
promote the Reproductive and Child Health Programme in the states of Uttar Pradesh, Bihar, Madhya Pradesh, Rajasthan, Orissa, Chattisgarh, Jharkand and Uttranchal which have been lagging behind in a number of socio-demographic indices. Several state governments have also framed state-specific population policies thereby broadening the policy discourse within the states.

The National Population Policy provides a policy framework for achieving the twin objects of population stabilization and promoting reproductive health within the wider context of sustainable development. The immediate objectives of the National population policy are to address the unmet need for contraception, the limitation in health care infrastructure and the shortages in health personnel, and to provide integrated service delivery for the basic reproductive and child health care. The national population policy aims to achieve the goal for bringing the total fertility rate to replacement level by 2010. The National Population Policy has delineated twelve themes to achieve these objectives, including decentralized planning and implementation, convergence of service delivery at the grassroots, empowering women and encouraging male involvement, meeting the unmet need for family welfare services, addressing the needs of disadvantaged and under-served population groups, and forging public-private partnerships.

The National Population Policy (NPP, 2000) affirms the government’s commitment to the provision of quality services, information and counseling, and expanding contraceptive method choices in order to enable people to make voluntary and informed choices (Santhya, 2004). Disincentives have not been included in the policy, though several promotional; and motivational measures are to be implemented at the community and individual level. Unlike in the past, these incentives are not just for sterilisation but have been linked to poverty, delayed marriage, antenatal and delivery care, birth registration, birth of a girl child and immunization (Pachauri, 2000). These
include, rewarding and honouring Panchayats and Zila Parishads for exemplary performances in universalising the small family norm, achieving reductions in infant mortality and birth rates, and promoting literacy with completion of primary education; providing cash incentives to mothers who have their first child after 19 years of age; and rewarding couples below the poverty line who marry after the legal age of marriage, register the marriage, have their first child after the mother reaches the age of 21 accept the small family norm, and adopt a terminal method after the birth of the second child (MOHFW, 2000). However, it is a cause of great concern that some of the policies adopted by the states espouse strategies and mechanisms that are diametrically opposed to the principles of equity and equality that the new National Population Policy entails. In their urgency to reduce population numbers, some states, including Andhra Pradesh, Madhya Pradesh, Maharashtra and Rajasthan, have articulated several open or “veiled” disincentives (Pachauri, 2001). For example, the population policy of Madhya Pradesh, advocated debarring individuals marrying before the legal age at marriage from seeking jobs, getting admission in educational institutions and applying for loans. The policy also calls for debarring individuals with more than two children from contesting local body election (Government of Madhya Pradesh, 2000). These policies will negatively affect women who hardly play a role in deciding the age at which they are married or the number of children they bear (Qadeer, 2000).

Bhattacharya et al., (2006) made a study of “Unmet Need for Family Planning among Women of Reproductive Age Group Attending Immunization Clinic in a Medical College of Kolkata”. The study shows that the major reason for unmet need is opposition from husband, family and community (32%). The next reason is found to be lack of information in 24% of women who are either not aware of contraceptive methods or do not know from where these can be obtained. 10% mothers found services were
unsatisfactory and 19% had health concern about side effects of the methods. Ram et al noted in Kolkata that 12% of women had suggested the reasons for unmet need to be opposition from family members, 26% mothers had no information regarding the different methods and 20% women found methods available to be inconvenient (Ram et al., 2000). Nag noted that a woman may have unmet need for family planning because of high social cost of challenging the opposition from her spouse or anyone else in her social influence group (Nag, 1984). Reasons behind opposition may be that they want more children, do not accept that male physicians would examine their wives or worried that their wives might be protected from pregnancy.

In pursuance of these objectives, the following National Socio-Demographic Goals to be achieved in each case by 2010 are formulated:

- Address the unmet needs for basic reproductive and child health services, supplies and infrastructure.
- Make school education up to age 14 free and compulsory, and reduce drop outs at primary and secondary school levels below 20 per cent for both boys and girls.
- Reduce infant mortality rate to below 30 per 1000 live births.
- Reduce maternal mortality ratio to below 100 per 100,000 live births.
- Achieve universal immunization of children against all vaccine preventable diseases.
- Promote delayed marriage for girls, not earlier than age 18 and preferably after 20 years of age.
- Achieve 80 peer cent institutional deliveries and 100 per cent deliveries by trained persons.
- Achieve universal access to information/counseling, and services for fertility regulation and contraception with a wide basket of choices.
• Achieve 100 per cent registration of births, deaths, marriage and pregnancy.

• Contain the spread of Acquired Immunodeficiency Syndrome (AIDS), and promote greater integration between the management of reproductive tract infections (RTI) and sexually transmitted infections (STI) and the National AIDS Control Organisation.

• Prevent and control communicable diseases.

• Integrate Indian System of Medicine (ISM) in the provision of reproductive and child health services, and in reaching out to households.

• Promote vigorously the small family norm to achieve replacement level of TFR.

• Bring about convergence in implementation of related social sector programmes so that family welfare becomes a people centred programme (MOHFW, 2000).

Population growth in India continues to be high on account of:

• The large size of the population in the reproductive age-group (estimated contribution 58 per cent). An addition of 417.2 million between 1991 and 2016 is anticipated despite substantial reductions in family size in several states, including those which have already achieved replacement levels of TFR. This momentum of increase in population will continue for some more years because high TFRs in the past have resulted in a large proportion of the population being currently in their reproductive years. It is imperative that the reproductive age group adopts without further delay or exception the "small family norm", for the reasons that about 45 per cent of
population increase is contributed by births about two children per family.

- Higher fertility due to unmet need for contraception (estimated contribution 20 per cent). India has 168 million eligible couples, of which just 44 per cent are currently effectively protected. Urgent steps are currently required to make contraception more widely available, accessible, and affordable. Around 74 per cent of the population lives in rural areas, in about 5.5 lakh villages, many with poor communications and transport. Reproductive health and basic health infrastructure and services often do not reach the village, and, accordingly, vast numbers of people cannot avail of these services.

- High wanted fertility due to high infant mortality rate (IMR) (estimated contribution about 20 per cent). Repeated child births are seen as an insurance against multiple infant (and child) deaths and accordingly, high infant mortality stymies all efforts at reducing TFR.

- Over 50 per cent of girls marry below the age of 18, the minimum legal age of marriage, resulting in a typical reproductive pattern of “too early, too frequent, too many.” Around 33 per cent births occur at intervals of less than 24 months, which also results in high IMR (MOHFW, 2000).