CHAPTER II

REVIEW OF LITERATURE

The health services provided in India and the family welfare programme which has come on their heels, could be better understood from the following review.

Review of related studies occupies a place of very great importance in any economic research. It is in fact a major pre-requisite for gaining a deep insight into ones research problem and to evolve a suitable conceptual framework for all analytical purpose. As far as the present study is concerned, the investigator feels that a review of the following books and research articles is absolutely essential.

Vallalar (2010)\textsuperscript{1} in the paper “The Hindu” reveals that family planning vital for population control. Effective birth control measures are essential to control growth of population in the country Intra-uterine contraceptive device is safe and effective temporary family planning device. Population was a great challenge to the country. India was
expected to match the population of China in 2050. But the present trend showed that it will cross it by 2030 itself. With no increase in size of the land and availability of resources, existing population was forced to share it. Rapid increase will stunt economic growth, population had increased three times in the world, five times in India and thrice in Tamil Nadu in the last century. Population in Tamil Nadu was six per cent of country’s total population and equal to the population in Thailand, Total fertility rate in Tamil Nadu was 1.6, lowest in the country and the decadal growth rate stood at 11.7 per cent. Elaborating family planning measures, contraceptive is very popular. In Dindigul, 8,268 women and only 13 men had undergone family planning operation.

Sarah L. Barber (2007)\(^2\) explains that it is necessary that providing information about family planning as a part of prenatal care is an important means of increasing contraceptive use in urban areas. Relatively low levels of method use in this setting may be addressed by increasing the proportion of providers family planning advice during prenatal care and strengthening their capacity to advise about the safety and efficacy of hormonal methods. These review findings may be relevant in other settings that are considering ways to integrate family planning advice and counselling into general health services.

Andreea et al., (2007)\(^3\) has emphasised that the family planning in Romania has been complicated by political oppression which
resulted in regulations restricting access to and reducing the quality of contraceptive. Despite a significant increase in modern contraceptive practice over the past 15 years, many Romanian women continue to view induced abortion as a acceptable method of birth control and rely on the procedure.

Rao (2004) in his book “Monitoring and Evaluation of Family Welfare Programme” reveals that the successful implementation of family welfare programme would also depend on social development in general so that the people involvement and ownership by the community becomes an essential ingredient of the programme. The general background required for high levels of acceptance of the family welfare programme besides quality care and services, are education, family income, social status of women including women empowerment, political will, community involvement and awareness. The Department of Family Welfare, mainly takes up the basic health care in which 100 per cent funding of family welfare activities is undertaken.

Kumaraswamy (2004) in his book “Environment Studies” reveals that most of the developing countries are passing through the second stage of demographic transition in which there will be more of births and less of deaths. In the first stage with poor economic development and little or no advance in medicine and science and also due to lack of medical care, more deaths are common. In the second stage, the
people share the benefits of development in science and technology. The death rate being appreciably curtailed without proper reduction of birth rate, the population increases in leaps and bounds. Only in the third stage of demographic transition, as most of the developed countries have reached, the birth rate will be curtailed by adopting birth control measures, limited family norms and wise parenthood concepts to enjoy the benefits of economic development to the optimum level. Reaching the third stage of demographic transition with less birth and less deaths to keep the population level more or less stable, the birth rate could be controlled effectively in the developed countries.

Clifford Gramich, Julie Davanzo and Kate Stewart (2004)\textsuperscript{6} said the changes in American opinion about family planning reveals that family planning programmes at home and abroad enjoyed broad support among all Americans. A 1998 survey of public opinion on family planning issues found that, Six in seven Americans agreed that health insurers in the United States should cover family planning services, just like other doctor’s visits and services, as part of their regular health-care coverage, A four in five favoured United States funding for voluntary family planning programmes in developing countries that request it and More than half believed that making family planning widely available in a country where it had not been would help reduce the number of abortions. Internationally the September 2001 terrorist attacks against the United States and the more
recent war against Iraq have raised several security issues for Americans potentially affecting their views on levels and types of foreign aid that the US government should offer. Using a 2003 follow-up survey, this report analyses shifts in opinion about family planning issues in recent years and considers possible explanations for changes. Continuity between the 1998 and 2003 results in large majorities still believe the United States health insurers should include family planning services as part of their regular health-care coverage and support United States government funding for family planning programmes in developing countries. Some change is seen as well. Support for family planning programmes in developing countries has decreased as has that for offering aid for selective abortion in countries.

Study made by Hantamala Refalimamana and Charles F. Westoff (2002) on “Potential Effects on Fertility and Child Health and Survival of Birth-spacing Preferences in Sub-Saharan Africa” reveals the preferences of family planning services the most fundamental and important population policy guideline is the premise that individuals and couples should be enabled to realise their reproductive intention and preferences that is to have the number of spacing of children that they desire. Conventionally, this premise translates into the promotion of family planning and related reproductive health measures. This article says that few studies have examined the spacing compound of reproductive
intentions. Another study of Sub-Saharan Africa revealed a clear picture of widespread desire among women to have longer birth intervals than are currently being experienced a birth sooner than they had wanted one. This preference for spacing instead of limiting children is peculiar to Sub-Saharan Africa. In this article we examine the extent to which the above preference is true. More specifically we compare the lengths of the birth intervals. They say that would prefer to have and assess the implications of the difference between the two for the demography and health of Sub-Saharan Africa.

Gavin Jones and Richard Leete (2002)\textsuperscript{8} said that Asia’s family planning programmes as low fertility to attained reveals that an effective family planning programme into the country’s extensive primary health care system. The programme with hardly any external funding has been remarkably successful in increasing contraceptive prevalence and reducing fertility. Although the population problems facing the large countries of Asia had elements of comparability. The nature of the family planning programmes put in place to deal with them was diverse. One of the key issues was whether the ministry of Health could be relied on to do the family planning job or whether an organisation needed to be created for the sole purpose of coordinating family planning efforts. As family planning programmes evolved they were modified over time, especially as fertility approached replacement level. Parallel consideration has been given to some broader aspects of population policy, migration policy,
urbanization human development in terms of education and health programmes, that have been the responsibility of planning ministries. As programmes evolved, functions were added and experiments were made with different administrative arrangements. The programme illustrates the dilemmas faced by programmes that have tried either to attach a relatively well-funded family planning programme to a poorly funded health infrastructure or to provide a parallel infrastructure.

Population Reports (2001) further show that the best divisions about family planning are those that people make for themselves based on accurate information about the contraception available. People who make informed choices are better able to use family planning safely and efficiently. Providers and programmer have a responsibility to help people in choosing the right type of family planning devices.

Study made by Marilou Costello et al. (2001) on “A Client-Centered Approach to Family Planning on the Davao project, Philippines, reveals the preference of family planning programme outlined at the 1994 International Conference on Population on Development in Cairo envisons the practice of family programmes as free of demographic targets. It places family planning in context as a comprehensive client-centered service that is part of a wider array of reproductive health services. Contraception stresses the importance of providing family planning services within broad contexts of total sexual and reproductive health. The population council in

...
Philippines conducted a series of operation research a client-centered approach was developed in response to this perceived need and was implemented and tested in the Davao del Norte and Compostela valley provinces. This project consisted of a review of the client-centered approach to family planning and contraceptive technology. The results of the situation analysed were presented and discussed by the group. The providers shared their difficulties in providing family planning services, especially when problems or complications arise. In particular the necessary development of a referral system in the province.

Rosemary Santana et al., (2001)\textsuperscript{11} state that the family planning using fertility survey data from the China’s family planning policy reflects couples voluntary compliance with policy regulations their concern by means of government sanctions, or a combination of both. Three family planning regulations are considered - birth-quota status, contraceptive use and length of prior birth interval. The results of the study provide support for both compliance and sanction perspectives. The state was less willing than it had been previously to negotiate with couples having three children. Evidence is found of cooperation between couples and the state to ensure that each family had at least one son.

John et al., (2001)\textsuperscript{12} explain in assessing the strength in Pakistan of set hypothesized obstacles to practicing contraception the social and cultural acceptability of contraception, health concerns and
perceived access to surveys. Net effects of each obstacle are estimated through structural equation modelling of the intension to practice contraception in the near future. The estimates indicate the principal obstacle in using a contraceptive as the woman’s perception that such behaviour would conflict with her husband’s fertility preferences on contraception. The review reveals that confirm the value of taking contraceptive costs, seriously and in particular of attempting to measure these costs in empirical research of family planning.

According to the Population Reports (2000)\textsuperscript{13} family planning programmes helps millions of people by providing reproductive health care that saves lives by avoiding unintended pregnancies.

Franciz Xavier and Sabupadmadas (2000)\textsuperscript{14} in their article “Use of a Spacing Method before Sterilization among Couples in Kerala, it seems that India” say that in Kerala, it seems that if couples intend to become sterilized, they do not bother using methods to space their children found lower levels of temporary method use of contrastive knowledge among sterilized women with comparatively less schooling. Kerala, Christians are more likely than those of other religions to practice family planning before become sterilized; this finding reflects Christians overall higher levels of method use in the state. The age at which couples choose to undergo sterilization is mediated through their knowledge of the procedure and their desire to stop child bearing, together with the
motivating efforts of health workers. Respondents who had experienced an induced or spontaneous abortion were more likely than those who had not used a spacing method. The overall poor performance of India’s family planning programme, coupled with people’s perceptions that the quality of care is substandard, could explain the low level of spacing methods before sterilization in Kerala.

Study made by John F. Stewart, Guy Stecklow and Alfred Adewwji (1999) on “Family Planning Programme Structure and Performance of West Africa” reveals the effectiveness of family planning services in poorer regions like West Africa. They have made a study on the vertical and integrated structure in family planning organisation and their effectiveness in implementing family planning programmes. Integrated programmes are those which perform combinations of various functions. Vertical programmes refer to organisation with single purpose of providing family planning services. According to them vertical programmes may be more effective than integrated ones, simply because it is easier to do one thing well. Many developing countries receive substantial funding for family planning programmes. Therefore vertical programmes were necessary to ensure that family planning funds were not diverted into other programmes. They are also of the opinion that though integrated programmes are cost-effective, relative merits of this programme
mostly depend on the economic, social and political environment in which they are implemented.

Shireen J. Jejeebhoy (1999) in his article “Reproductive Health Information in India” reveals that the Indian Government in turn finds it convenient to pass on the burden of the programme to poorest sections. The convenient plea being that the poor breed too fast and are therefore the root cause of their own poverty. The new policy of population in India explores various method of ensuring control of population in poor communities. Safe, effective, affordable and acceptable methods of family planning of choice. By far the most comprehensive data available in India pertain to contraceptive behaviour. While data on family planning have traditionally been available through programmes statistics and regular surveys.

Study made by Robert J. Magnani and David (1999) on the impact of the family planning on contraceptive, intentions and use in the preference of family planning programmes influence reproductive preference and it remains a subject of debate, observers note that such programmes play a key role in helping individuals to realize their contraceptive and reproductive intentions. Studies have quantified the magnitude of this facilitating or enabling effect of family planning service, and existing demand for contraception. This study takes advantages of panel survey data and linked information on the supply environment for
family planning services. Estimation procedures are used that control for unobserved joint determinants of contraceptive intentions and use. Evidence of a significant enabling or facilitating role of family planning services is found, and the results also suggest that family planning programme factors influence contraceptive intentions in important ways.

Nashid Kamal (1999) explains that family planning is a determinant of the use of modern contraception. It is necessary that, the multivariate models presented for controlling socio-economic and demographic variables, frequency of inter-spouse communication about family planning was the strongest predictor of the use of modern reversible methods. Use increased stepwise contraceptives as the frequency of family planning by the woman and her spouse increased. This is very important major policy implications.

Mariam et al., (1999) in their article “The Impact of Multimedia Family Planning Promotion on the Contraceptive Behaviour of Women in Tanzania” have made an elaborate study on the family planning. Only three percentage of women who had not been exposed to any family planning messages in the media were using modern methods, compared with eighteen percentage of those who had been exposed to at least one media source of family planning information. Becoming a regular user of modern contraception is a gradual and complex process. Few women adopt contraception immediately upon exposure to information about
family planning. Using multiple media sources helps to extend the reach of family planning messages. The family planning logo campaign reached fewer women than radio or newspaper its close association with visits to family planning services sites suggests that community are worthwhile; and that visual symbols such as the logo help to publicize service sites. Additional reach is needed to determine how to meet women’s information needs most efficiently and how to provide a continuous flow of information that is lively and interesting.

David et al., (1999) in their article “The costs and Benefits of IUD Follow-up Visits in the Mexican Social Security Institute” say that the decision to modify re-visit schedules will be left to program managers, who will have to determine, whether the extra costs of additional visits are worth the added benefits. The manager need only compare the costs and benefits directly and decide which regimen is adopt. If the two-visit regimen is chosen, then any concern about needles medical interventions and overestimation of the benefit is irrelevant. While the benefit of a service may be somewhat obscure, the costs are not. When a body of research shows that a service’s benefit is largely in-significant, managers must instruct providers to stop rendering it. This evidence-based approach to updating service delivery norms is an important component in improving services of all.
Akinsinola Bankole et al., (1998)\textsuperscript{21} in their article “Couple’s Fertility and Contraceptive Decision-making in Developing Countries: Hearing the Man’s Voice” reveals that in many countries covered in this study, both husbands and wives want a large family. At the couple level, though, differences between the family size preferences of husbands and wives may be larger than suggested by the aggregate level measure. This type of disagreement occurs in 21-40 percent of these couples and more husbands want to have the next child sooner than their wives do. They show that decline in family size preferences, which is a necessary precursor of decline in actual fertility, tends to occur first among wives. Contraceptive use either to space births or to limit family size is likely to be initiated by wives rather than the husbands. In this findings support the claim that reproductive intentions are important predictors of contraceptive behaviour.

Rajalaxmi Sarkar et al., (1997)\textsuperscript{22} said in the Journal of Family Welfare is reveals about client segmentation of eligible couples in Chandigarh for family planning. The Indian Family Planning Programme has acquired a rather negative image. The quality of services have been poor because of a more or less exclusive preoccupation with targets resulting in the use of inappropriate methods and a high incidence of side effects. Instead, planners need to identify segments of the population that are most in need of a particular service so that they can be served
effectively by the health care delivery system. This calls for modern marketing strategies based on sound data analysis and an action plan to differentiate needs of entire population. This study was undertaken as an exercise to try out his approach in a resettlement colony of Chandigarh.

According to Ashraf Lasee, (1997) knowledge and approval of family planning, husband-wife communication, desire for more children and ideal family size are all significantly associated with current use of contraceptives. Multiple logistic regression analyses show that husband and wife communication. Particularly the wife’s perception of her husband’s approval of family planning, is highly associated with current contraceptive use. Increase the effectiveness of communication. Specifically, one spouse’s perception of the other spouse’s approval is more likely to be correct if they have discussed family planning than if they have not and this relationship significantly affects contraceptive use.

Daniel Goodkind et al., (1997) in their article “Reasons for Rising Condom Use in Vietnam” say that six factors explain the rising prevalence of condom use among married couples in Vietnam. First, family size desires are still declining in Vietnam; second, vietnam’s free-market reforms have made condoms more accessible. Third, condoms are particularly suitable for use in tandem with traditional contraceptive methods, which remain popular in Vietnam. Fourth, the Confucian cultural group to which the Vietnamese people becoming seems to prefer the
condom over the pill; this cultural under tow will likely enhance the
demand for condoms. Fifth, those Vietnamese who are currently most
likely to use condoms are relatively better educated, wealthier and more
likely to live in urban areas. Thus, condom reliance may rise even without
any overall increase in preferences for condoms. Sixth, recent increases in
adolescent and extramarital sexual activity and a growing concern over
Sexually Transmitted Diseases (STD) infections have further expanded the
market for condoms.

Uche Amazigo et al., (1997) in their article “Sexual
Activity and Contraceptive Knowledge and Use Among In-School
Adolescents in Nigeria” reveals that among two thousand four hundred and
sixty secondary school surveyed in two southern Nigerian states, only
thirty six percentage could correctly the most likely time for conception to
occur. Female students were considerably more likely than males to
understand the timing of conception less dramatic differences emerged by
students’ residence and grade in school. Among students who supplied
information about their sexual activity, forty percentage had incourse,
thirty percentage had been involved with older businessmen, the young
women said they have intercourse more frequently and are less likely to
restrict intercourse to the safe period of their cycle when they are involved
with older partners than when they have boy friends their own age. Only
seventeen percentage of sexually active students had ever used a
contraceptive method other than abstinence. In focus groups and in-depth discussions, students expressed a strong desire for better education about contraception and the consequences of sexual intercourse and recommended that both schools and parents participate in educating young people about reproductive health.

Timothy Johnson et al., (1996)\textsuperscript{26} in their article “Estimating Contraceptives Needs from Trends In Methods Mix in Developing Countries” say that there are countries in which the rate of marital condom use is high. Among the 119 countries for which the United Nations recently compiled statistics on contraceptive method use, there eighteen in which at least ten percentage of reproductive age reported currently using condoms. While temporary use of condoms by married couples can be preventing the spread of diseases, only consistent long-term use can be effective against the transmission of HIV.

Pattnaik (1994)\textsuperscript{27} in his article “Coordinating Health Care and Primary Education” reveals that the health and family welfare status of the state showed that eighty per cent delivery was domiciliary and was conducted by untrained persons; only 35 per cent of married couples were using family planning methods and 68 per cent of infant deaths took place within the first 28 days of life. An effective implementation of health and family welfare service would help achieve health for all at the village level.
According to the population reports, (1992) the most important proximate determinant of fertility is the use of family planning. In country after country, surveys reveal that, where few couples use contraceptives, fertility is high. In the past two decades changes in the use of family planning have largely determined national fertility trends. Fertility levels have dropped in countries where there have been increases in the percentage of married women of reproductive age currently using contraception. National surveys suggest that many programs still have far to go in making family planning widely known and widely available. The survey shows that knowledge and use of contraceptive methods and access to family planning service vary sustainability among countries and population groups.

According to Population Reports, (1991) the family planning programmes serve millions of clients in developing countries and the number of clients growing fast. The very success of family planning programmes poses a challenge to pay for family planning services for all who needs and wants them. Family planning is part of the larger problem of paying for health in developing countries. Many governments in developing countries have tried to provide free health services to all, considering it a basic human right. Like the demand for family planning, the demand for all health care is increasing and governments along with donor agencies and private voluntary organizations are searching for new
ways to pay for health services, including family planning.

Vidya Ratan (1990)\(^3\) in his book “Handbook of Preventive and Social Medicine” reveal that in order to make a practical success of it, the family welfare programme has been integrated with other health services, instead of it being a separate service. For more concentration of this work in rural areas the original base has been made at subcentres, supervised by primary health centres district hospital at state and central levels. In addition there are family welfare centres, hospitals and dispensaries, sterilization and IUD units and voluntary agencies which are conducting the family welfare programme.

Shrileen J. Jejeebhoy (1989)\(^3\) in his article, “Reproductive Health Information in India” saw that the NFHS is to address such critical issues as the extent to which woman exercise choices in these matters without coercion where woman actually obtain a method of choice; and the constraints that the average woman or man faces in seeking contraceptives and follow up services. NFHS has succeeded in updating and enhancing our data base; but it has not gone for enough in reproductive health issues that lend themselves to large survey were not addressed adequately: maternal health status and morbidity and their correlates; quality of care concerns in family planning, material health and other dimensions of reproductive health and womans ability to exercise reproductive health are
behavioural concerns, including lack of autonomy and unequal gender relations.

Patil (1989)\textsuperscript{32} in his article “Population Growth and Family Planning” reveal that as population increases more than subsistence, it leads to starvation, death, misery and vice. To prevent this, Malthus advocated preventive and positive checks. This is the first theory of population which pleaded population control for economic prosperity, the excessive burden of population on natural resources should be minimised by controlling population growth. So family planning is introduced by the government. India is the first country in the world to have adopted an official policy favouring family planning.

An article published in Population Report (1989)\textsuperscript{33} “Family Planning Saves Lives” reveals that more family planning could save the lives of more than 200,000 women and at least five million children. Family planning saves lives, prevents deaths for each minute. Most will be women in poor countries not sufficiently strong or well-nourished for the task required of them. Poor maternal health in pregnancy, unsafe delivery and inadequate care after birth. Family planning saves lives because lack of family planning kills on a massive scale.

Srinivasan (1987)\textsuperscript{34} in his article “Changing Perspective on Rural Health Care” reveals that, the health and family planning programme in the third plan was to expand health services to bring about progressive
improvement in health of the people ensuring a certain minimum physical well being and to create conditions favourable to greater efficiency and productivity. Our five year plan saw the launching of the nationwide extension approach to family planning. The plan accords very high priority to family planning and due importance to nutrition.

Puthukuchi Purushotham Shastri (1987)\textsuperscript{35} in his article “Analysis of Cash Incentives in Family Planning” reveals that in India in order to make family planning programme more popular among masses, cash incentives are being offered to the acceptors of certain family planning methods in addition to the free clinical services. A great deal of criticism has been levelled against such cash incentives from time to time on the premise that cash incentives would only increase the number of acceptors without creating an awareness about the need for such a programme thus hindering the healthy and qualitative development of the programme.

Srinivasan (1983)\textsuperscript{36} in his article “How Adequate Are Our Health Care Services” reveals that primary health centre complex constitutes the care of family planning in India. Primary health centres are the principal institutions providing integrated health service to the rural population. They are focal points for delivery of health and medical care services in rural areas. It is close to the people and offers adequate medical care services to meet the basic health needs of rural people.
Premi, Ramanammer and Bamberwale (1983) in their book “An Introduction to Social Demograph” reveals that in the third five year plan, the strategy of family planning was changed to community extension approach which aimed at (i) embedding the concept of birth control in family planning and health services near home through an extension network of primary health centres and subcentres in the rural areas and hospitals and family welfare planning centres in the urban areas; (ii) conducting an intense educational, motivational and communication campaign which had the effect of lifting the taboo on free and open discussion on different aspects of family limitation such as physical, emotional, social and psychological and of widely disseminating the message of family planning.

Mathews (1979) in his book “Health and Culture in a South Indian Village” reveals that the small groups of neighbours or relatives influence each other about family planning. This influence could be made use of in educational programmes. But even though people do not say they would discuss family planning with leaders nevertheless leaders do seem to have a considerable influence on them. The strong belief that sterilization is harmful to health can only be overcome with follow up of acceptors and careful treatment for any disease following sterilization. Several studies have emphasized the adverse effect of the large number of child deaths on willingness to adopt family planning.
Oscar Gish (1978) in his book “Planning the Health Sector” reveals that the accent of work in the rural health centres was to be on improving standards of health rather than the treatment of disease. It was hoped that in course of time dispensaries would increasingly take on the same functions as the rural health centres. This centres helping to put into practice family welfare programmes and environmental sanitation.

Howard W. Mitchell (1970) in his book, “Studies in Demography” says that the size of a family could be held under ones control as long as one is serious about family planning. Hence it is absolutely essential to create an awareness among people about the need for family planning.

From this chapter we can understand about the nature of the study made on family planning programmes. The researcher finds that the study so far made are inadequate; particularly it is found that no elaborate study has been made on family planning in Kanyakumari district. Therefore the researcher has chosen the area of family planning in Kanyakumari district for an extensive study.
REFERENCES


