CHAPTER – IV
FAMILY PLANNING SCHEMES IN JHARKHAND STATE

The state-specific distribution of population during the period 1991-2001 reveals that the entire district has shown an increasing trend in population. However, the increase barring a few districts is much lower than the increase between the decades 1981-91. Even after bifurcation, Jharkhand continues to be with 2, 69, 45,829 populations, which is 2.6 per cent of the total population of the country. However, the same is not true in case of the density of population, which is low at 148 persons per sq. km. Gumla with 13.44 (1991) & 16.6 (2001) per cent with (13, 45,520 persons) population and the highest at 1167 person per sq. km. in Dhanbad with 23, 94,434 persons. The four most educationally deprived district of the state, in respect of female literacy rate namely E. Singhbhum 57.95%, Dhanbad 52.93%, Ranchi 52.77%, Bokaro 47.17%, Hazaribag 43.15%, and Gumla 40.56% (see table no. 3.6)

The six southern districts namely, Hazaribag, Koderma, Chatra, Giridih, Bokaro, and Dhanbad registered a decadal growth rate, 24.2 per cent, 26.32 per cent, 29.05 per cent, 27.9 per cent, 22.11 per cent and 22.82 per cent respectively. On the other hand, Lohardaga has the lowest population with its share to total population 3,64,405 followed by Koderma 4,98,683,Pakur 7,01,616, Chatra 7,90,680,Sahebgung 9,27,584 and Garhwa 10,34,151Ranchi has 27,83,577 the highest population and Lohardaga 3,64,405 the least population.

Organizational Structure: Family Planning was introduced in the country in 1952 and since then its important as well as significant is being increasingly realised. The programme in the rural area is implemented through Primary Health Centres as well as sub-Centres. In the urban areas is urban family welfare planning clinics. In the urban areas there are family planning welfare centres and each such centre caters 50,000 populations. At the District level is District Family Planning Bureau which forms part of the district medical and health organization. It is headed by District Family Planning Officer. At the state level is State Bureau, which is headed by State Family Planning officer. In 1966, at the Centre a full-
fledged Department of Family planning was created, which is headed by a Secretary/Deputy Secretary heads the cell in the Secretariat. It is responsible for guiding and directing all family planning programmes for the whole nation. Both in the centres as well as in the States are Cabinet Committees. Chief policy making body is Central Family Planning Council which is headed by Union Minister of Health and Family Welfare. There are similar councils in all the States. The whole programme is a centrally sponsored one and the States are required to implement the programme. Each district is entitled to its own Family Planning Bureau with a Class I officer in charge. The District Bureau has Division for administration, education and information, field operation and evaluation: Mobile units for IUD and sterilisation are also attached to the District Bureau. The headquarters of the rural family planning organization is the Primary Health Centre, with sub-centres attached to it. For the urban family welfare planning centres, different patterns of staffing are provided, according to the size of the population to be covered. Each city with a population above 2 lakh is entitled to its own Family Planning Bureau. All cities with a population of more than 10 lakh are allowed the pattern of the District Family Planning Bureau. Different patterns are laid down for the family planning units of public sector undertakings and those of the Ministry of Railways, Posts and Telegraphs Department and the Ministry of Defence, depending on the size of the population to be covered.

This review of the development of the organizational structure of the family planning programme is indicative to the rapidity with which the programme gained in importance. Another point which emerges in this review is that this programme has always been considered to be the responsibility of the Ministry of Health. Some critics of the family planning programme look upon this very fact as the reason for its rather poor performance over the years. “As the Health Ministry is one of the weakest and politically unimportant ministries both at the Centre and in the States, family planning is relegated o an unimportant position, in spite of pronouncements to the contrary.”

The solution to this problem may either lie in the setting up of a separate ministry for the implementation of the programme or a new autonomous Government agency like the Family Planning Board of Indonesia.

Family Planning programme, which is an essential part of our strategy of enlarging welfare, is being implemented as a wholly voluntary programme and as an integral part of the overall strategy of growth covering health, maternity and child care, family welfare, women’s rights and nutrition. The salient features of the strategy are: intensified efforts to spread awareness and information through imaginative use of multi-media and interpersonal communication; provision of services and supplies as close to the doorsteps of the acceptors as possible; development of facilities for rapid increase in female literacy; population education to the youth in schools and colleges as well as those out of schools; assistance and support of the elected representatives of the people, proper linkage with other Ministries and Departments concerned; incentives to individual acceptors and state governments and close monitoring and follow up of the programme at all levels.

**Approach to Family Planning Programme Implementation:** The family planning programme has undergone several revisions which, despite the criticism they have called forth, nevertheless show that those who administer the programme are willing to learn from experience. It is obvious that rigidity in the implementation of the programme would not have been the correct stance to adopt.

(a) **The Clinic Approach:** The family planning programme started with a very cautious approach. The First Five Year Plan emphasis field research with a view to identified values norms, customs and beliefs concerning child-bearing. The natural methods of family planning were considered to be the most appropriate.

The only model that was available for this purpose was the one used by the Planned Parenthood Organization in the west, which set up family planning clinics and those who need family planning were expected to take the fullest advantage to these facilities. The limitations of such an approach may well be imagined. It is based on the assumption that those who need family planning would visit such clinics without any hesitation. Such an assumption, however, ruled out the need to reach out to people to educate them about the need for family planning. Moreover, the Planned Parenthood model leaned heavily in favour of services for women.
rather than for couples. It also leaned heavily on medical personnel, which was, and is, rather scarce. This “clinic approach”, as it was called, “could be expected to reach only a relatively small fraction of the people, and could not be expected to make much impact on birth rates.” The approach was, therefore, not considered suitable for a Hazaribag. Hence, the need for the adoption of “extension approach” to family planning was soon realised.

(b) The Extension Approach: Lt. Col. B. L. Raina highlighted the need to strengthen the extension approach, which involves the adoption of an educational approach to bring about changes in the Knowledge, attitudes and behaviour of the people in regard to family planning; it also involves the acceptance of the principle that “the power, inherent in a group itself to bring about changes in deeply-rooted practice among the members of the group, is greater than the influence of individual instruction by outsiders.” In the extension approach, therefore, influential formal and informal leaders in different sub-groups of the population are first identified and then encourage to gain knowledge and to take interest in popularizing the acceptance of small family size norm among their own group. This approach thus calls for actively working with the people for whom the programme is meant rather than working for them as outsiders. It is also involves the transference of responsibility to such groups as Panchayat Samitis, village development committees or other groups. These operational goals should “create, for 90 percent of the married adult population of India, the three basic conditions needed for accelerating the adoption of family planning by couples: Groups acceptance, knowledge about family planning and easy availability of supplies and services.” It is necessary to elaborate on these three conditions. The emphasis on the need for group acceptance of family planning recognize the fact that individual do not live in a vacuum but are greatly influenced by the group in which they live. It is difficult for individuals to accept new forms of behaviour unless they are acceptable to their group as a whole.

3. I. bid, P. No. 46
4. I. bid, 45
If family planning is to be adopted by individual couples, they would do so more easily if the idea of family planning is acceptable to their group. It is, therefore, necessary to build up group and community support for the programme rather than work with individuals and expect them to adopt family planning by becoming “rebels” or “deviants”. While the first condition for the acceptance of family planning is socio-psychological and may be considered to be somewhat difficult to define, the other two are more practical. It is obvious that if a couple has to practice family planning, knowledge about family planning is essential—knowledge that it is possible it prevent conception, knowledge about the various methods of contraception so that the most suitable method may choose, and knowledge about where such methods are available. The third condition, “easy availability of supplies and services,” has also to be fulfilled if couples are to practice family planning successfully. It is true that if motivation for family planning is strong enough, a couple would seek out the sources of supplies and services even if they are not easily available. But such strong motivation is not always forthcoming. It is better, therefore to facilitate the practice of family planning by removing both physical and psychological barriers associated with the usual sources of services for that purpose. If a family planning centre is at a considerable distance and clinical atmosphere is quite imposing, both these factors may act as barriers to the acceptance of the family planning programme.

(c) The Integrated Approach: The “integrated approach” to family planning, which has assumed importance today, is not of recent origin. Even in the Second Five-Year Plan period, it was clarified that the “Family Planning Services is likely to succeed if the clinics are associated with maternity and child health work or with centres which provide medical aid and welfare services.” The principle of integration of family planning services with maternal and child health services have thus been accepted almost since the beginning of the family planning programme.

(d) The Camp Approach: Some of the salient feature of this camp, which contributed to their spectacular success, has been identified by the moving spirit behind these camps, the Collector of District.

These are: (i) The inter-departmental co-operation that the District Collector was able to generate; (ii) The festival atmosphere which these camps were able to create, dispelling of clouds of secrecy and embarrassment; (iii) The support from the representative of the people as well as from industries which the organization were able to muster; (iv) The special precautions taken while making technical arrangements in order to minimize infection and other complications following surgery; (v) Increased incentives to acceptors in additions to special prizes; and (vi) The employment of good management techniques for the organization of these massive camps.”

This approach, however, has some limitations. In the first place, the setting up of a vasectomy camp involves tremendous organization and inter-departmental co-operation and co-ordination, which is often possible only at the cost of the other developmental programmes. It disrupts the normal activities of several departments and leads to lethargy in the implementation of the family planning programme following concentrated activity in vasectomy camps. Moreover, the danger of poor motivation on the part of acceptors and a degree of coercion on the part of organizers can never be completely ruled out.

The report of the Ministry of Health and Family Planning to Parliament made this point very clear, “While the number of vasectomy operations did touch a record level, it has been felt that, in a larger perspective, such camps might become counter-productive. It was, therefore, decided not to continue this strategy, on a regular basis but to make an optimum utilization of available resources to strengthen the normal programme, even at the risk of a decrease in the number of acceptors in the short-term.”

Communication: For disseminating information and educating people about family planning, press, films, radio and television, oral and visual communication media like song and drama troupes and interpersonal communication through a network of media and extension workers are being used extensively.

Besides the eligible couples, an effort is also being made to reach potentially important sections of population to motivate them to accept small family norm when they reach reproductive stage. Population education has been introduced in the formal school and university system in the country. With the cooperation and assistance of official and non-official agencies working in the state for development programmes, like trade unions, co-operatives and panchayats, etc, their training programmes, are being used for introducing population education through non-formal channels.

**Implementation Machinery:** The programmes are implemented through the state government for which cent per cent central assistance is provided. In rural areas, the programme will be further extended through a network of primary health centres and sub-centres. The Central Family Welfare Council advises on family planning programmes at the national level. A number of central committees like the research co-ordination committee have been set up to study the progress of research programme.

**Performance:** Under the free distribution scheme nirodh, diaphragms, jelly cream tubes and foam tablets are also distributed. The oral pill programme was extended to all the urban centres, including those run by local bodies and voluntary organizations and those primary health centres where the programme could be monitored and patient followed up. The pills are now being distributed through rural and urban centres/hospitals in the state. Government should, as a matter of urgency, make universally available information, education and the means to assist couples and individuals to achieve their desired number of children. The statement went on to specify that family planning information, education and means “should include all medically approved and appropriate methods of family planning” in order to ensure “a voluntary and free choice in accordance with changing individual and cultural values.” The need to give particular attention to the most vulnerable and difficult to reach segments of the population was highlighted.
Decadal and Annual Growth Rates

As mentioned above, the decadal growth rate of population declined to 24.02 per cent (1991-01) from 28.63 per cent during the previous decade 1981-91 of Hazaribag (see table no.1.1). Despite the decline, a number of districts registered a high decadal growth rate than at the all Jharkhand level and a few others have high decadal growth in 1991-2001 than during the previous decade, 1981-91. The district-wise variations in population growth rate reveals an impressive slow down of population especially in Bokaro which can be compared well with the increase in Sahebganj and almost stagnant population in Ranchi Among the other major district Chatra (29.05%), Garhwa(29.05%), Lohardaga(28.14%), Giridih(27.09%), Koderma(26.32%), all registered a higher decadal growth rate than at the all-Jharkhand level. Garhwa and Chatra registered higher growth rates. The higher growth rates in these districts unless decline to a significant level, the goal to stabilize population by 2045 (long term perspective as envisaged in the National Population Policy, 2000) is not likely to be realised. Needless to mention that most of these districts are educationally deprived district. A large number of children in these districts are still out-of-school; literacy levels low, dropout rates very high and girl’s participation poor all that do not suggest that population in these states will decline in the near future.

The other interesting feature is slow down of population in such states that do not have such history in the past. Some of these districts are Bokaro (32.57to22.11percent), Deoghar (31.64 to 24.46 percent), Dumka (23.05to17.31 percent) and W. Singhbhum (20.58to16.35 percent) (see table no. 1.1). The decline particularly in case of the West Singhbhum is quite encouraging especially when its share to total population. The fertility and mortality data when available will throw more light on the causes of this dramatic decline in these four districts. Out-migration perhaps may not be the only reason of this sudden decline.

On the other hand, the lowest decadal growth rate is noticed in Dhanbad which has declined from 22.7 per cent during 1981-91 to 22.82 per cent in 1991-2001. Its share to total all-Jharkhand population in 2001 is only 23, 94,434. On the
other hand district such as, Koderma(26.32 per cent), Giridih(27.09 per cent), Chatra(29.05 per cent), Garhwa(29.05 per cent), Hazaribag (24.02 per cent), W. Singhbhum(16.35 per cent), Dumka(17.31 per cent) and Bokaro(22.11 per cent) all have the lower decadal growth rates than at the all-Jharkhand level (see table no. 1.1). However, in case of a few districts the decadal growth rate is higher than the all-Jharkhand average, which is also higher than the same in the previous decade. Such districts are Sahebganj, Pakur, Ranchi, Lohardaga, Gumla, and E. Singhbhum. Except Sahebganj, all other district is small in size and their contribution to total population is insignificant.

The first National Family Health Survey (NFHS-1) was undertaken in 1992-93 in order to collect demographic data regarding family planning. After NFHS-1, another National family Health Survey (NFHS-2) was conducted within a short period in 1998-99. The main objective of this survey was to collect additional data on national family health and to give impetus to its implementation and to monitor the programme related to family planning. The main objectives of NFHS-1 and NFHS-2 are as follows:

1. The primary objective of NFHS-1 was together information about fertility rates, trends in family size, demand for family planning devices, knowledge regarding family planning and various methods of family planning.

2. The other objective of NFHS-1 was to obtain knowledge regarding fertility rates, family planning and to know about socio-economic and demographic indicators of children’s and mother’s health.

3. The main objectives of NFHS-2 was to provide estimates about birth rates, family planning system, infants and child mortality rates, health of mother and children, and health facilities available to them.

4. To obtain information regarding status, education and living standard of women in society, health and family planning services, health problems of women and domestic violence and atrocities to them.
5. To know about nutrition level of women and children in NFHS-2.

NFHS-2 provided state level demographic and health data. It also give information about the socio-economic factors necessary to bring about derived changes in the prevailing demographic and health situation in state and also about the implementation of the family planning programme.

A uniform pattern of question, sample design and field procedure was adopted in NFHS-2 so that the available data could be easily compared and high quality data could be obtained, after the survey, the primary reports for the state was prepared and were handed over to the planners and authorities concerned with family planning and health.

NFHS-2 provided state level and national estimates of fertility, the practice of family planning. It also provided indicators of the quality of health and family welfare services, women’s reproductive health problems, and domestic violence, and information on status of women, education and the standard of living.

Main objective of the NFHS was to provide reliable and up-to-date state level and national level estimates on Knowledge and practice of family planning, fertility preference, child nutrition and health. A further objective is to explore the demographic and socio-economic determinants of these factors. The information collected was intended to assist policy makers and programme administrators and researchers in assessing and evaluating population and family welfare programme and strategies. One important feature of the NFHS is that data on nutritional status of women and children are collected by carrying out blood tests and collects information on two additional topics quality of care and status of women. The NFHS is one of the most completed sample surveys of its kind ever conducted in India. After completion of the data collection NFHS, the Reports have been written and published for each of the constituent state. Two volumes have been published for India.
Even within districts, there were large disparities between different socio-economic groups. Rural areas lagged far behind urban areas. Scheduled tribe populations, followed by scheduled caste, were distinctly undeserved. Similarly, religious groups differed greatly in their fertility levels, family planning acceptance rates, infant and child mortality, and utilization of maternal and child health services.

In every district of Jharkhand, special efforts were needed to reach rural women, illiterate and poor women, scheduled tribes women, who continue to be left out of the process of national development. Household with a low standard of living perform distinctly worse on most demographic and health outcome indicator than those having relatively high standard of living.

**Sex Ratio:** One of other causes of satisfaction in Census 2001 results is the improvement in the sex ratio during 1991 to 2001, which has marginally improved to 941 females per thousand males from 922 per thousand in 1991, an increase of 19 points. But complacency over development in sex ratio must be tempered by the fact that there are sharp differences across states. It may be a serious concern for the Sociologists who should study these varying patterns across states. The healthier sex ratio of Koderma as 1001 female per thousand male continues to remain a distant possibility. The small growth in the all-Jharkhand sex ratio for the first time in a century is best contrasted with a decline in sex ratios in as many as five major districts in the last decade. As mentioned above is the falling sex ratio among the child population of age group 0-6 years. It has declined sharply from 945 in 1991 to 927 girls per thousand boys in 2001, a decline of 18 points.

Despite the decline in child sex ratio, a few district, such as, Dhanbad (819to874) **Hazaribag (914to950),** E. Singhbhum(906to931) and Sahebganj (924to943) have shown improvement over their 1991 ratio (see table no.4.1). All other district have shown decline in child ratio in 2001 compared to the ratio in 1991. The sharp fall in child sex ratio suggests prima facie that the forces, which are against the girl child, are getting stronger even the over all sex ratio is improved a bit in favor of females. The decline in child ratio may be because of the following
reasons. First, it may be because of the higher mortality among girls in age group 0-6 year. Over time, gap in boys and girls mortality rate declined but still remained high. This may be because of the preference for son and discrimination against the girl child. This is perhaps the bleaker outcome of the Census 2001. Quite similar results have also been reported in the NFHS (1998), which reveals that for babies aged up to 11 months, female mortality is at least 10 per cent higher than that of the mortality rate among males. After the age one, sex differentials in mortality is even greater and it is at least 1.5 times higher than that of their male counterparts.

Table: 4.1

<table>
<thead>
<tr>
<th>District</th>
<th>Sex Ratio</th>
<th>1991</th>
<th>2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Garhwa</td>
<td></td>
<td>926</td>
<td>935</td>
</tr>
<tr>
<td>Palamu</td>
<td></td>
<td>932</td>
<td>937</td>
</tr>
<tr>
<td>Chatra</td>
<td></td>
<td>952</td>
<td>964</td>
</tr>
<tr>
<td>Hazaribag</td>
<td></td>
<td>914</td>
<td>950</td>
</tr>
<tr>
<td>Koderma</td>
<td></td>
<td>986</td>
<td>1001</td>
</tr>
<tr>
<td>Giridih</td>
<td></td>
<td>966</td>
<td>983</td>
</tr>
<tr>
<td>Deoghar</td>
<td></td>
<td>911</td>
<td>914</td>
</tr>
<tr>
<td>Godda</td>
<td></td>
<td>922</td>
<td>926</td>
</tr>
<tr>
<td>Sahebganj</td>
<td></td>
<td>924</td>
<td>943</td>
</tr>
<tr>
<td>Pakur</td>
<td></td>
<td>954</td>
<td>958</td>
</tr>
<tr>
<td>Dumka</td>
<td></td>
<td>955</td>
<td>961</td>
</tr>
<tr>
<td>Dhanbad</td>
<td></td>
<td>819</td>
<td>874</td>
</tr>
<tr>
<td>Bokaro</td>
<td></td>
<td>865</td>
<td>895</td>
</tr>
<tr>
<td>Ranchi</td>
<td></td>
<td>921</td>
<td>938</td>
</tr>
<tr>
<td>Lohardagga</td>
<td></td>
<td>971</td>
<td>976</td>
</tr>
<tr>
<td>Gumla</td>
<td></td>
<td>987</td>
<td>995</td>
</tr>
<tr>
<td>W. Singhbhum</td>
<td></td>
<td>965</td>
<td>976</td>
</tr>
<tr>
<td>E. Singhbhum</td>
<td></td>
<td>906</td>
<td>931</td>
</tr>
<tr>
<td>Jharkhand</td>
<td></td>
<td>922</td>
<td>941</td>
</tr>
</tbody>
</table>

Source: Registrar General of India (final report 2001)

FAMILY PLANNING METHODS IN JHARKHAND

It is generally claimed that here always adopted the “cafeteria approach” and continues to do so. Though this implies that all available methods of contraception are offered to the people with the choice left to them, in actual practice it is found that each technique of contraception has received varying
emphasis at different times. These methods have included the rhythm method, the diaphragm and jelly method, foam tablets, etc.

Family planning material is now being increasingly used. Some of the important methods are:

1. Use of I.U.D.
2. Sterilisation
3. Use of Contraceptive
4. Nirodh
5. Medical Termination of Pregnancy
6. Rhythm method

Contraception has played a dominant role in limiting the population levels of mostly area of Jharkhand. Contraception control involves all available methods for the prevention of conception. This includes a battery of technique- behavioural methods encompass complete abstinence from sex, coitus, interrupts, coitus sublimates, and the use of “the rhythm method”; the mechanical methods include the condom, the pessary, the diaphragm and the intra-uterine device; the chemical methods include foam tablets, spermedical jellies and the like; the physiological methods include the use of steroids, and other possible agents for controlling ovulation, possible anti-zygotic agents, and possible spermatic ides or other agents for including male sterility; the surgical methods include ligation and vasectomy. Methods to prevent birth include, of course all the methods of conception control, and, in addition abortion-the prevention of births even if conception has occurred.

Governments are committed to the use of all proven, safe and acceptable techniques of family welfare and control over reproduction and population growth. Following this policy encouragement has been given to the application of surgical methods, such as vasectomy and tubectomy as also the termination of pregnancy. Government has also supported programmes on mechanical prevention methods such as the use of condom and diaphragm and the use of intra-uterine devices. Following table gives the relative effectiveness of the contraceptives. Out of the 7 types of methods mentioned in the table, first 4 are for exclusive use of female (male sterilization is also exclusively used by male). The next two are exclusively
used by males and the last though used by both is based on the menstrual cycle of the female.

An ideal contraceptive is one that is safe, easily administered, preferable by the individual himself or herself, reversible, with no side effects, not interfering with location, not expensive and not repetitive. A method that has all these attributes is yet to be discovered. The conventional contraceptive (diaphragm and jelly) have proved highly expensive and inconvenient. The intra-uterine contraceptive device (IUCD), which was inducted into the family planning programme in India in 1965, has not fared uniformly well and has become unpopular in recent years.

Table: 4.2

Relative Effectiveness of Various Contraceptives

<table>
<thead>
<tr>
<th>S. No.</th>
<th>Method</th>
<th>Effectiveness (percent likely pregnancy in a year)</th>
<th>Possible side effects</th>
<th>Expertise required</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Sterilization (Male and Female)</td>
<td>0.003</td>
<td>None</td>
<td>Surgical</td>
</tr>
<tr>
<td>2</td>
<td>Oral Contraceptives</td>
<td>0.3</td>
<td>Weight gain, vomiting and nausea, epigastic discomfort</td>
<td>Prescribed and controlled by doctor</td>
</tr>
<tr>
<td>3</td>
<td>IUD</td>
<td>5</td>
<td>Infection, irregular bleeding, pain, backache, uterine perforation</td>
<td>Inserted by doctor and periodical check up</td>
</tr>
<tr>
<td>4</td>
<td>Chemical contraceptives (from tablets, jelly and cream)</td>
<td>20</td>
<td>Minor irritations</td>
<td>Nil</td>
</tr>
<tr>
<td>5</td>
<td>Condom (Nirodh)</td>
<td>14</td>
<td>Allergic reaction</td>
<td>Nil</td>
</tr>
<tr>
<td>6</td>
<td>Withdrawal</td>
<td>18</td>
<td>Physiological</td>
<td>Nil</td>
</tr>
<tr>
<td>7</td>
<td>Rhythm</td>
<td>24</td>
<td>None</td>
<td>Doctor's advice may be required</td>
</tr>
</tbody>
</table>

Source: Sharma, V.P.C. and Singh, Nawal: “Family Planning Motivation and Education Programme”

1. Provision of IUD must be made a part of the total health programme and the integration of family welfare with the general health services done at all services delivery levels.
2. IUD’s should be inserted at family welfare planning centres which are adequately staffed, and equipped with necessary instruments, sterilization facilities and medicines.

3. The centres where there are facilities for IUD insertion must have adequate arrangements for follow-up of the acceptor.

4. Field workers should preferably belong to the local areas as field-workers who are culturally acceptable to the population whom they serve can function better.

5. Only the trained medical officer with experience in gynaecology should be allowed to perform the insertions. The paramedical staff should not be allowed to perform the insertions.

6. A regular follow-up of the acceptors should be done and home visit made by the paramedical staff, in case women do not visit clinic.

7. The feasibility of providing IUD’s in a sterile package along with a sound and glove may be considered. This would be highly useful for centres which do not have adequate facilities for sterilization.

During the last few years there has been a very sharp increase in the usage of oral contraceptives (pills) in Jharkhand. In Jharkhand, of all women in the reproductive age group, over a third is already using pills as means of contraception. Recent information on the preferences for different method of contraception in the developing areas is of interest.

Sterilization has come to occupy an important place in the armoury of family planning methods. Sterilization renders a person incapable of reproduction and the result is usually permanent. It can be carried on the male as well as on the female but the male operation of vasectomy is becoming popular and is comparatively easy to perform. The fact that men’s sterilization is revocable, that is, the sterilized men can, if necessary, be de-sterilized is also a point in favour of this method. The official policy in favour of its more extensive use is definitely right and commendable. For its success and popularity, it is necessary that competent doctors and nurses and good equipment are provided. The concentration should be made on the quality of the acceptors rather than the number. The acceptors should be below 35 years.
Intensive programmes for sterilization should be insisted upon.

a) The population pockets in poverty zones where health, nutrition and balwadis service are already functioning with local participation, voluntary and state;

b) Industrial belt of high density population;

c) Urban slums and reconstituted slums,

d) Industrial belts of high density population;

e) Cattle fare, ‘country mela’ where people congregate naturally. Staff to be engaged in intensive programmes should be recruited for known good work and care should be taken that sterilisation operation are performed with extreme care. For sterilization follow-up care is essential and vitally important.

The tubectomy operation in the post-partum period is one thing which has a very good success, because women coming for delivery or after miscarriage were found to be psychological in a better receptive mind to accept advice on this. It is also easier to perform the operation after a delivery or involuntary or even voluntary abortion. The operation is to widen the scope for post-partum operations. To do that we must have a very big health programme providing facilities for delivery or post-abortion or post-miscarriage treatment under controlled conditions. By controlled condition we mean nursing homes or in a hospital or in a place where ‘Dais’ come to the house for helping in the delivery but have had orientation in and knowledge of family planning.

Abortion has been given an increasingly important place in the programmes of birth control in many areas of Jharkhand.

In India, Medical Termination of Pregnancy (MTP) Act was enforced from 1st April 1972, to liberalize abortion. It was introduce as a health measure rather than family planning method. Medical termination of pregnancy or legalized abortion should be encouraged. MTP service by properly trained doctors should be made available more freely in urban as well as rural areas and this should be suitably publicized. The procedures for registration record keeping and reporting for MTP services should be simplified. The programme of medical termination of

---

pregnancy through well-trained doctors in well equipped approved hospitals is essentially a health care measures. But in a way, it supplements the family planning programme as it provides for legalized abortion in cases of contraceptives failures also. A good proportion of the acceptors of abortion go in for some form of contraception like sterilization, IUD, etc.

Training of Multipurpose workers: To ensure package of family planning services at the peripheral level, multipurpose workers are being trained. The training is expected to be completed in all the districts. Retraining of district level medical officers and the ‘key trainees’ is organized at central training institution and that of medical officers of primary health centres, block extension educators and family planning training centres. The Para medical staff of the block is trained at these primary health centres.

Special Scheme: Four schemes, namely, all Jharkhand hospitals post partum programme at district and sub-district level hospitals and PAP smear test facilities in medical colleges selected for this purpose; revamping of organizational set up in urban slums of the state; sterilization beds schemes; and renovation of IUD room at rural family welfare centres attached to primary health centres are being implemented as special schemes.

(A) Post Partum Programme: The post partum programme is a maternity centered hospital based approach to family welfare programme covers district level. Besides, medical colleges are also implementing PAP smear test facilities programme for early detection of cervical cancer among acceptors of family planning methods.

(B) Sub-District Hospitals: The purpose of extension of the post partum programme to sub-district hospitals is to provide the family planning services in rural and semi-urban areas so as to bring as overall improvement in the health status of the mother and the infects.

(C) Reorganisation: A working group on re-organization of family planning care was constituted by Government for giving its recommendations for additional inputs for improving the out-reach system in urban slums. Proposals for strengthening the out reach system in specific urban slums as per the
recommendations of the working group are to be submitted by state government for according administrative approval by Government.

(D) Sterilisation beds: Sterilization beds schemes provides immediate facilities for tubectomy operation in the hospitals where such cases could not be admitted due to lack of facilities. Under the scheme, beds are sanctioned to those medical institutions, hospitals which are run by voluntary organizations on the basis their performance during the previous year. Beds are sanctioned to the voluntary institutions on the recommendations of the state government and regional directors of health and family planning.

In conclusion, it may be emphasised that the development of new acceptable methods in the field of contraception can be naturally expected to take time to prove their safety and efficiency because of especially stringent requirements related to these agents. While efforts in this direction are maintained, priority allocation of resources and energy should be applied for more effective use of established methods by mass education, training, personnel and streamlining of distribution channels. In fact, the cafeteria approach will become far more rewarding if it is organized as a “package programme” consisting of condom, the loop or the pill for younger couples, abortion for women who conceive accidentally, sterilization for those who do not wish to add to their families. It is obvious that in implementing the policy of birth control several measures will have to be undertaken in an integrated manner. There must be an expanded provision of clinic and distribution centres have been increasing in recent years but many of them are under worked for want of regular and adequate attendance. A mere installation of clinics is, therefore, not sufficient. The need to deploy a large staff of medical and paramedical personnel for carrying out the work of family planning is immediate and great.
Table: 4.3

Table Showing Family Planning Targets fixed for **Sterilisation, IUD, MTP, CC USERS, and OP USERS** in Hazaribag dist.:

<table>
<thead>
<tr>
<th>Year</th>
<th>Sterilisation</th>
<th>IUD</th>
<th>MTP</th>
<th>CC USERS</th>
<th>OP USERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000-01</td>
<td>8950</td>
<td>8170</td>
<td>2150</td>
<td>8240</td>
<td>10000</td>
</tr>
<tr>
<td>2001-02</td>
<td>11000</td>
<td>11400</td>
<td>1550</td>
<td>9000</td>
<td>9000</td>
</tr>
<tr>
<td>2002-03</td>
<td>11000</td>
<td>13990</td>
<td>0</td>
<td>16558</td>
<td>16558</td>
</tr>
<tr>
<td>2003-04</td>
<td>12200</td>
<td>20300</td>
<td>0</td>
<td>28414</td>
<td>28414</td>
</tr>
<tr>
<td>2004-05</td>
<td>12450</td>
<td>20570</td>
<td>0</td>
<td>29000</td>
<td>29000</td>
</tr>
<tr>
<td>2005-06</td>
<td>12700</td>
<td>21000</td>
<td>0</td>
<td>29000</td>
<td>29000</td>
</tr>
<tr>
<td>2006-07</td>
<td>13150</td>
<td>21915</td>
<td>0</td>
<td>30680</td>
<td>30680</td>
</tr>
<tr>
<td>2007-08</td>
<td>13315</td>
<td>22200</td>
<td>0</td>
<td>31065</td>
<td>31065</td>
</tr>
</tbody>
</table>

*Source: Family Welfare Department of Hazaribag*

**CONTRACEPTIVES**

**Condoms/Copper-T/Oral Contraceptives Pills**

The National Family Welfare Programme provides the following contraceptive services for spacing births:

a) Condoms
b) Oral Contraceptive Pill
c) Intra Uterine Devices (IUD)

Whereas condoms and oral contraceptive pills are being provided through free distribution scheme and social marketing scheme, IUD is being provided only under free distribution scheme. Under Social Marketing Programme, contraceptives, both condoms and oral pills are sold at subsidized rates. In addition, contraceptives are commercially sold by manufacturing Companies under their brand names also. Govt. of India does not provide any subsidy for the commercial sale.

**CONDOMS**

Condom is used by men and is the easiest way of introducing family planning. It can be used without help of any doctor. It is being supplied to the married couples at very concessional rates. These are now being commonly used and are proving very useful method for controlling family size.
Condoms are made available to the potential users by Government through the following schemes:

- Free Distribution Scheme
- Social Marketing Scheme

**Free Distribution Scheme**

Free disbursement of condoms was started with the objective of making them available to those who cannot afford to pay for it. Under this scheme, Department of Family Welfare procures condoms with brand name NIRODH from various Indian Manufacturers and supplies them to all the States/UTs for distribution to the users free of cost through dispensaries, hospitals, PHCs, Sub-Centers etc.

**Social Marketing Scheme**

Social Marketing Programme of condom was launched by the Govt. of India in 1968 with the objective of making condoms available to those who can afford to pay nominally for it. Under this scheme, three different varieties namely (i) New Lubricated Nirodh, (ii) ‘Deluxe Nirodh’ and (iii) ‘Super Deluxe Nirodh” are procured from the indigenous condom manufacturers and supplied to marketing companies/NGOs (called Social Marketing Organizations) at subsidized rates for sale in the open market. In addition, distributing companies i.e. SMO’s are permitted to market condoms under their own brand name. A promotional incentive of 10 paisa per condom sold for Deluxe and Super Deluxe varieties and 3 paisa per condom sold for New Lubricated variety is also being provided to the SMOs. Deluxe Nirodh is also sold by State AIDS Control Societies through their NGOs net work.

The country is self sufficient in the production of condoms. The names of manufacturers presently having rate contract with the department along with their annual capacity are given below:
Table: 4.4 Annual capacities of different firms about Contraceptives

<table>
<thead>
<tr>
<th>Firm</th>
<th>Annual Capacity (In Million Pieces)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Hindustan Latex Ltd.</td>
<td>600.00*</td>
</tr>
<tr>
<td>2. TTK LIG</td>
<td>321.28</td>
</tr>
<tr>
<td>3. Polar Latex Ltd.</td>
<td>178.50</td>
</tr>
<tr>
<td>4. J.K. Ansell</td>
<td>84.10</td>
</tr>
<tr>
<td>5. Suretex Prophylactics (India) Ltd.</td>
<td>60.00</td>
</tr>
<tr>
<td>6. Indus Medicare</td>
<td>34.50</td>
</tr>
</tbody>
</table>

*As per MOU. For others on single shift basis

The following Tables show the condoms distributed under Free Supply and Social Marketing Programme and maximum retail price charged under Social Marketing:

**Table: 4.5**

Retail Price (MRP) of Condoms under Social Marketing Programme

<table>
<thead>
<tr>
<th>Brand Name</th>
<th>No. of Pieces</th>
<th>Retail Price Per Pack(Rs.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ahsaas</td>
<td>4</td>
<td>5.00</td>
</tr>
<tr>
<td>2. Bliss</td>
<td>4</td>
<td>6.00</td>
</tr>
<tr>
<td>3. Deluxe Nirodh</td>
<td>5</td>
<td>2.00</td>
</tr>
<tr>
<td>4. Masti</td>
<td>4/10</td>
<td>5.00/10.00</td>
</tr>
<tr>
<td>5. Mauj</td>
<td>5</td>
<td>5.00</td>
</tr>
<tr>
<td>6. Milan</td>
<td>4</td>
<td>2.00</td>
</tr>
<tr>
<td>7. Mithun</td>
<td>6/12</td>
<td>4.00/7.00</td>
</tr>
<tr>
<td>8. New Lubricated Nirodh</td>
<td>3</td>
<td>0.50</td>
</tr>
<tr>
<td>9. Pick Me</td>
<td>4</td>
<td>5.00</td>
</tr>
<tr>
<td>10. Sangam</td>
<td>3</td>
<td>3.00</td>
</tr>
<tr>
<td>11. Sawan</td>
<td>4</td>
<td>4.00</td>
</tr>
<tr>
<td>12. Super Deluxe Nirodh</td>
<td>4</td>
<td>3.00</td>
</tr>
<tr>
<td>13. Ustad</td>
<td>4</td>
<td>4.00</td>
</tr>
<tr>
<td>14. Zarooor</td>
<td>3/12</td>
<td>4.00/12.00</td>
</tr>
<tr>
<td>15. Sathi</td>
<td>4/10</td>
<td>5.00/10.00</td>
</tr>
<tr>
<td>16. Sparsh</td>
<td>4/10</td>
<td>5.00/10.00</td>
</tr>
<tr>
<td>17. Thril</td>
<td>4</td>
<td>5.00</td>
</tr>
</tbody>
</table>

Source: As per medical store
**ORAL CONTRACEPTIVE PILLS**

Oral Contraceptive Pills are also made available to the potential users by Government through the following schemes:

- Free Distribution Scheme
- Social Marketing Scheme

**Free Distribution Scheme**

Under the free distribution scheme Oral Contraceptive Pills with brand name Mala D are procured and distributed to the acceptors free of cost in the same manner as that of condoms.

**Social Marketing Scheme**

On the pattern of Social Marketing scheme of condoms, Social Marketing Scheme of Oral Pills was launched by the Govt. of India in 1987. Under this scheme, Government procures Mala D from the indigenous manufacturers and supplies them to marketing companies/NGOs (called Social Marketing Organizations) at subsidized rates. Distributing companies i.e. SMOs are also permitted to market oral pills under their brand name. A promotional incentive of Re. 0.25 per cycle of oral pills sold is also being provided to the SMOs.

The tableting of pills from the raw material is done by the manufacturers. The manufacturers having rate contract with the Department during the current year and their production capacities are as under:

**Table: 4.6 Annual capacities of different firm about Levonorgestrel**

<table>
<thead>
<tr>
<th>Firm</th>
<th>Annual Capacity (In Million Cycles)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. M/s Pharmasia Ltd</td>
<td>53.57</td>
</tr>
<tr>
<td>2. M/s Hindustan Latex Ltd</td>
<td>51.86</td>
</tr>
<tr>
<td>3. M/s Famy Care Ltd</td>
<td>49.65</td>
</tr>
<tr>
<td>4. M/s IDPL</td>
<td>33.86</td>
</tr>
</tbody>
</table>
Table: 4.7

Retail Price (MRP) of Oral Pills under Social Marketing Programme

<table>
<thead>
<tr>
<th>Brand Name</th>
<th>No. of Cycles Per Pack</th>
<th>Retail Price Per Cycle(Rs.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Apsara</td>
<td>1/3</td>
<td>4.00/10.00</td>
</tr>
<tr>
<td>2. Arpan</td>
<td>1</td>
<td>5.00</td>
</tr>
<tr>
<td>3. Choice</td>
<td>1</td>
<td>7.00</td>
</tr>
<tr>
<td>4. Ecroz</td>
<td>1/3</td>
<td>6.00/10.00</td>
</tr>
<tr>
<td>5. Julie</td>
<td>1</td>
<td>5.00</td>
</tr>
<tr>
<td>6. Mala D</td>
<td>1</td>
<td>2.00</td>
</tr>
<tr>
<td>7. Pearl</td>
<td>1/3</td>
<td>5.00/10.00</td>
</tr>
<tr>
<td>8. Suvida</td>
<td>1/3</td>
<td>7.00/20.00</td>
</tr>
<tr>
<td>9. Khushi</td>
<td>1</td>
<td>5.00</td>
</tr>
<tr>
<td>10. Hamjoli</td>
<td>1/3</td>
<td>5.00/10.00</td>
</tr>
</tbody>
</table>

Source: Rate as per medical store

Social Marketing Organizations under social Marketing of Condoms and Oral Pills.
At present following SMOs are participating for distribution of contraceptives (Condoms/Oral Pills) under Social Marketing in India.

Table: 4.8

Social Marketing Organizations under Social Marketing of Contraceptives

<table>
<thead>
<tr>
<th>Sl.No</th>
<th>Name of the SMO</th>
<th>Condoms (Brand)</th>
<th>Oral pills (Brand)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Population Services International , New Delhi</td>
<td>Deluxe Nirodh, Masti</td>
<td>Mala-D, Pearl</td>
</tr>
<tr>
<td>2.</td>
<td>Hindustan Latex Ltd., Thiruvananthapuram</td>
<td>Deluxe Nirodh, New Lubricated Nirodh, Ustad</td>
<td>Mala, Arpan</td>
</tr>
<tr>
<td>3.</td>
<td>World Pharma, Indore</td>
<td>Deluxe Nirodh, Mauj</td>
<td>Mala-D, Julie</td>
</tr>
<tr>
<td>No.</td>
<td>Organization</td>
<td>Product Code</td>
<td>Brand Name</td>
</tr>
<tr>
<td>-----</td>
<td>--------------------------------------</td>
<td>--------------</td>
<td>-------------</td>
</tr>
<tr>
<td>4.</td>
<td>Parivar Kalyan Kendra, Panchkula</td>
<td>Deluxe Nirodh, Pick me</td>
<td>Mala-D Sugam</td>
</tr>
<tr>
<td>5.</td>
<td>Janani, Delhi</td>
<td>Deluxe Nirodh, Mithun</td>
<td>Mala-D, Apsara</td>
</tr>
<tr>
<td>6.</td>
<td>Parivar Seva Sanshta, New Delhi</td>
<td>Sawan, Bliss, Milan</td>
<td>Ecroz</td>
</tr>
<tr>
<td>7.</td>
<td>DKT India, Mumbai</td>
<td>Zaroor</td>
<td>Choice</td>
</tr>
<tr>
<td>8.</td>
<td>Pashupati Chemicals &amp; Pharmaceuticals Ltd., Kolkata</td>
<td>Ahsaas</td>
<td>-</td>
</tr>
<tr>
<td>9.</td>
<td>Dey’s Medical Store (Mfg) Ltd, Kolkata</td>
<td>-</td>
<td>Mala-D</td>
</tr>
<tr>
<td>10.</td>
<td>Eskag Pharma Pvt. Ltd., Kolkata</td>
<td>-</td>
<td>Suvida</td>
</tr>
<tr>
<td>11.</td>
<td>Family Planning Association of India, Mumbai</td>
<td>Sangam</td>
<td>-</td>
</tr>
<tr>
<td>12.</td>
<td>Indian Drugs &amp; Pharmaceutical Ltd., Gurgaon</td>
<td>-</td>
<td>Mala-D</td>
</tr>
<tr>
<td>13.</td>
<td>Population Health Services, Hyderabad</td>
<td>Thril</td>
<td>Khushi</td>
</tr>
<tr>
<td>14.</td>
<td>Medicon Enterprises, Rohtak</td>
<td>Sparsh</td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>Parivar, Patna</td>
<td>Sathi</td>
<td>Hamjoli</td>
</tr>
</tbody>
</table>

*Source: As per Medical Store in market*

**WEEKLY ORAL CONTRACEPTIVE PILLS (CENTCHROMAN)**

Since December, 1995 Centchroman, a non-steroidal weekly OCP for female developed by Central Drugs Research Institute (CDRI), Lucknow is socially marketed by M/s Hindustan Latex Ltd. (Public Sector) under the brand name SAHELI for which product subsidy and publicity support is being provided by the Government. This pill is to be taken twice a week on fixed days for first three months, followed by one pill in a week thereafter.
COPPER-T

COPPER-T is one of the important spacing methods offered under the Family Welfare Programme. Cu-T is supplied free of cost to all the States/UTs for insertion at the PHCs, Sub-centers and Hospitals by trained Medical Practitioners /trained Health Workers.

The earlier version of Cu-T 200 ‘B’ (IUDs) has been replaced by Cu-T 380-A from 2002-03 onwards which provides protection for a longer period (about 10 years) as against Cu-T 200 ‘B’ which provided protection for about 3 years only. The country has a large production capacity of Copper –T to meet country’s domestic need as well as export. The names of manufacturers presently having rate contract with the Department and their annual production capacity are given below:

Table: 4.9 Annual capacities of different firm about Cu-T

<table>
<thead>
<tr>
<th>Firm</th>
<th>Annual Capacity (In Lakh Pieces)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. M/s Famy Care Ltd</td>
<td>163.64</td>
</tr>
<tr>
<td>2. M/s SMB Corporation of India</td>
<td>85.33</td>
</tr>
<tr>
<td>3. M/s Hindustan Latex Ltd</td>
<td>59.20</td>
</tr>
<tr>
<td>4. M/s Contech Devices Pvt Ltd</td>
<td>20.72</td>
</tr>
</tbody>
</table>

Emergency Contraceptive Pill has been introduced for the first time under Family Welfare Programme during 2002-03. The emergency contraceptive is the method that can be used to prevent unwanted pregnancy after an unprotected act of sexual intercourse (including sexual assault, rape or sexual coercion) or a contraceptive failure. Emergency Contraceptive is to be taken on prescription of Medical Practitioners. A pack contains two tablets of Levonorgestrel.

Area Projects under Social marketing:

In view of putting concerted efforts with area specific projects, Social Marketing endeavors have been initiated in six States- Madhya Pradesh, Haryana, Andhra Pradesh, Bihar, Jharkhand and Orissa.
(i) To begin with, in 1998-99, the Department of Family Welfare had sanctioned a pilot project to M/s. Hindustan Latex Family Planning Promotion Trust, Thiruvananthapuram (HLFPPT) of HLL, for strengthening Social Marketing of Contraceptives programme. The project has been implemented in three districts of Madhya Pradesh viz., Gwalior, Bhind and Morena. This has been extended up to 31.3.2001 with inclusion of two more adjacent districts namely; Shivpuri and Datia.

This project has been evaluated by the International Institute for Population Sciences (IIPS), Mumbai in the beginning of year 2000. The study revealed that the model adopted by HLFPPT has made impact in rural areas also and it may therefore be replicated in some demographically backward districts of States.

(ii) Another area project on Social Marketing sanctioned to the Society for Woman and Child Health in Haryana has been launched in the districts of Ambala, Kurukshetra, Panchkula and Yamuna Nagar in April, 2000 for four years at a total cost of 1.32 crores.

(iii) Encouraged by the success of these area projects as revealed from impact evaluation conducted, a third project has been launched in Andhra Pradesh in Feb., 2000 by M/s. Hindustan Latex Family Planning Promotion Trust, Thiruvananthapuram (HLFPPT) of HLL, with the funding from European Commission, at a total cost of Rs. 4.66 crores for a period of three years.

(iv) Similar projects have been launched in the States of Bihar, Jharkhand and Orissa being implemented by HLFPPT of HLL.

**LAPAROSCOPIES/TUBAL RINGS**

Laparoscopes/Laparocators are essentially required for undertaking Laparoscopic sterilization which is a relatively quicker method of female sterilization. 25 Central Laparoscopic Training Centers have been identified for the purpose of training medical and paramedical personnel in this technique. The training is imparted to a team consisting of Gynaecologist/Obst./Surgeons with minimum 3 years experience in the field, Operation Theatre Nurse and Operation Theatre Attendant.
At present, Laparoscopes are supplied @ 1.5 Laparoscope per trained team. To meet this requirement, the Laparoscopes are procured centrally and distributed among the States/UTs. Tubal Rings for this purpose are also procured centrally and distributed to the States/UTs as per their demand.

**Government of India Scheme to compensate acceptors of sterilization for loss of wages:**

With a view to encourage people to adopt permanent method of Family Planning, Government has been implementing a Centrally Sponsored Scheme since 1981 to compensate the acceptors of sterilisation for the loss of wages for the day on which he/she attended the medical facility for undergoing sterilisation.

Under the Scheme, the Central Government released funds to States/UTs @ Rs.300 per Tubectomy, Rs.200 per Vasectomy and Rs.20 per IUD Insertion. The States/UTs had the flexibility to decide the amount of apportionment among various components, provided minimum amount of Rs.150 was paid to the acceptors of Tubectomy/Vasectomy and Rs.60 per Tubectomy, Rs.25 per vasectomy and Rs.20 per IUD insertion was used by the medical facility towards drugs and dressing. This was intended to ensure quality of service in these procedures. Flexibility rested with the States for determining sub components of the remaining amount, within the total package. In the case of EAG States viz. Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Orissa, Rajasthan, Uttar Pradesh and Uttarakhand, the compensation package for sterilisation had been raised from Rs.300/- to Rs.400/- per Tubectomy, Rs.200/- to Rs.400/- per Vasectomy if conducted in a public health facility or approved private sector health facility, and from Rs.20 to Rs.75 per IUD insertion, if conducted in an approved private sector health facility.

Apart from providing for cash compensation to the acceptor of sterilization for loss of wages, transportation, diet, drugs, dressing etc out of the funds released to States/UTs under this scheme, some States/UTs were apportioning some amount for creating a miscellaneous purpose fund. This fund was utilized for payment of ex-gratia to the acceptor of sterilisation or his/her nominee in the unlikely event of
his/her death or incapacitation or for treatment of post operative complications attributable to the procedure of sterilization, as under:-

i) Rs. 50,000/- per case of death.

ii) Rs. 30,000/- per case of incapacitation.

iii) Rs. 20,000/- per case of cost of treatment of serious post operation complication.

Any liability in excess of the above limit was to be borne by the State/UT/NGO/Voluntary Organization concerned from their own resources. The Hon’ble Supreme Court of India in its Order dated 1.3.2005 in Civil Writ Petition No. 209/2003 (Ramakant Rai V/s Union of India) has, *inter alia*, directed the Union Governments of India and States/UTs for ensuring enforcement of Union Government’s Guidelines for conducting sterilization procedures and norms for bringing out uniformity with regard of sterilization procedures by -

1. Creation of panel of Doctors/health facilities for conducting sterilization procedures and lying down of criteria for empanelment of doctors for conducting sterilization procedures.
2. Laying down of checklist to be followed by every doctor before carrying out sterilization procedure.
3. Laying down of uniform Performa for obtaining of consent of person undergoing sterilization.
4. Setting up of Quality Assurance Committee for ensuring enforcement of pre and postoperative guidelines regarding sterilization procedures.
5. Bringing into effect an insurance policy uniformly in all States for acceptors of sterilizations etc.

**Rhythm Method**

It is also called safe period method. It was hoped that this method would face least opposition from the people and did not involve any expenditure. It was, therefore, not surprising that the Government of India informed the WHO that it was “*definitely for the moment unwilling to consider any other type of family planning.*”

---

The government, therefore, decided to adopt it. But it was soon found that it was not suited for large scale application. Maintenance of cycle records, particularly in the rural areas was not easy. It was also difficult to practice this method because most women do not menstruate regularly. The method, therefore, was given up. Though the government is often blamed for selecting the rhythm method, which is often known as “the unsafe method” of family planning, it must be appreciated that, at that time, little or nothing was known about the attitudes of the people to the idea of conception control and therefore, the selection of a method which was in keeping with the tradition, culture and mores of the people was justified. The idea of controlled sex-life was well accepted, at least among the Hindus, who formed the majority in the population, for certain auspicious and inauspicious days were prohibited for sex and there were long periods of absistence following childbirth. Hence, the rhythm method was expected to face the least opposition from the people. This method, moreover, had the added advantage of not involving any expenditure.

**Diaphragm Method**

It was another method which was adopted but it too failed because it required the services of a doctor to fit the women with correct size diaphragm and called for certain degree of sophistication. It is also needed privacy and storage facilities. Therefore, it too failed to attract the people. After experimenting with the rhythm method, the family planning programme fell back on the diaphragm and jelly method, with fitted well with the western model for family planning services adopted. This method was known to have had a wide acceptability in the West, but was soon found to be unsuitable for India, despite the fact that it was highly effective if used correctly and regularly. This method required the services of a doctor to fit the women with the correct. Regularity of use, however, could be ensured only if the woman was highly motivated, and this involved repeated use of the diaphragm. It also requires some privacy as well as storage facilities.

**Provision of Contraceptive Services**

Among the more important direct policies are those concerning contraceptive services. It is expected that, by providing such services and by conducting family planning educational programme, individual couples would
accept family planning. Two points of view have to be considered in this context. There is a school of thought whom is optimistic and maintaining that, with an efficient management of the family planning programme in Jharkhand, it should be possible to bring down the birth rates, as has been demonstrated by some state. At the other extreme are those who maintain that current family planning programmes can never succeed in curbing the birth rates. Kingsley Davis puts forward several reasons in support of this argument. Most family planning programmes, following the Planned Parenthood approach, emphasizing the right of the parents to decide on the number of children they would like to have and how they should space them out. Davis points out that such an approach would reduce reproduction only to the extent that unwanted births would be eliminated, which may still result in a high rate of population growth.  

**New initiative: Family Planning Insurance Scheme:**

Under the existing government scheme no compensation was payable for failure of sterilization, and no indemnity cover was provided to Doctors/health facilities providing professional services for conducting sterilization procedures etc. There is a great demand in the States for indemnity insurance cover to doctors/health facilities, since many govt. doctors are currently facing litigation due to claims of clients for compensation due to failure of sterilization. This has led to reluctance among the doctors/health facilities to conduct Sterilisation operations.

With a view to do away with the complicated process of payment of ex-gratia to the acceptors of Sterilisation for treatment of post operative complications, incapacitation or death attributable to the procedure of sterilization, the present Family Planning Insurance Scheme is being introduced. This Scheme will not only take care of the cases of failure of sterilization, medical complications or death resulting from sterilization, but would also provide indemnity cover to the doctor/health facility performing sterilization procedure.

---

The package provided under the Family Planning Insurance Scheme is as follows:

**Section I:**

a) Death due to sterilization in hospital. Rs. 1,00,000/-
b) Death due to sterilization within 30 days of discharge from hospital. Rs. 30,000/-
c) Failure of sterilization (including first Rs. 20,000/-instance of conception after sterilization).
d) Expenses for treatment of medical complications due to sterilization operation (Within 60 days of operations) Rs.20,000/*

*To be reimbursed on the basis of actual expenditure incurred, not exceeding Rs.20,000.

**Section II:**

All the doctors/health facilities including doctors/health facilities of Central, State, Local-Self Governments, other public sectors and all the accredited doctors/health facilities of non-government and private sectors rendering Family Planning Services conducting such operations shall stand indemnified against the claims arising out of failure of sterilization, death or medical complication resulting there from up to a maximum amount of Rs. 2 lakh per doctor/health facility per case. The cover would also include the legal costs and actual modality of defending the prosecuted doctor/health facility in Court, which would be borne by the Insurance Company within certain limits.

Liability of the Insurance Company under this Section would be limited to four cases of negligence in respect of every doctor, beyond which the doctor/health facility concerned would be himself/herself responsible for his/her lapse, apart from any other action that may be taken by the Government against the doctor/health facility.

The Scheme is uniformly applicable for all States/UTs. Government of India has paid entire premium for the Insurance Policy. States do not have to incur any expenditure under this Scheme. The Insurance Company will make payment

*Report of Family Welfare Department, Hazaribag*
against the claims of acceptors of sterilisation directly to acceptors without any hassle.

**Settlement of cases not covered under the Family Planning Insurance Scheme:**
There might be cases not covered by the Family Planning Insurance Scheme, viz. cases of sterilisation operations conducted before coming into force of this insurance Scheme, cases not covered under the National Protocol, cases already pending in Courts etc. Liability in respect of such cases would be met by the State Government/UT Administration from out of the Miscellaneous Purpose Contingency Fund created in respective State/UT by apportioning some amount from the grants released to them by the Union Government under the Scheme of Compensation for loss of wages for acceptors of Sterilizations/ IUD Insertions or under the Scheme of Flexible Funding for State Programme Implementation Plans (PIPs). The States may choose to administer the Fund through the Insurance Company or through the government machinery.

**Operationalization of Scheme / procedure for claim settlement:**

1. The Insurance Policy, called Special Contingency Policy, has all Jharkhand coverage.

2. The premium is chargeable on the estimated number of persons undergoing sterilization during the currency of the Policy.

3. All persons undergoing sterilization operations in public health facility/accredited health facility in private/NGO sector are covered under Section 1 of the policy.

4. The Consent Form filled by the person at the time of enrolling himself/herself for sterilization operation shall be proof of coverage under the scheme.

5. All health facilities accredited by Government and doctors employed/hired/engaged/approved and empanelled by Government for conducting sterilization operations are covered under Section II of the Policy.

6. The premium has been paid by the Government of India at the time of commencement of the policy based on the estimated number of sterilization operations to be conducted and is subject to adjustment at the end of the policy period on the basis of actual number of operations conducted.
7. The claims settlement has been decentralized at State and District levels and nominated Offices of the Third Party Administrators (TPAs) will coordinate with existing machinery of the States/UTs.

8. For the purpose of verification and medical evaluation of the claim lodged by the beneficiary, the district level Quality Assurance Committee (QAC) shall be responsible for authenticating the claim by certifying the failure of sterilization operation. The proposed constitution of QAC is at Annexure II. *In case QAC is not in existence in a district, the claim may be certified by the CMO and a Gynecologist till such time the QAC is constituted.*

9. On receipt of any claim from the acceptor of sterilisation under Section 1 of the Policy, the designated official/doctor/health facility shall inform the nominated office of TPA/Insurance Company, in writing as soon as possible. A representative of the Insurance shall be visiting the nominated office/CMO periodically to receive such information/claim(s).

10. Duly completed Claim Form shall be the basis of lodging claim under Section 1 of the Policy. The Claim Form shall be duly completed in all respects by the beneficiary and shall be authenticated by the committee/persons designated for this purpose.

11. For claims arising due to medical complications following sterilization operation, the QAC shall certify the cost of treatment of such complications. Payment shall be made subject to the limits mentioned in the Policy for such cases.

12. In case of claims for death of the patient due to sterilization operation, a Death Certificate along with medical report certifying the sterilization procedure, as the direct cause of death, shall be required.

As regard states these also did not lag behind in achieving the targets. In fact many districts competed each other in their desire to win the pleasure of central leadership. The whole programme gat national importance and significance. It is believed that in every district the percentage of those who accepted family planning programme went insufficient. In order to motivate the people to willingly accept this programme in some states houses were allotted and quotas and permits were issued on priority basis. In other states some disincentives were provided e.g. they were denied medical benefit, house and traveling allowances. In some of the state
those who could motivate more persons were publicly honored and given awards and prize. But even at the time it was made amply clear that the whole scheme was voluntary and no force should be used. Then another care was that only those should be sterilized who were in reproductive age group and had minimum small size family.

Thus whole programme would have been a wonderful success, but unfortunately the way in which it was tried to be implemented by over-enthusiastic people, annoyed the people. Selfish people in order to get some incentives and awards lured and threatened and pressurized many to get operated, though they were old or had no children or otherwise were not interested in having any. The poor labourers and workers were hood winked by these selfish people in their race to get favour and money.

The government decided to give a new dimension to the whole programme. Instead of family planning, it decided to make it programme of family welfare. Under this programme each family was to be made conscious that their welfare laid in limiting the size of the family. It was only a small family that could benefit the state as well as the individual. The new policy did not provide for any use of force for getting the programme implemented. It wanted to awaken the people by properly educating them, so that every family became conscious of its responsibility. It was felt that proper education could bring more results than the use of force in matters of family planning. The new government however, did not change the old policy of giving cash incentives to those who went in for family planning operation on their own. Family planning material was continued to be supplied free of charge for the use of the people of reproductive age group.

The government made it amply clears that the whole programme will be run on voluntary basis and there will be no use of force, either direct or indirect. The government is however, of the view that if gains of economic advancement are to be achieved, for that it is essential that population explosion should be checked and small family size should be preferred over the bigger one. The same policy of voluntary implementation of programme is now being followed in the state.
Figure III-3: Conceptual Framework of Family Planning Supply Factors

- **External Development Assistance**
  - FP Organizational Structure
    - Service infrastructure
    - Sectoral integration
    - Delivery strategies
    - Public-private Partnership
  - Operations
    - Management and Supervision
    - Training
    - Commodity Acquisition
    - Distribution
    - I.E.C.
    - Research and Evaluation
  - Service Outputs
    - Access
    - Quality
    - Image
    - Acceptability

- **Political and Administrative System**
  - Political Support
    - Resources
    - Allocations
    - Legal Code
    - Regulations

- **Larger Societal And Political Governance Factors**
Jharkhand Government provides so many facilities for adopting family planning norms for limiting the size of family. When research was conducting in Hazaribag district some big signboard has seen in family welfare department for advertising the same. Dr. Ajay Kumar Manjhi, ACMO of Hazaribag explained the programme as follows: The male who gets the benefit of male NSV will reward by Rs. 1100 cash payment and free test, medicines and treatment facilities by Hospital itself. Not only beneficiary person will reward but also motivator can get Rs. 200 for motivating that man for adopting family planning device.

Same cash incentive facility is also available for female. That female personnel who get benefit of female sterilization will reward by Rs. 600 cash payment and same free test, medicines and treatment facilities by hospital itself and motivator will get Rs. 150 for motivation. In Hazaribag So many ANM worker are motivating the male and female personality both. Family welfare department provide them cash incentives as per motivation. PHC department of family welfare Sadar hospital Hazaribag explained that only 65 female adopt sterilization device in the session 2008-09.

- Women seeking family planning for the first time hoped that contraception would give them some relief from pregnancies spaced too closely together and from the burden of caring for large families.
- Most new users had discussed family planning with other women; never-users had rarely discussed family planning with anyone. Mothers-in-law were usually excluded from discussions, but sisters-in-law and aunts frequently offered support and advice. Study participants said women are expected to initiate family planning and persuade their husbands to allow them to attend the family planning clinic. Experienced users were generally optimistic that men would eventually agree if women explained the health and economic benefits of smaller families and pointed out successful experiences of others. Most never-users believed husbands would be opposed to family planning and feared that raising the issue would anger them.
• Married men were unanimous that women had no right to engage in family planning without their husbands' approval, and some advocated divorce for those who do.
• Married men expressed ambivalence about the concept of family planning; less than half said they did not expect their wives ever to use it. Some recognized economic and health benefits but believed protection from pregnancy might encourage women's sexual freedom.
• Women who were not able to gain husbands' approval sought support from husbands' older sisters and aunts who sometimes intervened on the wife's behalf.
• One-third of new users came to the clinic in secret, having failed to convince their husbands to let them use contraception. Most women feared punishment if discovered, from harsh words, to isolation, to divorce.
• At the time of the second interview, 9 of 24 new users had discontinued family planning -- six because of side effects, two due to fear of the husband's retaliation, and one because of costs.
• Successful family planning users with supportive husbands were sharing their experience with other women and advocating use of contraception.

Recommendations

• Men tend to be on the fringe of family planning discussions. However, in a patriarchal society men's views affect women's actions. Findings of this study point to a need to reach men with accurate information on contraception and opportunities for informal discussion of family planning with male role models.
• Community agencies could develop support networks that employ successful contraceptive users, both women and men, trained to do peer outreach through informal education.
• Because women are concerned about contraceptive side effects, providers should be trained to improve their counseling skills as well as their management of side effects.
Some women are eager to control their fertility but feel exceptionally vulnerable to punitive backlash from husbands and other family members opposed to contraception. These women should be identified in health clinics, helped to protect their confidentiality, and provided special counseling as needed to enable them to proceed safely toward their family planning objectives. Community outreach programs should be developed to help women who may be reluctant to attend family planning clinics.

The Reproductive and Child Health Programme is oriented to meet the health needs of women and children completely. With regard to family planning, the approach emphasizes the target free promotion of contraceptive use among eligible couples, the provision to couples of a choice of contraception and the assurance of high quality care for many years, the family planning programme has been using electronic and other means of mass media to promote family planning. Studies have confirmed that exposure to electronic mass media has a substantial effect on contraceptive use. In other to explore the reach of family planning message disseminated through various mass media channels, NFHS-2 asked women whether they had heard or seen any message about family planning in the past few months. The result indicate that- overall family planning message have reached about two out of every five ever married women.

Family planning methods and services in Jharkhand are provided primarily through a network of government hospitals and urban family welfare centres in urban areas, and primary health centre and sub centres in rural areas. The public medical sector is the sources of contraception for over three-fourth of current users of modern methods. The private medical sector, including private hospitals or clinics, private doctors, private mobile clinics, private paramedics is the source of current users.

Government of Jharkhand outlined several approaches to the improvement of family planning programme. Eight percent of the central assistance to be state plans was to be earmarked against the performance of family programmes. It also proposed rising age at marriage for girls at 18 years and for boys to 21 years. Any
violation was to be treated as cognizable offence. The policy statement provided for a system of graded monetary compensation based on the number of living children at the time of sterilisation. The contribution of voluntary organizations was reorganized and provisions were made for the legitimization of such bodies. It also recognized that family planning was a multi facet problem and should be tackled on the basis. It promised government support to research in reproductive biology and contraceptive technology. The statement proposed legalisation of compulsory sterilisation of a couple after they had certain number of children. It was the weakest point of the statement.

Though the speed of family planning is slow, yet it is a matter of hope that the people of Jharkhand, both in the urban and rural areas, of both the sexes and in all age groups are realizing the need and importance of restricting family size.