CHAPTER – II
REVIEW OF THE LITERATURE
(CONCEPT AND ISSUE)

Family planning
India was the first country to evolve a government–backed family planning programme in the 1950s when the rest of the world was not aware of the problem. Today, after 58 years, India is trailing behind in population control. During the notorious Emergency regime between 1975 and 1977, the political leaders and many of their cronies, government officials and policemen shouted themselves hoarse advocating sterilization. They devised ambitious programmes and carried them out against popular wishes and even used such harsh and coercive methods for sterilization that today one is reluctant to talk of family planning to the populace. The concerned officials have been scared away from it. The experts have jettisoned hopes of reaching the targets. In fact for all practical purposes, the country is without an effective programme or an effective target. Political parties studiously skirt the subject, and election campaigns are conducted without a word of it. What was once a highly dramatic political issue has suddenly become taboo?

The family planning programme in India as well as Jharkhand is being promoted on voluntary basis, as a people’s movement in keeping with the democratic traditions of the state. The two children norm is being promoted through independent choice of the family planning method best suited to the acceptor. The programme in the field is implemented by the State Government and Union Territories Administration and there is very wide disparity in the success rate.

It is realized that the people respond to the family planning programmes more readily, if they are assured of the survival of their children. Therefore, for many years family planning is being paused as a part of the integrated Programme of Family Welfare with special attention to the health and well being of the Family, specially mothers and children. A vast rural and urban infrastructure has been established to implement the Family Welfare Programme in the country.
Immunization Programme has been universalized to ensure better prospects of child survival which in turn would create the right psychological ambience for the small family norm. The desire for large families, especially male children in the prevailing socio cultural and economic milieu, characteristically low status of women, low female literacy, early marriage of girls and high infant morality rate are stumbling blocks in the progress of Family Welfare Programme.

Confronted with the grim prospects of population explosion and the inadequacies of the present strategies, radical and innovative strategies are called for to revamp the programme and bring about a more rapid decline in fertility. Population Control and Family Welfare Programme need to have a national consensus, cutting across political, religious and cultural differences. It needs to be based on active community participation and has to be transformed from a Governmental programme into a people’s movement. A differential need based strategy needs to be developed in the 206 low performing districts in the country to create an immediate impact. The status of women and female literacy are key factors for fertility decline, as seen in the state of Kerala and elsewhere. Age of marriage of girls is yet another crucial factor. In the big States, the average age of marriage for girls is well below the national average. Studies indicate that if the average age of marriage of girls is pushed up by two years, it may result in lowering the birth rate by about 25%. Besides, a comparatively higher age of marriage would bring down maternal and infant morality.

Information, Education and Communication effort is vital to the Population Control Programme. Fortunately, there has been a quantum jump in female literacy during the last decades, thanks to specific measures undertaken by the Government. Population education should be a part of school and college education. It should also form an important ingredient of adult education and non-formal education. Communication strategies should be so devised as to effective enough to bring about attitudinal changes and dispel apathy, ignorance and misgivings about family planning and small family norms. All non-governmental organizations-private sector, voluntary agencies, private medical practitioners, Local bodies and Panchyati Raj Institution should be fully involved in a massive effort of community participation.
In 1977, ‘Family Planning’ was rechristened as ‘family welfare’, and tasks beyond its competence embracing all aspects of family welfare, including improvement of women’s educational level, were included in it. In its family planning, awareness drive, the Government of India adopted the UNEP guideline of delaying the first child and spacing the subsequent birth(s).

Government of Jharkhand made a detailed presentation about the demographic situation in the started the measures being taken by the state govt. for improving the family welfare facilities with a view to achieving population stabilization. Jharkhand is demographically backward as could be observed from the data on selected indicators:

- Safe Deliveries- 19%
- Pregnant Women with any ANC-40%
- Couple protection rate-28%
- Children with complete immunization-31%
- Crude Death Rate-9%
- Crude Birth Rate-32.8%
- Population below Poverty line-54%

The state had also been suffering from a serious shortfall of personnel such as doctors, lab technicians, nurses, pharmacists, multipurpose worker, etc. The contraceptive prevalence rate in the state was very low. As a significant proportion of currently married women had a desire to use modern family planning method, meeting the unmet needs for contraception could go a long way to bring down the birth rates. The major problem face by the state were low age marriage of girls, high proportion of 3+ birth, low coverage of ante-natal care and high proportion of home deliveries, leading to high infant mortality rate. The special measures initiated under the RCH Programme were as below:

1. RCH Camps at PHC Level,
2. Out reach service at village level
3. Dai-training- one from each village, monthly family planning campest District Head Quarter- formulation of population and health policies, drug policy to promoter rational use of drugs, reorganization of health and family welfare department, HRD Policy for the department, up gradation of health facilities at all levels with the help of facility survey data, improvement of skill of MO’s and
paramedical staff, innovative strategies to serve disadvantage people living in remote and inaccessible areas, behavioral change communication to improve demand for services, mobile clinics to provide services. Reported said that Jharkhand also faced the problem of extinction of some tribal groups unless urgent measure were taken to save them. The government had also initiated innovative sterilization to much remote and inaccessible area by introducing mobile clinic to save the people in areas not having any health infrastructure. Other measures adopted by the state were to increase per capita allocation for health. Shri K.C. Pant emphasized the importance of focusing attention on a district wise basis. It was also necessary to look into the requirements of special groups like population the tribal areas and slums. The plan outlay for the department of family welfare had been stopped up in recent years

Promotional and motivation measures for the Adoption of small family norm:
* Panchayats and Zilla Parishads will be rewards and honored for exemplary performance in universalizing the small family norm, achieving reduction infant mortality and birth rates and promoting literacy with completion of primary schooling,
* The Balika Samridhi Yojna run by Department of women and child development, to promote survival and care of the girls’ child will continue. A cash incentive of Rs. 500 is awarded at the birth of girls’ child of birth order 1 or 2,
* Facilities for safe abortion will be strengthened and expanded,
* Products and services will be made affordable through innovative social marketing schemes,
* Increased vocational training schemes for girls leading to self employment will be encouraged,
* Soft loans to ensure mobility of the ANM’s will be increased.

A State of completely physical, mental and social well being and not merely the absence of dieses of infirmity in all matters relating to the reproductive system and to its functions and processes, reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. Implicit in
this last condition are the right of men and women to be informed and to have access safe, effective, affordable and acceptable method of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right to access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

Family Planning enables couples and individuals to decide freely and responsibility the number and spacing of their children, and to have the information and means to do so. It also means that people have ongoing availability of a full range of safe and effective contraceptive methods that enable them to take action according to these decisions. This ability to take action is also based upon the cost of contraceptives, ideal people have about the different methods and the support of lack there of the planners, extended family members and wider community. People are deciding to have families at both younger and older ages and contraceptive technology is enabling them to do so. It is important that these decisions be made not only freely but also with full information about the long term consequences for both the partners and children. Unfortunately, there are still many women in the worlds who die each year from pregnancy-related services. A considerable number of these women want to limit or space their pregnancies but are without the means to do so efficiently.

The methods adopted in FAMILY planning are; sterilization, loop, pill, withdrawal, rhythm, sheath, and diaphragm. The condom and the pill seem most popular among the high socio-economic groups, the with-drawl method and the condoms among the middle socio-economic groups and sterilization is preferred by people belonging to the low social strata. Operations for family planning are not very popular among the socially well-placed, as this group is exposed to other methods of birth control. A good number of women use more than one method, depending on the circumstances, availability and the mood of the moment.

One of the oldest social development programmes is family planning programme for social change. This was started with an objective to make people aware about the evils of population explosion in general and the benefit of better
living standard through small family in particular. The need of family planning programme was felt five decades ago. Family planning means to have children by choice and not by chance. That is way it is called Planned Parenthood. It emphasis’s to have only two children and simultaneously it also stresses proper spacing between the two children. Now this programme is known as family welfare programme, because it also includes the measures of maternal and child health care along with the measures of birth control. If we fails to check the rapid rising population, all our efforts in regarded to economic development would become useless.

Communication campaign on family planning has been faulty e.g. inverted red triangle on a yellow back ground with a slogan “दो या तीन कबे बस” later quietly changed to “हम दो हमारे दो” which was further changed to visual showing one child with a slogan “लड़का हो या लड़की, बस दो ही पूल खिलायें हम”. Inspire of these campaigns we find that India’s population has crossed the mark of 1000 million, that of Jharkhand 2,69,45,829 and it is at 13th place in order of population as per the final result of the census of India 2001. A number of factors have influenced the adoption or non-adoption of family planning methods e.g. Education, Religion, Income, Culture, Various social aspects, Social backwardness, Faith and Environment etc. It has been normally absorbed that the adoption of family planning methods in higher income group is more common firstly because of awareness, secondly their education level and finally the availability and the price. Some people adopted it for better living also.

As discussed earlier factors which affect family planning are social and economic. These factors are responsible both for high as well as low family planning in every society both developed and under developed districts. Among social factors, mention may be made particularly of the following:

(a) Whether society respects either both the sexes or only one sex, i. e. either women or man?
(b) Whether it is socially believed that small size of the family is a blessing or a curse?
(c) Whether family planning devices are socially a welcome or these are hated?
(d) Whether women are educated or illiterate?
(e) How far women are socially allowed to decide family affairs?
(f) How far has society been in a position to provide facilities like those of schooling, health, employment etc for the children?
(g) How far the society recognizes that it is responsible for proper bringing up of the children?
(h) Whether society prefers single or joint family system and if so by and large which patterns it is following?
(i) The age at which the society will like boys and girls to marry,
(j) What is the climate of the state, thereby what is age of the girl at which she becomes capable of producing children?

Economic determinants weigh considerably in so far as family planning is concerned. Some of the important determinants are:
(a) What is living standard of the people and what living standard does the society wish to reach?
(b) Whether the state is over populated or the society wants to have manpower to improve economic lot of the people?
(c) Whether the family planning is connected due to religious or other factors, what is its present economic condition?
(d) Whether each child is considered a source of income or economic burden on parents?
(e) What is the economy of the society, i.e. whether it has agricultural or industrial economy?
(f) Whether society is rural based or urban based and if former, rate at which it is getting itself urbanized?
(g) Whether in economy, women are earning partners along with men or not?

History of family planning in India

The family planning movement in India from its very beginning in 1916 till the Government launched an official programme in 1951 was the result of the efforts of a number of social reformers, thinkers and voluntary organizations. Prof. Raghunath Dhondo karve was the first to open a family planning clinic in India in 1925. The Neo-Malthusian league was formed in Madras a few years later. On June 11, 1930 the Mysore Government issued an order for setting up birth control clinics
in the Victoria and Vani Vilas Hospitals in Bangalore and in the Krishnarajendra Hospital in Mysore. In 1932, the Senate of the Madras University accepted the proposals to give instructions on contraceptives and in the following year, the Government of Madras agreed to open Birth Control Clinics in the Presidency. In the same year, the All India Women’s Conference at Lucknow passed a resolution recommending that “men and women should be instructed in methods of birth control in recognized clinics.”

The National Planning Committee, under the Chairmanship of Shri Jawaharlal Nehru, set up by the Indian National Congress in 1935, strongly supported family planning. At the invitation of the All India Women’s Conference, Mrs. Margaret Sangar visited India during 1935-36 and stimulated interest in the country in family planning. Dr. A.P.Pillai, a vigorous advocate for family planning conducted training courses in 1935. In 1939 the “Birth Control World-Wide” in Uttar pradesh and Matri Sewa Sangh, Ujjain, in Madhya Pradesh opened birth control clinics. In 1940 Shri P.N. Sapru successfully moved a resolution in the Council of States for the establishment of birth control clinics. The Health Survey and Development Committee under the Chairmanship of Shri Joseph Bhore appointed in 1943 by the Government of India recommended provisions of birth control service, but mainly for health reasons.

The general governmental attitude towards birth control is reflected in the final report of the Famine Enquiry Commission (The Woodhead Commission) set up by the Government of India in 1943. The Commission stated that; “At the present time a deliberate state policy with the objective of encouraging the practice of birth control among the mass of population is impracticable. A fall in birth-rate will tend to follow rather than precede economic betterment. This was the situation just before the country became independent.”

After independences, when the congress party came into power the vital role of population control in the overall planned development of national economy was fully recognized by the Government. In 1949, the family planning Association of India was formed in Bombay under the President ship of Shrimati Dhanvanthi Ram Rau and since its inception the Association has worked ceaselessly for greater

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Family planning acceptance.

Prof. A.G. Kaual rather rightly said that, “A reduction in fertility would make the process of modernization a success.” 3

Drawing attention of the nation to the gravity of the problem Prof. S. Chandrasekhar, said, “We are in great hurry. You can not wait for a night. One exposure lasting 6 minutes leads to a baby and every year India adds one Australia to its population.” 4

It was keeping in view this magnitude of the problem that Mahatma Gandhi, Rabindra Nath Tagore, Dr. Rajendra Prasad, Pandit Jawahar Lal Nehru among other raised their voice in favour of family planning programme.

Some of the guiding principles of the whole programme are as follows:
1. The people should be properly educated about the need and necessity of using family planning services, so that they use them as and when these are provided.
2. The number of children which a family should have should be left to care of the parents.
3. The people should be approached through the leaders to whom they respect.
4. Only such media should be used which is acceptable to the people.
5. Efforts should be made to provide services at the door steps.
6. Family planning services should be made an integral part of medical and public health services.

As regards family planning programme, it was a modest programme during the Second Five-Year Plan but this time somewhat more importance was attached to it. This time it was an action-cum-research programme. It was now decided that:
1. Family planning facilities and advices should be made easily available.
2. For providing facilities to the workers engaged in the programme, more arrangements should be made.
3. People should be educated about aspects of birth, death, etc.
4. The centres which are financially assisted should be regularly inspected.

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5. Every town having a population of 50,000 or above should have at least one family planning clinic.

During the Third Plan serious attention was paid to the whole programme. Now extensive approach was adopted and following aims were decided to be followed:

1. More propaganda for family planning programme should be carried out and people should be still more educated in this regard.
2. In the urban areas 2100 and in rural areas 6100 clinics should be opened.
3. Para-medical personnel should be given more and more training.
4. The people working out side the public sector should also be provided facilities for technical training for making the programme of family planning a success.
5. Family planning material production should be increased.
6. In every clinic material and men for family planning be made easily available.
7. Female education should be encouraged so that women become quite conscious of the significance of the programme.
8. There should be research in the fields of development of studies of human genetics. Studies in the physiology of reproduction; development of more effective local contraceptives, development of a suitable oral contraceptive and follow up of sterilization cases both male and female, to investigate possible after effects in such cases should be encouraged.

In Jharkhand, in which people of reproductive age group are spread both in the villages and cities. The programme of family planning can be success only when the people are properly educated and are motivated. Mass media, song, drama and extension education are the methods through which the people are approached and educated for family planning programme. For promoting the programme co-operation of trade unions, co-operatives, Panchayats and other local institutions is also sought. Department of family planning also distributes very good printed material for the consumption of masses, both in the urban as well as rural areas. This programme is undertaking by Mass Mailing Unit of Family Welfare Department which has lakh of addresses on its mailing list.
Regular research work is going on in the field of family planning to make the whole programme action oriented as well as a success. In the field of demography 112 Demographic Action Research Centres are functioning. There is also National Institute of Family Planning at New Delhi which is doing useful work in the field of family planning. At Mumbai there is also an International Institute of Population Studies, which imparts training in demography to both Indian as well as foreign students. The Population Council of India is another important research institute in the field. In the Bio-Medical field important institutions engaged in research work include Indian Council of Medical Research, New Delhi; Central Drug Research Institute, Lucknow.

Under the Fifth Five-Year Plan about 560 crore rupees were earmarked for the family planning programme. Some of the important features of the programme are:

1. The programme will be run along with other health programmes in the hospital.
2. In the running of the programme co-operation of local leaders and other influential person will be sought
3. Essential material connected with family planning will be supplied.
4. The workers will be given adequate training.
5. Adequate attention will be paid to child and mother health care.
6. Urban family planning centres will also help the villages.
7. Mobile vans will be properly maintained.

Family planning programme assumed a serious significance during internal emergency. The whole programme however enforced by the State authorities in such a manner that instead of winning pleasure of the people, it incurred their wrath. Every Indian felt the punch of the programme directly or indirectly. The programme was introduced through such media which were not acceptable to the tradition loving masses. In some cases it is alleged that even force was used to achieve the targets. The result of all these measured was that in the country the whole programme begun to be viewed with displeasure. But in spite of all this during this period on this plan front much was achieved. There
were many disincentives for bigger family size and incentives for small family size.

It is encouraging to note that the Planning Commission itself recognized in the beginning that a rapidly growing population can be a menace to economic development and advocated the need for family planning. The Government took a courageous stand on this question and displayed great foresight by adopting family planning as an integral part of its overall national development programme. In fact, India is credited to be the first country in the world to adopt family planning as a state policy.

**Measures Adopted**

Officially mobilized in 1951, only 147 family planning clinics were established during the first five year plan period (1951-56). Since then, a network of Community Health Centers (CHCs), Primary Health Centers (PHCs) and Sub-Centers (SCs) has been created for implementing family planning programme through state government with a hundred per cent central assistance.

Of the various methods of family planning, the government till recently depended more on the ‘camp approach’ which relied implicitly on the districts authorities applying pressure on their officials to intensify the sterilization campaign (mostly male sterilization). The government set targets for different states and districts and adopted persuasive, monetary, as well as coercive measures to achieve the targets. Sanjay Gandhi laid emphasis more on the sterilization method than on the IUD (loop) method or conventional contraceptives (condoms). The worst victims of cruelty and brutality of Sanjay Gandhi’s methods were the Harijans, peons, clerical staff, school teachers, innocent rural people, hospital patients, jail inmates and pavement-dwellers.

The Primary Health Centers in villages, engaged in family planning programmes, perform two specific functions: providing services to the people and disseminating information about these services in an effective manner in order to motivate the people to accept family planning. Nearly half a million medical and Para-medical persons were engaged in the programme, besides half a million part-time village health guides. A social policy with a new integrated approach to
population stabilization has now been adopted. Following are the components of this new approach:

1. **Target-free Programme**

A significant shift in the family planning programme is the introduction of target-free programme. Targets were a major obsession in our family planning programme in which village patwaris, school teachers and government functionaries had to achieve the minimum targets of sterilization and other measures. Postings, promotions and transfers of functionaries depended on the fulfillment of targets. A target-free approach is indeed a welcome change. But only time will show the extent to which the estimated 2.5lakh personnel involved in family planning activities will succeed through the new package of Reproductive and Child Health (RCh) without emphasizing on achieving the set targets.

2. **Bottom-Up Approach or Decentralized participatory planning**

Hitherto, planning was done at the top level and percolated down to the grassroots for implementation. Now the programme is to be chalked out at the village level in consultation with health workers of sub-centre and PHC, i.e., male and female workers (ANMs), panchayat members, and active individuals. Planning for the district will be the aggregation of PHC plans plus the requirements of district hospitals. These District plans will together make the state plan and the state plans will be aggregated to prepare the National plan.

3. **State Specific Reproductive and Child Health (RCh) Strategy**

Since states display a wide variation in health parameters, such as infant mortalities, maternal mortalities, birth rates, etc., area specific RCH approach has been worked out separately for three groups of states plus the special category states where considerable infrastructure input flows from state health systems projects.

4. **Integrated RCH Package**

It provides a minimum model framework for Reproductive Health Services at different levels in the district, namely, subs-centre, PHC and district hospitals.
These services are related to prevention and management of unwanted pregnancy, maternal care, services for the new-born and infants, and management of STDs.

5. Comprehensive Integrated Training

Emphasis will be laid on the training of personnel to improve efficiency of interventions, interpersonal communication, and management. The responsibility of training would be that of a district. The central and the state governments will support the district in training of trainers, providing training material and periodic evaluation.

6. Increased Involvement of NGOs

More NGOs will be involved in clinic-based interventions, in strengthening community participation in implementing project activities, and in the training of trainers of technical skills. Private rural medical practitioners, including those of indigenous systems of medicines will also be involved in plans.

7. Independent Evaluation of Programme

The programme will be monitored and evaluated for qualitative performance. Eighteen Population Resource Centres (PRCs) have been established which are at present engaged in working out formats for annual surveys. Eight regional teams have also been constituted by the government for cross-checking of activities.

PROGRESS ACHIEVED

The achievement of the targets has not been disastrous in all fields though the number of sterilizations has fallen. There is decline in the number of IUD (loop) insertions; and there is also fall in the use of number of conventional contraceptives. Only 6 per cent of women between the age of 13 and 49 years use any modern contraceptive. But another report is that half of the couples do not practice family planning though over 90 per cent are aware of it (The Hindustan Times, February 11, 1997). The data dished out by the survey about sterilization rate (30%) the mainstay of our family planning programmes achievement is unreliable as most of the sterilizations are undertaken only after having had three or more children. Today, the effort has altogether slackened to the extent Ashish Bose, a noted demographer of our country, in his talk on ‘Indian Population in the at
Delhi said that “family planning programme has completely failed in the country and entirely a new approach is need for its success”.

China adopted the norm of one child per couple in the urban centers and a ceiling of two children per couple in the rural areas, with several incentives for the planned child as also the parents. Those who violated these norms were penalized. The planned child was given special allowance till the age of 14 for education and upbringing, and the couple was provided with land for building a house or for farm machinery. A major component of the programme in China is encouraging late marriage and late child birth.

ATTITUDES TOWARDS FAMILY PLANNING

The idea of family planning has been sold to an average woman. The attitude of a woman towards family planning is influenced by her education, age, income background, husband’s occupation, and her (working) status among other factors. In terms of age, it has been found that the percentage of women approving family planning decreases as the age group increases. But the acceptance is about two-thirds even among the older age groups. This clearly shows that the great majority of women approve of family planning, irrespective of age. In this research it is also discovered that while women bound to tradition chose to resign themselves to ‘fate’; only the young, educated and more informed showed deep concern for the size of the family.

In this research conducted a survey in 2005 inside villages of Hazaribag district as Padma, Ichak, and Barkhatta etc. on “Awareness of Rights among Rural Women”. During the survey, many men were questioned on family planning. To the question pertaining to the optimum number of children a couple should have, 7.0 per cent females answered they should have as many children as they want, 63.5 per cent wanted 2-3 children who are basically literate, 29.5 percent wanted 4-5 children. Against this, 60.9 per cent males were of the opinion that a couple should have only 2-3 children, 27.8 percent were in favour of 4-5 children, and 11.3 percent wanted the couple to have as many children as they desired. Thus, about two-third respondents (66.0%) were in favor of 2-3 children only.

Further, 25 per cent of the female respondents were not in favour of using any methods of family planning, 45 percent were fully in favour, and 30 percent favoured family planning methods with a few conditions and reservations thrown in. Of the 566 women who were fully or partially in favour of family planning, 43.3 per cent were actually using some methods to control their family size. The reason given by the remaining 56.7% women for not using contraceptives were: their husbands did not permit the use of any measures (42.4%); they wanted one or two more children (25.2%); they had crossed the child-bearing age (15.0%); the required contraceptives were not available in their villages (6.5%); they did not have sufficient knowledge about the use of contraceptives (5.0%); they had no means to dispose off contraceptives after the use (2.8%); and they wanted sons as they had only daughters(3.1%).

All this shows that women want to control their fertility and men also want to plan their families. It is also necessary to give them the required information, education and means to do so through medical, Para-medical, social and community institutions and workers. These reports enable us to compare the attitude of family planning programme in various blocks of Hazaribag.

The reason given for the hostility to family planning methods were: it was harmful to women, it went against family economy, it was against god’s will, and it constituted unnatural behavior. However, since seven out of every ten persons were in favour of family planning, it points to the fact that people today have ceased to be very traditional in their beliefs and values.

The state Jharkhand having different literacy rate, different views about family planning. The report is very clear like mirror that, where literacy rate is higher people take more interest in using family planning programme, giving low birth rate, increase the living of standard with their family, create sound full society.

A study made by the National Institute of Community Development covering 365 villages in 16 states and 43 districts and 7,224 respondents also revealed that 51.6 per cent were in favour of family planning and 23.7 per cent were against it (Balakrishna and Narayan Murthy, The Journal of Family Welfare).
Khanna and Varghese’s survey showed that the acceptance of family planning is directly related to education. As many as 40 per cent of women with primary school education or below did not favour family planning. If education level increases to even the middle school level, the percentage drops to 14 per cent. This shows that education brings about a change in the attitude to family planning. If a woman remains unexposed to family planning methods, she continues to be conservative and holds on superstitious beliefs and fears.

Informal education also affects the practice of family planning methods. Many young women are in favour of family planning but do not know how to go about it. The illiteracy of the husband also acts as a barrier because they remain unconcerned about planning the family.

Since illiteracy is found more among the poorer section of our society, it is seen that women with low education in the lower strata are more reluctant to accept family planning methods. Their contention is that since they have no money to fall back upon, their only hope of survival is their children’s income. An average poor Jharkhand couple is not satisfied with less than two or three children. Time and again, studies in various parts of the country have revealed this fact. About a decade ago in India, a large scale survey covering some 32000 respondents sponsored by the Ministry of Health and Family Welfare came to the conclusion that most couples wanted not only three or more children but they also wanted that two of them should be sons.

The encouraging feature is that though the older generation is inclined towards passive helplessness, they want their daughters to have fewer children and adopt birth control methods. In the rural areas, it has been observed that a woman with six children now compels her married daughter to undergo an operation to stop childbirth after her third delivery. In the urban areas, especially with the breakdown of the joint family system, many women in nuclear families face difficulties in bringing up children. Servants are a problem and there is no help from the in-laws or one’s own mother. Housing is often a problem and

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commodities are scarce. No wonder that urban women in the younger age group favour family planning methods which allow them to devote their attention to their careers.

Though a large number of women approve of family planning, only half of them actually practice it, Khanna and Varghese’s survey revealed that the lower the social strata, the more ignorant a woman is about family planning methods. From over 75 per cent use of contraceptives in the high socioeconomic strata, the percentage came down to 56 per cent in the middle and dropped to 19.5 per cent in the lower socio-economic group in their survey. The message is loud and clear: women in the low and middle strata need to be more effectively covered by family planning methods than those who are economically better off.

**Evaluation of the Programme**

Expenditure in population control has been increasing over the years. From a budget of Rs. 14 lakh during the first plan period (1951-56), it increased to Rs. 284.4 crore in the Fourth Plan period (1969-74) and Rs. 6500 crore in the Eighth plan period (1992-97). In terms of percentage, however, this allocation is only 1.5 per cent of the total public sector outlay. The question is: why should population control be the sole responsibility? Will they not benefit from control over population growth? States spend money only on programmes like elementary education, health centers, etc., which indirectly contributed to check on population growth. But how do states actually spend money even on these schemes (of health and education, etc.)? An illustration will help us understand it. A sub-health centre in a village is supposed to have male (MPW-M) as well as female workers (MPW-F or ANM). Expenditure on the salary of ANMs is met out of the central government’s grant under the family welfare programme, whereas on the male workers, it is met by the State government from their health budgets. As a result, states fill up all posts of female health workers (ANMs) but keep all posts of male health workers vacant under the pretext of economy measure. While PHCs and CHCs in the rural areas are supposed to be run from the state budget, they are actually run out of a grant of about Rs. 300 crore from the central government.

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7. I. bid. P. no. 108
under the Family Welfare Centers Programme. Why should the central government not revamp and revitalize the family planning programme with as active partnership of financial commitment of the stage governments on equal cost-sharing basis? It is time that states change their attitude from “get as much as you can” to “do as much as you can”, if family planning programme is really to be made success.

Family planning has come to a standstill. In fact, the programme is moving backward. We are producing 52 children every minute in comparison to 21 children per minute in 1971 and eight children per minute in 1941. This stagnation is bound to wipe out all the effort that has been made since 1952. Thought it is true that the couple protection percentage has gone up steadily from 10.4 in 1971 to 43.96 in 1995, it should be asked who these couples are supposed to have obtained protection. It is none other than those who have had three or more children and who have already done their part of the damage to the two-child family norm.

The official calculations of the Health Ministry point out that it is the five district of Jharkhand Lohardagga, Palamu, Deoghar, Gumla, and Giridih as 5.6, 5.5, 5.31, 5.3, and 5.23 with high fertility levels which have to bear the cross. These five districts together hold higher per cent of the state’s population. The population increase rate was 23.36 in Jharkhand which is higher than national as 21.54 in 1991-2000, the growth rate in four districts of Jharkhand W. Singhbhum, Dumka, Gumla, and Godda are low. Surprisingly, the targets of sterilizations set for these four states are much lower than what their population size should warrant. Unless these four districts improve their performance level, containing the population may continue to remain a big problem for the state.

Various studies have highlighted that the services of Primary Health Centres (PHCs) in the rural areas are grossly underutilized. In district like Garhwa, Chatra, Koderma and Lohardagga where the need is more pronounced, utilization is less. Countless studies have pointed out that in villages only the media which answers people’s questions instantaneously can help in family planning. The Block Extension Educators and the Health Assistants have been assigned only this role. But significantly, interpersonal communication is very insignificant.
What should be our objective and method of family planning propaganda? One important suggestion made is that our slogan should be; “Third child should not be born and no child after 35 years of age.” These are the two options which are entirely within the control of the couple. This type of propaganda linked with improving the standard of living, provision of better education, and health guarantee of (two) children and improved services for the health of women/mothers will put the couples in a frame of mind where they would themselves be anxious to work for this objective. Money incentives cannot be a motivating factor. The money may be incentive for the campaigner to motivate the couple but not for the person undergoing sterilization.

Research presents optimistic blueprints to check the population explosion in coming years. One point usually made is that our state has many untapped resources which, if properly developed, will sustain even three times the present population. The second point urged is that industrial growth, economic development and increase in exports will take care of poverty, unemployment, and the increasing population. Both these views are rather naive and unsound. What is useful and important for any state is the goods and services actually available and not likely to be available to meet the needs of the population. With the present political instability in the country both at the districts and in the state, with the political parties laying focus on achieving and retaining power rather than the ‘community development’, and with increasing cartelism, parochialism, regionalism and linguism, how can we expect our power elite to take interest in development and modernization and/or tapping the untapped resources?

**Swaminathan Committee**

The policy draft submitted by the Swaminathan Committee, 8 suggested a holistic approach to health and some structural changes to implement the policy. The important measures suggested by this committee were- (1) Stabilizing population by achieving a total fertility rate of 2.1 by 2010 A.D. (2) Implementing a speedy

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8. I. ibid. P. no. 110
and effective minimum needs programme. (3) Replacing the present vertically structured family welfare programme with decentralized, democratic planning through panchayats, nagar palikas and state legislatures. (4) Involving all agencies in population control measures. (5) Abandoning the idea of fixing targets for the use of specific contraceptive methods by the Central and State Governments, except the goal of achieving the national average of fertility rate. (6) Discontinuing incentives in cash or kind to contraceptive users and motivators. Instead, a population and Social Development Fund may be set up out of the funds available from government and international donor agencies. This fund will be utilized for filling the gaps in the effective implementation of the village, town, district and state level socio-demographic charters. (7) Appointing a State Population and Social Development Commission to plan, implement and monitor the population policy of the country. The sub-committees of PSDC will also be set up at the state, district and panchayat levels comprising elected representatives of people from different political parties, professionals, representatives of NGOs and women’s and youth’s organizations. (8) Family planning has become a responsibility for women alone. As such there is a need for checking the trend of putting the entire responsibility for family limitation on women.

Some socio-economic and medical goals set by the committee in the field of population welfare for forming a necessary part of the national population policy were; (1) reducing the incidence of marriage of girls below the age of 18 years to zero; (2) increasing the percentage of deliveries conducted by trained personnel to 100 percent; (3) reducing the infant and maternal mortality rates; (4) universal immunization of children against tuberculosis, polio, diphtheria, whooping, cough, tetanus and measles; (5) provision for primary health care from all; (6) providing information to individuals on birth limitation methods so that they have the fullest choice in planning their families; (7) making available and accessible the quality contraceptive services on a universal basis; and (8) Universalization of primary education.

But the experts have criticized the recommendations of this committee and have suggested that they should be rejected outright. Their main arguments
are;

1) The report lacks in depth analysis, justification and urgency. The approach suggested is purely managerial and the strategies pointed out are at best a reiteration of the failed aphorism that "development is the best contraception".

2) Minimum needs have no relationship with population control. How could all the goals which could not be achieved in the past over four decades in spite of eight Five Year Plans and eleven general elections with all the political promises could be achieved by 2010 A.D.,

3) A political population commission will be ineffective.

4) The committee has not recommended any disincentive for those who violated family planning norms. The Committee had proposed the introduction of disincentives—even if unpopular – to make the family planning programmes more effective and fast acting. One such programme was introduced by the Government of Rajasthan according to which no individual can contest any election if he has more than three children. However, this programme exists only on paper. It is to be put in practice.

5) The report does not spell out why we failed in controlling our rapid population growth, though the population programmes have been going on. Is this failure because of the drawbacks in the administrative set up or because of wrong policies or faulty or tardy implementation? This is the fundamental issue which is ignored by the report. Without this analysis, the structural changes as proposed in the report may be quite irrelevant.

6) The biggest hurdle in the success of population control is political apathy, but the committee did not give any importance to this aspect. The political leaders have to be bold in enacting such legislative measures which may focus on the urgency of the issue. Denying promotions, debarring from holding any elected office, not giving reservation benefits, refusing bank loans, etc. to those who do not observe small family norm of two children could be some disincentives through legislation.

Measures Suggested to Control to Population Explosion

The continuing population explosion calls for some soul searching. The government is aware of the magnitude of the problem and considers the alarming population growth as the biggest challenge facing the state as well as the government. But the experience of the government in adopting serious measures to achieve the set targets in the field of family planning has made all the following
governments very cautious. There is, however, still time to act. The following programmes may be suggested to check population growth:

**Incentives vs. Disincentives**

An important question has now been raised by some thinkers pertaining to population policy---that of cooperation vs. coercion, or incentives vs. disincentives, or Kerala model vs. Chinese model? There are some thinkers who support cooperation while there are others who support coercion. An Indian professor (Amartya Sen, now settled in the USA and working in Harvard University) in a prestigious JRD Tata Memorial lecture in Delhi in August 1995 on “Population Stabilization Programme” favored ‘cooperation’ approach and denounced the use of coercion to bring down the lines of two famous theories of Condorcet (of France) and Malthus (of Britain).

He supported Condorcet’s approach to the problem of population which talked of the emergence of new norms of small family size based on “the progress of reason”. Condorat believed that female education would lead people to choose voluntarily smaller families and lower fertility rates. Malthus, however, was skeptical about this view of “voluntary acceptance of family planning”. In his opinion, “positive checks” such as economic penury or rise in mortality rate would eventually coerce people to reduce population growth rate.

Sen described Condorcet’s path of cooperation as unequivocally right and Malthus’s path of coercion as undesirable and even counter-productive in checking population growth. He gave the example of Kerala in support of his viewpoint (same argument is given also in his book entitled India: Economic Development and Social Opportunity) and developed a hypothesis called “Kerala hypothesis of demographic transition”. In this hypothesis, increases in literacy and primary health care are described as two important factors in population control. But while supporting his hypothesis, Sen has ignored some figures pertaining to Kerala.

Opposed to the “Kerala model” is the “Chinese Model” of coercion in population control. Looking at the near catastrophic state of our population scenario, thinkers support this “coercive model” as the only effective solution of
the population problem. These thinkers also point out the vested political interests that are promoting population growth rates of various vote banks to the detriment of the nation. Some thinkers, however, talk of the combination of cooperation and coercion or incentive and disincentives to check population growth, but the nature of disincentives has not been identified so far. Would denying the “benefit of reservation” to people with more than two children prove a disincentive? Can denying promotion or admission or a voting right or right to contest election be disincentives? Will such denials not be the violation of fundamental rights? Laying down mechanisms to implement the disincentives in the prevailing socio-political situation, particularly when thirteen political parties with different ideologies on “social justice and reservation issue” can join together to form a united front government at the Centre, will not easy.

**Division into Zones and Regions**

On the basis of the fertility pattern, research has divided the state’s 18 districts into 4 zones as commissionaire. Research has identified districts and zones which reflect the positive impact of family planning on the fertility rates, the areas where fertility rates have remained low despite hardly any family planning efforts, and those regions which are the hard core areas where the maximum effort is needed. The region wise approach is expected to help in correcting the lacuna in the implementation of the family planning programme.

**Searching for New Contraceptives**

The search for a new, inexpensive, easy to use and harmless contraceptive has not met with dramatic success so far. Though pills have come to be accepted in a big way and this method is catching on in large scale in different area of Jharkhand, it is necessary that people of herbs also be thoroughly investigated for their effects. Pursuing vigorous investigation of the health status and dietary habits of some of the tribal in Dumka, Palamu and W. Singhbhum among some of whom the fertility rate is found to be extremely low, might provide the needed solution.
**Increase in Marriage Age**

There is a direct relationship between age of marriage, size of family and attitude towards family planning. Sociologically, this is an important reason for the dramatic decline in birth rate in W. Singhbhum where marriage age comes after able education age. Rising the marriage age is, thus, bound to reduce the family size in other states too. This calls for serious and whole-hearted efforts for creating the necessary public awareness. In Hazaribag we must take a lesson from other district like W. Singhbhum for adopting increase in marriage age. Mostly people of Jharkhand live in rural area; they want to marriage their children in early age. So high rate of fertility found in Jharkhand.

The financial investments in the programme have substantially increased and service delivery points have significantly expanded. Services administered through the programme have been broadened to include immunization, pregnancy, delivery and postpartum care, and preventive and curative health care. The range of contraceptive products delivered through the programme has widened. Multiple stakeholders, including the private sector and non-governmental sector, have been engaged in providing contraceptive services. Of late, the programme has been integrated with the broader Reproductive and Child Health Programme. Not with standing these achievements, several issues continue to daunt the programme and many goals remain under-achieved: a significant proportion of pregnancies continue to be unplanned; the contraceptive needs of millions of women remain unmet; several sub-population groups including adolescents and men continue to be neglected and under-served; and contraceptive choice remains conspicuous by its absence, as is quality of care within the programme. Recognition of the changes worldwide and the challenges that are faced by the programme has led to the development of several new policy initiatives. Recently, the programme focus has shifted away from vertical family planning services towards the provision of comprehensive integrated reproductive health care at all levels of the health sector. Providing a backdrop of the changing policy environment, this paper reviews and synthesizes recent evidence on contraceptive use dynamics and the unmet need for contraception. While discussing some of the barriers that hindered the success of
the programme, the paper sheds light on new initiatives to address these and assesses their impact if any. However, it may be mentioned that it is too early to make any definitive assessment of the impact and data for making such an assessment are limited. The review concludes with a discussion of critical programmatic and research issues to be addressed in order to improve quality of services and meet clients’ needs.

Changing family planning scenario
(An overview of recent evidence)

The Family Welfare Programme was launched with the objective of reducing birth rates to the extent necessary to stabilize population at a level consistent with the requirements of the national economy. The programme has since evolved through a number of stages, and has changed direction, emphasis and strategies. Family planning was considered more a mechanism to improve the health of mothers and children than a method of population control. Clinic-centered family planning service delivery, along with health education activities, was promoted during this period. Over time however, the primary focus of the programme became the achievement of demographic goals. With growing concerns about the rate of population growth and its adverse effect on the pace of social and economic development, the Third Five-year Plan period marked a suitable shift in the emphasis of the programme from the welfare of women and children to the macro objective of population stabilizations. At the same time, an extension education approach replaced the original clinic-centered approach, and the programme was integrated with health services. The programme was further integrated with the maternal and child health programme. This period also witnessed the introduction of time-bound method-specific targets within the programme.

The National Population Policy 1976 called for a “frontal attack on the problems of population” and inspired state governments to “pass suitable legislation to make family planning compulsory for citizens” and to stop childbearing after three children, if the “state so desires” (Srinivasan 1998). The backlash of the coercive approach compelled subsequent governments to stress the voluntary nature of family planning acceptance. The Population Policy 1977 clearly
underscored that “compulsion in the area of family welfare must be ruled out for all times to come,” and emphasized the need for an educational and motivational approach to make acceptance of family planning completely voluntary. However, the time-bound, target-oriented approach was revived and efforts to encourage the use of reversible methods were initiated.

**Changing policy and programme environment**

Incentive payments *were vigorously promoted during Emergency period; leading to the violation of women’s rights in some cases. The 1990s witnessed dramatic changes in the family welfare policy and programme in the country. The passing of the 72nd and 73rd Constitutional Amendments and the Panchayati Raj** and Nagar Palika Acts in 1992 set in motion the process of democratic decentralization, and brought the Family Welfare Programme, legally, in Pressure from multiple constituencies to bring issues of quality and choice into the programme, and the recognition of inherent constraints in the programme contributed to changes in policy approach. The government took the radical decision of abolishing method-specific contraceptive targets that had been used to guide, monitor and evaluate the programme for decades, replacing it with what was initially called the Target-free Approach, where health workers’ case loads would be determined by needs identified at the community level, rather than centrally-assigned. In 1997, to avoid misconceptions and to direct the programme more towards addressing clients’ needs, the Target-free Approach*** was renamed as the Community Needs Assessment Approach, and decentralized participatory planning was initiated. The government has provided broad guidelines for conducting community needs assessment and has given states the responsibility for working out the practical details of implementation. The Reproductive and Child Health Programme espouses the principles of client satisfaction and high quality comprehensive and integrated.

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* Incentive payments were first introduced in Tamil Nadu in 1959 as compensation for loss of wages to acceptors of vasectomy. Such incentives were also given nationally, though to a limited extent, during the 1960s and 1970s to acceptors of sterilization and IUD.

** A Panchayat is an elected body of representatives that carries out village administration.

***The Target-free Approach was interpreted by some health care providers as “work-free”
Health services: It seeks to integrate services for the prevention and management of unwanted pregnancy, the promotion of safe motherhood and child survival, and the prevention and management of reproductive tract infections and sexually transmitted infections. The programme aims to expand services to meet the needs of hitherto under-served and neglected population groups, including adolescents, and economically and socially disadvantaged groups, such as urban slum and tribal populations. It envisages utilizing and upgrading the existing health infrastructure to deliver these services. To make the programme a people’s programme, the new approach champions local needs-based.

Changing family planning scenario regarding Decentralized, participatory planning and monitoring:

(An overview of recent evidence)

Decentralized, participatory planning and monitoring, and seeks to involve several stakeholders, including non-governmental organizations (NGOs), the private sector, Panchayati Raj institutions and civil society in more meaningful ways to move the new agenda forward (MOHFW 1997). The new approach represents a dramatic change in the culture of the Family Welfare Programme, and for the first time in the history of the programme in India, attention has been focused on gender concerns. The Reproductive and Child Health Programme seeks to address gender issues impinging on women’s health by improving quality of care, including promoting better interaction between providers and clients; increasing the availability of female health care providers at the primary health care level; addressing neglected concerns of women such as reproductive tract infections; addressing the needs of neglected population sub-groups such as adolescents; organizing gender sensitization training for stakeholders; encouraging male involvement in reproductive health; and facilitating women’s and men’s participation in programme monitoring through client feedback (World Bank 1997).

The Reproductive and Child Health Programme has been carried out with varying intensity and clarity in different parts of the country. Preparations for launching the second phase of the Reproductive and Child Health Programme are currently under way. The National Population Policy, adopted in February 2000,
further legitimized the paradigm shift to client-based services. Several state
governments have also framed state-specific population policies thereby
broadening the policy discourse within the states. The National Population Policy
provides a policy framework for achieving the twin objectives of population
stabilization and promoting reproductive health within the wider context of
sustainable development. The immediate objectives of the National Population
Policy are to address the unmet need for contraception, the limitations in health
care infrastructure and the shortages in health personnel, and to provide integrated
service delivery for basic reproductive and child health care. The National
Population Policy has delineated twelve strategic themes to achieve these
objectives, including decentralized planning and implementation, convergence of
service delivery at the grassroots, empowering women and encouraging male
involvement, meeting the unmet need for family welfare services, addressing the
needs of disadvantaged and under-served population groups, and forging public–
private partnerships. The National Population Policy affirms the government’s
commitment to the provision of quality services, information and counseling, and
expanding contraceptive method choices in order to enable people to make
voluntary and informed choices. Disincentives have not been included in the
Policy, though several promotional and motivational measures are to be
implemented at the community and individual level. Unlike in the past, these
incentives are not just for sterilization but have been linked to poverty, delayed
marriage, antenatal and delivery care, birth registration, birth of a girl child and
immunization (Pachauri 2000). These include, to list a few, rewarding and honoring
Panchayats and Zilla Parishads for exemplary performance in universalizing the
small family norm, achieving reductions in infant mortality and birth rates, and
promoting literacy with completion of primary schooling; providing cash incentives
to mothers who have their first child after 19 years of age; and rewarding couples
below the poverty line who marry after the legal age of marriage, register the
marriage, have their first child after the mother reaches the age of 21, accept the
small family norm, and adopt a terminal method after the birth of the second child
(MOHFW 2000).
However, it is a cause of great concern that some of the policies adopted by the states espouse strategies and mechanisms that are diametrically opposed to the principles of equity and equality that the new National Population Policy entails.

These new policy and programme initiatives articulate laudable principles and goals. The challenge lies in translating these principles into reality. A Zilla Parishad is the apex body at the district level within the three-tier panchayati raj system.

**Changing family planning scenario regarding contraceptive use**

*(An overview of recent evidence)*

Over the decades, contraceptive use has been increasing. At the same time, there is a substantial unmet need for contraception. The contraceptive scenario is also characterized by the predominance of non-reversible methods, limited use of male/couple-dependent methods, substantial levels of discontinuation, and negligible use of contraceptives among both married and unmarried adolescents. As will be seen in the following discussion, there are wide regional variations in all these aspects.

**Contraceptive use**

Official statistics report that eligible couples were effectively protected against conception by various contraceptive methods in the year 2000 (MOHFW 2003). Data from National Family Health Survey (NFHS)–2 indicate that nearly one-half of currently married women were using some method of contraception. Contraceptive prevalence increased with age except at the older ages (8 per cent among adolescent girls vs. 67 per cent among women aged 35–39 years), with education (43 per cent among illiterate women vs. 57 per cent among women with a high school education), with standard of living (40 per cent among women from households with a low standard of living index vs. 61 per cent among women from households with a high standard of living index), and with number of living children (5 per cent among women with no living children vs. 68 per cent among women with three living children) (IIPS and ORC Macro 2000). Similarly, at each parity, current use was lower among women with no sons than among women with
one or more sons, with a maximum differential at parity three, indicating that strong son preference prevails. Most of these differentials have persisted over time.

**The contraceptive scenario**

Prevalence differs among the states; there has been an overall increase in contraceptive use in almost all states. A preliminary comparison of data from the Reproductive and Child Health Survey–1 (1998–99) and the first phase of the Reproductive and Child Health Survey–2 (2002), reflecting changes after the introduction of the Community Needs Assessment Approach and the Reproductive and Child Health Programme, also indicate an increase in contraceptive use in all the major states.

**Method-mix**

A “cafeteria approach,” whereby clients are provided with a choice of contraceptive methods, has been adopted by the Family Welfare Programme. However, it is well documented that, until recently, the emphasis of the programme remained skewed towards promoting nonreversible methods, particularly female sterilization. Hence, not surprisingly, female sterilization continues to be used by the majority of contraceptive users. Nationally, data from NFHS–2 show that sterilization accounted for 84 per cent of the contraceptive prevalence rate due to modern methods and 75 per cent of overall current contraceptive prevalence (IIPS and ORC Macro 2000). Although reported by only a negligible minority, sterilization was the most commonly adopted method even among married adolescents. The predominance of sterilization is observed in almost all states. A comparison with data from NFHS–1 indicates that the same pattern prevailed throughout the first phase of the Reproductive and Child Health Survey–2 conducted in 2002 covered only one-half of the districts in each state. The comparative picture presented here is based on the data pertaining to the districts covered in both the rounds.
Use of male/couple-dependent methods

Gender inequalities favour men and sexual and reproductive health decisions are usually made by them. Therefore, there is a growing realization that unless men are reached, the Reproductive and Child Health Programme, including family welfare efforts, will have limited impact. Direct evidence on the use of male methods is scarce as men have been excluded from most of the surveys, and small-scale studies exploring the contraceptive behaviour of men are limited. Data from NFHS–2, based on the responses of currently married women, show that one in ten currently married “couples” were using male/couple-dependent contraceptive methods (condoms, vasectomy, withdrawal and periodic abstinence), which translates into 21 per cent of total current contraceptive prevalence.

Changing family planning scenario

An overview of recent evidence

Data specifically on the use of condoms reveal that only a small minority of currently married couples were using condoms. Condom use was typically low in almost all states, of currently married couples were using condoms. Despite the introduction of “no-scalpel” vasectomy and campaigns to promote male involvement in family planning and reproductive health, the acceptance of vasectomy remained negligible—2 per cent of currently married couples nationally.

Contraceptive practice among the unmarried

Available evidence suggests that a substantial proportion of unmarried adolescent boys and girls are sexually active, placing them at risk of unintended pregnancy and sexually transmitted infections. A review shows that 15–30 per cent of adolescent boys and up to 10 per cent of girls were sexually active before marriage. Little is known about the contraceptive behaviors of unmarried adolescents. Demographic and Health Surveys and other national surveys have largely excluded this group and only a few small scale studies have explored the contraceptive behaviours of unmarried adolescents. Because relatively few unmarried adolescents report being sexually active, data on contraceptive use from these studies may not accurately reflect their contraceptive behaviours. These studies indicate, however, that a large
majority of unmarried, sexually active adolescents do not use any contraceptive method. Those who report practicing contraception often use natural methods, which are more difficult for adolescents to use consistently and effectively because they require accurate knowledge of the reproductive cycle and active cooperation of the partner.

**Contraceptive discontinuation and switching**

As contraceptive use increases and becomes a more established behaviour, prevalence is no longer a sufficient marker of programme success. Contraceptive continuation may become more important than acceptance in increasing contraceptive prevalence. An analysis of contraceptive continuation rates and the reasons why women discontinue using contraceptive methods could provide important information about the adequacy of services provided. As the Family Welfare Programme is currently making vigorous efforts to shift its emphasis from non-reversible methods to reversible methods, and expand service delivery beyond the bounds of the public sector, information on contraceptive discontinuation and switching assumes greater significance. Data on contraceptive continuation/discontinuation, switching and failure are, however, limited.

Nationally, data from NFHS–2 show that one in ten currently married women who have ever used a contraceptive method had discontinued use at the time of the survey. Though the desire for a child was cited as the main reason for discontinuation, the fact that more than one-third reported method-related reasons such as method failure, side effects and inconvenience highlights the need for improved quality of services. The data also show that younger women (15–24-year-olds) were more likely to discontinue using contraceptives compared to older women. Younger women were also more likely to.

**Economic Development**

Economic development may prove to be the best contraceptive. We have to go for quick population control at any cost on sheer economic principles of supply and demand. To balance any economic equation, we can either increase the supply which depends on both financial and material resources, or reduce the demand which depends on the number of people asking for varied services and
commodities. For example, on the supply side, in housing alone an annual outlay of Rs. 3000 crore would be required to build three million houses for the 17 million people added to country’s population every year, assuming that we require only Rs. 10,000 to build one small house. But if we tackle the same problem from the demand side and prevent annual addition of 17 million to the population through an effective population control strategy, the demand for three million houses or Rs. 3000 crore required per year for constructing the houses will disappear (Ahluwalia, 1987). Thus, preventing the demand is as good as working for the supply. This is balancing the supply and demand at no cost. And it is the no-cost solution we are looking for. What applies to housing also holds good for education, jobs, and transport and health sectors. Tackling each problem from the demand side will have an enormous pay off.

This approach has another important dimension. If we tackle the problem from the supply side, it will increase the demand per se in other sectors. For example, if we increase the number of houses, it would increase demand for cement, bricks, wood materials and electrical goods. But if we approach the problem from the demand side and reduce the number of houses needed, the pressure in all sectors will be relieved. With 52 births every minute or about 17 million births every year, the demand for money and materials in sectors like education, transport and welfare, will so enormously increase that in ten years time the situation will have crossed the point of no return and incalculable and irretrievable damage will have been done to the states and its economy.

The declared core theme of the Third International Conference on Population and Development held at Cairo from 5-13 September, 1994 was also linkage between population issues, economic growth and sustainable development. However, for six out of ten days, the Conference was bogged down on the question of the legitimacy and efficacy of ‘abortion’ as a tool of population control. There was no discussion or debate on such vital issues as poverty eradication, illiteracy, employment, rural uplift, or free market access to Third World exports. In the first two International Conferences on Population held in 1974 and 1984, it was argued that large families were a result of poverty rather than a cause of it. The stress was
therefore on eliminating poverty. “Eliminate poverty and you eliminate the need for large families”. The experience of the developed countries has been that higher family incomes and improved services meant that fewer children were born. They therefore suggest that third world also should be allowed to follow the same path. The Brandt Report while commending an expanded family planning programme also noted that family planning programmes are effective only when they go hand in hand with economic and social progress. It is thus held that development alone will provide the most propitious environment for stabilizing the country’s population.

While this linkage between population and development is well taken, the nature or mode of ‘development’ has itself been a somewhat debatable question. There are leading third world analysts who contend the ‘development’ (through high technology, mass production, and induced consumerism) as projected by the affluent nations and sold to the Third World lends to aggravate the population problem. Hence, to continue to talk and apply this technology indicates how little people have thought about this problem. What this viewpoint implies is that modern technology generates largely profit- motivated elite in an industry which is concerned only with its own interests and is indifferent to the poverty and misery of workers. The result is an economic and demographic scenario that is becoming explosive both at the top (due to growing wealth) and at the bottom (due to increasing poverty of the masses). Thus, the feeling is that population problem should not be viewed out of social context. Development which aims at distribution and equality alone can remove poverty and contain population growth.

**Role of NGOs**

Success of any programme depends on its acceptance by the people. Unless the community is fully involved in the programme and it considers it to be its own programme, it may be possible to achieve the desired results. This can be achieved in a better way by the non-government organizations as these have very intimate relations with the people. Their role in removing deep-rooted beliefs favoring large

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families and male children, improving female literacy, rising age at marriage of girls, essential newborn care, birth spacing, etc., can be very significant. Such organizations not only have the capacity to reach the remote areas but their activities are cost-effective also. The Department of Family Welfare has launched several schemes in the last five to six years to ensure better participation of the NGOs in the family welfare programme. Some of these schemes are; (1) Helping NGOs of the extent of 90 percent of the cost of the project on promotion of small family norm and population control schemes. (2) Wide publicity of the government for informing voluntary organizations to come forward to undertake these schemes. (3) Holding of a number of regional conferences in last four to five years to increase the involvement of the NGOs. (4) Recognizing six larger organizations as Mother Units for identifying small NGOs in their areas and giving those grants for approval schemes. (5) Setting up State Standing Committees of Voluntary Action set up under the chairmanship of the Family Welfare Secretary with power to sanction up to Rs. 10 lakh per project. (6) Asking states to identify one institution in the NGOs sector for the purpose of providing training to health workers. (7) Arranging study tours for NGOs from states with poor community participation to better performing districts.

CRITICISMS OF FAMILY PLANNING PROGRAMME

The family planning programme has been criticized on the following grounds:

- **Multiple Approaches.** The government has been experimenting with a variety of approaches to provide family planning services to the people. It started with a clinical approach, switched over to the extension approach, to target-oriented approach, to selective approach, to method specific targets approach, and to decentralize area specific planning approach. Such policy changes have created confusion and indecisiveness in the minds of the field staff connected with the family planning programme.

- **Untrained Health workers.** According to Pravin Vasaria, the health workers recruited by the Family welfare Department are grossly ill-equipped for the difficult task assigned to them.11

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They do not have proper training for primary health care and in particular maternal and child care for rural areas. Moreover there is no system of feedback and interaction between health workers and their superiors stationed at the headquarters.

- **State Sponsored.** The family planning programme in Jharkhand, is formulated, sponsored and financed by the Central Government uniformly throughout the country. But it is implemented by the States at their district, block and village level bureaucrats. Such an indiscriminate and macro programme is counter-productive in Jharkhand where there are diversities of castes, creeds, religions, customs, etc. Thus it is not keeping with local needs and circumstances of different types of people and is counter-productive.

- **Emphasis on Quantitative Targets.** As a corollary to the above, one of the main weaknesses of this state sponsored programme has been to achieve quantitative method-specific targets of acceptors of family planning.

- **Confined to Urban Areas.** The propaganda of family planning has been largely confined to urban areas and that too among the educated masses. Little has been done to propagate it in States where the birth rate is very high and the majority of population is illiterate and lives in villages. As a result, backward district like Koderma, Pakur, Chatra and Saraikela & Kharsanwan have slightly almost unaffected by family planning programmes.

- **Lack of Experienced Medical Personnel.** There have also been practical difficulties in the implementation of family planning. Due to the lack of experienced doctors, nurses, midwives and other related staff, couples cannot be persuaded and their faith and trust cannot be won for the adoption of various family planning methods. Besides, even the quality of service has been poor. This has been one of the important factors for the failure of this programme.

- **Lack of Cheap Contraceptives.** There is the lack of cheap contraceptive methods in Jharkhand which may be readily adopted by couples in the reproductive age group. Family planning surveys have revealed that the majority of couples in the reproductive age group do not want more children but are reluctant to use contraceptives.
• **Decline in Vasectomies.** There has been a steady decline in acceptors of vasectomy waver the last decades. Presently, over 97 per cent of sterilizations are tubectomies of women.

• **Low level of Family planning practice:** The most important reason for high birth rate in Jharkhand is the lack of knowledge about birth control method. Until recently there has been complete absence of conscious family planning in Jharkhand, and the use of contraceptive has been practically unknown. It cannot be said that even now a substantial number of people have adequate and proper knowledge about the ABC of family planning. Many of those who know equate family planning with contraceptive or abortion etc. few regard it as equivalent to a planned family. The survey found that nearly 78 percent of the couples interviewed were aware of at least one method of birth control but only half as many had the knowledge of its use, leaving condoms out of account. The actual practice of any method was by only 13.6%. It was also found that those having three or more children have higher levels of awareness and knowledge than those having none or less than three. But even in the group having three or more children and not wanting any more. This shows the gap that exists between the need and the actual practice, and this gap is certainly not due to lack of awareness but cold being, to some extent, due to the lack of knowledge.

    Mostly people in Jharkhand live in rural areas. They have no any television, magazines, newspaper, journal and other. So they are aware from knowledge about family planning programme.

    Historically, social science research associated with family planning has focused on predicting contraceptive use or non-use. Because most modern contraceptive methods are designed for use by women, and because most programs assume that women are primarily responsible for family planning, women have been the primary subjects of contraceptive and family planning research. Researchers have asked the question, "How do various aspects of women's lives (e.g., residence, educational status, age at marriage, employment) affect the likelihood, or level, of family planning use?" Research suggested that the ability to plan childbearing "may
be examined separately for its effect on a woman's health, the health of her children and the exercise of her economic, social and political rights". The question was subsequently phrased, "How does family planning affect various aspects of women's lives?"

Critics of past family planning policies have challenged researchers to enlarge their vision and to focus on women's perceptions and experiences with family planning, women's reproductive health needs and the effect of family planning use has had on their lives. Women’s advocates and researchers around the district are raising new questions as to whether -- and under what circumstances -- greater contraceptive use and reduced fertility improve women's lives. The use of contraceptive is an important ingredient for personally, socially or economically rewarding life for women to beyond the well-documented benefits for family planning to the health of women and the welfare of their children? In other words, both groups want to understand the effect of family planning on the quality of women's lives. The purpose of this paper is to outline a conceptual framework developed to study the impact of family planning on women's lives and to present a number of studies being undertaken based on the framework.

In each of the district of Jharkhand, the research agenda differs somewhat depending on how stakeholders in the district have prioritized specific reproductive health issues. The common denominator, however, remains the effect of family planning on women's lives.

The present research work has developed a conceptual framework that adds the day-to-day experiences of women to traditional outcomes of fertility control. The framework takes into account the larger context of social, cultural, economic and other factors associated with the quality of women's lives as defined by women themselves. In developing a framework to assess the impact of family planning on women's lives, understanding both the concept of gender and the roles of women are important. While sex is a biological distinction, gender is defined as the socially constructed roles ascribed to males and females. "This means that from birth, males and females are reared to occupy different social positions having different rights and obligations". Socialization varies from individual to individual,
and gender norms can change over time and vary widely within and among cultures. Gender, while important, is a social classifier that operates in conjunction with other classifiers, such as social class, culture, race and religion.

While gender ascribes certain roles to women, an important consideration in research is the roles women play in a society, compared to those of men. Rather than the dual roles of reproduction and production that are generally ascribed to women, notes that women have three roles. "In most low-income households, 'women's work' includes not only reproductive work (the childbearing and rearing responsibilities) but also productive work, often as secondary income earners. In addition, women, within their gender-ascribed role of wives and mothers, struggle to manage their neighborhoods." At the community level, men often have a leadership role reflected in political participation, whereas women have a community management role, based on the provision of items of collective consumption. Demographic change, both at the individual and national level, can affect gender norms, women's roles and the time devoted to each role.

A. Family Planning Experience

The starting point of the Research conceptual framework is women's experience as users of family planning programs. This cluster of variables includes types of programs (e.g., public or private, integrated with other development activities or non-integrated), types of service providers (e.g., physicians or other service providers, male or female providers), and the quality of services. Aspects of services that may have an impact on a woman's experience with contraception include the sex of the provider, the organization of the service (integrated or vertical), the availability of services and methods, and the quality of interaction with service personnel and amount of counseling and information received by the client. Increasingly, district are moving beyond family planning to a more encompassing view of the role of reproductive health in women's lives; thus, the framework includes use of other reproductive health services as another dimension that may affect contraceptive use and childbearing experience. Reproductive health services will vary by district but might include sexually transmitted disease diagnosis and treatment, general gynecological care, infertility
counseling and treatment, maternal health services and abortion services, among others.

The model also draws attention to both use and non-use of contraceptives. In addition to the standard notion of use of contraceptive methods, we have included non-use by women who do not desire pregnancy, as well as by women who may desire pregnancy but are unable to achieve it. What is behind a woman's active or passive decision not to use a method, or to discontinue a method once she has started it? What are the consequences of unwanted pregnancy? If she uses contraception, other questions arise: What side effects do different methods have? And does the person who determines the method a woman gets make a difference in her experience with that method?

Use of reproductive health services may influence contraceptive use (e.g., if a women hears of family planning during a postnatal visit to a maternal and child health clinic) or it may affect childbearing experience (e.g., if a woman receives infertility treatment). Reproductive health services can be obtained through the family planning program or through a different program (e.g., an STD diagnosis and treatment center). The availability of general primary care for women or STD diagnosis and treatment may influence how a woman experiences family planning.

Since the use of contraception has a direct impact on a woman's childbearing experience, pregnancy and childbearing are pivotal concepts in the conceptual framework. Along with the number of births or live children a woman has, fertility variables also may include a woman's ability to space, delay or limit children, as well as her experience with infertility, child loss or planned or unplanned childlessness.

B. Domains of Women's Lives

In this framework, the outcomes of contraceptive use are expressed as consequences for various aspects of women's lives. These concepts have been combined into three dimensions of a woman's life: societal and economic, family and household, and the woman as individual. Together these dimensions reflect the quality of a woman's life. Quality of life is an elusive concept, which combines
objective elements with subjective perceptions and interpretations of personal experience. As such, it is observable only through an individual's self-reporting and is influenced by the social and cultural context of norms, values and expectations that give meaning to everyday life. It is difficult to fit the complexity and richness of a woman's life into a classificatory scheme. However, although cultural and individual differences challenge generalization, it has attempted to construct a framework that reflects aspects of women's lives most likely to be affected by family planning and reproductive health.

**Societal and Economic Roles.** A woman who uses contraception may have more opportunities to become involved in the workforce and in community-based activities, because having fewer children may relieve some of the domestic burden inherent in raising a large family. On the other hand, the same woman may be negatively perceived by the community for failing to produce as many children as expected. Thus, the impact of contraceptive use on the public lives of women is variable, depending on numerous contextual and mediating factors.

Women's social and economic lives may be operationalized in terms of their participation in community activities; access to community resources, education and employment opportunities; and access to health care services, security in old age and the status accorded to women by others in their communities. Economic productivity is an important aspect of this dimension. Through both formal and non-formal work roles, women contribute to the economy.

The extent to which contraceptive use and fertility influence the nature of women's work has not been well studied. A woman's ability to choose how she will allocate her time to work, family, community activity, political action or leisure is critical to this dimension. In the research study being carried out time allocation is a key variable, operationalized as how women balance their time across several domains, including family roles and interpersonal relations, employment, community participation and personal leisure. The research is assessing whether use of contraception influences women's decisions to join the labor market, and whether labor market activities and earning power affect household decision-making and plans for children's futures. A study has added a political change component to their
explanation of this dimension of societal and economic roles -- the participation of its women in community advocacy, as well as local elections, political campaigns and even running for office themselves. At issue in the study is the extent to which a woman who has taken control of her own fertility is empowered to act independently in other domains as well.

**Household and Family Roles.** Women's household and family roles include those of spouse/partner, household head, parent/guardian, and nuclear and/or extended family member (including being one wife of a polygamous husband). In many cultures, the status of women is derived from their performance in these roles, along with cultural expectations of how women "should" behave relative to others in the household unit. A woman's interaction with her spouse and other family members concerning decisions about family size may improve communication and strengthen relationships. On the other hand, it may result in negative sanctions, including domestic violence. Although the nature of women's domestic roles varies across cultures, common denominators may be found in partner relations (including issues of sexuality and sexual relations), family communication and dynamics, household decision-making, role strain and violence against women. The study in Hazaribag is addressing women's empowerment in the family as a result of family planning use and work experience. This module examines who makes decisions and what women do if they disagree with their partners or other household members.

In the extended family that values high fertility, a woman who uses contraception and produces fewer children may find herself in a state of conflict with her husband's relatives. The Center for Research on Population and Development in India is conducting a prospective qualitative study of new users of contraception. One outcome of interest in this study is the dynamic of family communication and its relationship to women's subsequent decisions to continue, change or abandon the method they have adopted. In this study of the mediating effects of gender on women's participation in development, researchers are focusing on the normative context in which empowerment emanating from a woman's decision to take control of her own fertility may be encouraged or discouraged, depending on the gender-based expectations of male partners and affinal family
members. Research is examining the effects of fertility regulation on the quality of conjugal relationships as perceived by spouses, highlighting aspects such as satisfaction with communication and the influence of extended family members on couples' decisions regarding use of economic resources and family planning.

**Individual Psychological and Physical Factors.** Numerous studies have documented the impact of family planning on women's physical health and well-being, offering strong evidence that the health benefits of contraception outweigh the risks. In contrast, a woman's psychological well-being, or the personal satisfaction she may or may not derive from critical decisions that affect her fertility and reproductive life, remain largely unexplored. Use of contraception may have positive psychological effects if it relieves women of anxiety about pregnancy and abortion. Negative effects may occur for a woman if she is using contraception secretly, or if she experiences or fears side effects or the disapproval of her spouse and others. The meanings of psychosocial concepts such as self-esteem, self-efficacy, satisfaction, control, personal autonomy (or their opposites in alienation, subordination, fear or guilt) are variable across cultures and subcultures but no less critical to understanding the effects of family planning decisions on women's lives. For example, one might speculate that use of contraception would promote a woman's sense of autonomy and increase her ability to make decisions in other areas of her life. But, in countries with strict family planning programs, women may feel their autonomy is limited by strong government promotion of the use of contraception. In another example, a woman who is unable to bear children may experience loss of self-esteem and severe role strain in relations with her spouse or family. Or, conversely, she may find a sense of personal empowerment, considering childlessness an opportunity to become more active in the workforce or the community. Sexual health, including sexuality, is an equally important and unexamined component of psychological well-being and is closely related to a woman's relationship with her spouse or partner.

Psychosocial factors tend to be difficult to measure and, hence, are often neglected in family planning research. However, several WSP studies are focusing on this dimension, attempting to operationalize women's sense of
themselves as women, conditioned by the cultural milieu of which they are a part. Study is exploring the effects of both modern and traditional contraceptive use on women's self-esteem and locus of control (i.e., whether she feels events in her life are controlled by her or by external forces) and asks, in addition, whether use of contraception enhances or diminishes sexual satisfaction for women and men. The impact of family planning on women's self-image as an important focus of study, hypothesizing that positive self-image leads to greater empowerment for women, which in turn may be the foundation for a better quality of life. Using primarily qualitative techniques to explore individual perspectives, the quality of women's lives is being studied in several countries. Research discussed to explore cultural constructions of quality of life and how the consequences of fertility may influence the quality of a woman's life positively or negatively.

The framework includes three additional sets of factors. These factors affect the family planning/contraceptive use/childbearing experience of women, as well as the three domains of their lives and, therefore, must be controlled in studies. The first set includes social, political and macro-economic factors that affect all aspects of women's lives and the impact of family planning. These include, among others, political system and climate, economic environment, prevailing religious climate, legal system and availability of educational and employment opportunities. Also relevant in this context is India's population policy, which might call for compulsory use of family planning or, conversely, might be pronatalist.

As noted previously, gender norms, which interact with social, political and economic factors, affect all aspects of women's lives. Research notes the need to study, at a macro-level, both gender norms and the processes by which valued goods are distributed among individuals, including access to and control over material resources; decision-making autonomy and freedom of movement; sexual norms and women's sexual freedom; legal rights; and public roles. Gender inequality can affect reproductive decisions made at the household level, as well as the nature of services that are provided and the individual who decides how services are provided. For example, family planning programs have traditionally targeted
women for contraceptive use. Recently, the need for male responsibility has been articulated around the world, but thus far, with little change in service provision.

Along with this institutional and normative context, a woman's life cycle stage forms part of the background against which we will try to understand the perspectives of the women who participate in our studies. Life cycle stage of the woman and other personal factors can affect fertility regardless of contraceptive use, as well as the three dimensions of women's lives noted in the framework. Adolescents, single and married women of reproductive age, and older women will be affected differently by family planning and childbearing experiences. For example, the intensity of a woman's feelings about her situation may change over time. A woman in her 20s who finds she cannot have children may express stronger feelings than the same woman in her 40s. Likewise, a woman with small children may experience more role strain than the same woman whose children are grown. Life cycle stage itself can affect women's lives, irrespective of family planning use. Other personal attributes such as ethnicity, social class and residence can also affect contraceptive use and its impact on women's lives. Social class can mediate the effects of gender in that women of different social classes are often held to different standards. In some cases, women of a higher social class have greater mobility and the ability to work, while in other cases, women of higher social class have more constraints in their movements outside the home.

The impact of family planning on women's lives, we acknowledge the difficulty in distinguishing direction of causality. We have included arrows indicating multiple lines of causality in this conceptual framework to reflect the complexity of women's lives. The studies outlined in the next section are one step in helping to establish directions of causality in the relationship between family planning and women's lives.

Following is a brief description of study collecting primary data, along with an illustration of how the project fits into the conceptual framework. While we acknowledge that all parts of the framework may be present in some form in study and may influence the measured outcomes, we attempt here to depict the primary variables of interest in study. In particular, the "outside" variable clusters -- social,
political and economic factors, gender norms and individual factors -- provide the context for study and will affect each woman's experience with family planning.

The research explores men's and women's knowledge, attitudes and behavior regarding family planning, reproductive health, information sources on reproductive health, ideal family size, sex preferences, and socioeconomic and demographic characteristics. It seeks to determine the influence of these factors on family planning use and satisfaction. Men's knowledge, attitudes and behaviors are also examined as mediating the effect of family planning use on women's self-esteem, locus of control and economic activity.

The study seeks to discern whether there are differences between groups in terms of socioeconomic status, psychological measures, personal and professional aspirations, and whether the pregnancy had been planned. The study is following the adolescents to determine if there are changes over time in their family planning use, acceptance of the pregnancy, school attendance and relationships with their parents and male partners. A sample of the teens' mothers is being interviewed, to look at mother-daughter patterns of reproductive decision-making. The study also asks the participants about their perceptions of the advantages and disadvantages of their choice to continue or abort the pregnancy, both for their lives and those of their partners.

The research work is investigating how family planning has affected the various roles women play and the opportunities they have had. The study addresses the changing roles and positions of women in the household and family, family relations and the value of children, changing roles of women in society and the community, and changing individual psychological and physical factors that have resulted from the use of family planning and subsequent childbearing experience. The study which has a booming economy and a rapid decline in fertility and in economy and a less effective family planning program. The family planning's effects on women's self-esteem, personal autonomy, family relationships, public standing, educational level, work for cash outside the home, economic resources and physical and psychological health.
Figure III-4
Conceptual Framework of Family Planning Demand and Program Impact on Fertility

Societal and Individual Factors → Value and Demand For Children → FP Demand: Spacing, Limiting

FP Demand → Other Intermediate Variables

Other Intermediate Variables → Fertility Wanted Unwanted

Fertility Wanted Unwanted → Contraceptive Practice

Contraceptive Practice → Service Outputs: Access, Quality, Image/Acceptability

Service Outputs: Access, Quality, Image/Acceptability → Service Utilization

Service Utilization → Other Health and Social improvements
Conclusion

The population policy of our government should aim not only at controlling the unregulated human growth of numerical strength (population explosion) of underdeveloped state like Jharkhand, but also at checking the unregulated movement of population and the increasing concentration of people in the urbanized areas (population implosion), and providing adequate living space and attractive environment to heterogeneous mixture of people (population displosion). These goals have to be jointly linked with the formulation and implementation of policies aimed at population regulation and planning for harnessing both natural and human resources for uplifting of social and economic status of Jharkhand. Thus, only population growth per se may not be perceived as a problem but its relation with the availability of resources may be viewed great concern.

Family planning needs to be salvaged from the morass into which it has drifted. For this, the programme has to look inwards and treat itself as a development input in its own right. In fact, development is the best method of controlling population growth though the reserve is also true that high population growth is a sure recipe for slow, if not negative development. A variety of measures will have to be introduced to put the family planning campaign back on its feet. Compulsion will not work; only persuasion will succeed. Legal measures may help, but what is urgently required is social awareness and involvement to create responsible parenthood.

What is to be stressed most in achieving a commensurate demographic effect is promoting spacing method instead of overemphasizing on sterilization in the family planning programme. About three-fifths of the married women in our state are under the age of 22 years and already mothers of two or more children. We have to check the phenomenon of “children producing children”. This could be achieved only by promoting spacing methods and marrying girls after 21 years of age.

In addition to its important role in checking the population explosion in Jharkhand, family planning will help to improve the general status of women. A woman who has a large number of children to support and who goes through
repeated deliveries spends more time as a mother and a wife and is confined to the four walls of her home. She cannot play any role in the community and the society, unless she is able to limit her family to a reasonable size. Family planning will improve not only family welfare but will also contribute to social prosperity and individual happiness. After adoption of family planning programme we must see the smiling face of human being in Jharkhand.