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Periodic Research

Family Planning Programmes in India & Uttar Pradesh and Demographic Variables & Family Planning Adopters

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Abstract

Rapid growth of population in the developing countries in general and in India in particular has been one of the primary concerns of not only demographers, but also for the social scientists and planners throughout the world. The most burning problem in India today is the population explosion with all its serious consequences. India ranks second in population and seventh number in land area in the world. The trend of population growth is really alarming and this situation has become a matter of great concern. In spite of planned effort through family welfare programmes, to curtail the population growth, the result is not quite satisfactory and population growth continues to pose a serious problem.

Keywords: Family planning, Population growth, Family Planning Programmes Demographic Variables of population growth, Family Planning Adopters, Family Planning Programmes in India, Variables of Family Planning Family Planning Adoption, Family Planning Programmes in Uttar Pradesh.

Introduction

The problem

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Review of literature

The undesirable population growth castes major problems relating to poverty, fee capital income, ford and nutrition, clothing, health medical facilities and job opportunities etc. Dr. V.M. Dandwal and Neel Kantha Rain in this publication[1] poverty in India. Estimated that the percentage of those living below the poverty his increases from 30 in 2001-02 to 33 in 2009-10.

The different studies on the adoption of family-planning are not adequate enough to throw sufficient light on factors accounting for variation in the extent of adoption from place to place these variation are yet to be analyzed more scientifically and examine factors that account for low rate of adoption and identify the steps for effective family planning adoption. The present study is an attempt in this direction with refrence to Meerut District in U.P.

Objective of the Study

Family planning adoption in Meerut District is the overall theme of the study and as such exploring the nature and extent of family planning adoption and the factors behind narrations in family planning adoption for further clearly we take into account the following specific objectives for one study.

1. To examine the trend of family planning adoption in India with focus on Meerut District.
2. To examine critically the influence of selected demographic variables on family planning adoption through empirical study.
3. To suggest some measures for bringing more under the orbit of the Family Planning and for effective implementation of programme.

Family Planning Programs in India & Uttar Pradesh

Demographic Scenario

The population of the country was 1027 million in March 2001 as

per current census enumeration with 531 million males and 496 million females. As per census 2001 results, the sex ratio (number of females for every 1000 males), of the country was 933, which is higher than 927 as per 1991 census. The literacy rate has also gone up from 52.21 in the year 1991 to 65.38 in 2001. Every year, around 16 million people are added to the population, creating more demand for additional resources like clothing, housing, food, education, health, schooling, etc. At present, India accounts for only 2.4% of world land area, supports as much as about 16% of the world's population. The estimated Indian population and annual exponential growth rate (in per cent) as per Census 1991 and 2001 and estimates of Technical Group on Population Projection for future years are given below:

Year	Population (In Million)	Annual Exponential Growth Rate (%)
1991	843	2.14
2001	1027	1.93
2006*	1094	1.55
2011*	1179	1.49
2016*	1264	1.39

* Projection by Committee on Population Projection appointed by Planning Commission chaired by RGI-1996.

The data from the Sample Registration System (SRS 2000) indicate that the Crude Birth Rate (CBR) at the national level has gone down to 25.8 per 1000 population from a level of 29.5 in 1991. Within this, States exhibit wide variation in the estimated Crude Birth Rates. Among major States, Uttar Pradesh (CBR 32.8), Rajasthan and Madhya Pradesh (CBR 31.2), Bihar (CBR 1.9), Haryana (CBR 26.9) and Assam (CBR 26.9) recorded higher crude birth rate than the national level of 25.8. Among smaller States and UTs, D and N Haveli (CBR 34.9), Meghalaya (CBR 28.5), Chhattisgarh (CBR 26.7), Daman and Diu (CBR 23.7) and Jharkhand (CBR 26.5) recorded higher birth rate than the national average. The lowest birth rate was recorded in the State of Kerala (CBR 17.9) among major States. In smaller States and UT's, Goa (CBR 14.3) recorded the lowest birth rate during this year.

Crude Death Rate (SRS 2000) at national level was estimated as 8.5. The States of Madhya Pradesh (CDR 10.2), Orissa (10.5), Uttar Pradesh (CDR 10.3), Assam (CDR 9.6) and Bihar (CDR 8.8) recorded excess from national average. Among the smaller States and UTs Chhattisgarh (CDR 9.6), Meghalaya (CDR 9.2) and Jharkhand (CDR 9.0) recorded higher Crude Death Rate than the national average.

The Infant Mortality Rate (1MR) 2000 was estimated to be 68 at national level. The States of Orissa (IMR 96), Madhya Pradesh (IMR 88), Uttar Pradesh (IMR 83), Rajasthan (IMR 79) and Assam (IMR 75) recorded higher IMP. Than the national average. As per SR estimates, the Child Mortality Rate (CMR) (0-4) years has come down from 57.3 in 1972 to 26.5 in 1991 and 22.5 in 1998. The highest CMR has been recorded in Madhya Pradesh? 14 (32.6) followed by Uttar Pradesh (29.6) and Orissa (29.0) and the lowest in Kerala (3.6) per thousand children.

The natural growth rate, which is the difference between the birth rate and death rate, was estimated 1.73% in 2000 against 1 .97%in 1991 and 1.91%in 1992.

Annexure III gives State/UT wise variation in respect of selected demographic indicators,

Deep-rooted customs, traditions and socio-cultural beliefs favour large family size in many parts of the country and impede the process of change which would accelerate the willing adoption of the small family norm. As per National Family Health Survey- II, 72% of couples with two children and 84% of couples with three children are either sterilized or do not want more children. Socio-economic factors such as female literacy, age at marriage of girls. status of women, strong son preference and position of employment of women have a crucial bearing on the fertility behaviour of the people.

Policy Framework

National Population Policy, 2000

The National Population Policy. 2000 envisages constitution of the following bodies:

1. National Commission on Population.
2. State/UT Commission on Population.

The National Commission on Population has been constituted on 11th May, 2000 under the Chairmanship of the Prime Minister to oversee and review the implementation of the Policy.

State/UT Commission on Population has been constituted in Andhra Pradesh, Arunachal Pradesh, Assam, Haryana, Jammu and Kashimir, Himachal Pradesh, Kerala, Maharashtra, Meghalaya, Mizoram, Rajasthan, Sikkim, Tamil Nadu, Andaman and Nicobar Island and Lakshadweep.

The National Population Policy, 2000 has identified meeting the unmet needs for contraception health care infrastructure and health personnel and to provide integrated service delivery as the immediate objective with the following interventions:

1. Strengthen community health centers, primary health centers and sub-centres.
2. Strengthen skills of health personnel and health providers.
3. Explore the possibility of accrediting the private practitioners for a year at a time and assign to each a satellite population, not exceeding 5000 population, for whom they provide reproductive and child health services.
4. Review the earlier system of the licensed medical practitioners who after appropriate certificate from the Indian Medical Association may participate in the provision of clinical services.

There are significant inter-sectoral differences in the demographic transition among the States and UTs. As such the National Population Policy, 2000 envisages strengthening and energising the family planning services in 8 demographically weaker State viz. Uttar Pradesh. Bihar, Madhya Pradesh. Rajasthan, Orissa, Jharkhand, Chhattisgarh and Uttaranchal. At the first meeting of the National Commission on Population, Prime Minister announced the formation of an Empowered Action

Group within the Ministry of Health and Family Welfare in particular for paying focused attention to these States with deficient national socio-demographic indices.

Accordingly, an Empowered Action Group (EAG) has been constituted in the Ministry of Health and Family Welfare for the area specific programmes with special emphasis to States that have been lagging behind in containing population growth. Presently the States of Uttar Pradesh, Madhya Pradesh, Rajasthan, Bihar, Orissa, Uttaranchal, Jharkhand and Chhattisgarh are being covered. Success of population stabilization efforts in these States will impact the socio-demographic indicators at the national level.

Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994

The pre-natal techniques like amniocentesis and sonography are useful for the detection of genetic or chromosomal disorders or congenital malformations or sex linked disorders, etc. However, this technology is misused on a large scale for sex determination of the foetus and mostly if the foetus is pronounced as female, this prompts termination of the pregnancy and brings to an end the unborn child.

In order to check female foeticide, the Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994 and the rules framed there under were brought into operation from 1st January, 1996. The Act prohibits determination and disclosure of the sex of foetus, advertisements of facilities relating to pre-natal determination of sex and prescribes punishment for contravention of its provisions. The person who contravenes the provisions of this Act is punishable with imprisonment up to 5 years and fine up to Rs 100,000.

Under the Act, facility of pre-natal diagnostic techniques and genetic counseling is to be provided only at clinics registered under the Act. Use of these techniques is permissible solely for detection of certain abnormalities (like chromosomal abnormalities, genetic metabolic diseases, sex linked genetic diseases, etc.) subject to specified conditions.

As per the direction of the Hon'ble Supreme Court of India the Act has been amended keeping in view the emerging technologies like selection of sex before conception and difficulties encountered in implementation of the Act. The Bill has also received the assent of Hon'ble President of India.

A Central Supervisory Board under the Pre-natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994 had already been constituted on 5th February, 1997 to monitor the implementation of the Act with Minister of Health and Family Welfare as its Chairman. The Board consists of 23 members including 10 non-official members from various fields, Members of Parliament and representatives of States/UTs. The main functions of the Central Supervisory Board are to advise the Government on the Act and Rules and recommend changes therein to create public awareness against sex selection and sex determination. Meetings of the Central Supervisory Board are held within six months.

Further two Sub-Committees viz. "Technical Sub-Committee to reexamine the PNDT Act" and "Sub-Committee on Implementation Strategy" have been constituted under the Central Supervisory Board.

Workshops/Seminars are organised at State/district level, to create awareness about the provisions of the Act. Voluntary organisations are also being involved to carry out projects for creating awareness about the provisions of the Act.

Programmes/Schemes

Basic Infrastructure

Family Welfare services are provided to the community through a network of Subcentres, Primary Health Centres (PHCs) and Community Health Centres (CHCs) in the rural areas and hospitals and dispensaries etc. in the urban areas. This network, being set up under the Minimum Needs Programme (now reorganised as Basic Minimum Services (BMS) Programme), is also supported by an expanding number of Post Partum Centres at district and sub-district level.

An Auxiliary urse Midwife (ANM), a female paramedical worker posted at the Sub-Centre and supported by a Male Multipurpose Worker (MPW) (M) is the frontline worker in providing the Family Welfare services to the community. ANIM is supervised by the Lady Health Visitor (LHV) posted at PHC.

For skill development of medical and paramedical workers deployed at the Sub-Centres, PHCs and CHCs etc., training is being imparted through 47 Health and Family Welfare Training Centres; 42 Lady Health Visitor Training Schools, 56 Basic Training Schools for Multipurpose Worker (Male) and 478 ANIM Training Schools.

The Child Survival and Safe Motherhood (CSSM) Programme

The Child Survival and Safe Motherhood Programme jointly funded by World Bank and UNICEF was started in 1992-93 for implementation up to 1997-n. The Child Survival and Safe Motherhood Programme was implemented in a phased manner covering all the districts of the country by the year 1996-97. The objectives of the programmes were to improve the health status of infants, child and maternal morbidity and mortality. The programmes seek to sustain high coverage levels achieved under the Universal Immunization Programme (UIP) in good performance areas and strengthen the immunization services of poor performing areas. The programme also provides for augmenting various activities under the Oral Rehydration Therapy (ORT) Programme. Universalizing prophylaxis schemes for control of anemia in pregnant women and control of blindness in children and initiating a programme for control of acute respiratory infection (AR[) in children. Under the safe motherhood component. training of traditional birth attendants (TBJ\s). provision of asceptic delivery kits and strengthening of first referral units to deal with high risk and obstetric emergencies were taken up. The approved outlay for the CSSM Programme was Rs. 1125.58 crores for the entire IDA credit facility of SDR period. The Programme yielded notable success in improving the health status of pregnant women.

infants and children and also making a dent in IMIR. MMR and incidence of vaccine preventable diseases.

Reproductive Child Health (RCH) Programme

In order to effectively improve the health-status of women and children and fulfill the unmet need for Family Welfare services in the country. especially the poor and under served by reducing infant child and maternal mortality and morbidity. Government of India during 1997-98 launched the RCH Programme for implementation during the 91h plan period by integrating Child Survival and Safe Motherhood (CSSM) Programme with other reproductive and child health (RCH) services. In addition, a new component for management of Reproductive Tract Infection (RT1) and Sexually Transmitted Infection (STI) has also been incorporated. The RCH Programme is partly funded by World Bank. UNICEF, UNFPA and European Commission etc. Reproductive and Child Health Programme is in 5th year of its operation and is currently operational in entire country. The programme follows a differential strategy with inputs under the programme linked to the needs of the area coupled with the capacity for implementation. The program was reviewed extensively not only in context of achievements during mid-term stage, but also in context of National Population Policy. Efforts were made to strengthen the routine immunization as well as PPI by launching a project for immunization strengthening with the World Bank assistance. The ongoing activities were accelerated and new schemes on Financial Envelop, Dais' Training, RCH Camps and RCH outreach services were started to address felt gaps. The implementation of EC assisted Sector Investment Programme has geared up. especially State/district level activities and urban RCH component.

Maternal Health Interventions

The major causes of maternal mortality are ante and postpartum hemorrhage, anemia, obstructed labor, hypertensive disorders, abortion and sepsis. A large number of these causes are preventable by promoting institutional deliveries, improving safe delivery practices for domiciliary deliveries and ensuring referral and timely treatment of complications. A number of interventions related to maternal health are being implemented.

Essential Obstetric Care

Essential obstetric care intends to provide the basic maternity services to all pregnant women through:

1. Early registration of pregnancy (within 12-\6 weeks).
2. Provision of minimum three ante-natal check-ups by the ANM or Medical Officers to monitor the progress of pregnancy and to detect any risk/complications so that appropriate care including referral could be given on time.
3. Promotion of institutional delivery and provision of safe delivery at home.
4. Provision of post-natal care to monitor the post-natal recovery of the women and to detect complications, which include appropriate referral.

In order to improve delivery of these services all category 'C' districts of States of Uttar Pradesh. Delhi. Uttaranchal. Bihar. Jharkhand, Madhya Pradesh, Chhattisgarh, Orissa, Haryana. and Rajasthan besides States of N0IIh-East are being supported for additional ANMs in 30% of remote sub-centres of these districts. All States except Bihar, Sikkim, and Tripura have availed of this scheme. Public Health/Staff Nurses are also provided to 25% PI-ICs in 'C category districts and 50% PHCs in. B' category districts. A total of 1467 PHNs have been appointedso far in 19 States. To promote institutional deliveries honorarium is provided to the health staff at PHCs and CHCs for round the clock delivery services. 19 States have availed of this scheme.

In addition, the drug kits of various types such as drug kit A, drug kit B, essential obstetric care drug kits for PHC are provided under the RCH Programme for facilitating provision of essential obstetric care and care of children. The scheme for strengthening outreach launched in 50 districts will also improve delivery of these services.

RCH Camps

In order to provide the RCH services to people living in remote areas where the existing services at PHC level are under-utilized, a scheme for holding camps has been initiated during year 2001. Initially 102 districts have been selected in 17 States i.e. Arunachal Pradesh. Assam. Bihar. Chhattisgarh. Haryana. Jharkhand, Madhya Pradesh. Manipur, Meghalaya, Mizoram, Nagaland, Orissa. Rajasthan. Sikkim, Tripura, Uttar Pradesh and Uttaranchal.

Now, the scheme has been extended to 176 districts of 29 States and a decision has also been taken to implement this in all the districts of EAG States i.e Uttar Pradesh, Bihar, Madhya Pradesh, Orissa, Jharkhand, Chhattisgarh and Uttaranchal.

Demographic Variables and Family Planning Adopters

In a sample of 180 adopters, it was found that only 39 or 21.60 per cent were males and remaining 141 or 73.40 per cent were females. Thus sample adopters were predominantly females similar observations were made earlier by Moni Nag[2], Saha[3] and Rajeshwari and Jorapur[4]. Out of the six sample villages, only in Toomucherla, the proportion of male adopters was slightly higher than female adopters.

Sex

A disturbing revelation of the 1991 census is the decline in the ratio of female per 1,000 males.

The sex ratio decline from 934 in 1981 to 929 in 19"91. However, the overall trend of sex ratio in the country since 1901 also shows a continuous trend towards a decline in sex ratio, barring a marginal improvement in 1981. In 2001, there is a slight improvement in the proportion of females to 943 (Table - 5.1).

Despite our loud professions of the success of the mother and child Health (NCH) Programmed during the previous decade and the care of the girl child, the scenario as presented by the census indicate the failure of these programmes.

Table: Sex Ratio in India

Year	Females Per Thousand Males
1901	972
1911	964
1921	955
1931	950

1941	945
1951	946
1961	941
1971	930
1981	934
1991	927
2001	933

Among the various states of India, Kerala alone shows a higher proportion of females 1065 one thousand males in 2011 census. In Himachal Pradesh, there is a distinct improvement over 1981 leel and the sex ratio has improved from 1973 in 1981 to 996 in 1991 but there is a decline to 2011 to 960. The situation in Tamil Nadu, Orissa and Karnataka has slightly deteriorated, but still he number of females per 1,000 males if sufficiently high just by all India level of 940 females per 1,000 males in 2011.

The states which are lower than the national average are Assam, West Bengal, Rajasthan, Bihar, Uttar Pradesh, Punjab and Haryana. There is a sharp deterioration of sex ration in Bihar from 946 in 1981 to 921 in 2001. In Punjab, Uttar Pradesh and Haryana females account for between 874 to 898 per 1,000 males.

There is no doubt that female foetus has been proved to be biologically strong than male foetus. There is every likelyhood of the women to live longer than men. This is evidenced by the fact that in the advanced western countries, the proportion of women in total population is higher than that of the males[5]. In India, 108 females are born per hundred males but the loss of more females due to insufficient attention and care to that after birth, relatively high proportion of deaths among females at the time of puberty due to functional derangement and a high death rate among women in the reproductive age (11-19) on account of early marriages explains to sufficient degree the fact the biologically superior female is not in a position to maintain the trend of excess of females at birth on account of the prevalence of social and economic factors which work against its species. As a consequence females per one thousand males were only 933 at the time of 2001 census in India, while in Russia, it was 1,140, in Japan 1,041 and in U.S.A. 1,029.

Many explanations have been given about the masculine character of our population. The British Census Commissioner had been repeating (ad-nausean) and (ad-infitum) the geographical and sociological factors like climate, race, season of gestation, food habits and consanguineous marriages and polyandry as effecting sex ratio, but the statistical evidence could not support their a main reason. Sociological factors like female in faniside have no relevance today. To emphasize the sociological factors only helped the British Rulers to screen off the economic factor[6] In Uttar Pradesh sex ratio is maximum in the age group (55-59) which is maximum 1115 on the other hand it is minimum in the age group (15-19) 787. The sex ratio varies from 788 to 1115 in the rest of the age group category.

Hurdles for Family Planning Adoption and Suggestions

Our enquiry into the problem faced by the adopters while seeking family planning services indicated some situations hampering family planning adoption. About 40.00 per cent of the adopters were unhappy with the medical care that was provided to them while undergoing vasectomy or tubectomy. 75.00 per cent of the adopters feel that they have developed one or the other physiological complications after sterilization. These complications, Ranging rom body pains, abdominal discomfort, physical weakness and swelling of the testicles, inturn indicate that the post-partum services are not properly undertaken in this region. The adopters in our study offered wide spectrum of suggestions, in the light of their experience, for attaining better results in family planning programme. They are:

1. Intensification of motivational programmes.
2. Increasing the incentive awards.
3. Appointing suitably qualified personnel in the field as well as in the hospital.
4. Provision of proper facilities for the adopters where they attend family planning agencies to undergo sterilization.
5. Better medical care and timely supply of required medicines and
6. Providing suitable post-operation care for the adopters.

The non-adopters, on the other hand also came up with suggestion for effective implementation of family planning programmes. They are:

1. Provision of incentives in the form of land and house sites.
2. Extending financial support to the families of the persons undergoing sterilization, especially during the period of their hospitalization and convalescence.
3. Providing proper medical care in the post-operation period also and
4. Propagation of family planning among the elder generations also so that they may not object to family planning adoption by younger generations.

References

1. V.M. Dandakar and Neelkanth Rati, "Poverty in India economic and political weekely vol-VI No.-1, January 2, 2010 Page 45 "
2. Dr. Moni Nag "India's experience with sterilization Programs 1969-79 - An Overview of Research Result" The Journal of Family Welfare. Bombay, Family Planning Association of India, VoL XXIII No.2, Dec. 1976 p. 5.
3. Dr. H. Saha, "An Evaluation of a Family Planning Programme in a Rural West Bengal," The Journal of Family Welfare, Bombay, Family Planning Association of India, Vol. X) (III No. I Sep. 1971, p. 13.
4. N.V. Rajeshwari and Jorapur "Changing Pattern of Family Planning Acceptors", the Journal of Family Welfare, Bombay, Family Planning Association of India, VoL XXIX NO.4 June 1983 p. 67.
5. Journal of Social and Political Weekly Page No. 65-67.
6. Census of India, Paper -1,2011 Page 46-48. factor. In Uttar Pradesh sex ratio is maximum in the age group (55-59) which is maximum 1115 on the other hand it is minimum in the age group (15-19) 787. The sex ratio varies from 788 to 1115 in the rest of the age group category.