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THE JOURNAL OF FAMILY WELFARE

FERTILITY IMPLICATIONS OF ADDRESSING UNMET NEED FOR FAMILY PLANNING IN INDIA

MANORANJAN MOHAPATRA

Introduction

India launched the national family planning programme in 1952, with the view to stabilize population at a level consistent with the requirement of national economy. India adopted many population policies with different strategies as per the requirement of time. Empirical studies show that the usage of contraception has increased in a rapidly both among educated and non-educated people, both in urban and rural areas and both poor and rich couples due to the availability of family planning methods but simultaneously there is a visible gap between demand and supply of contraception. In general parlance women are interested to use contraception but due to some circumstances they are not getting these opportunities. This demand-supply mis-match has given us a concept called the "*Unmet Need for Family Planning*". The Population Policy 2000, which reiterates the voluntary and informed choice and maintaining a target free approach with continued family planning services. One of the major objectives of the Population Policy, 2000 is to address the unmet need for family planning.

According to the standard definition of unmet need for family planning used in the Demographic and Health Surveys (DHS), which includes all fecund women who are married or living in union, presumed to be sexually active, who wish to postpone the birth of their next child for at least two more years or who either do not want any more children and are not using any method of contraception. The unmet need also includes all pregnant married women whose pregnancies were unwanted or mistimed or who unintentionally became pregnant because they were not using contraception. Similarly, women who have recently given birth and are not yet at risk

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REGIONAL VARIATIONS IN USE AND NON-USE OF CONTRACEPTIVES IN RAJASTHAN

SHERIN RAJ, V.K TIWARI AND J.V SINGH

INTRODUCTION

The best option to check population growth is by lowering the fertility levels.[1] Contraceptive use, as a proximate determinant of fertility, plays an important role in reducing fertility; and at times contraceptive prevalence has been used to evaluate the effect of family planning programmes.[2] In 2000, the heads from 189 countries endorsed the Millennium Declaration[3] where universal access to contraceptive methods was reemphasized as the cost-effective way of reducing maternal mortality.[4] Family planning research and policy have efficiently reoriented the choice of avoiding pregnancy along with convenient and informed access to contraceptive methods to control fertility, especially unwanted/unintended or mistimed pregnancy,[5,6,7] and to attain the desired family size.[8]

Rajasthan is one of the largest states by area in India with a high population growth rate. There are 32 districts and four regions[9] in Rajasthan and the acceptance of different contraceptive methods varies in each district and region, and also among different caste and religious groups. The possible reasons for the lower acceptance include cultural background, attitude towards family planning, meagre knowledge of family planning methods, the lack of accessibility and availability of services, and the prevalence of traditional methods of birth control.[10] In view of these variations in Rajasthan, it is imperative to examine the reason for not using contraception among currently married women of reproductive age group, reason for discontinuing the contraceptive method and factors associated with the future intention to use contraceptives and associated regional variations.

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SON PREFERENCE AND GENDER COMPOSITION OF CHILDREN IN BANGLADESH

MOHAMMAD SALIM ZAHANGIR AND CELIA H. Y. CHAN

Introduction

An overview of son preference

Son preference in a society means that couples favour sons over daughters. Most of South and East Asian, and North African countries have a strong preference for sons.[1-8] Parents in developing countries highly value their sons for economic, social, and cultural reasons.[9-11] In fact, sons are thought to have higher economic net utility than daughters, since male offsprings are perceived to be more competent to support their fathers in agriculture and household income, and to secure their parents in old age.[12–15] On the other hand, daughters are largely considered to be an extensive economic burden in societies in which parents are frequently expected to pay dowry to the groom during marriage.[11,16]

Bangladesh is among the countries with a strong son preference.[15,17,18] Evidence for this emerges from two sources: direct evidence attained from survey data on reproductive preference and indirect evidence of excess mortality among girls. Reproductive preference means the intention of couples to have as many children as they desire. In developing countries, such as Bangladesh, reproductive preference is lower than actual fertility; whereas, in developed countries, the two are identical. In general, developing countries have a higher actual fertility that exceeds the desire for the number of children.

Despite having a history of high fertility, Bangladesh has experienced a dramatic decline in fertility levels, i.e., from almost seven children per woman in the late 1970s to just over three children per woman in the early 1990s. After 1990, fertility slowed

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POSTPARTUM INTRAUTERINE CONTRACEPTIVE DEVICE: STILL A LONG WAY TO GO FOR ACCEPTANCE - A STUDY CONDUCTED AT A TERTIARY CARE CENTRE IN CHHATTISGARH

ABHA SINGH AND RUCHI KISHORE

Introduction

India is far behind in attaining the Millennium Development Goal 5 in mid-2015. The current maternal mortality ratio is 178/100,000 live births while the expected was 109.[1,2] Family planning and adoption of birth control measures reduces unintended pregnancies, unsafe abortions and averts one third of maternal deaths.[3] One of the major hurdles in the way to achieve the goal of family planning in India is the unmet need for contraception. According to the National Family Health Survey (NFHS) 3 (2005-06) data, the contraceptive prevalence rate in India is 56.3 percent and more than 40 percent of couples do not use any method of contraception.[4] The postpartum period is a critical period when women are vulnerable to unintended pregnancy as limited contraceptive choice is available and ovulation is unpredictable. Implementation of various government plans promoting institutional deliveries have created opportunities for providing quality postpartum family planning services.[5]

Intrauterine contraceptive device to prevent pregnancy is one of the proven method of contraception. According to the World Health Organization Medical Eligibility Criteria, an IUCD can be inserted within 48 hours postpartum, referred to here as postpartum IUCD.[6] A 2010 Cochrane review concluded that PPIUCD is a safe and effective contraceptive method.[7] In a country like India, postpartum IUCD insertion is more applicable as delivery may be the only time when a healthy woman comes in contact with health care personnel and the chance of returning for contraceptive advice is uncertain.

Despite its safety and advantages as a family planning method, IUCD is not

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WOMEN'S AUTONOMY AND UTILIZATION OF ANTENATAL AND DELIVERY SERVICES IN A TRIBAL BLOCK IN MAHARASHTRA, INDIA

AMBADAS S. ADHAV AND NILESH GAWDE

Introduction

Gender refers to socially constructed characteristic of women and men and includes norms, roles and relationships of and between groups of women and men [1-3]. In most societies, the relations of power between men and women create disadvantage for women by vesting decision-making and authority in the hands of men. Women, especially young women of childbearing age have less say in household decisions including those involving access to healthcare.[4] Literature suggests that women's autonomy has positive influence of health behaviour including family planning use[5-9] and utilisation of maternal health care.[10-14] However, contradictory findings have also been reported where autonomy was not found to play significant role in health seeking.[11,15,16]

Women's autonomy has been defined in various ways and the concept has evolved over time. This may partly explain the inconsistent results reported in literature. Earlier, education and employed status were thought to result in women's autonomy and were used as proxy measures for the latter.[17] This concept was challenged subsequently with evidence that education and employment do not necessarily shift power balances between men and women. Jejeebhoy and Satar[18] defined autonomy as the control women have over their own lives and the extent to which they have an equal voice as well as control over resources, access to information and authority to make independent decisions. This definition clarifies that autonomy has many dimensions including freedom of movement, discretion over earned income and decision making with respect to economic matters and health care. Recent studies have examined various dimensions of autonomy including freedom

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HOUSEHOLD EXPENDITURE ON MATERNAL HEALTH CARE IN RURAL KARNATAKA, INDIA

JYOTI S. HALLAD, JAVEED A. GOLANDAJ, B. M. RAMESH, ARIN KAR AND KRISHNAMURTHY J.

INTRODUCTION

Skilled attendance at birth is widely recognized as a single most effective strategy for reducing maternal mortality and morbidity,[1] and this is being used as an indicator to measure progress toward the fifth Millennium Development Goal of improving maternal health (MDG 5).[2] However, around half of the deliveries, in the developing world, are not attended by skilled professionals. The situation is worse in some regions, such as South Asia, where only less than one-third of deliveries are attended by skilled professionals.[3] Safe motherhood still remains a distant dream for many around the world, especially in developing countries,[4] leading to most of the maternal deaths in poor countries[5] suggesting that, most of these can be attributed to low level of supply and utilization of skilled maternal health services.[6]

Research studies have documented a range of social, economic and geographic factors that act as barriers to low use of skilled maternity care during childbirth around the world.[7-13] As far as India is concerned, maternal education, economic status of household, caste and religion;[14-18] availability of and accessibility to a health facility, presence of a lady medical doctor, availability of drugs;[19-21] community attributes and programme-related factors play a critical role in the utilization of facility-based maternity care.[22] Though, costs - both direct and indirect—have also been shown to be an important barrier to women's use of facility-based maternity care [23-27] there are a limited number of studies that have explored the issue in detail at

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ASSOCIATION OF DIFFERENT DOSES OF IRON AND FOLIC ACID SUPPLEMENTATION DURING PREGNANCY ON POSTPARTUM ANAEMIA, LOW BIRTHWEIGHT AND SURVIVAL OF THE OFFSPRING: FINDINGS FROM THREE LARGE-SCALE CROSS-SECTIONAL SURVEYS, INDIA

HANIMI REDDY MODUGU, ANIL CHANDRAN S. AND MANAS RANJAN PRADHAN

INTRODUCTION

Iron deficiency anaemia (IDA) is the most common form of malnutrition affecting more than two billion people worldwide,[1] women and children being the main carriers of this burden.[2] The World Health Organization (WHO) estimates that, 41 percent of women and 27 percent of preschool children suffer from IDA.[3] Consequences of IDA during pregnancy leads to maternal mortality, preterm delivery, low birthweight (LBW)[4] and neonatal mortality.[5] For preventing IDA in pregnancy, WHO recommended the following three interventions: weekly iron + folic acid (IFA) supplementation in women of reproductive age, daily IFA supplementation during pregnancy, and presumptive treatment of hookworms during pregnancy in areas where hookworms are endemic.[1] Based on available reviews, there is a clear evidence of positive effect of iron supplementation during pregnancy in preventing low hemoglobin at delivery or at six weeks postpartum,[6] although quality of evidence for LBW was weak.[1] There is no evidence of any effect on clinical outcomes for the mother and the baby [6], while two studies established reduction in early neonatal mortality among the mothers

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ROLE OF LOCAL-SELF GOVERNMENTS IN IMPLEMENTING NATIONAL RURAL HEALTH MISSION AND JANANI SURAKSHA YOJANA IN INDIA: WHERE RUBBER HITS THE ROAD?

NANJUNDA

Background

The state of maternal, newborn, and child health in India is an important issue. A study has shown that more than 78,000 (20%) of 387,200 maternal deaths, and more than 1 million (31%) of 3·4 million neonatal deaths occurred in India in the year 2005.[1] These figures show a stable but regular progress in India over the last 15 years. The study shows that the maternal mortality ratio declined from about 520 per 100 000 live births in 1990 to nearly 290 per 100 000 in 2005 and the neonatal mortality rate decreased from 54 per 1000 live births in 1990 to 38 per 1000 in 2005.[1]Inspite of this improvement, the number of maternal and neonatal deaths is still high especially in rural parts of the country. Further, recent reports highlight the national average also cloaked outstanding inequalities in maternal and child health, with the number of child deaths ranging from 16 per 1000 live births in the most developed state like Kerala to 96 per 1000 live births in under developed states such as Uttar Pradesh.[2,3]

Janani SurakshaYojana (JSY) is safe motherhood intervention under the National Rural Health Mission(NRHM) scheme since 2003.[4] The basic objective of JSY is to reduce maternal and neo-natal mortality by increasing institutional delivery among the poor pregnant women including postpartum care, particularly with a focus on low performing states in the country such as Uttar Pradesh, Madhya Pradesh, Andhra Pradesh, and Bihar. JSY is totally funded scheme of the central government and is providing funding support with delivery and post-delivery care for the young mothers who are in the below poverty line.[5]

Decentralization of responsibilities down to the local level and, in particular, engaging constituents at the Panchayat Raj level (PRI) (Local-self Governments) can

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   Garg S., Sharma N., Sahay R. May 2001. Socio-cultural aspects of menstruation in an urban slum in Delhi, India. Reproductive Health Matters, 9(17):53-62.

   Ramachandar L. and Pelto P. J. December 2009. Self-help groups in Bellary: Microfinance and women's empowerment. The Journal of Family Welfare, 55(2), 1-16.

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   Bang, R. and A. Bang. 1994. Women's perception of white vaginal discharge: Ethnographic data from rural Maharashtra. In: J. Gittleson et al., (eds.), Listening to Women Talk about Their Health:

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   Ministry of Health and Family Welfare (MOHFW). 2000. National Population Policy 2000. New Delhi. Government of India.

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   Narayana, M.R. 1994 . Selection of PHCs for Evaluation of the Family Welfare Programme in a Developing Country: Alternative Methods and Applications", Artha Vigyana, 34, 79-82.

   1995. Evaluation of Family Welfare Programme in Chitradurga District of Karnataka State: Part II Report (Role of Peoples' Response) Population Research Centre, Institute of Social and Economic Change, Bangalore.

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   Jejeebhoy, Shireen. 1998a. Wife-beating in rural India: A husband's right? Economic and Political Weekly, 33(15):855-62.

   1998b. Association between wife-beating and fetal and infant death: Impressions from a survey in rural India", Studies in Family Planning, 29(3):300-8.

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    Progress in reproductive health research. 2001. HRP, No. 57 part 2, 1-9.

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FAMILY PLANNING ASSOCIATION OF INDIA

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AIMS AND OBJECTS

To create awareness, disseminate knowledge and education, provide counselling and services where appropriate on all aspects of reproductive, child and sexual health including family planning and HIV/AIDS, with free and informed choice, gender equality and equity, the empowerment of women, male involvement, child and adolescent health, and their inter-relationships with social development and environmental concerns in order to advance basic human rights, of all men, women and youth, family and community welfare, the achievement of a balance between population, resources and the environment and the attainment of a higher quality of life for all people.

To place its considered views before government and other agencies when appropriate and assist whenever possible in the formulation of the national programme of reproductive and child health including family planning.

To formulate policies, set priorities and devise programmes in pursuance of the above objectives and to undertake or promote studies and activities for information and education, training, services, and research covering the sociological, psycho-social, economic, medical and other relevant aspects of reproductive, child and sexual health including human fertility and its regulation, methods of contraception, infertility, family life education and counselling, stabilisation of population and environmental concerns, with special reference to the needs of adolescents and young people.

To organise conferences, seminars, training courses and other meetings and events whether local, national or international, in the furtherance of the Aims and Objects and allied subjects of the Association.

To establish Branches, Projects and other types of units to expand the coverage and activities of the Association.

To foster, develop contacts and collaborate or network with other organisations engaged in similar types of work in India and abroad.

To maintain its status as a Founding Member Association of the International Planned Parenthood Federation and to be affiliated to other international bodies as may be deemed fit from time to time.

To take any or all appropriate measures to further the Aims and Objects.

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