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Critical Review of Family Planning Programme in India

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Abstract
Increases in GDP and standard of living are seen as benefits of putting people's health first. Protecting public health might be challenging in India since the bulk of the population lives in extreme poverty. It is predicted that India will have a larger population than China's current total by the year 2050. The population of India is growing faster than the government can expand its infrastructure to accommodate it. India pioneered the use of a nationwide family planning programme in 1952. There have been some mixed effects from the policy shifts enacted by the government since then in response to recommendations made at international conferences such as those in Mexico, Cairo, and Beijing. It's undeniable that the state lacks the means to rein in its expanding population, finance universal healthcare, or jumpstart its faltering economy. Collaboration between neighbourhood groups, government agencies, and private citizens is necessary. There are just four states in India that are home to almost 40% of the country's total population: Uttar Pradesh, Bihar, Madhya Pradesh, and Rajasthan. The future shift of India's fertility rate and the process of population stabilisation will be profoundly impacted by any changes in these states. As women have come to the fore, they have also assumed more responsibility for enforcing birth control. Within this context, this research intends to assess the Indian government's family aid programme.

Keywords:Family Planning Programme, Economy, Uttar Pradesh, Bihar, Madhya Pradesh

Introduction:

Over 40 percent of India's population lives in only four states: Uttar Pradesh, Bihar, Madhya Pradesh, and Rajasthan. These states will have a major influence on India's demographic features, future fertility transition, and population stabilisation. The acronym "BIMARU" is often used to refer to these states. The population had lower levels of development in almost

all areas while having vast natural and human resources. The state's abundance of natural and human resources positions it to play a pivotal role in driving economic and social development throughout India. Uttar Pradesh's high population density is a major barrier to the efficient exploitation and use of the state's natural resources. If population goals and stabilisation are not met, the state will have a hard time achieving sustainable development. India has challenges and opportunities as a result of its rapidly transforming population. The country's large population will be both economically active and fertile, improving the outlook. Accelerating India's population stabilisation and sustainable development is a top priority, and we want to do so by synchronising the country's continuous demographic, educational, economic, and technological transformations. as reported by Singh and Singh (2006). In New Delhi, there is a government agency called the Family Welfare Department with a very sophisticated organisational structure. Aside from the traditional core of family planning programmes, other initiatives and programmes have been introduced, such as MCH, CSSM, and RCH. In the 7th Plan (1984–89), the Maternal and Child Health (MCH) component prioritised the health needs of women of reproductive age and children under the age of five by making birth control and family planning services available to consenting married couples. In 1992, the World Bank and UNICEF partnered to create the Child Survival and Safe Motherhood (CSSM) Program to bolster the National Family Welfare Program's focus on mother and child health. The Comprehensive Stroke Service Model also covered treatments for severe respiratory infections, diarrhoea, and emergency obstetric care (CSSM). The goal was to protect the health and safety of newborns and infants via the first-ever concerted effort to do so. At the International Conference on Population and Development held in Cairo in 1994, a global RCH strategy was pushed for the first time. During population stabilisation, RCH prioritised on-site care that was personalised, convenient, effective, and coordinated for all patients. Promotion of child survival via immunisation, diarrhoea and acute respiratory disease control, and newborn care; I. avoiding and managing unwanted pregnancies; II. managing pregnancy and delivery; III. preventing and treating sexually transmitted infections and genital warts Community-based organisations like panchayats, NGOs, youth clubs, and SHGs play an important part in the day-to-day operations of RCH efforts, as mandated by the national population plan of 2000. Basic RCH services will be coordinated and provided by local self-help organisations as part of the ongoing Integrated Child Development Scheme. Members of the community will

provide primary care, family planning, and maternal and child health services in the village. The participation of non-governmental organisations was actively sought in order to carry out RCH initiatives. In 1943, the Indian government established the Bhore Committee to assess healthcare in the country and provide suggestions for change. The Beveridge Committee in England had a major influence on the Bhore Committee, and its recommendations helped pave the way for the establishment of the National Health Service in that nation. To begin, it is the responsibility of the government to guarantee all citizens timely and adequate medical attention. Second, regardless of one's financial standing, everyone deserves access to high-quality medical care. The design for the expansion of health services was laid out for the short and long term, with a concentration on preventative services, rural regions, and the connection between health and general development. More than half of the First Plan's money went toward building new medical facilities, including hospitals and clinics, while another 40% supported medical schools and residency programmes. Primary health care facilities were planned to be constructed as part of the Community Development Program. For infectious diseases including malaria, smallpox, filariasis, leprosy, cholera, and gonorrhoea, the First Plan allowed for the introduction of what are known as unipropose, vertical programmes. During this time period, India was the first country to implement a comprehensive national family planning programme. Pregnancy and childbirth care were acknowledged to be crucial but were to be treated similarly to other medical concerns. At the encouragement of international organisations, the Second Plan rebranded its malaria control efforts as the National Malaria Eradication Program. The plan's target year for malaria eradication was 1966. The family planning program's first two planning periods used a clinical approach inspired by international organisations. The Health Survey and Planning Committee, often known as the Mudaliar Committee, provided recommendations that were implemented in the Third Plan. The primary healthcare system that had developed so slowly was found to be quite different from what had been envisioned by the Bhore Committee. The committee has reached the conclusion that the existing level of service must be raised. The National Tuberculosis Program began in 1962 after the widespread success of previous attempts to eliminate smallpox. Even though India spent a lot more money trying to get rid of the illness, they were successful in 1975. The Fourth Plan considerably sped up the family planning programme by adding over a thousand mobile service units to complement family welfare centres for vasectomy. The highest annual total of sterilisations ever recorded was

3.01 million in 1972–1973. About two-thirds of them went to summer camps. Developmental perspectives are shared by the World Bank and the Population Council. When the Fifth Plan started enforcing this paradigm change, India saw its impacts. According to the research, helping people get basic public health services like family planning and nutrition is the top priority. There are two reasons why 1975 is seen as a watershed moment in the history of India's public health. India was the first country to declare its smallpox-free status this year. Second, a state of emergency was declared the same year, which paved the way for the strict National Population Policy to be enacted in April of that year. In 1977, the government made a commitment to implement the Srivastava Committee's recommendations to enhance rural health services. The Community Health Volunteers Scheme was launched this year to help get the population back on a "war footing." In 1980, a different approach called "Health for All" was established. In addition to delivering appropriate, effective, and fair referral services, this community-based approach also unified the best features of the Western System with the essential values of our culture and history. The Sixth Plan aimed for a long-term demographic target of a net reproduction rate of one throughout the country by the year 2001. It acknowledged the need to eliminate poverty and advance in areas such as maternal health, girls' education, and children's diets. This increased the frequency with which surgical camps were utilised to sterilise women throughout the plan period. The 20-Point Program established objectives for fighting illnesses including TB, leprosy, and UIP, but the CHV programme was discreetly abandoned. While the Sixth Plan's aims of rural infrastructure development and communicable disease control were not realised, the enormous health burden of noncommunicable illnesses was handled owing to the proliferation of specialties and superspecializations, which was lauded in the Seventh Plan. With US $84 million in World Bank soft credit and WHO technical backing, a natural AIDS prevention programme was launched at this time. As a result, the NACO emerged as a separate organisation. Unfortunately, the Eighth Plan document shows the same pattern of underachievement in communicable disease control and family planning as shown in previous plans. Efforts to battle the AIDS epidemic gained momentum around this time, but not because the pandemic was finally recognised as a serious public health issue. The reduction of the rate of population growth during the execution of the Ninth Plan is an important goal. The plan's main objectives were to reduce baby and mother death rates and fulfil the anticipated demand for contraception. Two major policy documents, the National Population Policy and the

National Health Policy, were published during this time. Commission on Planning, 2001). Of the eight, three pertain to health. The worldwide community agreed to focus its efforts on improving health and lowering death rates by setting health-related Millennium Development Goals. By 2015, we should have accomplished three goals set back in the 1990s: We aim to prevent and reverse the spread of HIV/AIDS, malaria, TB, and other diseases by the year 2000 by halving the under-5 death rate, the maternal mortality rate, and the number of new cases of these diseases. India's Vision 2020 aims to decrease the number of instances of malaria by 50 percent and the number of fatalities in children caused by diarrhoea by eliminating both the disease and the causes of these deaths. To address the current shortage of resources, including buildings, personnel, and money, the research recommends increasing public spending on healthcare from 0.8 percent to 3.4 percent of GDP. Public health programmes that fail to provide basic necessities like clean water and air and adequate sanitation are doomed to fail. Decentralization and devolution of power make it all the more important to take into account the requirements of local bodies when creating public policy. It is not the intention of decentralised or regional approaches to public policy to replace federal authority. It necessitates increased involvement by the federal government in regulating and monitoring compliance on the part of the states. There are fewer CBOs and nonprofits in low-income neighbourhoods. Care in far-flung areas can only be provided if the number of caregivers is increased and they are provided with suitable working conditions. A comprehensive initiative to enhance maternal, infant, and child health is being launched by the Indian Ministry of Health and Family Welfare (MOHFW). This is why it's so important to collect data on healthcare delivery models as they exist now throughout the nation. Primary Health Centers (PHCs), Community Health Centers (CHCs), First Referral Units (FRUs), and District Hospitals may benefit from a district-level facility review that considers the accessibility of qualified staff, equipment, and supplies, as well as their use (Ram Chandran, 2002). India, on the other hand, has jumped headlong into the RCH programme. However, there aren't many academic investigations of the RCH programme, especially those that centre on the community's function in such endeavours. This is why the study also covered the northeastern states of Mizoram and Tripura. The study's major objective is to learn how different social factors affect people's health, medical care-seeking behaviours, and access to RCH services. According to the state's family welfare programme, the population of Uttar Pradesh has changed and the fertility rate has decreased, but at a slower rate than

projected. India's fertility rate remains below the replacement level, despite the country's family planning scheme having been in existence for half a century. Changes have been made to the initiative's aims, and efforts are under way to update the strategy and set new objectives. Services that help women plan their families so that reproductive years are spread out are in high demand but currently undersupplied in India. The government programme hasn't given them a lot of choices in birth control so far. Improving services is key to spreading the message of informed contraceptive choice. Clients cannot achieve their reproductive objectives without approaches that are tailored to their unique circumstances. There is an urgent need to address the high rate of unmet demand for contraceptives among young couples, especially among teenagers who are married. Both fertility and death rates have paused in their decline. As a result, these jurisdictions need special care. There is an immediate need for more effective and efficient integrated programmes to fulfil the varying requirements of individuals in the area of reproductive health. Integrated programmes with a gender focus are necessary in India because of the prevalent desire for boys in the country's patriarchal culture. Parents' preferences for sons over daughters tend to result in bigger families. Several promising new approaches to reducing the occurrence of unintended births are currently in development. Scientists developing these technologies need to work with professionals involved in programme planning and implementation, and everyone involved needs to have an appreciation for the needs and perspectives of end-users if they are to be effectively delivered by service providers and accepted by clients.

Review of Literature:

A comprehensive literature review is the only way to ascertain the need for more research and the presence of data gaps. Historically, the emphasis of international initiatives to enhance reproductive health and family planning has been on women (Greene, 1998). Therefore, fundamental family planning programmes directed at women were the primary implementers of population policies. Low male involvement in family planning was attributed to a number of causes, including societal stigma and efforts to enhance STI identification and treatment, according to research by Amatya et al. (1994). (Mbizvo et al., 1996). Both men and women care about their reproductive health and the ability to plan their families, but most demographic studies have only looked at women. Greene and Biddlecom (2000) and (1996), as well as Berer (2005), We may be underestimating the influence that males have on the reproductive lives of both sexes. Access to reproductive health information, counselling, and services is important for men because of its possible impact on

marriage choices (Bloom et al. 2000). In certain countries, men are the ones who make choices about their families' reproductive health because of cultural norms, religious practises, and even legal constraints. According to Ringheim (2002), couples all over the globe are seeking out reproductive health counselling and services. Because of these problems, programmes are putting more effort into finding ways to get men to use reproductive health services like family planning. Understanding the intricate workings of reproductive decision-making (for both women and men) necessitates investigation into the roles that males play in this process (Clark et al. 2008). It's a popular myth that fewer men than women participate in family planning, yet men actually do so at higher rates. Men want what's best for their families and put a premium on their involvement in interventions, according to the vast majority of research. Narayan et al. (2000) and others have stated that men need to be educated on the topic of sexual and reproductive health for both sexes. There is a fear that if we prioritise men over women, women's reproductive health will suffer and they will have less say in the workplace (Berer 1996 and Helzner 1996). On the other hand, couples that have open discussions about family planning and reproductive health are more likely to make healthy choices for their own families (Drennan, 1998). To achieve gender equality and create a society where men take responsibility for their own sexual and reproductive health as well as their social and family responsibilities, men's involvement in reproductive health initiatives is essential (Bernstein and Hansen, 2006; Helzner, 1996). Studies of men's roles in Indian society have increased dramatically since then. Studies on condoms and their ability to halt the spread of HIV/AIDS first focused on those already living with the virus. Men in Maternity (Varkey et al., 2004) was one of the first studies to examine the value, expense, and general acceptance of including dads in their partners' prenatal and postnatal care. The research was done between 2000 and 2002. Participants demonstrated no improvement in their prior knowledge or attitudes about STIs as a result of the teaching (Varkey et al. 2004). It's not totally up to the pair whether they want to have a family or not. This is particularly true in societies that value family relationships and family history. Sexual and reproductive health in young couples has been the subject of very little research. Although mothers-in-law have been the focus of qualitative studies on family dynamics that impact Indian women's reproductive choices, there is a dearth of comprehensive empirical data on the degree to which family interactions affect contraceptive method choice. There is a dearth of data on the impact of gender roles on family decision-

making outside of the context of health and family planning in developing nations. These studies suggest that men, not women, are the ones who ultimately make decisions.

Research Methodology:

This study draws on data collected by the Pt. G. B. Pant Institute of Studies in Rural Development in Lucknow, India, with support from the Indian Ministry of Women and Child Development. To that end, this study intends to examine India's family support programmes in depth. The research relied on prior research and other secondary sources. Books and secondary material from reputable sources were gathered. We also considered and analysed the findings of comparable research, surveys, publications, and other resources.

Appraisal of Family Welfare Programme:

With the stated goal of "reducing the birth rate for demographic stability within the framework of the national economy," India launched the National Family Welfare Programme in 1951. This programme receives significant funding from the Indian government. Building "health facilities for service delivery" was an objective of both the First and Second Five-Year Plans. After the first two stages, the therapeutic strategy was replaced with an "extension and education approach" that prioritised expanding services while maintaining a focus on strengthening conventional nuclear families. Priority was given to implementing a plan to reduce the birthrate by the end of the fourth plan (1969–1974). At the end of the Plan, contraception was available to 16.5 million couples, or 16.5% of all couples of reproductive age. In order to bring down the birth rate to 30 per 1,000 by the end of 1978–1979, the Fifth Plan (1974–1979) aimed to integrate family planning services with those of health, maternal and child health (MCH), and nutrition. Sterilization output skyrocketed in 1975–1976 and 1976–1977. However, the programme was abandoned in 1976–1977 because field functionaries were using excessive force to achieve family planning goals. The government's family planning initiatives have changed from goal attainment to societal mobilization, encouraging couples to take contraceptives as a result of the failure. The study contributed to a shift in focus away from reproductive health and toward family well-being. Long-term demographic targets were prioritised during the Sixth Five-Year Plan with the end goal of achieving reproductive targets (1980–85). Better spacing measures, community participation, and maternal and child health care were all areas that the Family Welfare Programme continued to focus on during the Seventh Five-Year Plan (1985–1990). In 1985, the government of India launched the Universal Immunization Program to ensure that all infants and pregnant women were safe from vaccine-preventable illnesses. After the

initiative proved successful, it was mandated in all of the country's cities. In its last years, 1990–1992, the Seventh Five-Year Plan maintained its prioritisation of family well-being. Between 1990 and 1991, MahilaSwasthyaSanghs (MSS) were formed at the village level to address the absence of effective community engagement in family welfare. The Child Survival and Safe Motherhood (CSSM) Project grew out of the Universal Immunization Program in 1992 and 1993. Maintaining a high vaccination rate via the Universal Immunization Program is only one part of this strategy; we must also increase our efforts in oral rehydration therapy, prophylaxis against baby blindness, and the treatment of acute respiratory infections. The Safe Motherhood subcomponent of family welfare funded the education of traditional birth attendants, the distribution of aseptic delivery kits, and the improvement of first referral facilities in order to manage high-risk pregnancies and obstetric crises. The Family Welfare Program was revitalised in the Eighth Plan by the addition of new initiatives and the improvement of older ones (1992–97). It has long been recognised that non-governmental organisations (NGOs) should play a bigger role in supporting and complementing official efforts, despite the fact that government attempts to urge and inspire people to accept the small family norm would definitely fail. The 9th and 10th Five-Year Plans both reduced the rate at which new residents may join the population (Govt. of India, 1997–2012). Methods include a regional micro-level planning initiative and a primary health care needs assessment with an emphasis on maternal and infant health. By reducing maternal and infant mortality and morbidity, we may achieve our desired fertility rate reduction, which motivates us to provide high-quality, integrated reproductive and child health care to those in need. Meeting the perceived needs of eligible couples was the only justification for planned family planning programmes under the Nineth Five-Year Development Plan (1997–2002). Family planning initiatives were severely undermined as funding was diverted to other areas to focus on reproductive and child health. The focus of India's Ten-Year Plan (2002–2007) shifted from demographic aims to aiding couples in attaining their reproductive goals and covering all unmet contraceptive requirements, including family planning, maternity and child health, and integrated health care for women and children. Centrally specified targets for community needs assessment brought back the goal regime for planned family planning efforts. The National Rural Health Mission was founded, and the Departments of Family Welfare and Health were integrated as part of the plan. The goals of the National Rural Health Mission, such as bringing the overall fertility rate down to replacement levels, have

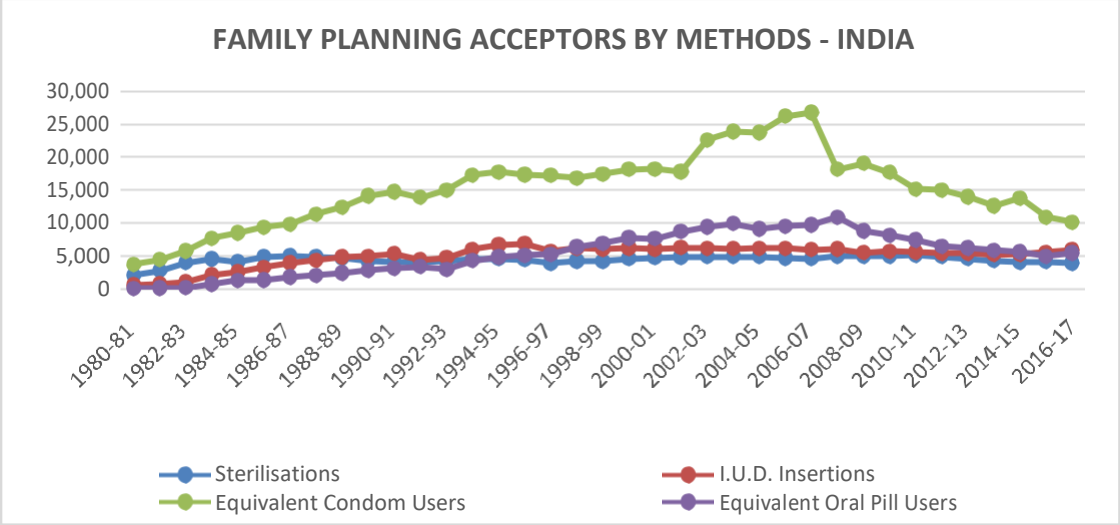
been carried over into the Eleventh Five-Year Plan (2007–2012). Political leaders, on the other hand, have shifted their attention from ensuring everyone has access to family planning to ensuring everyone has access to health care. This means that all efforts to limit fertility are now part of the healthcare system and restricted to methods that participants opt for. The overall fertility rate is still above the replacement level that was projected to be achieved by the end of the Eleventh Five-Year Plan, and the couple protection rate has not altered, as stated in the approach document for the Twelfth Five-Year Plan (2012–2017). The study's emphasis is on population stabilisation because of the potential for regional instability in a democratic society brought on by dramatically varying rates of population growth. The strategy paper recommends that the National Rural Health Mission combine family planning services with reproductive and child health care services in states with high fertility rates. Convergence with initiatives that tackle child mortality, women's empowerment, and early marriage are all important elements to consider since they all contribute to high fertility. There is no comprehensive strategy for population stabilisation in the approach paper. There is no discussion of population momentum, for instance, in those states and union territories where replacement fertility has been realised or is very near to being accomplished (Government of India, 2017). The National Family Welfare Programme (IUD) in India provides funding for a variety of methods of birth control, including condoms, oral contraceptives, and intrauterine devices. While condoms and OCPs are made available through both free distribution and social marketing, IUDs are only made available through free distribution. Nonprescription drug and condom usage promotion is another focus of the social marketing programme. Contraceptives are also sold under the manufacturers' own brand names on the open market. There are no corporate tax incentives in India. In the Family Welfare Program, Cu-T is a required method of birth spacing. The government of India provides free Cu-T to all primary health care clinics, secondary care facilities, and hospitals in India for use by qualified medical professionals. The Emergency Contraceptive Pill (ECP) was introduced in 2002–03 as part of the Family Welfare Program, and the Cu-T 200 "B" (IUDs) were gradually phased out in favour of the Cu-T 380 "A," which provides women with more continuous protection over the course of a year. An emergency contraceptive may be used to avoid pregnancy in the case of unprotected sexual activity (such as sexual assault, rape, or sexual coercion) or if another method of birth control has failed. Birth control should only be given in medical emergencies. Mini-laparotomy

tubectomy (A) and laparoscopic percutaneous excision of the ureter (Lapro) (B) are two forms of long-term help provided to couples under the National Family Welfare Program. One of the most efficient methods of male contraception today is method B vasectomy, often known as open surgery with knives or second-generation no-scalpel vasectomy. This alternative to vasectomy is less invasive and has fewer risks than the conventional method. Men who have settled down and started families are the primary target audience for this innovative strategy. To increase male sterilisation and participation in the Family Welfare Initiative, the Indian government has created the No-Scalpel Vasectomy scheme. health coverage that focuses on families and communities; the FWLHIS has been used to promote long-term contraception measures since its inception in 1981. Participants in sterilisationprogrammes get paid for their time spent at a medical facility. Also, some areas were putting money aside for a "miscellaneous purpose fund" that would be used to cover things like ex-gratia payments to the sterilising acceptor or his or her nominee in the exceedingly improbable event of the acceptor's death or incapacity after a sterilisation surgery. Despite efforts by the government, India has the largest democratic population. India's population has increased to 121 million from 35 million in 1951. There haven't been many issues recently. To begin, national population programmes often place a premium on sterilisation and contraception. An efficient population control plan will include measures to ameliorate poverty, enhance the standard of living, and expand access to quality education. Second, the program's limited viewership prevented it from effectively promoting birth control. Thirdly, and lastly, the absence of health infrastructure, a lack of competent employees, a lack of enthusiasm among health professionals, and a limited use of population control technologies contributed to the failure of the health and population plan. Last but not least, many people were outraged by the forced sterilisations that were carried out during the Emergency Era (1976–1977). As a result, the National Population Policy was already a divisive topic before it was put into effect (Char, 2011). It was the states' lack of commitment to the Family Planning Program that caused the most problems. The program's production and dissemination suffered from a lack of urgency. The findings of state family planning boards have been shown to vary widely. State Family Planning Bureaus' authorised staffing pattern was insufficient to satisfy the demands of management and administrative responsibilities (Pachauri, 1996). Furthermore, district family planning committees were not unified in their support of the endeavour. Family planning programmes at the state level

(including monitoring, mobile sterilisation or IUCD services, mass advertising, and other components) have identified transportation as a severe and catastrophic hurdle to success. Mission Parivar Vikas was established to increase access to family planning and contraception in seven priority states with TFRs of 3 or above. Forty-four percent of India's population lives in the seven states with the highest TFR: Uttar Pradesh, Bihar, Rajasthan, Madhya Pradesh, Chhattisgarh, Jharkhand, and Assam. Injectable contraceptives, Centchroman, and progesterone-only pills have joined the options for birth control now available (POP). However, only 46.5% of current users reported receiving counselling on the risks associated with their form of birth control in the NFHS. The sterilisation compensation plan has been improved in 11 priority states, which includes increased payment for surgical castration (8 EAG, Assam, Gujarat, Haryana). A new IUCD (Cu 375) with a 5-year effective duration has replaced the current one (Cu 380A with an affectivity of 10 years). LUDs have been linked to a variety of negative health outcomes, including vaginal bleeding, vaginal spotting, and even infection. Unless an infection takes hold, all negative symptoms will go away promptly. The transmission of STDs like HIV cannot be stopped by using ECPs or lUDs. For IUCD insertion, a novel technique termed "PPIUCD" has been developed. Emergency medical personnel's hesitancy to insert an IUD is not limited to India. Eighty-five percent of US doctors, according to research published in Obstetrics & Gynecology this past February, do not provide IUDs to their patients as a means of emergency contraception. Minilap should be promoted as the main technique of postpartum sterilisation to take advantage of the vast number of recorded institutional births. If the patient and her loved ones approve, this effort might have a significant impact. In rare cases, usually in less accessible regions, women have reported not being given enough information before undergoing PPIUCD. A sterilisation drop-off service is available for individuals in need. Counselors trained in RMNCH+A should work full-time in busy hospitals. Despite numerous complaints from users about the program's behaviour and service quality, the program's popularity is evident in healthcare settings. A special mechanism allows ASHAs to provide contraceptives directly to the houses of programme participants. Birth spacing programmes like the one ASHA helps implement advocate a minimum of three years between the births of each kid. Eighteen states throughout the nation have joined the initiative (8 EAG, 8 North East, Gujarat, and Haryana). Additional states and union territories have also given their approval, including West Bengal, Karnataka, Andhra Pradesh, Telangana, Punjab,

Maharashtra, Daman, and Nagar Haveli. Providers and approved facilities are protected from legal liability over the deaths, complications, or failures of sterilisation patients under the "National Family Planning Indemnity Scheme" (NFPIS). To enable sterilisation acceptors to make up for lost income, the Ministry of Health and Family Welfare has instituted a compensation mechanism. The Prerna plan was created to encourage women to delay marriage and the birth of their first child, as well as to increase the interval between the births of their first and second children. If the pair follows this plan, they will be rewarded monetarily. Because of this, people's opinions will change in the area. Benefiting from the Santushti approach's promotion of PPP sterilisation initiatives are private gynaecologists and vasectomy surgeons. Private hospital and nursing home objectives were achieved in the states of Uttarakhand (61%), Nagaland (58.8%), Delhi (57.8%), Jammu and Kashmir (57.8%), Daman & Diu (53.6%), and Dadra & Nagar Haveli (53.6%). (52.3 percent). Between 2016 and 2017, there was a 7.76 percent rise in the overall number of IUD insertions in the United States. Andhra Pradesh, Assam, Chhattisgarh, Gujarat, Jharkhand, Maharashtra, Odisha, Rajasthan, Jammu & Kashmir, Uttar Pradesh, and West Bengal all had increases in use in 2016–2017, while Bihar, Haryana, Karnataka, Kerala, Madhya Pradesh,

Punjab, Tamil Nadu, and Telangana all had decreases. The number of condom users increased from 4.42 million to 4.57 million under the free distribution plan. During 2015–16 and 2016–17, the number of people who said they used condoms dropped from 10.9 million to 10.1 million.

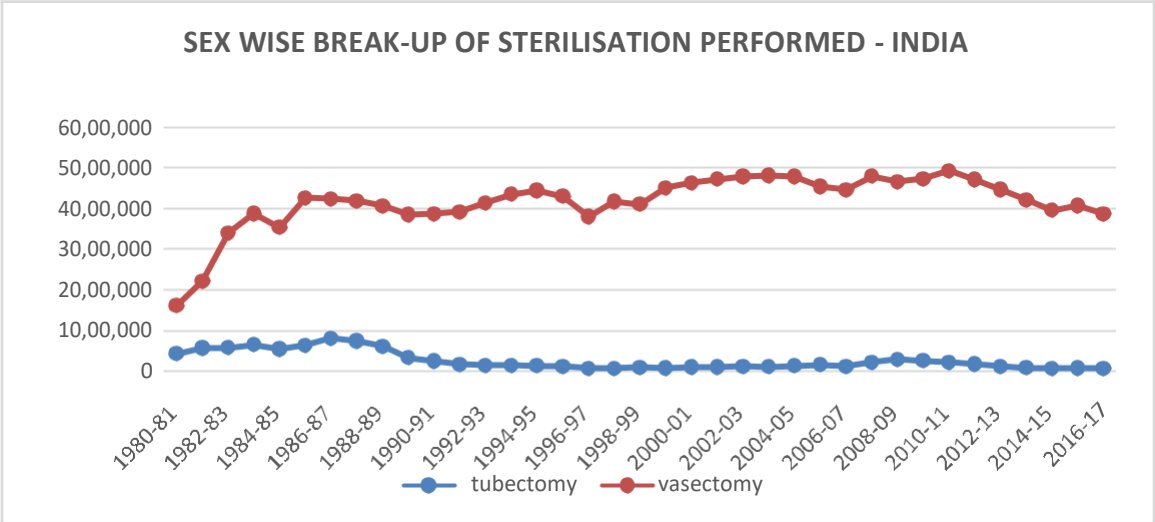


The usage of free condoms grew from 2015 to 2016 in several big states, including Andhra Pradesh, Assam, Bihar, Gujarat, Haryana, Karnataka, Kerala, Odisha, Tamil Nadu, Telangana, and West Bengal.One noteworthy fact is that the number of people who accepted free condoms rose by 3.4% between 2015-16 and 2016-17. However, Social Marketing

Scheme has seen a decline in its user base. The number of people who took use of the free distribution plan for oral pills increased to 3.47 million in 2016–17 from 3.3 million the year before. Andhra Pradesh, Assam, Gujarat, Haryana, Jharkhand, Karnataka, Kerala, Maharashtra, Punjab, Tamil Nadu, Telangana, and Uttar Pradesh are some of the most populous states. The number of people using oral pills in India and West Bengal climbed in 2016–17 thanks to the free distribution system, whereas the number of people taking oral pills in the other major states fell. The number of people using oral tablets rose from 1.65 million in 2015-16 to 1.99 million in 2016-17 as a result of the social marketing campaign.

The total population consuming oral tablets rose from 4.97 million in the previous year to 5.45 million in the current one.(Govt. of India, 2017).

One of the most common methods of modern contraception in India is sterilising of females. Three-sixths of married women between the ages of 15 and 49 use some kind of female sterilisation, whereas just six percent of males use condoms and nine percent use oral contraceptives (2 percent). Four percent. Only 6% of the population relies on a conventional approach, most often the rhythm technique. Among sexually active, never-married women, sterilisation is the most common technique (19%), followed by condoms (8%). (12 percent). The percentage of married women between the ages of 15 and 49 who use contraception has dropped dramatically, from 56% in 2005–06 to 54% in 2015–16. Manipur, Bihar, and Meghalaya have the lowest contraceptive use rates (24 percent), whereas Punjab has the highest rates (76 percent). With the exception of Sikkim, Tripura, and Goa, the contraceptive



use rate among currently married women in the smaller northeastern states is rather low. The percentage of women who use a contraceptive varies widely throughout the union territory,

from 30% in Lakshadweep to 100% in Chandigarh (74 percent). Currently, 69% of all contraceptives are obtained via some kind of public health programme. Only 6% of those who are now using a technique got theirs from private businesses, while 24% got theirs via the public health system (government, NGO, or trust hospitals or clinics). Public health care access was 58% lower in urban areas compared to rural areas (64 percent). That's almost 76% of the total. Public health concentrates on sterilisation services for both sexes and IUDs/PPIUDs, whereas the private health industry mostly deals with oral contraceptives, injectables, and condoms/Nirodhs. More than half of married women between the ages of 15 and 49 want to reduce the number of children they have, and 11% would like to space out their pregnancies. 54% of currently married women, according to an estimate from the 2015-2016 National Family Health Survey, use some kind of contraception in order to postpone or reduce the number of children they have. Unmet family planning needs include the desire to limit or space out pregnancies and affect one-third of already married women. If all currently married women who want to restrict reproduction actually employed family planning tools, the contraceptive prevalence rate would increase from 54% to 66%. From 2005–06 to 2015–16, the contraceptive prevalence rate among married Indian women aged 15–49 dropped from 70% to 66%. Both NFHS-3 and NFHS-4 have almost the same number of unmet family planning requirements. (IIPS, 2016). Recent research into India's family planning laws and activities has shown a complete set of principles and practises that promote quality assurance and improvement in perinatal and paediatric health care. NRHM and RCH II have joined forces for the first time on a long-term plan to increase service availability, quality, and coverage. What may be efficient legal requirements and operational procedures for managing human resources and using infrastructure and commodities in India are hampered by a lack of accountability and transparency. Personalized health care, patient privacy, and grievance resolution mechanisms have not been implemented despite the establishment of a robust regulatory framework for monitoring the quality of health care services supplied by the public and private sectors. Timeliness, transparency, and ethical behaviour are essential components of our current healthcare policy. (Pachauri, 2014) "The goal of the Family Planning 2020 campaign is to empower women and girls to make informed decisions about their reproductive health." The London Summit on Family Planning in 2012 launched Family Planning 2020 with the aim of providing modern contraception to an extra 120 million women and girls in the world's poorest nations by the year 2020. Family Planning 2020 is a

coalition of over 125 public and private organisations working to expand access to family planning services that are grounded in respect for human rights. In India, efforts are being made as part of the Family Planning 2020 programme to broaden access to and satisfaction with these services. India has achieved significant progress on the Family Planning 2020 goals, which aim to enhance access to a range of contraceptive methods by increasing the number of people who have access to them. India has made family planning a top priority in its fight to improve the health of mothers, babies, and young people. The Indian government has been able to enhance its supply chain with the use of the Family Planning Logistics Management Information System (FP-LMIS). Family planning services have received increased attention and demand because of media efforts. Family planning funding has been boosted by the Indian government. India reaffirmed its commitment to boost family planning financing to $3 billion by 2020 in July 2017, a target it had announced at the 2012 Summit. Differences in the quality of care people get at different hospitals might influence how often they visit certain hospitals. There has been no reduction in maternal mortality as a consequence of conditional cash transfers being used to promote hospital deliveries. The total value of the exchange was also quite small. It is important to consider pregnant women's mental and emotional health when designing incentives for improved delivery outcomes. It is essential to treat the whole person, not just their symptoms. The Indian government has increased its financial and human resource commitment to healthcare, with a particular focus on maternal and child health (MCH). The guidelines should emphasise training and skill development in order to provide high-quality clinical health care. Training should include aspects of "person-centered care" such as counselling, information exchange, confidentiality, and more. Reports of care providers' disrespect and abuse of patients are seldom recorded as part of quality improvement efforts. When designing healthcare facilities, it is essential to include community engagement and monitoring procedures. In public hospitals where NRHM has addressed infrastructure issues, it is essential to place the patient at the centre of care. To flourish, patient-centered health care requires better legislation in certain areas and the closing of current quality care gaps.

Conclusion:

The focus of efforts to reduce projected population growth has switched from men to women. Despite growing awareness of the importance of male sterility, fewer men are actually being sterile. As a result, more and more Indian women are turning to contraception and other

forms of planned parenthood. The fact that more family planning tools are now in the hands of women might have various root causes. Discriminatory laws, the skewed representation of women in positions of power, a dearth of male health care practitioners, and a lack of birth control choices aimed specifically at males all play a role. Perhaps the higher rate of female contraceptive use might be attributed to cultural and economic factors. A number of factors contribute to this, including women's reluctance to involve their partner in permanent family planning out of concern for their partner's health and the widespread belief that women should bear the bulk of the responsibility for family planning due to men's financial support and awareness campaigns that focus exclusively on women. In spite of this, over half of individuals who answered the survey indicated their partners approve of their getting help. The whole contraceptive supply chain has to pay greater attention to increasing access to male contraception. To encourage greater adoption of such strategies, it is critical that more family planning services be made accessible via community-based organisations and non-governmental organisations (NGOs). Stay away from family planning programmes that place too much focus on achieving certain results. The primary goal of family planning should change from gaining the approval of others to gaining the approval of one's own family members. More resources should be directed to IEC initiatives that support family planning, and the motivation and motive for all providers (doctors, nurses, and support staff) should be eliminated. In order to increase the use of contraception and other methods of family planning, IEC programming should put greater emphasis on males. **References:**

Amatya R, Akhter H (1994) , McMahan J, Williamson N, Gates D and Ahmed Y. The effect of husband counseling on Norplant contraceptive acceptability in Bangladesh. Contraception. 50:263–73.

AVSC International. (1997) Profamilia's Clinics for Men: a Case Study. AVSC International, New York.

Barnett B and Stein J. (1998) Women's Voices, Women's Lives: The Impact of Family Planning. A synthesis of findings from the Women's Studies Project. Research Triangle Park, NC: Family Health International.

Barnett B. (1998)Family planning use often a family decision. Network. 18(4):10– 11,13–14.

Basu AM. (2005). Ultramodern contraception: Social class and family planning in India. Asian Population Studies. 1(3):303–323.

Basu I, Jana S, Rotheram-Borus MJ, Swendeman D and Lee SJ. (2004) HIV prevention among sex workers in India. Journal of Acquired Immune Deficiency Syndromes. 36(3):845–8

Battala M.(2001). Knowledge of STDs, HIV / AIDS and risk behaviour among single male migrants from Karnataka in the Govandi slum area of Mumbai, India. International Institute for Population Sciences. 10 p.

Bloom SS, Tsui AO, Plotkin M and Bassett S.(2000)What husbands in northern India know about reproductive health: Correlates of knowledge about pregnancy and maternal and sexual health. Journal of Biosocial Science. 32(2):237–251.

Boulay M and Valente TW. (2005) The selection of family planning discussion partners in Nepal. Journal of Health Communication. 10(6):519–36.

Bremner WJ, Elliesen J, et al.(1993) Determinants of the rate and extent of spermatogenic suppression during hormonal male contraception: An integrated analysis. J Clin Endocrinol Metab; : 1774-83

Bremner WJ, Elliesen J, et al.(1993) Determinants of the rate and extent of spermatogenic suppression during hormonal male contraception: An integrated analysis. J Clin Endocrinol Metab; : 1774-83.

Bryan AD, Fisher JD and Benziger TJ. (2001) Determinants of HIV risk among Indian truck drivers. Social Science and Medicine. 53(11):1413–26.

Chankapa YD, Pal R and Tsering D. (2010) Male behavior towards reproductive responsibilities in Sikkim. Indian Journal of Community Medicine. 35(1):40– 45.

Char, Arundhati (2011) Male Involvement In Family Planning And Reproductive Health In Rural Central India, Academic Dissertation University of Tampere, School of Health Sciences International Postgraduate Programme in Epidemiology Finland

Clark J, Young KM and Rochat R. (2008) Men's involvement in Family Planning in rural Bangladesh. Journal of Biosocial Science. 40:815–840.

Cleland JG,. Zeba AS.(1984) The effect of birth spacing on childhood mortality in Pakistan. Popul Stud; 38 : 401-18

Das BM and Ray S. (2007) Adolescent male reproductive health: Awareness and behaviour among peri-urban and rural boys in West Bengal, India. International Journal of Men's Health. 6:79–99

Drennan M. (1998) Reproductive Health: New perspectives on men's participation, Population Reports. Series J, No. 46.

Finger WR and Ndong I. (1998) Male responsibility for reproductive health. Network. 18(3):4–6.

Government of India (2017) Health And Family Welfare Statistics In India 2017, Ministry of Health and Family Welfare, Government of India, New Delhi

Green CP. (1995) Male involvement in reproductive health including family planning and sexual health. United Nations Population Fund (UNFPA). Technical Report. 28:104.

Greene ME, Barker G.(2011) Masculinity and its public health implications for sexual and reproductive health and HIV prevention. In: Parker R, Sommer M, editors. Handbook of global public health. London: Routledge;

Greene ME, Mehta M, Pulerwitx J, Wulf D, Bankole A and Singh S. (2006) Involving men in reproductive health: Contributions to development. Background paper to the report Public Choices, Private Decisions: Sexual and reproductive health and the Millennium Development Goals, UN Millennium Project.

Greene ME. (1998). Male involvement in reproductive health: Translating good intentions into sensitive programmes. George Washington University, NW

Greenhalgh S. (Ed.). (1995). Situating fertility. Anthropology and demographic inquiry. Cambridge University Press, Cambridge.

Gupta P, Joshi A and Crook B. (2002). Gender and social justice: nurturing young men's partnership with women to improve reproductive health. A case study of the central Himalayas. Men and reproductive health subcommittee of the U.S. Agency for International Development Interagency Gender Working Group. Washington, DC.

Hall MAK, Stephenson RB and Juvekar S.(2008) Social and logistical barriers to the use of reversible contraception among women in a rural Indian village. Journal of Health, Population and Nutrition. 26(2):241–250

Helzner J. (1996). Gender equality remains the objective. Planned Parenthood Challenges. (2):4–7.

Helzner JF. (1996). Men's involvement in family planning. Reproductive Health Matters. 7:146–154.

IIPS (2016) National Family Health Survey, IV , 2015-16, International Institute of Population Sciences, Mumbai

Jeffrey P and Jeffrey R. (1994) Killing my heart's desire: Education and female autonomy in rural North India. In Nita Kumar (Ed.). Women as subjects. South Asian histories. Charlottesville: University Press of Virginia, pp. 125–171.

Jeffrey P, Jeffrey R and Lyon A. (1989) Labour pains and labour power: Women and child-bearing in India. London: Zed Books.

Kadir MM, Fikree FF, Khan A and Sajan F. (2003) Do mothers-in-law matter? Family dynamics and fertility decision-making in urban squatter settlements of Karachi, Pakistan. Journal of Biosocial Sciences. 35:545–58.

Kanitkar T and Kulkarni S. (2002). Involvement of males in practice of contraception in Maharashtra. Demography India. 31(1):1–16.

Karra MV, Stark NN and Wolf J. (1997). Male involvement in family planning: a case study spanning five generations of a south Indian family. Studies in Family Planning. 28(1):24–34.

Karra MV, Stark NN, Wolf J.(1997) Male involvement in family planning: A case study spanning five generations of a South Indian family. Stud Fam Plann 28 : 24-34.

Khan ME and Patel BC. (1997).Male involvement in family planning: a KABP study of Agra district, India. Final report. New Delhi, India, Population Council, Asia and Near East Operations Research and Technical Assistance Project.

Khan ME, Gupta RB, Patel BC.(1999) The quality and coverage of. family planning services in Uttar Pradesh: Client perspectives. In: Koenig MA, Khan ME, editors. Improving quality of care in India's family welfare programme: The challenge ahead. New York: Population Council;

Khan ME, Mishra A and Morankar S. (2008) Exploring opportunities to project a "responsible man" image: Gatekeepers' views of young men's sexual and reproductive health needs in Uttaranchal, India. International Quarterly of Community Health Education. 28(1):13–31.

Khan ME, Townsend J. (1999)Target free approach: Emerging evidence. In: Pachauri S, Subramanian S. editors. Implementing a reproductive health agenda in India: The beginning. New Delhi: Spectra Visual Word;. p. 41-74.

Libbus K and Kridli S. (1997) Contraceptive decision making in a sample of Jordanian Muslim women: delineating salient beliefs. Health Care for Women International. 18(1):85–94.

Mbizvo MT and Basset MT. (1996). Reproductive health and AIDS prevention in Sub-Saharan Africa: the case for increased male participation. Health Policy and Planning. 11(1):84–92.

Moore M. (1994) Indian plan thwarted by quest for sons. Population grows as farmers insist upon two male heirs. Washington Post, Sept. 7, A26.

Moore M. (1999)Men in Uttar Pradesh, India, know little about women's reproductive health needs. International Family Planning Perspectives. 1999:25(2):107.

Nag M and Dusa MB. (1988). Opposition from husband as constraint on wife's contraception use in Matlab, Bangladesh: a qualitative analysis. Presented at the annual meeting of the Population Association of America, New Orleans, Louisiana, April 21–23

Narayan D, Chambers R, Shah MK and Petesch P. (2000). Gender Relations in Troubled Transition. In: Voices of the Poor: Crying Out for Change. New York, N.Y. Published for the World Bank, Oxford University Press.

Narayan D, Patel R, Schafft K, Rademacher A and Koch-Schulte S.(2000). Changing gender relations in the household. In: Voices of the Poor: Can Anyone Hear Us? New York, N.Y. Published for the World Bank, Oxford University Press.

Ndong I, Becker RM, Haws JM, and Wegner MN. (1999). Men's Reproductive Health: Defining, Designing and Delivering Services. International Family Planning Perspectives 25(Supplement): S53–S55.

Osrin D, Tumbahangphe KM, Shrestha D, Mesko N, Shrestha BP, Manandhar K, Standing H, Manandhar DS and Costello AML. (2002) Cross sectional, community based study of care of newborn infants in Nepal. BMJ. 325(7372):1063.

Pachauri S.(1996) A shift from family planning to reproductive health: New challenges. In: Srinivasan K, editor. Population policy and reproductive health. New Delhi: Population Foundation of India

Pachauri, Saroj (2014)Priority strategies for India's family planning programme, Indian Journal of Medical Research , 140 (Supplement), November

Piet-Pelon N, Rob U and Khan ME. (1999) Men in Bangladesh, India and Pakistan: Reproductive Health Issues. Population Council, New Delhi, India. pp. 90–91.

Piet-Pelon, NJ, Rob U, Khan ME, (1999)editors. Men in Bangladesh, India and Pakistan: Reproductive health issues. New Delhi: Hindustan Publishing Corporation;

Planning Commission, (2001), Report of the Working Group on Health Care Services for Tenth Five Year Plan, Planning Commission, Govt. of India.

Raju S, Leonard A, (2000) editors. Men as supportive partners in reproductive health: Moving from rhetoric to reality. New Delhi: Population Council;

Ramchandra, P. (2002), Health Nutrition, Population Vision 2020, IN: Indian Vision 2020, Planning Commission, Govt. of India.

Reed KD. (2001). A tale of two cities: Brothel based female commercial sex work, spread of HIV, and related sexual health care interventions in India, using Bombay and Delhi as examples. Journal of Family Planning and Reproductive Health Care. 27(4):223–7.

Ringheim K. (2002). When the client is male: client-provider interaction from a gender perspective. International Family Planning Perspectives. 28(3):170–175

Säävälä M. (1999). Understanding the prevalence of female sterilization in rural south India. Studies in Family Planning. 30(4):288–301.

Säävälä M. (2002)Fertility and Familial Power Relations: Procreation in South India. Richmond: Curzon Press.

Saha S.(2000) Adolescents and their need for sex-education. Health for the millions. 26:(5):10–2.

Singh A and Arora A K. (2008) How much do rural Indian husbands care for the health of their wives'. Indian Journal of Community Medicine. 33(1):19–25.

Singh K K, Bloom SS and Tsui AO. (1998)Husband's reproductive health knowledge, attitudes, and behavior in Uttar Pradesh, India. Studies in Family Planning. 29 (4):388–99

Singh S. K. and Singh A. K. (2006), Reproductive Child Health in North East Region, Serials Publication Delhi.

Thomas BE, Rehman F, Malaisamy M, Dilip M and Suhadev M. (2004) A study of condom acceptability among men in an urban population in South India. AIDS and Behavior. 8(2):215–220.

Varkey LC, Mishra A, Das A, Ottolenghi E, Huntington D, Adamchak S, Khan ME and Homan F. (2004). Involving Men in Maternity care in India. Frontiers in Reproductive Health Programme, Population Council, New Delhi, India.