Chapter VI Outcome of the Study

Quantitative Study

Finding of the quantitative study is arranged in a thematic manner in the following paragraphs.

1. Educational Indicators

A comparison of different educational and population indicators across these five slums would help understand situational analysis of these slums.

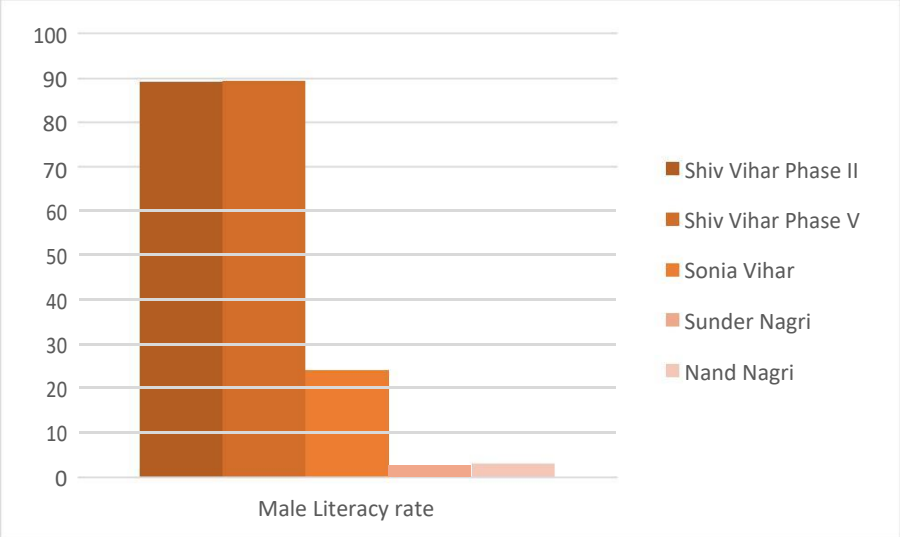

Figure 7: Male literacy rate in the slums under study

As per 2011 census, the literacy rate of India is 74%. The male literacy rate is 82.1% and the female literacy rate is 65.4%. Delhi has a literacy rate of 86.3%. The male literacy percentage for Delhi is 91% and the female literacy is 81%. As can be seen from the figure above, the male literacy percentages for Shiv Vihar Phase II and Shiv Vihar Phase V are both better than the national average and are comparable to the Delhi average. However, the male literacy percentage of Sonia Vihar is poor at around 24%. It is much below the male literacy percentage of Delhi. The male literacy percentages of Sunder Nagri and Nand Nagri are very poor at around 3% each. Massive efforts towards literacy is therefore needs to be launched in slum areas of Sonia Vihar, Sunder Nagri and Nand Nagri. Even the NGOs need to be engaged for this purpose as the task is huge and urgent interventions are required in these three slum areas.

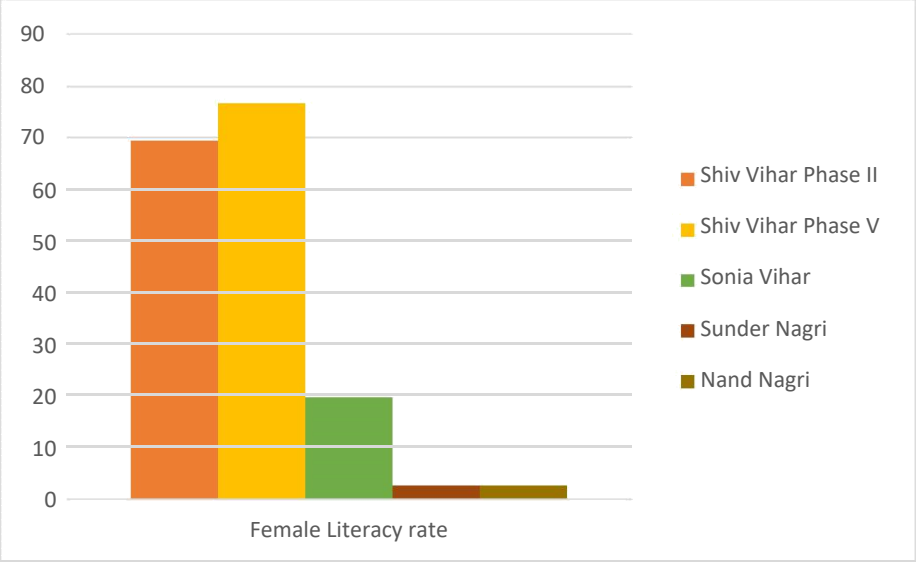

Figure 8: Female literacy rate in the slums under study

As far as female literacy in these slums is concerned, in the slums of Shiv Vihar Phase II and Shiv Vihar Phase V, it is better than the national average. However, in both these slums, it is lower than the female literacy rate of Delhi at 70% and 76.6% respectively. There is a real issue in other three slums of Sonia Vihar, Sunder Nagri and Nand Nagri. These slums have a very poor female literacy rate of 19.6%, 2.5% and 2.6% respectively. Like the male literacy rate requirement, special intervention schemes both by the government and the NGOs need to be launched immediately in these three slums.

As the females have different work schedule and family time requirements, the intervention strategy for them have to be different than the ones adopted to improve male literacy rate in these three slums. Maybe the intervention timings and methods and personnel to impart such interventions would have to suit their free time and should be in tune with the social value system of the females in these slums.

Programmes should be introduced to increase enrollment of children. Adult education programmes also need to be initiated. Drop out rate and the reasons for the same should be ascertained and corrective action taken.

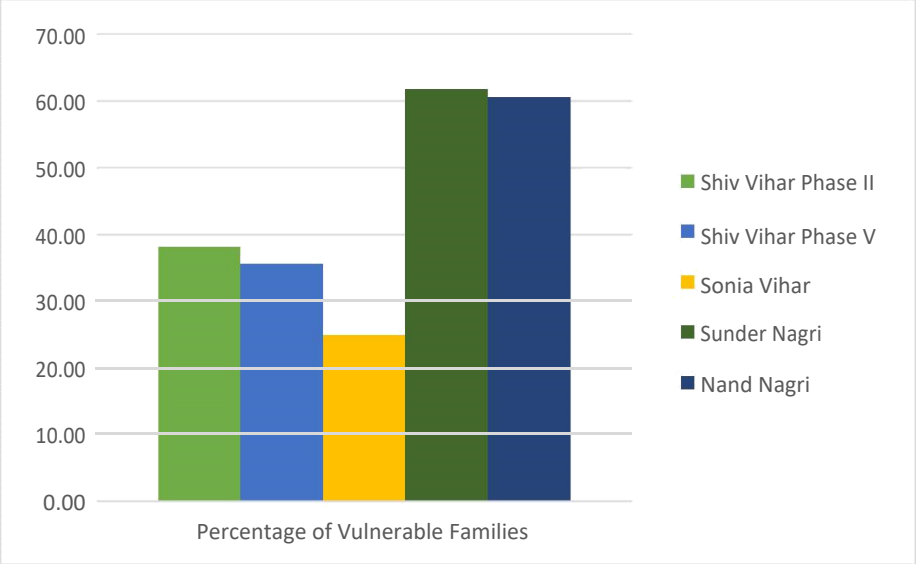

Figure 9: Percentage of Vulnerable families in the slums under study

2. Percentage of Vulnerable Families in the Slums under Study

In any society, economic and social backwardness invariably leads to low educational levels. Though there may be other influencing factors, there is generally a direct correlation between these variables. In Sunder Nagri and Nand Nagri, the percentage of Vulnerable families is more than 60%. This has directly affected their educational and literacy levels. In these two slums, the literacy levels of both males and females is less than 5%. Quite often there is reverse causality as well. Though without further investigation it is difficult to say whether low economic levels lead to low literacy levels or whether the reverse is true, the studies world over have shown that it is mostly the better educational levels which drive the economic prosperity.

Similarly, in Shiv Vihar Phase II and Shiv Vihar Phase V, there seems to be similar reverse co-relation between literacy level and percentage of vulnerable families. The strange case is of Sonia Vihar, where though the literacy level is low, the percentage of vulnerable families is also low. This could be due to recent large scale in-migration into this slum. There could be other factors as well, which would need to be investigated.

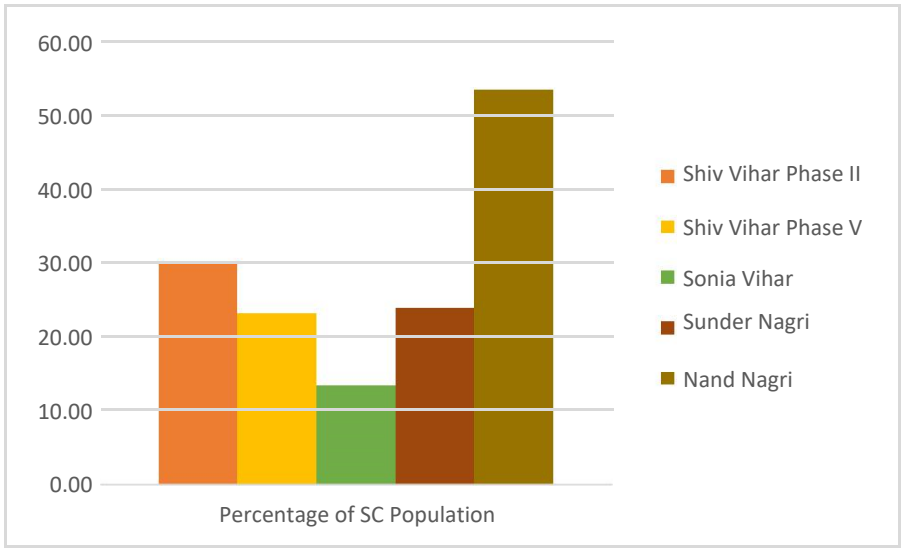

Figure 10: Percentage of SCs in the slums under study

3. Percentage of SCs in the Slums under Study

The population of members of Scheduled Caste in the country as per 2011 census is 166,635,700, which is 16.2% of the total population of the country. This percentage in relation to Delhi is 17.2%. Seen in this context, Nand Nagri has a very high percentage of the members of Scheduled Castes. This slum also has very high percentage of vulnerable families and has a very poor literacy rate, both for males as well females. Therefore, there is an immediate need to fully implement the existing governmental schemes for SCs in this slum and to roll out new ones, depending on the requirement of the SC population of this slum. Out of the five slums, only Sonia Vihar has a percentage of Schedule Castes lower than both the national percentage and the Delhi percentage. Hence, government needs to focus more on the other four slums as far as welfare of SCs is concerned.

Further, there may be other factors which are contributing to high literacy of Shiv Vihar Phase II slum, because although the SC population in this slum is substantial at around 30%, the male literacy rate is also high, which means that a large proportion of scheduled castes are also literate. Even amongst the vulnerable families, the literacy rate appears to be high.

4. Sex ration in 0-5 age group in the Slums under Study

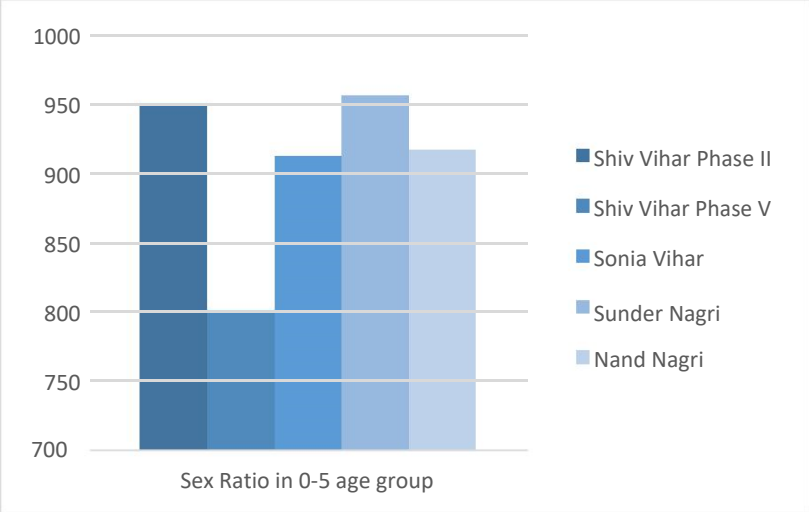

Figure 11: Sex ration in 0-5 age group in the slums under study

The sex ratio for India in 0-5 age group is 919 as per 2011 census. This figure for Delhi[205] is 871, which means that there are only 871 girls in the age group 0-5 for every 1000 boys. Seen in this light, except Shiv Vihar Phase II, all other slums have better sex ratio as compared to the state as a whole. Shiv Vihar Phase II has high male and female literacy, hence a low child sex ration seems strange. More research in this area is probably required. For Shiv Vihar Phase II, it is important that reasons for lower sex ratio are identified. ASHA workers can be helpful in this area. Schemes like Beti Bachao, Beti Padhao, Sunkanya Samriddhi Account, The Girl Child Protection Scheme should be introduced and implemented in these communities. Assessment should also be made whether PCPNDT Act has been enforced properly in these slums or not. Further, awareness campaign should be undertaken to address the slum residents about the importance of girl child.

[205] http://www.census2011.co.in/census/state/delhi.html

5. Married Females in the Slums under Study

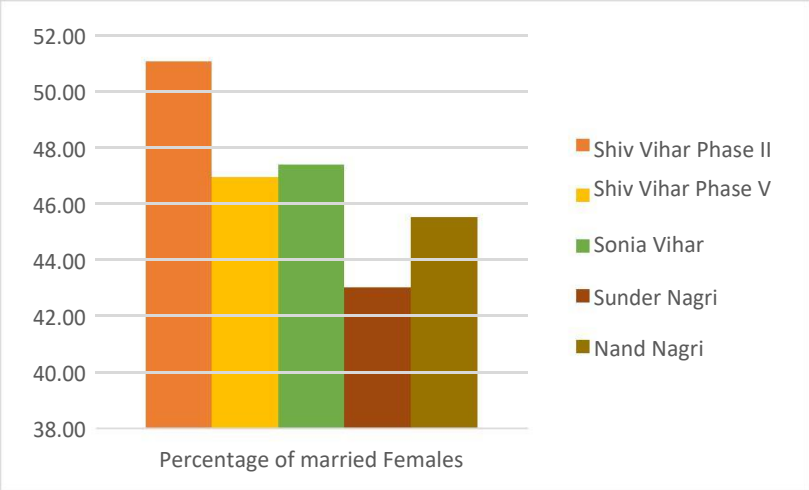

Figure 12: Percentage of married females in the slums under study

As it is apparent from the figure above, the percentage of married females in the slums of Shiv Vihar Phase II is highest, whereas Shiv Vihar Phase V and Sonia Vihar also have high percentage of married females. The Sunder Nagri slum comparatively has lower percentage of married females and Nand Nagri has the lowest percentage of married females. This calls for the attention of female health activists in these slum areas. Though ASHA workers are available in these slums, one needs to provide more of these workers per thousand of population in the slums, where the relative married female population is higher.

6. Adolescent Girls in age group 13-18 in the Slums

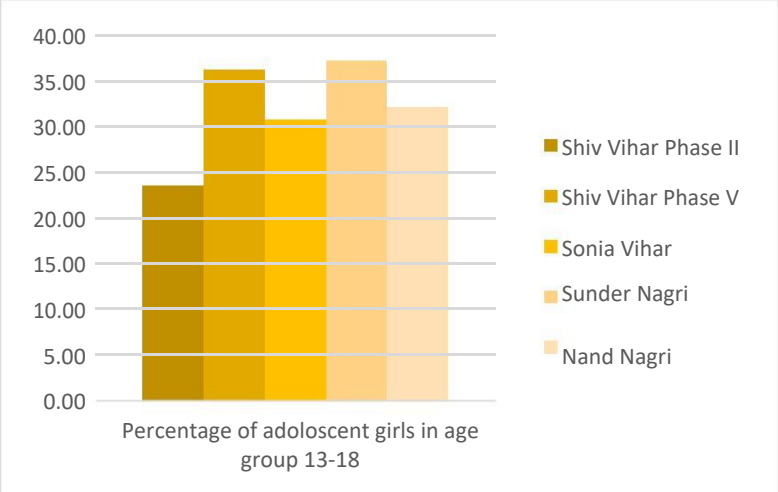

Figure 13: Percentage of adolescent girls in age group 13-18 in the slums under study

Adolescents need correct education about sexuality to practice healthy sexual behaviour as adults. Early exposure to sexual activity can lead to health problems such as unintended pregnancy and STD. In India, a very high percentage of adolescents get married before attaining the age of 18. This exposes them to early sexual activity, and hence early and often repeated pregnancies. This also deprives them from completing their natural development, physically, emotionally and psychologically.

It can be seen in the figure, there is a very high percentage of adolescent population in these slums. It is important that special facilities like adolescent health centre, door to door distribution of sanitary napkin, counselling of parents and adolescents separately and together is provided. Sexuality education should also become an integral part of the community programme in these slums. This would prevent early and repeated pregnancy, which affects the health of women who get married at an early age.

7. Unmet Need of Family Planning in Slums

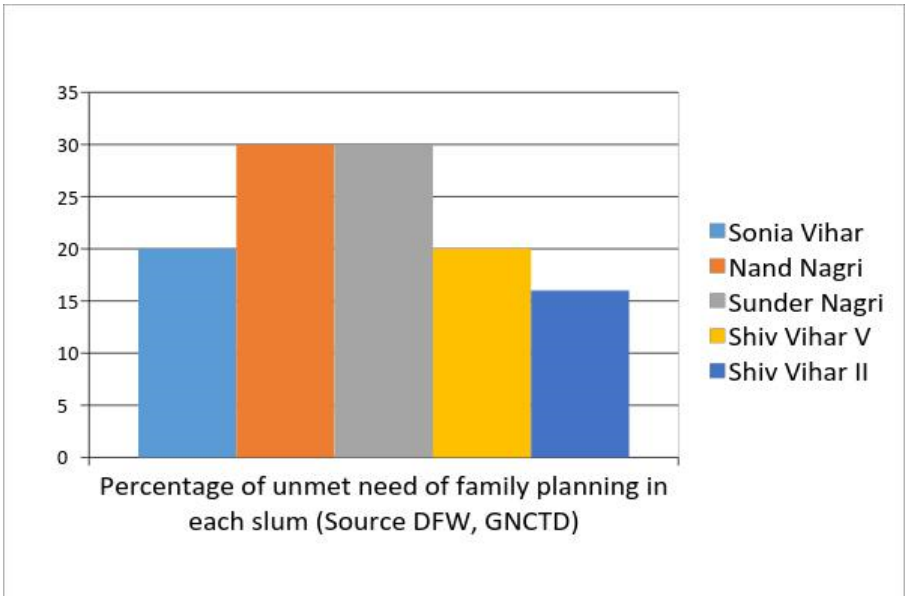

Figure 14: Percentage of unmet need of Family Planning in slums under study

As explained earlier, the reproductive health of women residing in the slums of North East Delhi is a challenge for policymakers (chapter I, methodology). North East Delhi is highly urbanised with nearly 92% of its population marked as urban. Literacy rate is much below the State's average literacy rate of 82%, which makes it the most deprived district. Another important component in relation to the present study made was unmet need (Women with unmet need are those who are fecund and sexually active, but are not using any method of contraception, and report not wanting any more children or wanting to delay the next child) of family planning in the slums. According to National Family Health Survey- 3 (NFHS – 3), the national figure for unmet need is 13%, Whereas the figures in these slum pockets is as high as 30%. Nand Nagri and Sunder Nagri have 30% of unmet need of family planning, where as it is 20% in both Sonia Vihar and Shiv Vihar Phase V. It is the lowest in the Shiv Vihar Phase II at 16%. For this purpose, data on percentage of unmet need of family planning was sourced from Directorate of Family Welfare, Government of NCT of Delhi.

8. Women Married before the Age of 18

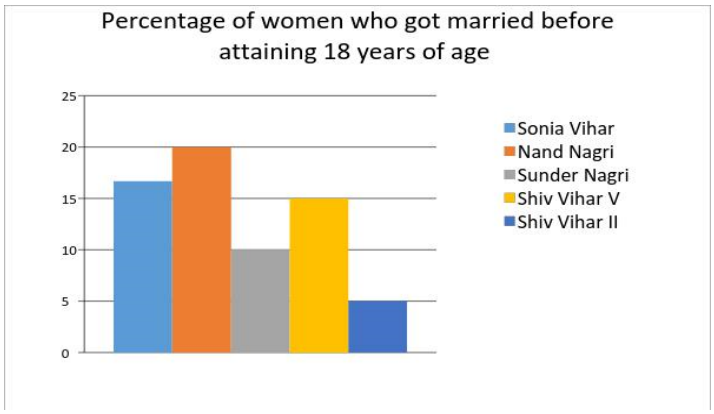

Figure 15: Percentage of women married before 18 years of age in slums under study

In the above figure it is apparent that in Nand Nagri, 20% women got married before attaining the age of 18, whereas in Sonia Vihar it is 16.7%. In Sunder Nagri and Shiv Vihar Phase V, it is 15% and the lowest percentage of women who got married before 18 is in Shiv Vihar Phase II, which is 5%.

9. Women Who used Modern Family Planning Methods before having First Child

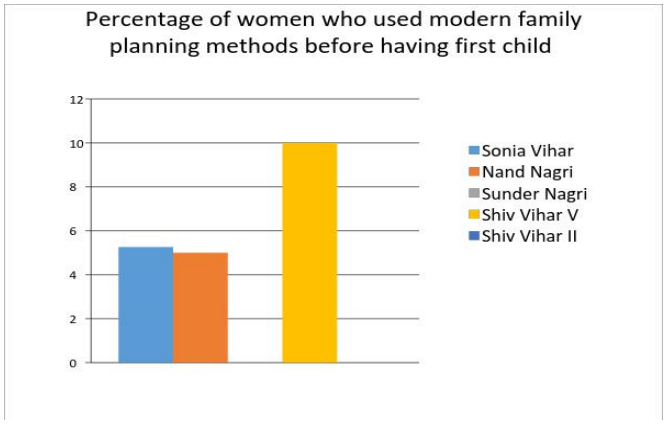

Figure 16: Percentage of women using modern family planning method before first pregnancy

In the above figure, Sonia Vihar has 5.3% of women who used modern family planning methods before having first child. Shiv Vihar Phase 5 has the highest percentage (10%) who used family planning methods. Only 5 percent women used these methods in Nand Nagri. None of the respondents used Family Planning Method in Shiv Vihar Phase II and Sunder Nagri. As compared to other three slums, women of these two slums are less likely to adopt contraceptives. This evokes curiosity to further investigate the factors which are influencing the variation across the slum pockets. The cultural variations across the slums may be the reason for this difference.

10. Employment Status of Women

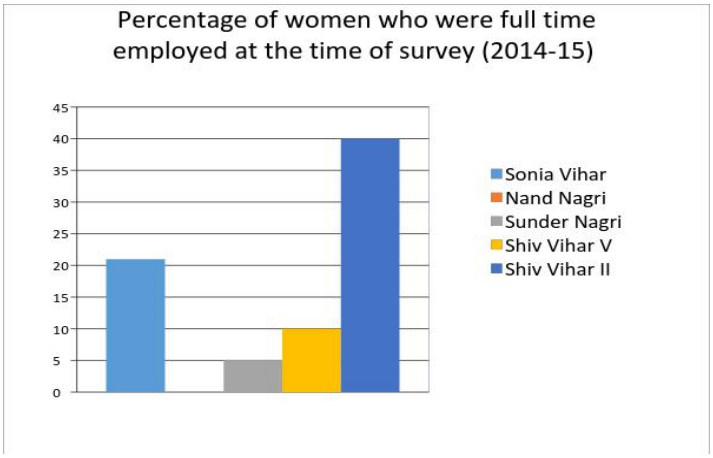

Figure 17: Percentage of women fully employed at the time of survey

In the above figure it can be seen that Shiv Vihar Phase V has the highest percentage (40%) of women who were found employed at the time of survey. Sonia Vihar has 21%, Shiv Vihar Phase II has 10% and Sunder Nagri has 5% of such women, who were employed. Nand Nagri did not have any woman, who was full time employed at the time of survey. Economic dependence of women is an obstacle to their empowerment.

11. Attitude of Women about Sex Education to Unmarried Girls

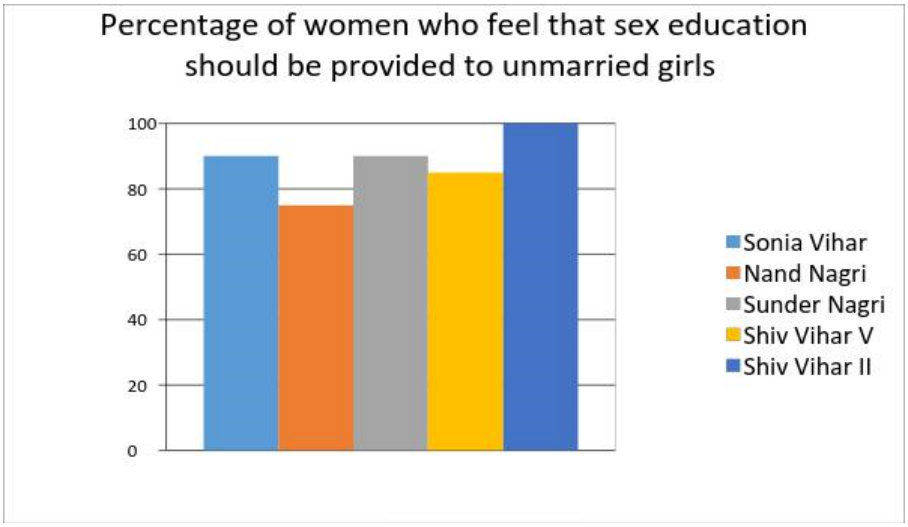

Figure 18: Percentage of women who feel that sex education should be provided to unmarried girls

It is evident in the above diagram that 100% women in Shiv Vihar Phase V believe that Sex education knowledge should to be provided to adolescents. 90% Respondents of Sonia Vihar and Sunder Nagri felt that this is important. 85% women from Shiv Vihar Phase II also firmly believed that this should be made available to children. Nand Nagri respondents have the lowest percentage of 75% in this regard.

A high percentage of women feeling positive about sex education to unmarried girls, is an encouraging trend. This shows that women realize the importance of knowledge of sex education before getting married. They do not want their children to face the problems of unintended pregnancy and AIDS/STD.

With the help of ASHA workers, the reproductive status of men and women residing in the selected slum pockets was compiled. The following state of affair was noted in the North East district as per ASHA portal 2015-16[206]:

Table 7: Reproductive Health Indicators in North East District

Reproductive Health Indicator	Sonia Vihar	Nand Nagri	Sunder Nagri	Shiv Vihar Phase II	Shiv Vihar Phase V
Total delivery (Institutional)	1088	1370	1041	795	539
Complete ANC checkup	1154	1299	1032	370	223
Total female sterilisation	29	65	42	23	9
IUD insertions	184	320	200	299	112
Male sterilisation	1	0	0	0	0

In the above table, it can be seen that the institutional delivery is highest in Nand Nagri and is lowest in Shiv Vihar phase V. Though female sterilization method is the most accepted family planning method among women, but the number of temporary method adopters (IUCD insertion), is also encouraging. The percentage of male sterlisation adopters is almost nil, which conveys the message that the onus of family planning service adoption is on women.

Correlation Between Women Empowerment and Family Planning Index

For further analysis, the data from five slum pockets was collated and entered into an excel sheet (As enumerated in the chapter on methodology). The questions were

[206]Reproductive Health Indicators in North East District, ASHA Portal 2015-2016, Government of NCT of Delhi

entered into top row and for each question the answer found out as in the enumeration questionnaire was entered. The ground survey involved three hundred fifty women in 15-45 age group and the survey covered seventy such women in each slum pocket. Therefore, there are three hundred fifty rows in which the data was entered. Many of the questions in the questionnaire has answers as yes & no and many of them had different options, in some cases going up to nine options (Question number 8 of the questionnaire for example). A copy of the questionnaire is given at Annexure F. The answers to each question were required to be given different weightage depending on the type of question, so that they can be analysed. For this purpose, each of the options in a question was given a weightage of 0, 1, 2 or 3. For example in question no. 10 and 11 which has two options "Yes" and "No", the corresponding weightage given to the answers are "1" and "0". However, for question no. 25 which has seven number of options starting from 1 to 7, the weightage to each of the option was carefully chosen. In this particular question, the question and the weightage given to the options was as follows:

25. What is your view about contraceptive methods?

1. I have used contraceptives without any problems
2. I have used contraceptives in spite of problems
3. It is troublesome to use
4. It has side effects
5. It is against nature
6. I don't like to use
7. I never used

Table 8: Method of giving weightage to options

Option No.	**Weightage**
1	1
2	1

3	1
4	0
5	0
6	0
7	0

All the options of different questions were enumerated in a similar manner.

Questions on empowerment – These were included in the questionnaire from question number 41 to 55. Question number 55 had five parts. For calculating the empowerment of women in the household, the empowerment information part of the questionnaire was subdivided into 4 parts. These were included in the questionnaire as question number 41, 42, 43, 44 and 45. As a measure of Household Economy Empowerment Index, an average of weight of all these five questions was used.

For Socio Economic Index, the interpreted data of question numbers 46 and 49, which are questions regarding as to who normally decides about her meeting her family members and relatives and who takes decision about availing health services, have been used. For index on sexual activity, the weighted answers to question number 51, 52, 53 was taken. For assessment of women empowerment regarding the absence of domestic violence, which were included in question number 55(i), 55(ii), 55(iii), 55(iv) and 55(v), a weighted average was taken and has been defined as Domestic Violence Absence Index. Using these components, a Composite Empowerment Index was calculated, which is the average of all the above points related to empowerment section of the questionnaire.

Data on family planning was divided into three parts which gives information about the women on her knowledge of the family planning, her aptitude towards family planning and on family planning practices being used by her. Accordingly, three indices named Knowledge Index, Aptitude Index and Practice Index have been designed.

Knowledge Index – It has been calculated using the weighted average of interpreted data of question number 9, 10, 11 and 12, which is regarding knowledge about the family planning practices.

Aptitude Index – The interpreted data related to question number 13, 17, 18, 19, 20 and 23 has been used.

Family Planning Practice index – For calculating this index, the interpreted data from question number 26, 27, 28, 30, 34, 39 and 40 has been used.

As was done for data related to Empowerment Index, the Composite Family Planning Index has been calculated using the weighted average of Knowledge, Aptitude and Practice of family planning practices.

All these indices, which are primarily four indices on empowerment, a composite empowerment index, three indices of family planning and a composite family planning index were taken to separate excel sheet for correlation.

The data of various indices were arranged slum area wise. As stated earlier, from each of the slum, a sample of 70 respondents was taken and the analysis of these indices after calculating the Pearson Correlation, was undertaken.

The Microsoft Excel program provides for a statistical function called “Pearson Correlation”. This is a measure of correlation between two data sets. For example, a dataset having the following data have a Correlation Coefficient of 1:

Table 9: Dataset returning a Pearson Correlation of 1

1	2
2	4
3	6
4	8

A correlation coefficient of 1 means a perfect positive correlation. Similarly, the dataset in the next table,

Table 10: Dataset returning a Pearson correlation of -1

1	-2
2	-4
3	-6
4	-8

has a correlation coefficient of -1. A correlation nearer to 1 indicates more positive correlation and the one near to 0 indicates little or no correlation. Values in –ve indicate negative correlation.

Using the Pearson Correlation function of excel, the following are the calculated correlations for different slum areas:

Shiv Vihar Phase II

Table 11: Pearson correlation for Shiv Vihar Phase II

Correlation between	Area Name	Correlation Index
Overall Empowerment Index - Overall Family Planning Index	Shiv Vihar Phase – II	0.80
Household Economic Index – Overall Family Planning Index	Shiv Vihar Phase – II	0.78
Socio Economic Index – Overall Family Planning Index	Shiv Vihar Phase – II	0.67
Sexual Activity Index – Overall Family Planning Index	Shiv Vihar Phase – II	0.28
Domestic Violence Absence Index – Overall Family Planning Index	Shiv Vihar Phase – II	0.64

The correlations, as seen from the table above, between the overall empowerment index and overall family planning index is very high at the level of 0.80. As explained in previous paragraph, this correlation of 0.80 means that a higher level of empowerment

has led to a higher level of knowledge, aptitude and practice of family planning in Shiv Vihar Phase II slum area. Similarly, it can be seen that a better economic status has led to better overall family planning index. Further, there is high correlation between socio economic index & domestic violence absence index with overall family planning index. However, there appears to be low correlation between empowerment index related to sexual activity with the overall family planning index. Though generally it is understood that an empowerment in the choices of sexual activity should lead to higher family planning index, some of the answers by the respondents to the questions related to sexual activity, are likely to be incorrectly stated due to social pressure and general reluctance to talk about it. Hence, a low correlation finding in this aspect may have to understood in conjunction with other correlations.

Shiv Vihar Phase V

Table 12: Pearson correlation for Shiv Vihar Phase V

Correlation between	Area Name	Correlation Index
Overall Empowerment Index - Overall Family Planning Index	Shiv Vihar Phase – V	0.89
Household Economic Index – Overall Family Planning Index	Shiv Vihar Phase – V	0.83
Socio Economic Index – Overall Family Planning Index	Shiv Vihar Phase – V	0.69
Sexual Activity Index – Overall Family Planning Index	Shiv Vihar Phase – V	0.78
Domestic Violence Absence Index – Overall Family Planning Index	Shiv Vihar Phase – V	0.43

The correlation, as seen from the table above, between the overall empowerment index and overall family planning index for Shiv Vihar Phase V, is very high at the level of 0.89. Similarly, it can be seen that a better economic status would lead to better overall family planning index in this slum, as the related correlation is very high at 0.83. Further, there is high correlation between socio economic index & domestic violence

absence index with overall family planning index. These figures are 0.69 and 0.78 respectively. In this slum pocket, there appears to be high correlation between empowerment index related to sexual activity with the overall family planning index. The correlation between domestic violence absence index and the overall family planning index at 0.43 in this slum area, can be termed as good correlation.

Sonia Vihar

Table 13: Pearson correlation for Sonia Vihar

Correlation between	Area Name	Correlation Index
Overall Empowerment Index - Overall Family Planning Index	Sonia Vihar	0.62
Household Economic Index – Overall Family Planning Index	Sonia Vihar	0.47
Socio Economic Index – Overall Family Planning Index	Sonia Vihar	0.57
Sexual Activity Index – Overall Family Planning Index	Sonia Vihar	0.31
Domestic Violence Absence Index – Overall Family Planning Index	Sonia Vihar	0.26

The correlation, as seen from the table above, between the overall empowerment index and overall family planning index for Sonia Vihar, is high at the level of 0.62. Similarly, it can be seen that a better economic status might lead to better overall family planning index in this slum, as the related correlation is moderate at 0.47. Further, there is high correlation between socio economic index with overall family planning index. This figures for this slum is 0.57. In this slum pocket, there appears to be low correlation between empowerment index related to sexual activity with the overall family planning index. The correlation between domestic violence absence index and the overall family planning index at 0.26 in this slum area, can be termed as low correlation, making it difficult to indicate to a policy prescription.

Sunder Nagri

Table 14: Pearson correlation for Sunder Nagri

Correlation between	Area name	Correlation index value
Overall Empowerment Index - Overall Family Planning Index	Sunder Nagri	0.63
Household Economic Index – Overall Family Planning Index	Sunder Nagri	0.44
Socio Economic Index – Overall Family Planning Index	Sunder Nagri	0.26
Sexual Activity Index – Overall Family Planning Index	Sunder Nagri	0.23
Domestic Violence Absence Index – Overall Family Planning Index	Sunder Nagri	0.46

The correlations, as seen from the table above, between the overall empowerment index and overall family planning index for Sunder Nagri, is high at the level of 0.63. Similarly, it can be seen that a better economic status might lead to better overall family planning index in this slum, as the related correlation is moderate at 0.44. Further, there is low correlation between socio economic index with overall family planning index. This figures for this slum is 0.26. In this slum pocket, there appears to be further low correlation between empowerment index related to sexual activity with the overall family planning index. The correlation between domestic violence absence index and the overall family planning index at 0.46 in this slum area, can be termed as moderate correlation.

Nand Nagri

Table 15: Pearson correlation for Nand Nagri

Correlation between	Area name	Correlation index value
Overall Empowerment Index - Overall Family Planning Index	Nand Nagri	0.62
Household Economic Index – Overall Family Planning Index	Nand Nagri	0.33
Socio Economic Index – Overall Family Planning Index	Nand Nagri	0.28
Sexual Activity Index – Overall Family Planning Index	Nand Nagri	0.21
Domestic Violence Absence Index – Overall Family Planning Index	Nand Nagri	0.28

The correlation, as seen from the table above, between the overall empowerment index and overall family planning index for Nand Nagri, is high at the level of 0.62. However, the hypothesis that a better economic status might lead to better overall family planning index in this slum, does not really stand for this slum pocket, as the related correlation is low at 0.33. Further, there is moderate correlation between socio economic index with overall family planning index. This figures for this slum is 0.57. In this slum pocket, there appears to be low correlation between empowerment index related to sexual activity with the overall family planning index. The correlation between domestic violence absence index and the overall family planning index at 0.28 in this slum area, can be termed as low correlation, making it difficult to indicate to a policy prescription.

Apart from the above mentioned findings a comparison was made of the various correlation across the slum pockets. Some of these comparison are given in next few pages.

Correlation between Different Indexes across Five Slums

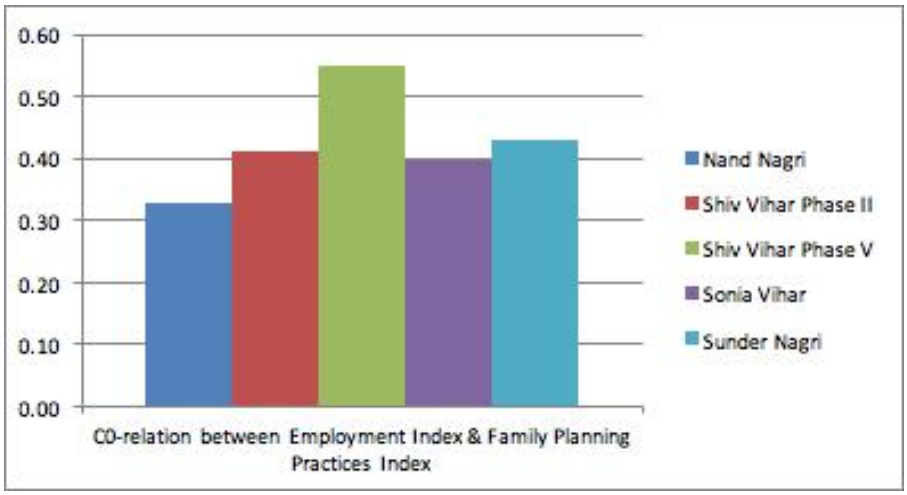

Figure 19: Correlation between Employment Index and Family Planning Index of All Five Slums

The table above gives correlation between Employment index and Family Planning Practices for different slum pockets. The Employment index has been calculated by taking survey data on the employment status of women. During survey, the respondents were asked whether they have worked before marriage or not and if they have worked, whether the employment was full time or part time.

As can be seen from the chart above, there is reasonable correlation between these two indexes. The correlation is highest in the Shiv Vihar Phase V slum at around 55% and it is lowest in Nand Nagri at around 30%. This positive and reasonable correlation between the two indexes suggest that higher employment rate aids to the level of family planning practices. Of course, there would be correlations between the higher social status with status of the employment itself. The employment status would also get affected by the level of education which woman has. This high correlation also leads to policy prescription that women should be encouraged to take up employment before marriage as well.

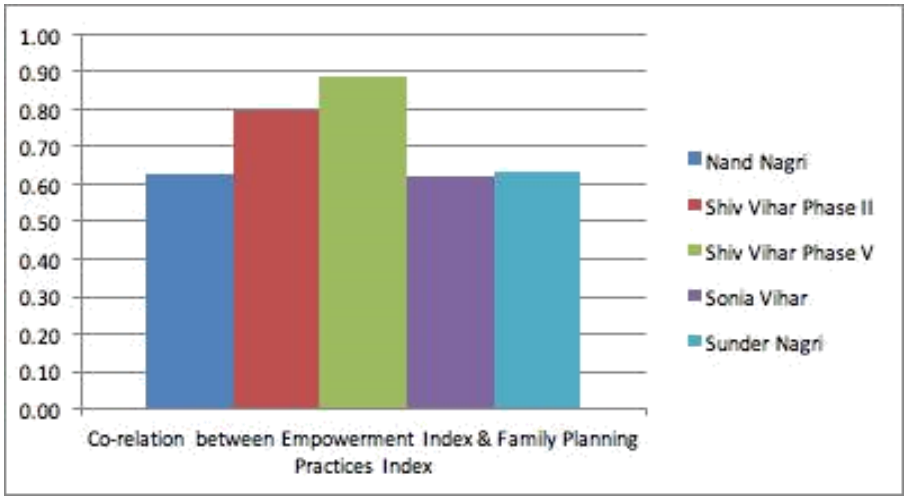

Figure 20: Correlation Between Women Empowerment and Family Planning Index

The above chart depicts correlation between Empowerment index and Family Planning Practices index in five slum pockets under study. As expected, there is very high correlation between the Empowerment index and Family Planning Practices index in all five slum pockets. this correlation is highest in Shiv Vihar Phase V at around 90% and is lowest in Sonia Vihar and Nand Nagri at around 60%. The empowerment index includes components like how the money is spent in the family, who decides about the household purchases, who takes decision as to which relatives should be met and when, who takes health related decisions, whether the women can go out of house without seeking her husband's permission or not etc. Though the correlation between the two indexes is high, because of the way empowerment index has been constructed, it does not lead to straight policy prescription. Looking at the components forming the Empowerment index, it is only a long time and consistent effort by the government and non-government organisations that would help in women being empowered.

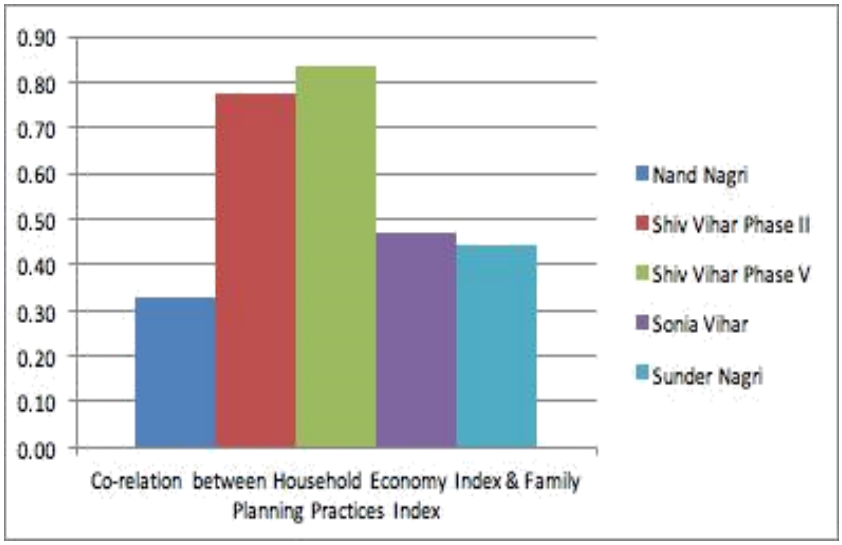

Figure 21: Correlation Between Household Economy Index and Family Planning Practices Index

The above chart depicting correlation between Household Economy and the Family Planning Practices is again on expected lines. In the Shiv Vihar Phase V slum, this correlation is very high at the level of 80% and in the slum of Nand Nagri the correlation, though positive, is low at around 30%. In the slum of Nand Nagri there could be other factors which are restricting high correlation between the Household Economy and the Family Planning Practices. These hindrances would be clear in the next few charts as the individual components of the indexes may not have a substantial impact on Family Planning Practices, if there are other non-contributing or less contributing factors which impact adoption of Family Planning Services.

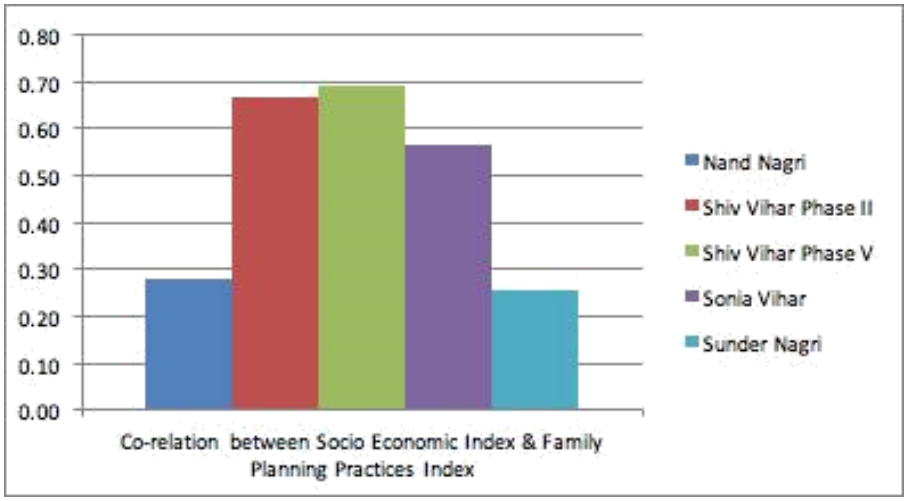

Figure 22: Correlation between Socio Economic Index and Family Planning Index

Socio-economic index is slightly different from Household economy index. The socio-economic index is calculated on the basis of the responses as to who takes the decision, as to which of the relatives should be met and where. Also who in the family takes health-related decision and whether such decisions are taken individually by the women or by the husband or by both of them in consultation with each other. Household economy index relates primarily to decisions concerning expenditure of money in the household.

As can be seen from the chart above, the correlation between the household economy index and the family planning practices is highest in Shiv Vihar Phase V. It is lowest in the Sunder Nagri slum. However, in all the five slums, this correlation is positive. Hence, a clear inference can be drawn that a higher level of socio economic index of empowerment would lead to higher adoption of family planning practices.

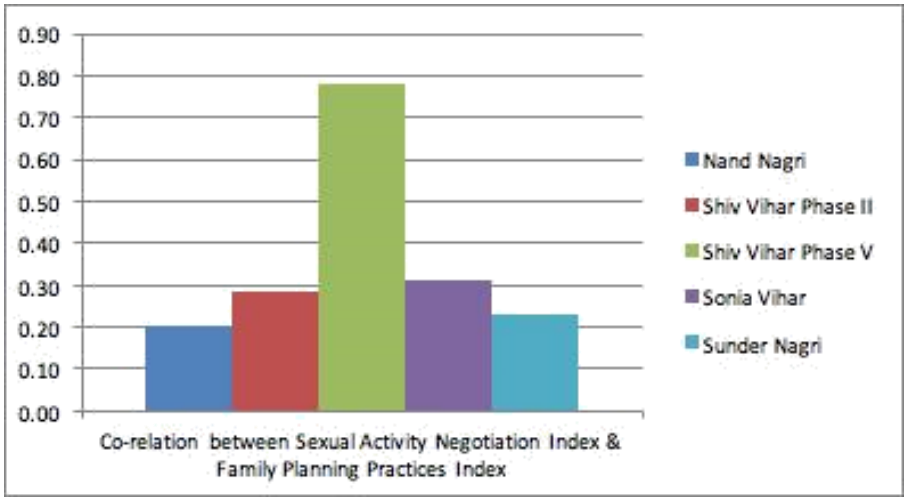

Figure 23: Correlation between Sexual Activity Negotiation and Family Planning Index

The above chart depicts the correlation between Sexual activity negotiation and Family planning practices. Though this correlation is very high in relation to Shiv Vihar Phase V, for others slums this correlation is low. One of the reason for this low correlation could be the sensitivity of the topic itself and the likelihood that the women may not have come up with the correct answers in this regard.

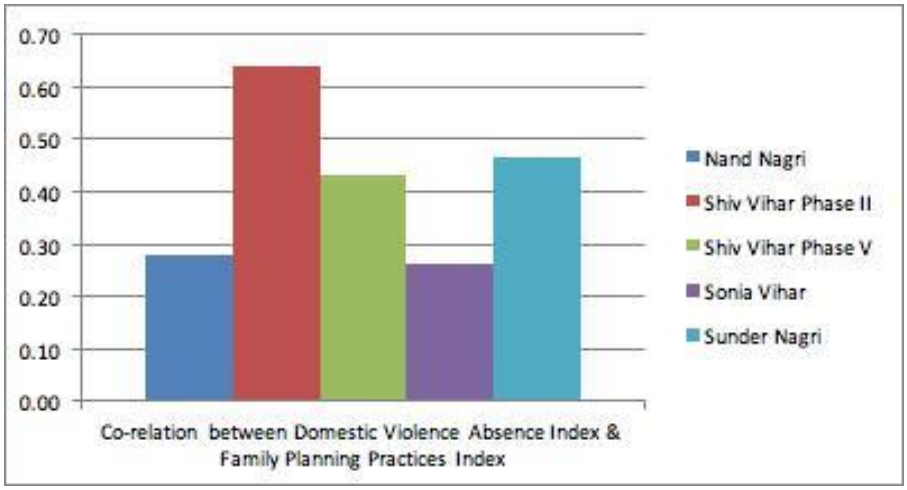

Figure 24: Correlation between Domestic Violence Absence Index and Family Planning Index

The above figure depicts correlation between Domestic Violence Absence and the Family Planning Practices. The indexes vary a lot in this correlation chart and as we

can see, the correlation is highest in Shiv Vihar Phase II at the level of 60%. It is lowest in Sonia Vihar at around 27%. The wide variation between the correlation between the two indexes can again might be due to the sensitivity of the question asked to assess the perception regarding domestic violence and the likelihood that the women may not have come up with the correct answers as to whether their husbands are entitled to beat them up in certain situations or not.

It can conclude from the above tables and charts that overall Empowerment Index has a high to very high correlation with overall Family Planning Index. This goes on to prove the hypothesis that empowerment leads to higher levels of family planning practices including awareness and usage. An important component of empowerment index is household economy level and socio-economic level. Even these two have high correlation with family planning. The sexual activity index and domestic violence index do have positive correlation, but do not have high correlation with family planning.

The objective of the thesis also included finding the correlation between the knowledge, aptitude and practice of modern family planning methods. The questionnaire used for survey included questions related to Knowledge level, Aptitude and Practice levels of the respondents, in the section 2, 3 and 4 respectively of the questionnaire. (The KAP correlation result is annexed as Annexure G).

Using the responses received during the field survey and finding correlations between the responses using Pearson function of excel, an analysis of the correlations have been done for each of the slums. The objective was to understand if the knowledge about family planning services has an impact on the aptitude of women. Also, an attempt has been made to find out if there is a correlation between the knowledge about family planning methods and it’s adoption.

Nand Nagri

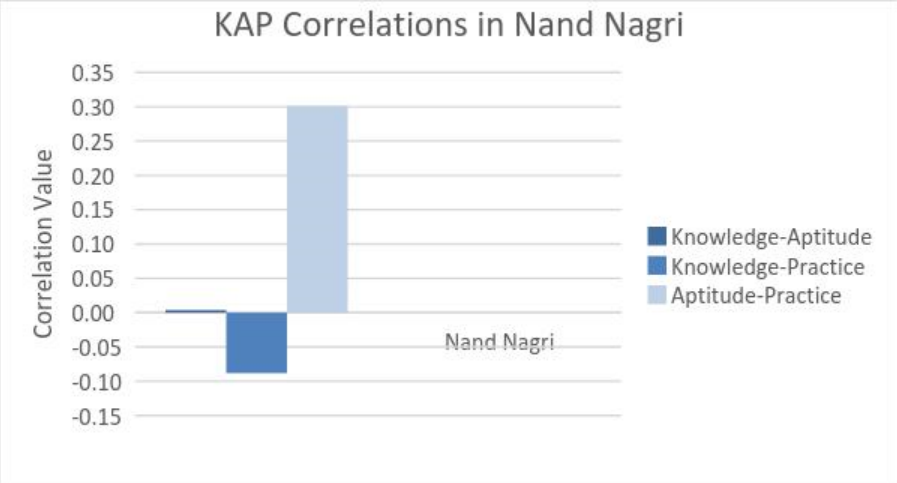

Figure 25: KAP correlations in Nand Nagri

The findings of KAP study reveal that the concept of family planning was well known to respondents in the slum pocket of Nand Nagri. In Nand Nagri, all the respondents knew about family planning services. But, the correlation between the knowledge and aptitude about the family planning services in Nand Nagri is almost zero, which means there is no correlation between the two indicators. This could be because of responses received for aptitude questions, where the respondents might have given expected answers, rather than what exactly they think about those issues. However, there is moderate correlation of 0.30 between aptitude and practice of family planning services in the Nand Nagri slum.

Table 16: KAP correlation for all five slums

	KAP Correlation for all five slums
Knowledge-Aptitude	0.14
Knowledge-Practice	0.06
Aptitude-Practice	0.30

If the correlation between KAP indicators of all the slums is seen, the correlation between knowledge and aptitude & knowledge and practice index is small or insignificant. The only moderate correlation is between aptitude and practice indexes.

Shiv Vihar Phase II

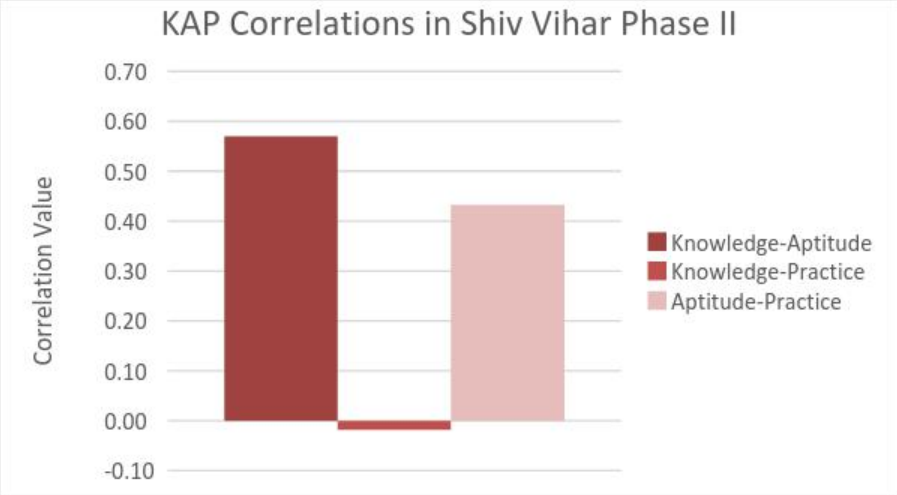

Figure 26: KAP correlations in Shiv Vihar Phase II

Correlations in relation to Shiv Vihar Phase II shows that there is high correlation between knowledge-aptitude and aptitude-practice in this area. Further, there is very small negative correlation between knowledge and practice. This could be because of responses received for practice questions, where the respondents might have given expected answers rather than what exactly they thought about those issues. In the actual responses given by the respondents in Shiv Vihar Phase II, majority of them give positive reply to the knowledge questions and to the aptitude questions. This could be the reason for a small negative correlation as the Pearson correlation calculates the variance, answer to answer, between the two variables and does not consider the answers per se.

Shiv Vihar Phase V

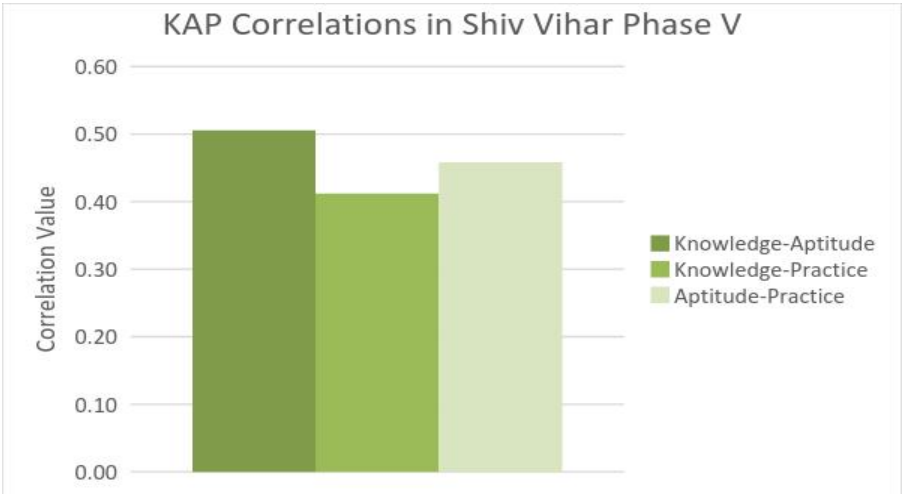

Figure 27: KAP correlations in Shiv Vihar Phase V

Shiv Vihar Phase V has moderately high correlation between all three correlations of family planning services. The reason for this could be high literacy level in this slum.

Sonia Vihar

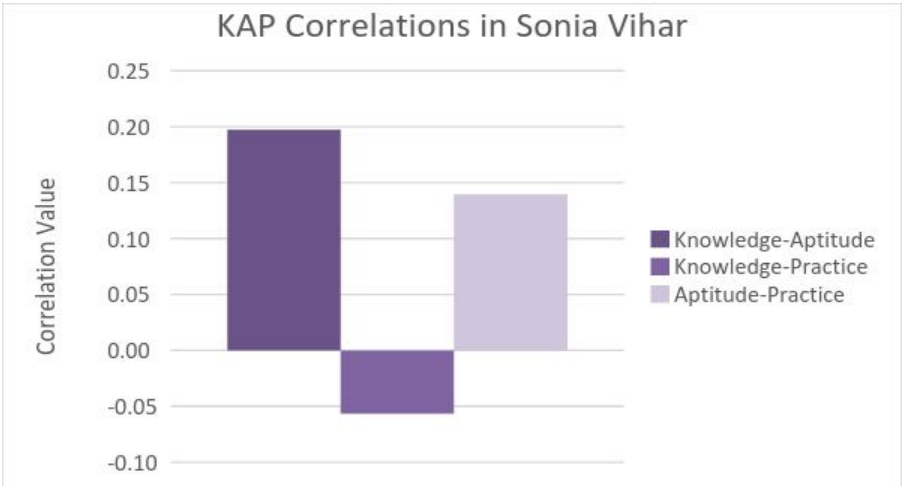

Figure 28: KAP correlations in Sonia Vihar

The KAP correlations in Sonia Vihar slum has moderately low correlation between knowledge and aptitude towards the family planning services. The correlation between

the knowledge and practice and between attitude and practice related to family planning services in this slum pocket is -0.06 and 0.14 respectively.

Sunder Nagri

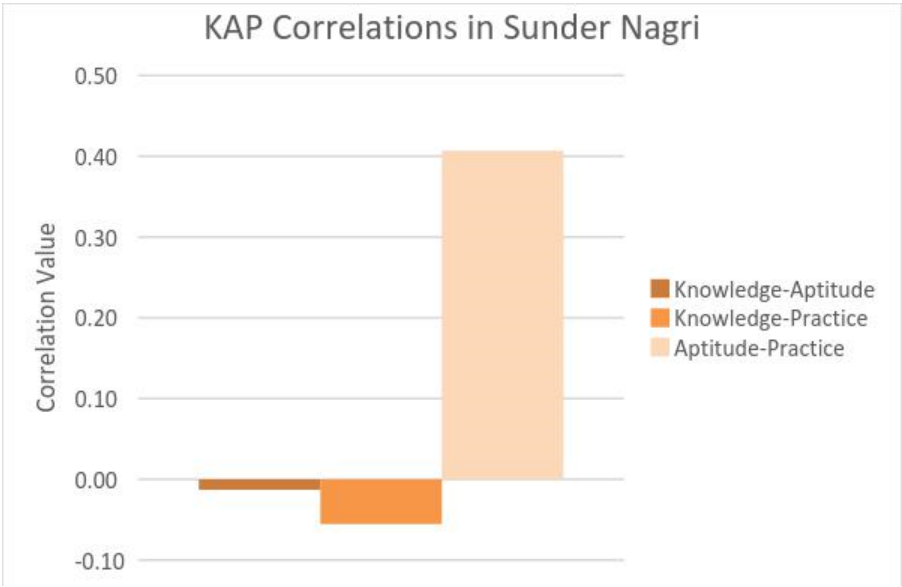

Figure 29: KAP correlations in Sunder Nagri

The findings of the survey show high level of knowledge of modern family planning methods in the respondents in the Sunder Nagar area. However, the KAP correlation in the above figure show that there is almost no correlation (-0.01) between the knowledge and aptitude towards family planning services. In fact, there appears to be negative correlation of -0.06 between the knowledge and the practice of family planning services. The correlation between attitude and practice towards family planning services is positive at significant level of 0.41. Further research is required to investigate the causes of negative and low correlations in this slum.

Qualitative Study

Finding of the qualitative study is given in the following paragraphs.

Focus Group Discussion

This qualitative study was aimed at learning from women and men regarding the unmet need for family planning and the reasons for non-use of modern family planning methods by them. Focus Group Discussion was held to assess methods used by participants with unmet need to avoid unplanned pregnancies and the factors responsible for non-use of modern family planning methods amongst participants with unmet need. FGD also helped in identifying factors responsible for the adoption of family planning services among participants and challenges still existing in the adoption of family planning methods among participants with met need.

Majority of the women with unmet need adopted natural methods of birth control. Breastfeeding was also identified as one the natural family planning methods used by women with unmet need. Although natural methods were reported in all the group discussions held with women who have unmet need, the findings show that the use of these methods is not universal. The effectiveness of natural family planning is hinged on the mutual motivation, cooperation and commitment of partner involved.

Men with unmet need reported use of a range of natural family planning methods to prevent unplanned pregnancies. They specifically use withdrawal/coitus interrupts and periodic abstinence. Men in this category reported the periodic use of condoms to prevent unplanned pregnancy.

Overall discussion revealed certain barriers that inhibit men and women from using modern family planning. Respondents identified a range of side effects including changes in body weight, physical weakness, menstrual disturbances, infertility, malformation in newborn babies and death of newborn. Men feared the consequences that family planning would have on the health of their wives. These fears were mainly attributed to the experiences that men had heard from their peers and other family members who reported adverse consequences after using family planning. Men with

unmet need reported that their wives attempted to use family planning methods in the past, but were unable to continue with the practice due to the side effects experienced.

My wife tried pills but she got headache. At times she would even fail to work. When I suggested that she changes the method, she insisted she had had enough of it (Men's FGD, Shiv Vihar)

The decision to stop a method was sometimes taken without seeking professional guidance.

The findings show that low levels of communication between partners was key hindrance to adoption of positive practices among women who are motivated to use modern methods. Some of the women with unmet need reported that they were not using modern family planning methods because of their perception about what their husband's responses would be. Women make assumptions about their husband's response to family planning use. Discussions show that some women with unmet need were afraid to introduce the subject of modern family planning due to the fear that their partner may become suspicious.

I have heard that condoms are one of the methods of family planning. I think that is the only method that I can use, because it does not cause diseases. But how do I begin to tell my husband to use a condom. (Women's FGD Sonia Vihar)

Some of the male respondents said that they had attended counselling sessions on family planning, but these were organized mainly for women. Further, women had difficulties communicating with their partners on what they have learnt from such programmes.

ASHA didi gave us lot of information about family planning methods but I think men should also be sensitized on these issues. They also have concerns. If you talk only to women, you cannot make a difference (FGD, Sonia Vihar Women)

Women who wanted to use family planning were discouraged by the family members, particularly mothers-in-law and partner/husband from doing so. Some of the women with unmet need reported that they were not using modern family planning methods

because their husband had refused permission. The men have control over the women's reproductive health and they often take decisions on whether to produce more children or not. Some women who are motivated to use family planning methods are unable to do so because of lack of control over decision making related to their sexual reproductive health.

I had accepted to join family planning but my husband is the one who refused; he said that he still needs children (Women's FGD Sunder Nagri)

Discussion with men revealed that family expectations also act as a barrier in the adoption of modern family planning methods.

Elders in the village are not happy with those women who use family planning. Parents always complain about their sons who give permission to their wives to adopt family planning methods. Specifically, elders of the family do not want us to adopt any method till the first child is born. (Men's FGD, Shiv Vihar)

The study observes that some men with unmet need consider decision making on family planning to be responsibility of women. Participants appreciated availability of health activist ASHA in their slum pocket.

We are lucky that ASHA didi helps mother of our children learn to adopt family planning services (Men's FGD, Shiv Vihar)

The idea that family planning is a woman's responsibility is strengthened by programmes which target only women and do not include men.

Does family planning also work for men? The reason I am asking is because most of the gatherings which are called for family planning are targeting women. I think it is only for women (Men's FGD, Shiv Vihar)

Some of the men reported a lack of knowledge on family planning. The focus group discussions held were appreciated as an opportunity to understand their role in family planning.

*We are not using family planning methods because we do not have sufficient information. If people understand family planning the way we are discussing it here now, it will help us a lot. (*Men's FGD, Sunder Nagri)

Many factors were identified during FGD which influenced men and women in the adoption and continued use of family planning. Visit and advice of health activist ASHA worker helped women decide to adopt family planning methods. Women also have the opportunity to visit health centers for a number of reasons including antenatal care, taking children for immunization and health treatment. Such visits are used as an opportunity for health workers to disseminate family planning information and to provide advice to women on modern methods.

I used to go to the hospital and the nurses who were there, told me that I should have space between the two children. And she also told me to discuss this with my husband so that he can also agree on using family planning methods. (Women FGD, Sonia Vihar).

While social networks are mostly hindrance to family planning, they are also sometimes a facilitating factor for family planning. Some of the women during this discussion revealed that they used family planning methods because of the advice they received from some relatives and friends.

Economic factors play an important role in helping men in taking decision about the adoption of family planning methods. They felt that with limited means, they will not be able meet the basic need of the children.

*At first I thought that we should have many children but when my income reduced, I realised that it would be difficult to take care of a large family. Nowadays a child's education is must. Everybody is sending their children to school. This is the reason I told my wife to go for family planning. (*Men FGD, Sonia Vihar*)*

Women reported that they observed the people in their community using family planning were able to take care of their children in a better way. This motivated women to adopt modern family planning.

*I was encouraged to use family planning because I saw that people who were using it had happy families (*Women FGD Sonia Vihar*)*

The discussion revealed that few men were in support of their partner's use of modern family planning methods. Few men indicated that communication with their wife had helped them to adopt modern family planning. Open discussion enabled couples to discuss choice of family planning methods to be used. Some of the men using family planning methods were motivated to do so by the information received from family planning communication campaigns on TV.

Challenges faced by participants

Women reported that their husbands had initially rejected the idea of using family planning.

*When I decided to use family planning, I waited for a time my husband was in a good mood to bring up the topic. He quarreled as he wanted many children though we had very little income. (*Women's FGD, Shiv Vihar*)*

Some of the women delayed their adoption of modern family planning methods due to the resistance by their partners. On the other hand, discussions with the men revealed that in some cases, women are reluctant to use family planning even after the men have made a decision to adopt modern methods. Such situations develop due to lack of information and fear of side effects of family planning.

Commonly held misinformation about the side effects of family planning is another obstacle that women and men using family planning have to overcome. Men feared that using contraceptives would have negative effects on the health of their wives. Majority of the men said that they did not have sufficient information about the use of modern family planning.

When we decided to use family planning, my wife became afraid. She started telling me that she had heard that pills affect the capacity to conceive later. But I encouraged her to go ahead and promised to support her. (Men's FGD, Nand Nagri)

According to the participants this could be solved with the help of the ASHA workers who provide professional advice on the use and benefits of family planning methods.

Women with unmet need have a tendency to rely on natural family planning methods particularly withdrawal and the rhythm method. Women have basic knowledge about modern family planning methods. They were aware of a range of short term and long term methods, but in some cases were lacking knowledge to use these methods. Fear of side effects associated with family planning is the key factor for unmet need among women. Women who wanted to use family planning were discouraged by their friends and family members, particularly mothers-in-laws and partners/husbands from doing so.

Low levels of communication between partners is also a barrier in the adoption of family planning methods among women, who otherwise are motivated to use modern methods. Women had formed opinions about their husband's reaction to the use of family planning methods, even when they had never discussed the same with them. The lack of couple communication is mostly female focused. Women with unmet need are not likely to seek for information on family planning from professionals.

Factors Which Encouraged Adoption of Family Planning Services

The factors which encouraged women in adopting family planning methods include information from health workers, the desire for a healthy family life and support from partners. Health activist ASHA workers were identified as an important information source, who had encouraged women to begin using modern family planning methods. Women's visits to primary health centres helped them obtain family planning information which further helped them to make informed choices on adoption of modern methods. While social networks are in general a hindrance to family planning, they are also a facilitating factor for family planning in many cases. Some of the women reported that they used family planning methods because of the advice they had received from some relatives and friends. The desire for healthy children was identified as a reason why some women decided to use family planning. Women used modern methods, because they recognized the need to have healthy children. Support and encouragement from partner is a key factor for women's use of modern family planning methods. The study results show that at the beginning men are usually not supportive of

their partner's use of modern family planning methods. The men however later realize the benefits and supported their wives to use modern methods. This support was acknowledged as useful in sustaining the use of modern family planning methods.

Men with unmet need demonstrated knowledge on the benefits of family planning. Factors for unmet need of family planning among the men include fear of side effects, as well as lack of appreciation of the role of a man in the adoption of family planning methods. Family planning was perceived to be a woman's responsibility by men. Lack of information was identified as a barrier to family planning use.

None of the men targeted in the study were directly using a modern family planning method. The partners of these men were however using a modern family planning method. The economic factor was the most dominant reason for use of modern family planning amongst the men. Men, however, approved use of modern methods by their wives, because of the lack of financial capacity to meet the needs of a large family size. Family planning campaigns were identified as a main source of information on family planning for men. The information received during communication campaigns helped some men to take decision on using modern family planning methods.

There are lots of misinformation and misconceptions about modern family planning methods. This misinformation is widespread and believed to be the truth amongst those with unmet need. Social and cultural factors are important, but they can be overcome if respondents have correct information about family planning and its side effects.

Lack of communication among the couples also adds to the reason of unmet need. The communication campaign on unmet need has to address the fear that respondents have about modern family planning methods.

The study focused on knowledge, perception, practice, involvement and barriers to Family Planning which are personal and sensitive. Some respondents were not willing to share information.

Interview with Government/Health Officials

To collect quantitative data from the field, a survey was conducted in five slum pockets of North East Delhi. The questionnaire itself was very detailed and it solicited answers on various issues so as to get information on empowerment of women and family planning methods which they use. However, any quantitative data has its own limitations, because various other thoughts and practices which the respondents and their partners might be willing to express, does not get captured in a structured questionnaire.

To supplement and to support the field survey, a focus group discussion was held in which both men and women of the area participated. Though the focus group discussions for men and women were held separately to ensure that a free and frank discussion is held, the focus group discussion brought out many points which have been covered in another part of this thesis.

However, a third perspective which is from the health providers as well as from the side of policy planners, is also very important as to what inputs they are getting while planning the policy or changing the strategy and then to correlate it with what has been understood in the field survey and in the focus group discussion of the women and families, who are of the similar background as those who have been assessed in the field survey.

Accordingly, many government officials and the health officials were requested to give answers to a structured questionnaire and two government officials and six health officials responded to the request and gave their opinion. These opinions have been consolidated in the next few paragraphs.

A certain percentage of women are forced by their male partners for not using any contraceptive either by himself or the woman**.** Some men believe that this would act as a barrier in their sexual relation with their wives and will hinder their pleasure. Inadequate and inappropriate knowledge about contraceptives acts as a barrier. People do not know from where to procure contraceptives. Even when they are aware of their availability at the chemist shop, they hesitate in asking for the same.

Women are not in charge of their fertility. It is regulated by their husband or mother in law. In case of less educated & illiterate women, despite wanting to delay their first pregnancy, many of them conceive early because of family pressure. Usually it is the educated married women who despite wanting to delay their first pregnancy are unable to do so for variety of reasons like marrying late & thus having a fear of not being able to conceive late. Side effects due to oral contraceptives (hormonal method) & IUD also might be a mental hindrance in certain percentage of women.

Generally, men and women are unaware of the benefits which they can derive if they avail of family planning services. Many of them have "I will cross the bridge when it comes" attitude (when something happens, take care of it at that time). According to the experts, non-use of family planning method can be solved by home delivery of contraceptive by ASHA workers in the vulnerable groups.

On being asked about the barriers in desired reproductive health and rights for women, the officials responded that reproductive health remains a forbidden subject due to cultural norms. Social status of women is such that they are generally subdued. They have been conditioned to feed other family members first and eat whatever is left by them and seek permission from their mother-in-law/husband for any medical assistance. Women, in India are not treated at par with their male counterpart. In educated classes this view may be changing, but in general, she holds a lower status than a man. The preconceived notions in the Indian society view her as a mother, sister, wife, homemaker, but not as a person who would assert herself. Whatever may be her educational attainment, to be accepted by her family elders, she has to fall back to stereotype of typical Indian women. So if she is married, she should get pregnant soon or else she has to be in a readiness to face the consequences of her defying acceptable social norms. The practice of restraining women's impulse and emotions is so deep rooted that even the girl's parents subscribe to the same view and require her to accept such a role completely. In order to claim her rights in society, she has to stand up against all these people or take the usual route of getting subservient and following the wishes of her husband, in-laws and parents.

Contraceptive programs including emergency contraception methods need to be strengthened. This requires increasing the awareness of such methods, enhancing the knowledge of both men and women, and also educating the women about the role they should play in family life. Women in particular also need to be educated about their role as change agents and need for their association in making economic contribution to the society. Women's participation in economic and social field is of paramount importance to ensure all round development of family, society and nation. Therefore, it is imperative that women should be educated, motivated and organised to work as a demand group. Although the modern jurisprudence guarantees equality between men and women, women still suffer lot of injustice due to many health disadvantages inflicted on them in form of sterilization operations. Besides suffering these health disadvantages, women have lower social status and are hardly given any important social role. Though the international treaties, conventions and the national laws guarantee equal treatment to the women, they are still relegated to secondary positions when it comes to getting adequate nutrition and health care. They are also neglected in providing education. In a country like India, these would be taken as denial of human rights. Therefore, there is an urgent and important need to ensure that not only the rights of women related to sexuality and reproduction is correctly translated into laws, but also that appropriate programmes are formulated to ensure that they get full advantage of these rights.

While many civil society organisations and social movements in India have increasingly turned to the law (and actively worked for the passage of new legislation) to force the state to actively promote social change for the well-being of women, there remain notable challenges to such legalistic strategies. There is a perceptible lack of political will necessary to enforce them. Another practical difficulty in their implementation is the legacy of an overburdened judiciary, implying that cases may take several years to be resolved.

India has traditionally been a male dominated society. There is a preference for male child in most parts of India, and great prejudice against girls tend to beset such families.

Demographic trends indicate deep-rooted gender discrimination. Social stigmas of female feticide, prenatal sex determination and sex pre-selection still exist in many states in India. Girls are deprived of educational opportunities, access to healthcare and equal opportunity in employment. In many places, girls are taken out of school when they reach puberty.

From the very beginning of life, girls are groomed to accommodate in the society where the males hold primary power. Girl children grow into adulthood without being able to experience the important period of adolescence. They work at home, look after siblings, and assist their mothers in the fields. Then they are married off early to soon become mothers themselves, still unarmed with knowledge about their reproductive needs and rights.

Physical inaccessibility (location of health center) and lack of access to contraceptive devices also act as stumbling block. There is poor access to reproductive health services e.g. antenatal check-ups, high risk pregnancy, emergency obstetric care etc., which limit attainment of desired reproductive rights.

Generally, there is shortage of well trained staff who could provide counseling. Also the health service providers are insensitive towards the reproductive health needs of the poor people. Lower literacy levels, poor health of women leads to repeated abortions which further leads to vicious cycle of pregnancy.

There is low awareness amongst the classes of population, which require the government funded services the most. There is fear of incurring financial expenditures even at public sector hospitals. The health service outlets are inadequate & are inappropriately / inconveniently located, and further have inconvenient timings & undedicated / non confidential environment. Comprehensive child & maternal survival strategies are the central theme around which population control revolves. Sadly, in most of our states/districts, the gaps persist between demand and supply.

According to health experts, India as a whole has been able to significantly bring down its Total Fertility Rate from around 4.5+ in 1990 to 2.3 as per the latest SRS data 2013, but it is still far away from the target of 2.1 in 2015. Further, the pace of reduction has

been slowed down because of highly populated poor infrastructural states having high illiteracy and high poverty (malnutrition), where the reduction in IMR, MMR & under 5 Mortality rates has been comparatively lesser. This again points to the need for higher investment in survival related programs & strategies. Family planning goals can be achieved if the mindset of the community changes by showing advantage of family planning in a larger perspective provided that government takes certain decisive action in this field. Some sections of society have their specific myths regarding family planning (Bacche allah ki den hain, Jitne hath honge utna accha). To deal with these myths sympathetically and in a manner acceptable to that community, what is needed is to increase the literacy rate and to create awareness regarding family planning methods and to ensure its easy availability in a nearby centre.

People with higher socio economic status and education have started following family planning methods and have limited their size of family to one or two children. However, population with lower socio economic status and illiteracy still do not use any method and have more than two children.

In Indian society, it is the male member who mostly decides about the usage of any contraceptive. Hence as long as there is a desire to have a son, the family size cannot be planned. One health official was of the opinion that the success has been moderate and India has been able to achieve the relatively easier part of mission, but the problem now is to tackle the tougher part and sustain the momentum. As documented in various policy papers, the family welfare goals and objectives are the guiding factors for the family planning programs, but still the desired objectives have not been achieved due to various factors like unavailability of resources, lack of knowledge, different myths and functional difficulty faced during implementation of the programmes. This has resulted in vulnerable section still opting for multiple pregnancies.

There is a need to encourage male participation in planning the family size & spacing of children. Success stories should be shared at local level, in the community itself. Side by side, creating pool of well-trained & fully equipped surgeons who should be visiting

& demonstrating to the workers in their own work place how ‘safe’, ‘secure’, simple’ & ‘trustworthy’ methods are available, would be of great help.

Provision of precise knowledge of different temporary or permanent contraception methods, especially vasectomy, and clearing misconceptions about it, is necessary. Counseling should be provided by assessing the level of knowledge and attitude towards family planning. A strong preference for son leads for failure of family planning, so development of IEC / BCC for gender equality and for adoption of suitable family planning method should be introduced. There is a need to develop better methods like male pill, which is unobtrusive, long lasting and is easily reversible.

Male participation has to be encouraged by changing the mindset of the male dominant society and economic liabilities of larger families should be explained to the family members. Myths about male weakness post NSV should be cleared through seminars, workshops, rallies etc. Counseling is one of the critical elements in provision of family planning services. Through counseling, providers help men and women make and carry out their own choices about reproductive health and family planning.

On being asked as to what suggestions they have for women residing in the slum areas to improve their Knowledge, Aptitude and Practice regarding Family Planning, they advised to use more AV media (Audio-Video) with community based examples, involve local language and culture, provide home based solutions and that women residing in slums should be helped by the local functionaries (as ANM, AWW & ASHA’s) in their area. Community should be made aware of different family planning methods, its availability and easily accessibility in the field. Women must be made aware that her own health is critical to the whole family and thus she must take care of her own nutrition & get regular antenatal care. All contraceptive methods should be explained in all its dimensions, so that she is facilitated in choosing the best that suits her needs, interval / spacing or terminal / sterilization. She should be enlightened about the benefits of breast feeding, vaccinations at correct age, complementary feeding introductions, care during diarrhea, pneumonia, use of ORS & Zinc which are life savers, toll free contact numbers of emergency ambulance service, the nearest PHC/CHC/District

Hospital & it's contact numbers for emergency, about the JSSK/JSY Schemes, the WCD schemes like IGMSSY, etc. She must be assured of a "no out of pocket" expense. Ample availability of contraceptives should be ensured at the nearest health facilities.

A majority of girls are obliged to leave studies after $8^{th}/10^{th}$ standard under pressure from their families. This does not help them get any fruitful job/ financial independence. They should be encouraged to learn some skilled work at places like ITIs, so that they can become financially independent. Financial Independence is key to women taking their own decisions. Unless they are free to take decisions for themselves, knowledge, aptitude and practice alone will not help women to take adequate family planning measures.

Another important set of opinions sought from the health officials was regarding better accessibility, affordability, acceptability and awareness of reproductive health services in Delhi. They advised adequate publicity and ensuring availability of family planning supplies at health facilities, involvement of local private practitioners, proper implementation of "Home Delivery of Contraceptives" scheme. They also suggested that Seminar and FGD should be organized at work places in sectors other than health. Women empowerment should be encouraged by giving equal chance of education. Availability of family planning methods at right time and at a right place should be ensured. They opined that it is important to increase the number of trained lady doctors. These trained lady doctors should be posted in sufficient numbers to outer / rural dispensaries and at smaller hospitals so that they can help ensure provision of women centric contraceptives (OCP, IUCD). Involving the Colleges teachers (after initial brief training to them) for interaction with women's groups at selected social events and chaupals will be beneficial. Doctors & nurses and the paramedical staff should be sensitized that their own attitude towards the visiting clients improves acceptance and reduces the drop-outs. There are Government Health Facilities providing free services, but these are beset with problems like long queues, non-availability of required medicine, rude behavior of staff and unclean environment. The health centre should be within a walking distance, so that the women requiring services doesn't have to spend

any money on transport. Timing should be such that she doesn't miss her work. It is important to listen to women visiting health centre patiently, to give enough time to explain to her about the problem and treatment. Privacy must be maintained during examination. All medicines should be made available and usage of medicines should be explained clearly to them. The Health Centre should maintain an affable ambience.

Limitations of the Study

Measurement of women's empowerment is a difficult endeavour. The sufficiency of data is always an issue. This study is also limited by the data, which has been collected from the field survey. A larger data set would certainly lead to a better measurement of women of empowerment, however, beyond a point the increase in accuracy percentage of interpretation decreases, while increasing the cost and logistics of such data collection. The data for this study came from response of the women chosen for the survey and many of the questions of the survey were hypothetical questions to elicit information about knowledge, aptitude and practice related to family planning. In such questions, there is always a risk that women gave answers, which they feel is a socially acceptable answer, rather than giving an answer which they considered to be a correct answer as per their belief and practice. This bias is specifically important in sensitive questions related to absence of domestic violence and sexual activity negotiation. Further, if the communication between the couples is not up to mark, the women's response may not reflect the reality, in questions related to the number of children they want, the correct age to have the children and the spacing between two children.

Another limitation is related to the spectrum of the data. Since the two important propositions of the population and development programmes viz. the prevalence of contraceptive use and questions related to measurement of women empowerment were collected together at the time of survey, the study has the limitation that the time relation between them i.e. simultaneity or ordering in time could not be determined. The direction of cause and effect may be contrary to common presumption that the choice of contraceptive use may impart a sense of empowerment to the women who will have the satisfaction of controlling their fertility.

Initially the survey was done by visiting each respondent at their place of residence. The respondents were surrounded by their in-laws at their place of residence, who were fearing that the surveyor might misguide their daughter in law. They were present throughout the interview, which might have affected the respondent's answer. Later, it was done with the help of ASHA workers who were residing in the same slum pockets where the respondents were staying. These ASHA workers were familiar with the family members of the respondents. So these respondents sometimes could have given answers which are more socially acceptable, fearing that the workers would later share their response with their family members.

The study was also restricted to married women. Therefore, it might be possible that the women as a group are more empowered that the group of married women alone. This is likely to be true as the unmarried women are generally younger in age and hence are better educated, are more aware due to better access to television, newspapers and mobile services. Hence the results of this survey are applicable only to married women living in urban slum areas.

In slums, the gender inequality is higher. Therefore, even though the women might have reported fertility preference agreement between them and their spouse, in reality it may not be there as the women might be presenting their spouse's wishes rather than a mutually agreed fertility preference. They might be doing this to avoid displeasure of their spouse, if he comes to know about it later.

Analysis

The overall finding of this study proves that better empowerment status of women would lead to better overall family-planning. In the empirical study, the overall empowerment index was created from the following six measures:

- Household economy
- Socio-cultural
- Health seeking behaviour
- Fertility preference

- Negotiation of sexual activity
- Women's attitudes regarding domestic violence

This study identified association between these dimensions and the use of family planning services in the slum pockets of North East Delhi. The other two methods used in this study are:

- Focus Group discussion
- Interview of the family planning providers, which included both health specialists as well as government officials.

Findings of the research suggest that different slums require different strategies to promote family planning. This study points out that the problem of overpopulation has to be dealt at two levels. Firstly, as the availability and affordability of the family planning services in the slums is a serious issue, it need to be improved and made more accessible. Secondly, factors which promote women empowerment needs to be given importance. Government officials have identified socio economic factors, illiteracy, ignorance, myths and beliefs, social pressure, lack of cooperation from partner, fear of side effect, cultural barriers and male dominating society as hindrance in the adoption of family planning services. It was also revealed that awareness about family planning services was more than 90% amongst the respondents, still there existed a gap in the adoption of family planning services in the slums of Delhi. For example, in Shiv Vihar Phase II, 36 percent of the eligible couples are still unprotected. In Shiv Vihar Phase V, the percentage is 33.8%, whereas in Sonia Vihar 24.2% couples are unprotected. This calls for the attention of all the stakeholders who play a key role in improving the adoption of family planning services amongst the eligible couples. Though the Primary Health Centres are existing in all the identified slums of North East District, their number needs to be increased. Primary Health Centres can also be an ideal place for providing information to eligible men and women.

An important factor, which can help in the adoption of family planning services, is counseling and information from Community Health Workers. ASHA workers can play

a key role in this matter. According to NFHS-3, there was an information gap within the users of contraception services. While administering these services, only a one third of the contraceptive users were inform about the side effects of these services. Further, only one fourth users were told as to what to do if such side effects occur.

In the context of five identified slums, the number of ASHA workers in Sonia Vihar is 31, whereas the number of eligible couples is 12,500. In Shiv Vihar V, the number of eligible couples is 2,336 whereas the number of ASHA workers is 18. Shiv Vihar Phase II has 12,500 eligible couples, whereas number of ASHA workers in Shiv Vihar II is 19. Data for other two slums, that is, Sunder Nagri and Nand Nagri is not available. These ASHA workers are expected to visit the area and are required to record the activities regularly. If they work effectively and are monitored regularly, the existing gaps in reproductive health can be bridged. Also, it is important to sensitize them on the issues of women's empowerment and family planning. It was observed during the empirical study that a few of these workers were under the wrong notion that it is better to adopt family planning services only after having the first child. In her interaction with the female clients, one of the ASHA workers in Shiv Vihar V was found using the sentence *"Tumhare paas ek ladka already hai, is liye tumhe family planning apnana chahiye* (You already have one son, hence you should adopt family planning).

ASHA workers' attitude need to change. They have the first hand interaction with the female population of the slums. If they have their own prejudices, biases and beliefs, it will have an impact on the mindset of the people. For example, in one of the interaction with the female respondent in Shiv Vihar Phase V (where ASHA worker was also present), when asked about her attitude towards the wife beating by husband, when child is not taken care of, the immediate response came from ASHA worker "*Thik hi to hai, agar wife apna kaam nahin karegi to uske pati ka haath uthana sahi hai."* (It is right on the part of husband to beat his wife if she does not perform her duties). This prompted the respondent to repeat the same matter. This type of knowledge level might affect the mindset of vulnerable families who are residing in these slums and who have complete faith in these health activists. There is a book available for the benefit of these workers named "*ASHA* ke liye pathya pustika" by Ministry of Health and Family

Welfare, Government of India, which should be read by them after every five to six months. Also, training and sensitization programs should be organised for them regularly.

It is well established that any strategy to contain the population growth cannot solely depend only on the clinical methods (also explained in chapter IV), but it also requires societal initiatives in equal measure. Women empowerment is the ideal way to check this unwanted growth. This is also evident in the result of the present empirical study. This study found correlation between many dimensions of women empowerment and adoption of family planning services. The results of this study are also in agreement with the findings of NFHS-3 survey, which brings out the fact that participation of women in decision making process is positively correlated with the use of family planning services.

This study also reveals that a woman's status, her own self-image and her sense of empowerment affects her ability to control her fertility and her choice of contraceptive method. As the cooperation of the spouse is an issue, the women may choose a method which is not dependent on the agreement of spouse and are less likely to be evident. The degree of a women's empowerment is also reflected by the number of decisions in which she has a final say. It also means that such women have reasonable control in areas, which affects her life.

Findings of the present study suggests that different strategies are required to be employed in different slums to ensure promotion of family planning. For example, in Shiv Vihar Phase II, Sunder Nagri and Nand Nagri, the strategy to enhance contraceptive use could be to promote discussion amongst couples on the issues of fertility, and to involve men in decisions related to fertility and contraception. The findings of Focus Group Discussion reveal that very small percentage of couples discuss about planning a family. The finding further prove that a discussion amongst couples about family planning, leads to planned family. As per the findings of Focus Group Discussion, the couple's discussion about fertility can be increased with the help of health workers. Also, it was found out in the study that men have reservations about the

family planning services, and lots of myths and misconceptions are existing amongst them. In Focus Group Discussion, male participants desired to have Male Health Activist in their respective slums. This would make them comfortable in clearing their misconceptions. At present, Male Health Workers are not existing in any of the identified slums.

In Sonia Vihar, programs aimed at improving women's earnings and their contribution to household in terms of money is more important than the ones aiming at increasing couple's discussion on issues of fertility. In Shiv Vihar Phase II, Sunder Nagri and Nand Nagri, strategies should be employed to improve women's self-efficacy and their attitude related to the negotiation of sexual activity. As per the findings of group discussion, low levels of communication between partners was a key barrier in the adoption of family planning methods among women, who otherwise are motivated to use modern methods. Women had formed opinions about their husband's reaction to the use of family planning methods, even when they had never discussed the same with them. The lack of couple communication is mostly female focused.

The correlation between domestic violence absence index and the overall family planning index was found good in three slum areas that is, Shiv Vihar Phase II, Shiv Vihar Phase V and Nand Nagri, where as it was found low in other two slum pockets of Sonia Vihar and Nand Nagri. The abuses perpetrated by the males against the female partners is a disgrace to the society. The following observation in the NFHS-3 is disturbing which says the same thing. "More than half of women believe that it is justifiable for a husband to beat his wife under certain circumstances".

As family planning programs are not fully implemented in the slums, interventions that aim to increase the ability of women to negotiate sexual activity might be more important in these slums. As the availability of modern contraception methods is also an issue in the slums, such interventions need to take care of this aspect as well. Another important aspect is involvement of men in the process of women empowerment, as it will help the purpose of population stabilization. It is heartening to note that as per results of NFHS-3, three fourth of men accept that contraception is their business as

well. Also two third of men believe that condom use correctly protects against pregnancies. This is an encouraging trend.

People's attitude towards reproductive health, sexuality and contraceptive methods forms primarily during adolescence. It is also during this period that most of the misconceptions creep in and it is important that information needs of adolescents are taken care of. Sex Education is not a part of curriculum in Secondary School of Delhi as yet, although under Kishori Scheme, the girls are informed about their private parts and how to take care of these parts. Gender Sensitization Cards have been prepared by SCERT which are available to all the teachers of Government Schools. These cards depict respect for other gender and boost self-esteem & self-respect. Also these cards talk about 'Good Touch & Bad Touch'. "Komal", an animated film in the form of CD on child abuse has been prepared by Child Line India for Middle Classes 'VI-VIII' and all Education Vocational Guidance Counselors (EVGC) have been told to download the same from YouTube and to show it to all the students of classes VI-VIII under the activity 'How to keep yourself safe'. Preparations for parenthood are required to be started early in life. As nearly half the population of urban poor is under the age of 15, special IEC schemes need to be prepared and launched to educate the children in this age group.

The overall indicators are better in Shiv Vihar Phase II and Shiv Vihar Phase V. Nand Nagri, Sunder Nagri and Sonia Vihar show comparatively poor indicators. Though the correlations between women empowerment and adoption of family planning services were found positive, poor and moderate correlations call for the attention of Social Welfare and Health and Family Welfare Departments.

Recommendations

Address Socio Economic Factors

Government officials have identified socio economic factors, illiteracy, ignorance, myths and beliefs, social pressure, lack of cooperation from partner, fear of side effects, cultural barriers and male dominating society as hindrance to the adoption of family

planning services. It is important that the policy makers should focus on need of having a policy, which focusses on the factors which are acting as barriers in the use of family planning methods by young women before they start their own family. Women should be encouraged to go for higher level of education. Special programmes should be initiated to spread awareness about the health problems associated with early child bearing. There exists a variation in the slums due to underlying socio-cultural faiths and practices. Studies should be done to identify the factors which is offering this variability.

Up gradation of Primary Health Centres

Women who come for prenatal and antenatal checkup at these health centres should be briefed about the benefits of having a small and planned family. Women who come for institutional delivery should be counselled before and soon after the delivery, so that they take right decision at right time. These Primary Health Centres, which exist right in the middle of the slum, can be easily approached by women who desire to adopt family planning services. These health centres should also have a separate counsellor, who can provide information to men and women who visit these public health centres for any purpose. These counsellors can help in removing the myths and beliefs existing in the minds of men and women.

Myths, Fear and Misinformation

There are lots of misinformation and misconceptions about modern family planning methods. This misinformation is widespread and believed to be the truth amongst those with unmet need. Social and cultural factors are important, but they can be overcome if respondents have correct information about family planning and its side effects.

Communication Campaign for Couples

Spousal communication and adoption of family planning methods are closely linked. Lack of communication among the couples adds to the reasons of unmet need. The communication campaign on unmet need has to address the fear that respondents have about modern family planning methods.

Empowerment of ASHA Workers

ASHA workers act as a bridge between the government run health centres and women residing in the slums. It is important to continuously build the capacity of these activists. During the study, it was observed that they had their own biases, opinions and prejudices regarding adoption of family planning services. ASHA workers' attitude need to change. Regular training programmes should be organized to sensitize them on the matters of family planning. Their number should be increased.

Availability of Contraceptives

Another requirement is that all contraceptive methods should be explained in all its dimensions to the women who visit Primary Health Centres, so that she is facilitated in choosing the best method which suits her needs. Contraceptives should be available in ample quantity at the nearest health facilities. Doctors, nurses, ANM, ASHA workers should be sensitized in all the health centres within the slum pockets, so that their own attitude to the visiting clients improve, leading to increased acceptance of family planning services.

The visit of these Health Centres by the surveyors also highlighted the fact that effort should be made to upgrade the existing Primary Health Centres in all the identified slums of Delhi. There are NGOs like Rastriya Parivardhan Sansthan working in North East slums, who should be involved in social mobilization in these areas. They can be used in promotion of awareness and creation of demand of family planning services.

Unmet Need to be Addressed

Studies have identified that gender preference, lower level of education, women's occupation as home maker and age are some of the factors associated with unmet need. In this study, it was found that the awareness level amongst respondents was very high (more than 90%). High awareness level and high unmet need indicate that there are certain user perspective among non-users, which have not been addressed.

Financial Independence of Women should be Promoted

"Stree Shakti" program of Delhi Government was launched to empower poor women, especially those belonging to economically weaker sections of the society through initiatives in income generation. These programs should be properly implemented in these slums. It is important to provide employment opportunities to women who are residing in the slums. Also, skill development programs like "Decent Employment for Women" initiated by an NGO Rastriya Parivardhan Sansthan in Nand Nagri, should be introduced in other slum pockets as well. An humble beginning can be made by training them in conventional pursuits like stitching, embroidery and knitting. Prime Minister Sri Narendra Modi recently launched the Stand Up India Scheme, under which banks will give loans of up to Rs.1 Crore to SCs, STs and female entrepreneurs. There is a need to bridge the knowledge gap between these programmes and the target group.

Issue of Domestic Violence should be Addressed

Policies should be introduced on domestic violence and related gender issues to address violence against women. Also, women should be made aware of their rights of not accepting violence from anyone including their partners and how to act, if inflicted with violence. Self-confidence and esteem should be instilled in women. Gender Resource Centre of Delhi Government was formed to take care of all dimensions related to women empowerment in a holistic manner, and it was envisioned to act as an instrument to bring social, economic and legal empowerment of women, particularly those belonging to underprivileged sections of society. One such centre appears in each slum. An effective implementation of objectives of Gender Resource Centre can act as a single window where women affected by the physical and mental abuse can avail legal counselling.

Women bear ill treatment by their husbands (If certain task is not done as per their wishes), taking it to be nothing odd or unusual. This mindset of women to bear domestic violence as a way of life, has to be addressed by this centre. Also these Centres should enlighten women towards modernization, so that they become an integral part of the

workforce and reshape its demographic makeup. Modernisation will bring many benefits specially to the status & conditions of women.

Educational Opportunities

Modernization is a powerful and favourable factor for promotion of the contraceptive behaviour. Education is an important component in leading women towards modernization. There is no investment more effective than educating girls. Latest report published in one of the newspapers also affirm that if the girls are more educated, the decision to get married gets delayed. Thus an educated woman is likely to become mother at a later stage of her life. It is also an important dimension of women empowerment. At present, there are 128 Government schools in North East District under Directorate of Education. It must be a priority of all schools to foster the education of girls of all sections residing in these slums of Delhi. Education also reduces women's fertility rate and leads to fewer unintended pregnancy. This would save on public sector spending for health, water, sanitation etc. It is important to raise the social status of women because it has a strong relation with health seeking behaviour of women. This can be done by providing them with equal opportunities of education and employment.

Involving Men

When men's perception of societal norms and their concept of female gender and its need will change, it would help the woman's cause of self-worth. Male health workers should be available for counseling of men folk in the community. Also health camps should have provision for the separate counseling counters for men. Men's involvement in IEC activities is important as till the perception completely changes, the men would continue to take important decisions regarding family size and the use of family planning methods. Lack of knowledge in men regarding reproductive health issues has difficult implications for women, who often take help of their male family members regarding issues related to their health. Therefore, men’s knowledge and understanding of fertility and the reproductive health of women is vital to women's health and their well-being.

Strengthening of RCH related Education Components for Adolescents

The School Health Scheme of Delhi should comprehensively cover the knowledge components of RCH in its program. There is also need to localise the components of family planning programs to suit the specific community needs. As the slums have a high proportion of Muslim community, the religious and the Muslim opinion leaders need to be consulted to develop a customised program, so that acceptability of such programs amongst the Muslim community is enhanced.

Gender Discrimination Should be Addressed

Indian women are on the rise as the country is moving away from the male dominated culture. Still discrimination against women is evident in many strata of the society, as they are not considered capable of earning money and seen as economically and emotionally dependent on men. The daughters are regarded as liability as the fear of loss of money due to dowry tradition haunts the parents. They are thus conditioned to believe that they are inferior and subordinate to men. It is only when women participate in the economic and social development, that the full potential of the Indian society can be unfolded. This can be addressed by exposing women to the benefit of education and empowering them in the process. It is important to provide culturally appropriate sexual health information to the adolescents. These adolescents should be assisted to develop communication skills, negotiation and refusal. Medically accurate information should be provided to prevent HIV, other STI, and /or teen pregnancy.

Awareness Must be Created

Awareness must be created through media campaigns.TV is a strong medium and should be used to convey the message of the family planning to both men and women. As revealed by the NFHS-3, only 61 percent of women as against 92 percent of men have seen or heard a family planning message in the media. Since almost all the families of the identified slums possess a TV set, the programs on family planning will emulate interest in them. Extensive Health Education/publicity/awareness should be carried out by using all available media to make public aware. For imparting family planning education and publicity/awareness, all indoor and outdoor media should be used. These could be – Newspapers, TV, Radio, Munadi, Cable, Electronic media,

Hoardings, Kiosks, Bus queue shelters, Cinema slides, Road railings, Public convenience, Video Van/AV van, hiring of agencies, street plays, Metro trains/stations, posters, handbills, calendars, charts and other printed materials.

Role of NGOs

NGOs can play an effective role in the adoption of family planning programmes. The work in areas like male responsibility, integration of family planning in development efforts, community participation, women empowerment, reproductive rights, etc. can be done with the help of local NGOs which are working in these slums.

Address the Problem of Female Foeticide

The significant gap in the number of males and females in the city of Delhi, to which the slums under study belong, points to widespread female foeticide. It is important to increase awareness to address this problem. Ladli (The loved ones), Beti Bachao (Save the girl child) and Beti Padhao (Educate the girl child) schemes should be properly implemented in these slums. Most of the slum dwellers were blissfully unaware of such programs.

Empowerment of Women

The International Conference on Population and Development (ICPD) of 1994 shifted the focus from slowing down population growth to improving the lives of the individuals, particularly women. “Population policies should address social development beyond family planning, especially the advancement of women, and that family planning should be provided as part of a broader package of reproductive health care”. Women empowerment directly affects the reproductive behaviour of women and has a regulating impact on their fertility. Women's reproductive activities and their fertility is influenced by their own sense of empowerment. If she feels more empowered, she would have more freedom to choose her education, timing of her marriage, her choice of contraceptive, her timing to have children and her participation in societal and work related activities. Gender Resource Centres are a single window programme to deal with all difficult issues of women. There is a possibility of these

centres getting closed. Request should be made to the concerned department to continue with these centres.

Strengthen the Legal Framework to prevent Child Marriage

As per UNICEF, 15% of the girls in rural areas are married before the age of 13 and 52% of the girls across the country have their first pregnancy between the age of 15 and 19. The practice of child marriage, associated with the poor level of education, are the biggest contributors to population rise in India. It raises doubts whether appropriate legal and programmatic framework exists to prevent the archaic practice of child marriage. There has been a substantial decline in the child marriages in India, the share of girls getting married before the legal age of 18 years fell from 44% in 2001 to 30% in 2011. However, the proportion still unquestionably high. Let there be awareness that child marriage is an intolerable practice which affects the growth and metal development of a child. Such brides are not physically fit to carry the burden of child birth and consequential responsibilities. Thus, prevention of early pregnancy can be an effective way to check the population increase.

Family Planning should be made a Flagship Programme of Government

The health officials further advised to increase funding and to again make family planning a flagship programme of government instead of one of the activities to be routinely performed. The structured review of the program should happen at highest levels of responsibility. The governments should generously spend money to find out new methods of family-planning. Success stories should be made more visible, so that it does not remain a closed door discussion agenda. The referral linkages with secondary and tertiary care hospitals should be strengthened. More awareness should be created regarding the availability of ambulance. The health services, particularly those catering to women, girls and vulnerable groups should be strengthened. These will require advocacy at the highest level and a strong political will.

Avoid Coercive Policies

Malthus's ideology in action is often seen in China's one child policy. This seems to be a good example for any country to check its population increase. However, the policy

was not without flaws. China had limited most urban couples to one child and rural couples to two if their first was a girl. There were exceptions for ethnic minority, and city dwellers could break the policy if they were willing to pay a fee calculated at several times a household's annual income.

Future Research

It is recommended to capture women empowerment from men's perspective so as to capture the power equation between the couple and to assess the decision making dynamics between them.

Kerala Population Development Model should be Followed

Kerala population development model should be considered a brilliant example. The state of Kerala in our country amazed the western demographers and garnered international acclaim by its population development model which recognizes that women empowerment and development of people are the best contraceptives. Instead of putting economic growth at the centre-stage and making people subordinate to it, the state focused on its people and improved their quality of life by high literacy rate, better healthcare and by ensuring better standards of living. Other states need follow this model by suitable adapting it to their local conditions.

Foucault Theory of Biopower

This finding also approves the adoption of theoretical framework of Foucault's theory of bio power. This theory was well explained by another reaearcher[1] who also explained the importance women's empowerment in the adoption of family planning. Empowerment discourse would encourage adoption of modern contraception by the women and would also make them feel empowered. It would further help them to have small families and to engage in formal work to feel empowered. The same perspective has been recognized by different development agencies. By creating desire and by encouraging women to discipline themselves as an empowered women, would help them adopt modern methods of family planning services. Working on the factors affecting population growth such as poverty, education and public health care, would be

[1]Dewar,F S, Empowering Women? Family Planning and Development in Post-Colonial Fiji , 2006, Retrieved from https://ir.canterbury.ac.nz/bitstream/handle/10092/943/thesis_fulltext.pdf;jsessionid=1B0FDADF89E2ADF222F4103429F5A2A5?sequence=1

very different from the family planning programme we have been pursuing from the very beginning. Overall, this study suggests that increase in contraceptive use is positively associated with women's

empowerment. However, a uniform strategy for contraceptive use in all the slums is unlikely to work. A different strategy will have to be drawn up for each of the slum separately, depending on its requirements.

It is important to introduce programmes, which will improve women's earnings and their contribution to household expenses. The empowerment theory enjoins that the women should have access to information, education and other social-economic support. According to NFHS-3 “Abused women often seek help from their own families. Very few women seek help from any institutional source such as the police or social service organizations”. This can be achieved only by providing wider access to women for secondary education and higher level education.

Social Work intervention

Family planning has many dimensions and interpretations. The objective of family planning in India can be grouped under the following heads.

1. Welfare of the families and the children
2. Help of the mother and Infant
3. Improvement of the status of women
4. Demographic economics objective

Since the launching of family planning programmes in India in 1952, it was realized that social workers could be assigned a key role in its success. During 1970, there seems to be a bigger role of social work initiatives in family planning programs. For instance, the International Conference on Social Work Education organised a workshop on the theme, Family planning and population dynamics, at Manila and sought the attention of social workers all over the world in general and in the developing countries in particular, to their role in the national family planning programmes. The association of school of social work in India also sensed the significance of social work education and family planning in promoting social change and development in India. It was observed that despite campaigns of mass vasectomy and free distribution of contraceptives, the results were achieved only marginally. The task is not yet complete and there is more to

family planning than the mere availability of contraceptive at affordable cost. The users have to reconcile with the available method and this is determined by psychosocial factors. Family planning in turn, has a social consequence for the practicing individuals and this has been appreciated in the due course of time. The present gap in educational, motivational and behavioural change efforts and services in family planning can be bridged only when professions like Social Work lend their knowledge and skills to make the program more productive. Social work is essentially enabling individual, groups and communities to upgrade their social situation to adopt the changing conditions and to partake in the task of development. The beneficence of social work to family planning can be manifold. It may relate to direct services, to area of motivations and communication, to supportive services, to the determination of policy, to program formulation and evaluation and research.

Family planning programmes must be formulated by professional hands supported by committed social workers using the modern methods of communication to the utmost. The relationship of social work and family planning calls for perseverance for a variety of reasons. The primary objective of Social Work profession are core humanitarian values and client centered approaches on one hand, and injecting awareness about the programmes and policies and challenges on the other. The family planning inertia amongst Indian populace necessitates the significance of relationship between the two. Social work as a profession has always acknowledged the significance of motivation in human behaviour. It has focused on this aspect in practice and laid stress on looking at the problem from the client's perspective.

The fragility of family planning programme is due to absence and inadequacy of motivation to practice family planning and the requisite follow up in case of irregularity or complications. It is against this background that social work can make fruitful contribution to the family planning programmes. Social workers with their familiarity and knowledge of the individual, his behaviour, feeling, values, attitude and family relationship, can be valuable in any research in the domain of family planning. In Cairo conference, the seriousness of the problem of overpopulation was recognized and its

exemplary shift towards client centered approach made room for social work research. It recognized association of social work profession, which is deep rooted in client centered humanitarian philosophy, in family planning plan formulation and execution.

National Rural Health Mission of Government of India relies on the reports of the grassroots activist of the population Control Programme called as ASHA. There was also a feeling that mass media can play a dominant role in fostering awareness, whereas interpersonal communication can play a very decisive part in changing behaviour and promoting the acceptance of family planning among diverse people. This brings in the role of social workers with their professional insight into human behaviour and scientific skills of handling the problems. During 1970s, like other disciplines, there were also many initiatives in framing and streamlining the role of professional social worker in family planning sector. The TISS (Tata Institute of Social Sciences), perceiving the need for involvement of social workers in family planning programmes, introduced a two month compulsory training course at the Government of India's Family Planning and Research Centre, Bombay, for those seeking specialization in family and child welfare. With Cairo conference focus on reproductive rights, individual choices and informed consent, there is enough work for social work professionals to contribute on this issue. The results of this research also makes a strong case for integrated approach on reproductive health issues by associating social workers in such issues. In the capacity building of community and health workers, professional social workers can contribute significantly. However, for this, it is imperative that social work professional are specifically trained on these issues. There is also a strong case for making reproductive health training an essential component of social work curriculum and field practices.

The outcome of the study proves that population stabilization is dependent on factors like availability of family planning services, reproductive health care to all and on empowerment of women. This also implies modifying the curriculum of primary and secondary education, making women empowered by providing equal opportunities and safeguarding their rights in areas of health and reproductive health, nutrition, education and employment. The Department of Family Welfare in the Ninth Five Year Plan

(1997-2002) envisaged the contribution of NGOs under the RCH programme. Since then, the role of social workers in delivery of RCH services has assumed great importance. Hopefully, these social workers would work in areas which are under-served or unserved (areas which are socially and economically backward and is deprived of access to health services especially urban slums, tribal areas, hilly and desert areas). They can help in developing a strategy to assess the needs of eligible couples and young adults in terms of knowledge, aptitude, practice and requirement of Family Planning Services in the slum areas of Delhi. In such areas, the social worker should be associated in complementary roles in strengthening the family planning service delivery system to address gaps in delivery system.

The National Population Policy 2000 recognizes that men and women have right to be informed about the family planning methods and they also have right to access to safe, affordable and effective contraception methods of their choice. Male involvement in RCH programmes is designed to improve joint decision making on issues of sexual and reproductive health. Male participation in acceptance of temporary or permanent method is negligible. There is an insignificant percentage of males, who prefer male sterilization to tubectomy. It was observed during the focus group discussion, that there are socio cultural beliefs which influence the acceptance of family planning services. Social worker should lay emphasis on bringing attitudinal changes among men about temporary and permanent methods of family planning. Male group activities for participatory community diagnosis of health services needs to become business of women, and this would encourage men's participation in reproductive health and child health issues.

To organise orientation programmes for various stakeholders such as eligible couples, family members of the couples, teachers, religious leaders and community leaders. They can also help in designing communication plan/activities for men/women/adolescent girls and boys for addressing myths, misinformation, biases and barriers relating to Family Planning Services. It is also be important for social workers to mobilise eligible couples, individual men and women to participate in Family Planning and Reproductive Health Camps. There is a need to work on organising training of health service

providers. Social workers can help in provisioning of an expanded range of quality contraceptives. They can also assist in clinical and gender training of service providers, including lady health supervisors (Doctors, ASHAs, ANMs) in IUD insertions, from gender and quality of care perspective. They can contribute in establishment of depot holders in every slum pocket for easy availability of family planning services and in training of depot holders/volunteers in non-clinical spacing contraceptives, gender issues and in counseling skills. Initiatives to boost affiliation of women's groups with the health system can be spearheaded by social workers.

Social workers can help provide access to adolescent girls and boys to knowledge and counseling related to adolescent reproductive health. Social workers can further help them in enhancing their life skills (self-awareness, self-esteem, negotiation and communication skill etc.). Orientation programmes for various stakeholders such as parents, teachers, parent-teachers association, community leaders, women's groups on adolescent health issues would also require association of social workers.

Violence against women has an adverse impact on reproductive health issues. Social workers can play an important role in upgrading the awareness of the family and community members, identifying the victims of violence and linking them with medico-legal or medical-social support services. Apart from the aforesaid requirements, assistance from social workers would also be required to create an enabling environment for promotion of women empowerment, which includes providing educational and employment opportunities and providing legal aid on the issues of domestic violence, child marriage and female feticide.

Conclusion

This thesis has already illustrated that modern methods of contraception are positively associated with the empowerment discourse. This association has positive outcome for men and women, their households, for the communities in which they live and for the nation. These outcomes are having desired number of children, to have desired spacing between the children, having control over their own bodies and subsequently enhancement of their civil rights. It also results in women's equality with men. The use

of family planning has wide implications both at local and national level. It results in good health, alleviation of poverty, economic prosperity and personal development of women. Empowerment ensures greater autonomy for women, better health and improved nature of their work day. This enhances the status of women allowing her to limit her fertility, to improve her health as well as of her children and helps her to get involved in the formal economy. Therefore, the family planning and the modern contraceptive methods help women to become empowered. As empowerment helps women in achieving disciplinary and regulatory control over their fertility, it can be taken as a version of Foucault's biopower. In the past, population control policies have often been coercive. According to Foucault, the most powerful way of achieving social change and control is "not through threat of violence or force, but rather by creating desires, attaching individuals to specific identities" (Sawicki 1991: 67). The empowerment discourse will prove to be a different but effective strategy to achieve goals of population control without being coercive in nature.