CHAPTER – I
INTRODUCTION

Family planning and Birth control

India started the first national family planning programme in the world nearly sixty years ago. Those were very different times with different realities. The life expectancy of the average Indian was more than thirty years less than it is today (thirty five years to sixty seven years), the average number of children a woman had in her lifetime was about six and about more than one fifth of infants born did not see their first birthday. Contraceptive usage had begun earlier, but interestingly female sterilization, the most common contemporary contraceptive, did not exist as we know it today. Since then India’s family planning programme had a chequered history. From being a programme which was a seen as being essentially supportive to a more robust maternal and child health programme it became so big that it overwhelmed the entire health programme in the size of its scope and budget as the fears of a ‘population explosion’ overwhelmed planners. From seeing development as the best contraceptive (1974), Indian policy makers moved to a radically different policy of forced sterilization within a very short time span (1975 –77). Over time men’s involvement in family planning fell and it became an entirely target driven numbers game where all government officials from the subordinate village school teacher to the District Collector being judged by the number of ‘tubectomies’ they delivered in a year (twenty point programme of the 1980’s).

Some degree of sanity was restored when post- ICPD (International Conference on Population and Development, Cairo 1994), India went into a target free, reproductive and child health regime (1996 -97), adopted a new National Population Policy (2000), which called for an integrated approach which transformed itself over the years into a more holistic National Rural Health Mission (2005). In the interim the spread of HIV/AIDS had introduced the new paradigm of dual protection with the consequences of unsafe sex being linked to both unwanted pregnancy as well as sexually transmitted infections. But somehow this concern remains isolated from mainstream health policy concerns in India today. In 2010 the family planning concerns were revisited by the National Parliament, after a long hiatus of thirty three years (since the Emergency) by holding a five and half hour discussion on the topic in early August.
It is against this backdrop that this paper will explore some of the new priorities and concerns around family planning and contraception.

Overall contraceptive usage has increased from about 13% in the 1970s to 41% in 1992-93 (NFHS1 – pre ICPD) to 56% in 2005-06, 2007 to 2012 (NFHS 3). For rural India this increase has been from 37% to 53%. The proportionate change during this period has been more in rural India.

Effective family planning programs make the rapid spread of voluntary modern family planning methods possible in any country. Such programs help people achieve their personal reproductive goals (Robey et al., 1994). Many women in developing countries use family planning methods to prevent unwanted and unplanned pregnancies. Contraceptive use levels have increased from 10 percent in the 1960s to more than 50 percent in the 1990s in developing countries (Robey et al., 1994), including some sub-Saharan countries. Despite the recent increase in contraceptive use in India, the region is still characterized by high levels of fertility and considerable unmet need for contraception (Babalola et al., 2001). For instance, in Karnataka, use of modern contraceptive methods has dramatically increased from 7% in 1992 to 26% in 2000, while the fertility level has slightly decreased from 6.7% children per woman to 6.3% during the same period. However, nearly one in three currently married women has an unmet need for family planning and the demand for family planning is satisfied for only half these women (CSA and ORC Macro, 2001).

India has also experienced a fairly slow decline in fertility over the past decade. The reported total fertility rate (TFR) was 6.4 children per woman in 1990 (CSA, 1993), and by the year 2000, it had decreased to 5.9 children per woman (CSA and ORC Macro, 2001). Although the contraceptive prevalence rate among women of reproductive age (15-49 years) has doubled during the last ten years, it still remains very low. This may indicate the existence of some barriers that prohibit couples from using family planning even if they desire to limit or delay births. In the developing world, a substantial gap exists between women’s stated reproductive preferences and their use of contraception. This discrepancy is referred to as the unmet need for family planning (Bongaarts and Bruce, 1995). Unmet need is important for the design of family planning programs because it affects the potential demand for family planning services and has
important implications for future population growth. Its definition, however, has changed over time.

Currently married women have an unmet need for family planning if they say that they want no more children (unmet need for limiting) or want to wait at least two years before having another child (unmet need for spacing) but are not using contraception. Pregnant married women whose pregnancy is unwanted or mistimed and who became pregnant because they were not using contraception also have an unmet need. Amenorrhea women whose pregnancy was unintended are also considered to have an unmet need (CSA and ORC Macro, 2001).

Many married women and women living in a union in developing countries have unmet need for spacing or limiting (Robey et al., 1996). On average, the level of total unmet need for contraception in Indian states is more than 20 percent. In some countries this is even higher with one in three women having an unmet need (30 percent in Malawi and 37 percent in Rwanda). India is one of the countries with a high level of unmet need. The 2000 Indian Demographic and Health Survey (DHS) indicates that the unmet need for family planning among currently married Indian women is 36 percent, with 22 percent having a need for spacing and 14 percent having a need for limiting (CSA and ORC Macro, 2001). In contrast, the met need for family planning is only eight percent. The unmet and met need together constitute the total demand for family planning, which is 44 percent at the national level. Because of the low level of contraceptive use, the proportion of demand that is satisfied is only eighteen percent.

Therefore, a major concern is which factors are contributing to the observed high level of unmet need for family planning in India and which strategies can best bring about changes to the current situation. Many factors may contribute to the observed discrepancy in unmet need and met need; however, this study focuses on “life stress locus of control and attitude towards family planning and birth control”.

Life Stress

During recent years, numerous studies have investigated the relationship between life stress and susceptibility to physical and psychological problems. Most of these studies have
been based on assumptions that (a) life changes requires adaptations on the part of the individual and are stressful, and (b) persons experiencing marked degrees of life change during the recent past are susceptible to physical and psychiatric problems.

There is considerable evidence that a relationship exists between life stresses, operationally defined in terms of self reported life changes, and physically illness (Dohrenwend & Dohrenwend, 1974b). Rahe & Lind (1971) have reported a relationship between life stress and sudden cardiac death. Theorell and Rahe (1971) and Edwards (1971) have provided data suggestive of a link between life stress and myocardial infraction. Holmes (1970) and Rahe (1968) both found a relationship between life stress and major and minor health changes, and Wyler, Masuda, and Holmes (1971) have shown that life change is related to seriousness of chronic illness.

There also have been studies of non-health related correlates of life change that have yielded positive results. For example, significant negative relationship between life stress and academic (Harris, 1973) and teacher (crranza, 1973) performance have been found. Several researchers have demonstrated a relationship between extent of life changes and psychiatric symptomatology (Dekker & Webb, 1974). Have also found life stress to be related to the occurrence of depression, anxiety and tension. A comprehensive review of life stress literature and a consideration of methodological issues in this area of research has been presented by Rabkin & Struening (1976). Questions of both a methodological and theoretical nature can be raised concerning present methods of assessing life changes. By far the most widely used instrument in life stress research is the schedule of recent experience (SRE; Holmes and Rahe, 1967). In this instrument identified many events that seemed to be especially stressful. By observing and testing thousands of people, they were able to rank a series of “life-change event” in the order of their disruptive impact. They assigned each event a corresponding number of “life-change units” (LCUs). The most stressful event was death of spouse (100 LCUs). The number in Brakets indicates the intensity of stress or LCUs. Let us take some more situations that cause stress-divorce (73), imprisonment (63) and the death of a close family member (63). The other factors are theft in house, academic failure, son / daughter running away, loss of job loss in business, retirement from the job, death of a friend, family partition. All these examples are the ones that are painful or distresses. There are many pleasant
situations (estruses) that cause stress such as marriage (of self), marriage of arson/daughter, birth of child, promotion (because more responsibilities!), building a own house, etc. Women have their own specific stresses such as menopause, physical and physiological changes, going to parents-in-laws home after marriage, child bearing, etc. It is clear that both pleasant and unpleasant situations cause a stress.

Many people consider stress to be something that happens to them, an event such as an injury or a job loss others think that stress is what happens to our body mind, and behavior in response to an event. While stress does involve life event and our response to then, there are not the most important factors. Our thought about the situations in which we find ourselves are the critical factor. When something happens to us, we automatically evaluate the situation mentally. We decide if it is threatening to us, how we need to deal with the situation, and what skills we can use. If we decide that the demands of the situation as ‘stressful’ and react with the classic “stress response”. If we decide that our coping skills outweigh the demands of the situation, then we don’t see it as stressful.

Stress can come from any situation or thought that makes your feel frustrated, angry, or anxious; everyone sees situations differently and has different coping skills. For this reason, no two people will respond exactly the same way to a given situation. Additionally, not all situations that are labeled ‘stressful’ are negative. The birth of a child, being promoted at work or moving to a new home may not be perceived as threatening. However, we may feel that situations are stressful because we don’t feel fully prepared to deal with them.

Stress is a normal part of life. In small quantities, stress is good; it can motive you and help you become more productive. However, too much stress, or a strong response to stress can be harmful. How we perceive a stress provoking event and how we react to it determines its impact on our health. We may be motivated and invigorated on our health. We may be motivated and invigorated by the events in our lives. Or we may see some as stressful and respond in a manner that may have a negative effect on our physical, mental and social well-being. If we always respond in a negative way. Our health and happiness may suffer. By understanding ourselves and our reaction to stress – provoking situations, we can learn to handle stress more effectively. In the most accurate meaning, stress management is not about learning how to avoid or escape the pressure and turbulence of modern living; it is about
learning to appreciate how the body reacts these pressures, and about learning how to develop skills which enhance the body’s adjustment. To learn stress management is to learn about the mind-body connections and to the degree to which we can control our health in a positive sense. The word “stress” is defined by the oxford Dictionary as “a state of affair involving demand on physical or mental energy” a condition or circumstance (not always adverse), which can disturb the normal physiological and psychological function of an individual. In medical paralance “stress is defined as perturbation of the body’s homeostasis. This demand on moderation stress is normal and in many cases, provs useful. Stress, nonetheless, is synonymous with negative conditions.

Stokes and Kite (2001) suggest that the term’s stress can be viewed as “…an agent, circumstance, situation or variable that disturbs the normal functioning of the individual … stress, is also seen as an effect that disturbed state itself. This bifurcation of meaning is arguably the most fundamental source of the confusion surrounding the stress concept. Tepas and price (2001) suggested that stress is commonly connected with, adaptation, anxiety, arousal, burnout, coping, exertion, exhaustion, exposure, fatigue, hardiness, mental load, repetitiveness, strain, stressor and tension. McGrath (1976) that seems to be broad enough to incorporate most of the current assumptions about what stress is and is not, yet focused enough to be meaningful. McGrath conceptualized stress as the interaction between three elements; perceived demand, perceived ability to cope, and perception of the importance of being able to cope with the demand. Unlike many previous definition of the stress, this formulation distinctly incorporates the transactional process believed to be central to current cognitive appraisal theories. No longer is stress seen merely as a mismatch between demand and ability; on the contrary one’s perception of these two elements, and more importantly the desire or motivation one experiments to meet the demand, is central to the construct. Despite decades of research in to stress there is still no agreed upon definition of what stress is (Rees & Redfern 2000) Despite this, stress is often defined as “the response of the body to threats or demands” (Schiraldi & Kerr, 2002). The word stress was introduced during the 1930s by Scientist Hans Selye. Selye was the first to take serious note of the human physiological system that were brought into play when a person responded to a challenge (McEwen, 2002). Selye’s research (1978) led to the conclusion that the human body possesses a mechanism which assists in coping with demands placed upon it. Selye named this mechanism the general adaptation syndrome. Eventually selye
replaced this term with the word stress. The early work of selye focused on the body’s physiological responses but more recent work, such as that of Lindemann (1944) and Caplan (1964), Halmes & Rahe (1967) and Cohen (1988) (Bjorck 1999 cited in Benner &Hill 1999) focuses upon the psychological component of when a person is stressed, the autonomic (involuntary) nervous system is brought into play. The automatic nervous system controls involving muscles such as heart, stomach and skin. This system has two divisions. These are the sympathetic and parasympathetic systems. It is the sympathetic division that comes into play when stressed. It is this system that prepares the body for “fight or flight”. The heart rate increases, pupils become dilated, the digestive system stops, respiration increases, adrenaline is pumped into the body by the adrenal glands and peripheral blood vessels constrict (Meier, Minirth, wichern and Ratcliff, 1996). The parasympathetic system works in the opposite way and maintains balance (McEwen, 2002).

The reality of life for most people is that although they may not be able to define what stress is, they know when they are stressed. The word has become an everyday part of the vernacular. When we are stressed we feel like life is overwhelming as and that we are going to lose control. “Stress refers to the pressure that life exerts on us and the way this pressure makes us feel” (McEwen, 2002).

Models of Stress :

Sutherland and cooper (1990 cited in Irvine, 1997) outline three models for understanding stress. These are described as the stimulus based model, the response based model and the interactive model.

The stimulus based model sees a human being as an object affected by external stressors. The person affected in this way has to cope with these stressors. Although such an understanding of stress can assist in identifying external phenomena that create distress, it ignores the subjective reality that is an essential part of human experience, diagram shows outlines the stimulus based model.

The response based model places the emphasis on the response of the individual to external stimuli. In such a model of stress, the focus is upon the observable response of the person under stress. The response base model assists in understanding the reaction to stress, but
the limitation is that the solution to stress is viewed as wholly internal. The Diagram shows the
outlines of the response based model of stress.

It is generally accepted that an interactive model of stress in needed to incorporate the
complexity of the human stress experience (Irvine, 1997). An interactive model takes into
account external stressors. The reaction of the person, the temperament of the person and the
interaction of these factors.

Wutherland and cooper (1990) state that,

Within the interactive model of stress, it is necessary to consider all three conceptual
domains in the stress process:

1. Source of stress
2. Mediators of the stress response
3. The manifestations of stress. Situations are not inherently stressful, but are
   potentially stressful.

The interactive model of stress allows for the place of perception in the experience of
stress. Perception is the end result of the central nervous system translating sensory input into a
new form of information.

Perception means that the individual is no a passive object upon which external stimuli
acts. Stimuli based model of stress makes. No allowance for this aspect of human experience.
The response based model is also found wanting in that it doesn’t allow for external stimuli
influencing the way in which a person thinks about the world and their place in it. It is in an
interactive model that there lies the best chance of an understanding of stress that reflects the
reality of human experience.

**Psychological stress:**

It has already been mentioned that perception plays a major role in the experience of
stress. What goes on in the head is important. The way we think about things influences the
degree to which things affect us. This explains why what is stressful to one person is not stressful to another. Hans Selye used the terms distress and eustress to describe two different kinds of stress. The stress is a positive stress that energies for life whereas distress is a negative stress which saps energy.

McEwen (2002) places a great deal of emphasis on the place of perception when he says, the human mind is so powerful, the connections between perception and physiological responses so strong, that we can set off the fight or flight response by just imagining ourselves in a threatening situations. Imagine a person who loves their work. They find that it interests them and that they become totally absorbed in it. They might invest themselves fully in it and lose track of time as a result. This is an example of esters. It is not unpleasant.

The worker in the example could easily become a workaholic. The subtle danger of esters is that it doesn’t necessarily feel unpleasant but it still taxes the system.

Theories that focus on the specific relationship between external demands (stressors) and bodily processes (stress) can be grouped in two different categories: approaches to 'systemic stresses based in physiology and psychobiology (among others, Selye 1976) and approaches to 'psychological stress' developed within the field of cognitive psychology (Lazarus 1966, 1991, Lazarus and Folkman 1984, McGrath 1982).

**The model of coping modes:**

Similar to Miller's monitoring-blunting conception, the model of coping modes (MCM) deals with individual differences in attention orientation and emotional-behavioral regulation under stressful conditions (Krohne 1993). The MCM extends the (largely descriptive) monitoring blunting conception (as well as the repression–sensitization approach) in that it relates the dimensions vigilance and cognitive avoidance to an explicative cognitive-motivational basis. It assumes that most stressful, especially anxiety evoking, situations are characterized by two central features: the presence of *aversive stimulation* and a high degree of *ambiguity*. The experiential counterparts of these situational features are *emotional arousal* (as being primarily related to aversive stimulation) and *uncertainty* (related to ambiguity). Arousal, in turn, should stimulate the tendency to cognitively avoid (or inhibit) the further processing of cues related to the aversive encounter, whereas uncertainty activates vigilant tendencies. These
two coping processes are conceptually linked to personality by the hypothesis that the habitual preference for avoidant or vigilant coping strategies reflects individual differences in the susceptibility to emotional arousal or uncertainty. Individuals who are especially susceptible to states of stress-induced emotional arousal are supposed to habitually employ cognitive avoidance. The employment of avoidant strategies primarily aims at shielding the person from an increase in arousal (arousal-motivated coping behavior). Individuals who are especially affected by the uncertainty experienced in most stressful situations are supposed to habitually employ vigilant coping. Thus, the employment of vigilant strategies follows a plan that is aimed at minimizing the probability of unanticipated occurrence of aversive events (uncertainty-motivated coping behavior).

The MCM conceives the habitual coping tendencies of vigilance and cognitive avoidance as independent personality dimensions. That means, aggregated across a multitude of stressful encounters, the employment of vigilant strategies and of avoidant ones does not preclude each other. Thus, four coping modes can be defined. (a) Persons who score high on vigilance and low on cognitive avoidance are called sensitizers. These persons are primarily concerned with reducing uncertainty by directing their attention towards stress-relevant information. (b) Individuals with the opposite pattern are designated as repressers. These persons minimize the experience of arousal by avoiding aversive information. (c) No defensives have low scores on both dimensions. These persons are supposed to flexibly adapt to the demands of a stressful encounter. Instead of frequently employing vigilant or avoidant coping strategies, they prefer to act instrumentally in most situations. (d) Individuals who exhibit high scores on both dimensions are called high anxious. In employing vigilant as well as avoidant coping strategies, these persons try to reduce both the subjective uncertainty and the emotional arousal induced by stressful encounters. Because the two goals are incompatible in most situations, high-anxious persons are assumed to show fluctuating and therefore less-efficient coping behavior. Approaches to assess individual differences in vigilance and cognitive avoidance are described in Krohne et al. (2000). Empirical results related to predictions derived from the MCM are presented in Krohne (1993, 1996), and Krohne et al. (1992).

Future Perspectives:
Although the fields of stress and coping research represent largely explored territory, there are still fertile perspectives to be pursued in future research. Among the promising lines of research, two perspectives will be mentioned here. 1. Compared to the simplistic stimulus-response conception of stress inherent in early approaches on stress, the 'psychological' (i.e., cognitive transformation) approach of the Lazarus group clearly represents progress. However, in advocating a completely 'subjective' orientation in conceptualizing stress, Lazarus overstated the 'cognitive turn' in stress research. In stating that 'we might do better by describing relevant environments and their psychological meanings through the lenses of individuals' (Lazarus 1990, p. 8) he took a stand that is at variance with the multivariate, systems-theory perspective proposed in his recent publications on stress and emotions (Lazarus 1990, 1991). First, the stress process contains variables to be assessed both subjectively and objectively, such as constraints, temporal aspects, or social support networks, as well as responses to be measured at different levels (cf. Lazarus 1990, Table 1). Second, the fact that most objective features relevant to stress-related outcomes exert their influence via a process of cognitive transformation (Mischel and Shoda 1995) does not mean that objective features can be neglected. It is of great practical and theoretical importance to know which aspects of the 'objective' environment an individual selects for transformation, and how these characteristics are subjectively represented. Third, as far as response levels are concerned, it is obvious that stressors do not only create subjective (cognitive) responses but also reactions at the somatic and the behavioral-expressive level. In fact, many individuals (especially those high in cognitive avoidance) are characterized by a dissociation of subjective and objective stress responses (cf. Kohlmann 1997; for an early discussion of the psychological meaning of this dissociation see Lazarus 1966). These individuals may manifest, for example, relatively low levels of subjective distress but at the same time considerable elevations in autonomic arousal. In recent years, the concept of subjective-autonomic response dissociation has become increasingly important in clarifying the origin and course of physical diseases and affective disorders. 1. It is important to define central person-specific goals (or reference values) in coping, such as reducing uncertainty, inhibiting emotional arousal, or trying to change the causes of a stressful encounter. These goals are not only central to understanding the stress and coping process, they are, in fact, 'the core of personality' (Karoly 1999). Goals define the transsituational and trans-temporal relevance of certain stressors, serve as links to other
constructs such as self-concept or expectancies, influence regulatory processes such as coping, and define the efficiency of these processes (cf. Karoly 1999, Lazarus 1991, Mischel and Shoda 1995). Instead of applying global and relatively content-free trait concepts in stress and coping research such as anxiety, depression, or optimism, a more fertile perspective would be to study personality in this field by paying attention to what people are trying to do instead of only observing how they actually respond to stressful events.

The Impact of Stress:

The stress response is a protective system. It assists us to face a challenge. The protective stress response is designed for short term activation. When a person is faced with perceived danger, the body prepares the person for the challenge. Such a response is meant to be infrequent. When that person lives out a life style that overtaxes the inbuilt coping mechanism then health can start to suffer. When this happens allostasis has given way to allostatie load (McEwen, 2002).

All static load affects people in various ways. The cardiovascular system is particularly sensitive to stress. When stimulated the human body needs extra reserves of oxygen and glucose. In response to these requirements the heart beats faster to drive more oxygen and glucose through the body. When repeated surges in blood pressure occur as in the case for people under constant stress, hypertension can be the result. Hypertension increases the likelihood of heart attack. As part of the process for keeping the body supplied with fuel when under stress, adrenaline and cortisol work together to balance the energy supply. If a person remains under stress and cortisol levels therefore, stay high energy becomes stored as fat. This fact often accumulates along blood vessel walls, increasing the likelihood of atherosclerosis, another risk factor in the likelihood of heart attack (McEwen, 2002).

The immune system like the cardiovascular system is sensitive to stress. If stress continues for an extended period of time the immune system can start to fatter (Hempel, 2003). When stress is present the immune system sends white blood cells to where they are needed. If stress is ongoing and becomes allostatie load, the immune system becomes suppressed and the likelihood of infection increases (McEwen, 2002). In some people ongoing stress does not suppress the immune system. In these people the opposite occurs and the immune system
becomes so sensitive it starts to attack threats that don’t exist. This is the basis of many autoimmune diseases (McEwne, 2002).

**Life stress and Family planning and Birth control:**

There are lots of ways that stress or depression could affect birth control use. Feeling depressed can make it a challenge to keep up with routine responsibilities like taking a pill every day or stopping by the clinic or pharmacy to refill a prescription. Folks dealing with stress or depression might have a harder time dealing with side effects from birth control. In fact, the same researcher found in earlier studies that women who felt depressed and stressed were more likely to notice changes in their weight or mood; they were also more likely to quit the pill. Some women may feel stressed or depressed to begin with because of sex. Ratter (2012) stressed, depressed women terrible at using birth control, In the study, women with moderate to severe depression and stress symptoms were less likely to use contraception consistently — that is, use it each time they had sex — compared to women with mild or no symptoms. Women with depression or stress were also more likely to say they did not use contraception at all in the past week compared to women with less severe symptoms.

The findings, presented here on Monday at the annual meeting of the America Public Health Association, are concerning because, although preventing unplanned pregnancies is important for all women, it may be especially important for women with mental health issues, said study researcher Kelli Stidham Hall. "Perhaps an unintended pregnancy for these women could make things even worse," said Hall, of the University of Michigan's Population Studies Center.

Family planning providers should consider mental health symptoms when they council their patients, Hall said. In addition, women with depression and stress who do not want to become pregnant in the near future may be good candidates for long-acting reversible contraception, such as an IUD — highly effective methods of birth control that women do not need to remember to use every day or each time they have sex, which may be burdensome for some, Hall said. Hall and colleagues analyzed information 689 non-pregnant women ages 18 and 19 living in Michigan. Participants first answered questions about their mental health. Then, for the next year, they filled out weekly journal entries that included the number of times
they had sex in the past week, and whether they used contraception when they had sex. About 25 percent of women had moderate to severe depression, and 25 percent had moderate to severe stress.

Overall, women used contraception consistently 72 percent of the time. The most common forms of contraception were oral birth control or condoms. For women with depression, the odds of using contraception consistently each week was 47 percent lower than for women with less severe symptoms. For those with stress, the odds of using contraception consistently were 69 percent lower.

Women with depression and stress may have social circumstances, such as unemployment, that interfere with their ability to effectively use contraception, Hall said. In addition, mental health issues may impair a person's ability to make decisions.

**Locus of Control (LOC):**

Another construct encompassing the role of people’s perceptions and beliefs in their health-related behaviors is that of health locus of control. This construct has stemmed from the original concept of locus of control.

People’s health behaviors may not be influenced by their beliefs about threat, risk, susceptibility, or benefits alone. These also depend upon how much control do they believe they have over their own life, circumstances, destiny, or health.

Locus of control refers to a person’s perceptions or beliefs about the location of responsibility for his or her life; circumstances, happenings, events, conditions. The perception of who is in charge of one’s life, who decides one’s fate, and who is responsible for whatever the person is experiencing, is determined by the person’s locus of control (LOC). People’s perceptions of success and failure, of health and illness, ability or inability, all reflect their locus of control. In other words, the concept of LOC refers to perceived control; the perception of how much a person feels in control of life (Lefcourt, 1982).

The earliest formal investigations of the concept were reported by Julian Rotter (1966, 1975). Rotter showed that people have different views about things that happen to them. People
have their own beliefs or generalized expectations about where the control of life, or events, resides.

Rotter’s original formulation of LOC had a dualistic approach. People’s beliefs regarding what is responsible for events, and who influences life, were classified along a bipolar dimension. Rotter showed that people have different views about the source of control, and the things happening to them; these beliefs, and therefore people holding them, were seen as falling into two categories namely, internal and external.

**Internal Locus of Control:**

People who believe that they themselves are responsible for whatever happens to them, feeling in-charge of their lives, and blame themselves if anything goes wrong. This attitude is based upon the belief that the control of events, and the future outcomes resides within the person. This category of people was labeled as having an internal locus of control (ILOC). The ILOC people keep trying to find causes of mishaps, and ways of improving matters, keeping in view their own skills, faults, strengths and weaknesses. For this purpose they scrutinize their own behavior, evaluate their abilities, and analyze where, how, and why they went wrong. Consequently, they may keep changing and improving their own behavior (Lefcourt, 1982; Rotter, 1966, 1975).

**External Locus of Control:**

The second category comprises people who believe that the control of their life lies outside of themselves. They foster a belief that they are not responsible for their lives, or events that happen to them. They do not blame themselves when things go wrong. They believe in the impact and control of external forces.

Such people are considered as having an External Locus of Control (ELOC). Those with an ELOC tend to find fault with others if a mishaps happens in their lives. They either blame other people, fate, chance happenings or even God for whatever happens. As a result of this belief and attitude towards life, these people do not feel the need to change their behavior. They look up to others for changing their circumstances. The concept of LOC, although a
simple idea, appealed to researchers a great deal and was used in a number of researches especially in the West. As the body of research-based knowledge concerning LOC expanded, psychologists realized that this concept could be stretched beyond its initial dualistic, bipolar, version: it may be more than just a simplistic categorization into ILOC and ELOC (Foreshaw, 2002; Lefcourt, 1982; Rotter, 1966, 1975).

Hannah Levenson (1973) proposed an alternative model that stemmed from Rotter’s original paradigm. She offered the idea of splitting the concept and dimensions of ELOC into two further categories.

Levenson felt that not all of the ELOC beliefs were the same. Some ELOC people believed that it was merely the chance factors that accounted for events, whereas others found the influence of other people to be the most significant variable affecting their lives. Consequently she split the concept of ELOC, and it was subdivided into two categories, namely:

i. Powerful others locus of control (PLOC).

ii. Chance locus of control (CLOC)

iii. Individual control

PLOC refers to a person’s belief in the influence and significance of other people in her life, whereas CLOC indicates the belief that chance happenings, fate or other similar forces control a person’s life. The modern formulations of LOC have also included a category of God-LOC, i.e., belief that only God determines what one’s life is going to be like.

The Concept of Health Locus of Control (HLC)

The concept of LOC was later on used to understand the health beliefs and behaviors of people as well. Hence, health locus of control (HLC). K. A. Wallston and B. S. Wallston (1982) have given a very comprehensive model of health locus of control. Considering the beliefs of perceived control over health, people can be divided into two broad categories according to the type of HLC they believe in. The HLC categories include:

1. Internal Health Locus of Control (IHLC)
2. External Health Locus of Control (EHLC)

1. **Internal Health Locus of Control (IHLC):**

   People with IHLOC feel responsible for their health. In case of illness they try to find out what wrong did they do that led to the development of their malady. The IHLOC people are more likely to indulge in health-promoting and protective behaviors; they may be doing regular physical exercise, and they have more knowledge about health conditions, about risk factors and services as compared to others.

   Research findings have revealed that internals, or people with an IHLOC, are less susceptible to psychological and medical problems (Strickland, 1978). Some other studies have shown that personal control plays a role in buffering health against the results of stress (Matheny & Cupp, 1983; Suls & Mullen, 1981). Krause, and Stryker (1984) have reported the buffering role of ILC against the effects of job and economic stress on health.

2. **External Health Locus of Control (EHLC):**

   According to K. A. Wallston and B. S. Wallston (1982), EHLC refers to the belief that factors other than the self are responsible for one’s health. People with EHLC look up to other people for health care. When something goes wrong with their health, they tend to blame other people or fate for that. These people generally seem oblivious to the significance of adopting health protective behaviors such as regular exercise, wise eating, or of keeping their health knowledge up to date.

   EHLC further consists of two categories:

   i. **Powerful others health locus of control (PHLC)**

   PHLC refers to the belief of people that other people, and not they themselves, are responsible for their health. That sort of an attitude may be observed in the hypothetical case of a woman who has chest pain for a month and gets breathless very soon, does not go to the doctor on her own and waits for her husband to take her to the doctor. Such a person probably has a PHLC.

   ii. **Chance health locus of control (CHLC)**
On the other hand, take the case of a 50 year old obese man who eats, drinks, and smokes excessively, believes that he will fall ill only if it is written in his fate, and if that is the case then he can not prevent the malady no matter how hard he may try. Such a person probably has a Chance Health Locus of Control (CHLC).

The development of locus of control

Although a number of psychologists have explained and investigated the various dimensions of LOC, yet little has been written about the origin and process of the development of LOC, which is how people develop their perceptions of control. However, the available literature indicates that a person’s LOC has its roots in the family, culture, and past experiences, particularly those leading to a reward. Externals and internals appear to be belonging to different types of families. It has been found that most Internals belong to families where effort, responsibility, and education are focused upon. On the other hand, most externals have families that belong to lower rungs of the socio economic ladder, where the family experiences a lack of life control (Levenson, 1973; Wiked, 2007). Like any other belief, the perceived control beliefs and LOC / HLC may stem from any or all of the following six variables:

Family:

Every family has its own way and system of child rearing. Different parents adopt different parenting styles, and reward or punish children accordingly. Parental treatment, and family circumstances generate different perceptions of control e.g. if the parents are over-protective of the child, never allowing her independence, and doubt her potential, the child will be more likely to have an external locus of control, wherein the influence of powerful others is considered very important.

Personal beliefs:

People develop certain beliefs on the basis of their past experiences, education and observation etc. Personal beliefs about events, and life in general, also contribute to LOC, for instance repeated experiences of success will contribute to ILOC, whereas failure, poverty, or lack of resources may lead to an ELOC.
Religious Beliefs:

In many cultures, religious beliefs and values are the roots of other beliefs. If a person has been taught and told that only God decides everything, and that fate is a pre-fixed phenomenon, then he will learn to be an external with a strong CHLC. On the other hand if a person has been taught about life in a scientific and objective manner, then he will be more likely to have an internal locus of control.

Cultural beliefs, values, and practices:

Many beliefs are transmitted from generation to generation, and these have their roots in value systems that are an integral part of a culture. For example the concept of “hot”- and“cold”-natured foods is prevalent in many cultures, implying that the nature of food-substance brings about “hot” or “cold” effects on a person’s health. Similarly many cultures believe in the presence of supernatural phenomena. In such cultures people learn to be dependent upon unseen forces. Consequently a relevant ELOC or EHLC is developed. People in collective cultures are more likely to have a high PHLC, whereas people in individualistic cultures will probably be high on IHLC.

Health knowledge:

Health knowledge or knowledge in general has a positive influence on a person’s beliefs. Appropriate, established, and scientific knowledge strengthens a person’s belief in personal control, thus leading to the development of ILOC / IHLC. Conversely a lack of knowledge, or faulty knowledge is more likely to create a feeling of dependence on those who seem to know more, hence the emergence of PHLC.

Available healthcare facilities:

If substantial, good quality health care facilities are available to a person, and the uptake of the same is convenient for her, then she learns that health conditions can be managed by timely and appropriate action. This experience helps her to develop an internal health locus of control, and vice versa (Shahed, 1990).
ATTITUDE

Attitude has always been a subject of interest to many researchers as well as psychologists. It is considered as exciting and mysterious to some researcher. It can function as a shield to someone or it can even function as a weapon to someone. Having a certain attitude in life is crucial to people so as to help them live in harmony and towards better understanding of things around them. Attitudes play a major part in determining a person’s personality. This is because attitude affect the way people perceive and act towards people, objects or events that they encounter. Besides that, attitudes can also have an effect on one’s social interactions. That is why it is important to know what attitude is, how it is developed and its impact on people. Therefore, this paper will discuss about attitude and it will be divided into six sections which are Definition of Attitude, Components of Attitude, Attitude Formation, Attitude Functions, Attitude Change, and Persuasion. It is hoped that through this paper, readers would develop a better understanding about attitude.

Many psychologists have given different definitions for attitudes. According to Schneider (1988), ‘Attitudes are evaluative reactions to persons, objects, and events. This includes your beliefs and positive and negative feelings about the attitude object.’ (179). He also added that attitude can guide our experiences and decide the effects of experience on our behaviours.

Besides that, Baron and Byrne also gave a similar definition of attitude which is, ‘Attitudes can be defined as lasting, general evaluations of people (including oneself), objects, or issues. Attitude is lasting because it persists across time. A momentary feeling does not count as an attitude.’ (1987). According to him attitudes are lasting since it remains across time. This is similar to a statement made by Vaughan & Hogg (1995), ‘Attitudes are relatively permanent- persist across times and situations. A momentary feeling in one place is not an attitude.’ Therefore, if you encountered a brief feeling about something, it does not count as an attitude.

Moreover, Vaughan & Hogg (1995) defined attitude as, ‘A relatively enduring organization of beliefs, feelings and behavioural tendencies towards socially significant objects, groups, events or symbols or A general feeling or evaluation (positive/ negative) about some
Several attitude change categorization schemes have been proposed in the literature (Eagly & Chaiken, 1993; O'Keefe, 1990), and most are similar. For this discussion, attitude theories have been organized into four categories (see 11.6):

- Learning theories
- Social judgment theories
- Functional theories

The study of attitudes has been approached with varying emphases and methods during most of this century. Prior to World War II, the emphasis was on definition issues and attitude measurement. Most studies were of a survey nature and provided important correlational findings, but little insight into causality. Experimental techniques such as control groups or comparison groups were notably absent. This changed dramatically during World War II. Attitude change was an important topic of Army-sponsored research. Because of the influence of experimental psychologists such as Carl Hovland, true experimental techniques were used to study the persuasive effects of propaganda. The work of Hovland and his associates in the area of attitude change research was continued after the war at Yale University. Theories developed by this group served as an organizational framework for the study of attitude change (Hovland, Janis & Kelley, 1953; Himmelfarb & Eagly, 1974; Insko, 1967; O'Keefe, 1990). Most of Hovland's attitude change research can be considered classical. Most of this research and theory building approached the concept of attitude from the behaviorist perspective, and most research activities dealt with trying to relate attitudes to observable outcomes in learners.

**Early Learning Theories**

This section might more accurately be called *behavioral theories of attitude change*. These theories were also developed during the 1950s and 1960s. During this time,
learning theories reflected behavioral psychology. A major commonality of these theories was their emphasis on the stimulus characteristics of the communication situation.

Staat's work reflected the ideas of classical conditioning, and focused almost entirely on the formation of attitudes. Events in the environment create an emotional response in an individual. As new stimuli are consistently paired with old stimuli (events), the new stimuli develop the power to create an emotional response in the individual.

Learning theories of attitude change received major emphasis by Hovland and his associates in the Yale Communication Research Program (Hovland, Janis & Kelley, 1953). They proposed that opinions tended to persist unless the individual underwent some new learning experience. Persuasive communications that both present a question and suggest an answer serve as learning experiences. Acceptance of the suggested answer is dependent on the opportunity for mental rehearsal or practice of the attitude response, and on the number of incentives included in the communication. Hovland and his colleagues assumed that as people processed persuasive message content, they rehearsed the message's recommended attitudinal response, as well as their initial attitude. For attitude change to occur, more than rehearsal and practice had to take place. The Yale researchers emphasized the role of incentives and the drive-reducing aspects of persuasive messages as mechanisms for reinforcement, thereby creating acceptance of new beliefs and attitudes.

In the Yale model of attitude change emphasis is placed on attention, comprehension, and acceptance. An individual must attend to and comprehend the communication before acceptance can occur. It is during the attending and comprehending phases that the individual has the opportunity to practice the recommended new opinion. Practice alone does not lead to acceptance, but when combined with incentives and recommendations imbedded in the communication, attitude change is likely. Incentives are broadly defined by Hovland et al. (1953). They could be direct financial or physical benefits (e.g., money, improved health), or they could take on more abstract forms such as the knowledge gain from persuasive arguments, social acceptance by others who are respected, or self-approval from the feeling that one is correct.
Hovland and his associates identified three classes of variables that influenced the effectiveness of the message: (a) source characteristics, (b) setting characteristics, and (c) communication content elements. Research using the Yale model focuses on variables in one or more of these three classes. Examples include research in communicator credibility (trustworthiness and degree of expertness), fear-arousing appeals, and the placement of persuasive arguments within the communication (Himmelfarb & Eagly, 1974; Kiesler et al., 1969; Insko, 1967).

A Skinnerian approach to the study of attitude change was employed by Bem (1967), whose major assumptions reflected the viewpoint that attitudes were learned as a result of previous experience with the environment. Bem proposed that since the person trying to change attitudes usually lacked direct knowledge of the internal stimuli available to the learner, it was necessary to rely on external cues in order to reward and punish the individual. It was the combination of external cues and observable behaviors that produced changes in attitude (Himmelfarb & Eagly, 1974; Kiesler et al., 1969; Insko, 1967).

Today, few attitude change theorists feel that the early research by Hovland and others has direct impact on current procedures (Eagly & Chaiken, 1993). Newer research and theory building is directed toward approaches that emphasize multiple modes of processing information. However, these early researchers investigated basic issues, such as reinforcement, incentives, and drive-reduction constructs, that are related to how motivational states influence information processing and persuasion. Early-learning theorists' efforts provided a foundation for more modern process models of attitude change.

**Social Judgment Theory**

Social judgment theory focuses on how people's prior attitudes distort their perceptions of the positions advocated in persuasive messages, and how such perceptions mediate persuasion. In general terms, the theory assumes that a person's own attitudes serve as a judgmental standard and anchor that influences where along a continuum a persuader's advocated position is perceived to lie (Sherif & Hovland, 1961). Social judgment theory is an attempt to apply the principles of judgment to the study of attitude change.
According to Sherif, Sherif, and Nebergall (1965), an individual's initial attitude serves as an anchor for the judgment of related attitude communications. Opinions are evaluated against this point of reference and are placed on an attitudinal continuum. Opinions that most characterized the individual's own opinion are in the latitude of acceptance. Those opinions found most objectionable are placed in the latitude of rejection. The latitude of noncommitment consists of those opinions that are neither accepted nor rejected.

Communication that falls within the latitude of acceptance is assimilated, and if judged to be fair and unbiased will result in a change in attitude. Within the limits of the latitude of acceptance, the greater the difference between the initial opinion and the communicated opinion, the greater the attitude change. Though some change is possible when Opinions fall within the latitude of rejection, the greater the discrepancy the less the change in attitude (Himmelfarb & Eagly, 1974; Kiesler et al., 1969; Insko, 1967).

Social judgment theory's core propositions can be summarized as follows (Eagly & Chaiken, 1993):

- A person's current attitude serves as a judgmental anchor for new attitude positions.
- Latitude widths determine whether a message's position will be assimilated or contrasted (e.g., accepted or rejected). Positions falling within the latitude of acceptance will be assimilated toward a person's current attitude. Positions falling within the latitude of rejection will be contrasted away from the person's own attitude.
- Ego involvement of a person broadens the latitude of rejection and narrows the latitude of noncommitment.
- Both assimilation and contrast effects increase as a positive function of a message's position and the recipient's attitude,
- Ego involvement increases the anchoring property of initial attitudes.
- Greater assimilation produces more positive evaluation of message content, which produces greater amounts of attitude change. Conversely, greater contrast produces more negative evaluations of message content, which produces lesser amounts of attitude change.
Ambiguity enhances the likelihood of judgmental distortions. Therefore, other effects are greater when recipients are exposed to persuasive messages whose content positions are ambiguous.

In summary, social judgment theory predictions for attitude change are largely home out by the research literature and by practice. Recently however, researchers have questioned the basic principles of social judgment theory and how the theory's principles relate to one another. Social judgment theory is important because it demonstrates the importance of people's prior attitudes. Most other approaches only deal marginally with previous attitudes. Newer theories incorporate social judgment principles as covariates and control variables in experimental designs (Wood, 1982).

**Functional Theories**

A fundamental question about attitudes concerns their purpose: That is, what functions do attitudes serve? Understanding the purposes of attitudes is the identifying characteristic of functional theories. Attitudes serve different functions for different individuals or for the same individual in different settings. The reasons for attitude changes are individualized and related to personal functions of attitudes.

Functional theories of attitude entered the literature in the 1950s when researchers developed the idea that attitudes served varying psychological needs and thus had variable motivational bases. A common and central theme of these early efforts was the listing of the specific personality functions that attitudes served for individuals. Unlike other theoretical approaches developed during this golden decade of attitude research, functional theories are still relevant and important today (Eagly & Chaiken, 1993).

Functional theories hold that successful persuasion entails implementing change procedures that match the functional basis of the attitude one is trying to change. Katz (1960) proposed that any attitude held by an individual served one or more of the four distinct personality functions. The more of these functions that contributed to an attitude system, the stronger and less likely it was that the attitude could be changed.
Katz (1960) identified four personality functions of attitudes as follows: (a) utilitarian function, (b) knowledge function, (c) ego-defensive function, and (d) value-expressive function. In order for attitude change to occur, there must be a discrepancy between the need being met by the attitude and the attitude itself. Attitude change is accomplished by recognizing the function of the attitude for the individual, and designing strategies to produce a disparity between the attitude and one or more of the attitude functions.

The *utilitarian function* acknowledges the behaviorist principle that people are motivated to gain rewards and avoid punishments from their environment. Utilitarian attitudes are instrumental in securing positive outcomes or preventing negative ones. For example, parents' opposition to busing might be based on the utilitarian belief that it would be harmful to their child. Often, utilitarian beliefs are associations to stimuli. For example, children often acquire a positive feeling about the month of December because they associate it with holidays, presents, and vacations (Eagly & Chaiken, 1993).

The *knowledge function* of attitudes presumes a basic human need to gain a meaningful, stable, and organized view of the world. Attitudes supply a standard for organizing and simplifying perceptions of a complex and ambiguous environment. Attitudes provide a way of sizing up objects and events so they can be reacted to in a meaningful way. If people's attitudes toward school are positive, then when they are asked about schools they will be likely to say positive things without needing to "think about it too much."

Katz's *ego-defensive function* emphasizes the psychoanalytic principle that people use defense mechanisms such as denial, repression, and projection to protect their self-concepts against internal and external threats. People protect their feelings by developing convenient, if sometimes biased, attitudes that do not require active involvement in threatening or unfamiliar situations. For example, a high school student may think: "Chemistry is for nerds, and I do not want to be a nerd; that is why I do not like chemistry." Or a student might think: "Only really smart people study chemistry, and I study chemistry, so I must be really smart; that is why I like chemistry."

Finally, Katz's *value-expressive function* acknowledges the importance of self-expression and self-actualization.
Attitudes are a means for expressing personal values and other aspects of self-concept. A person who draws self-esteem from being a liberal and an environmentalist is motivated to hold attitudes that reflect these ideologies (Eagly & Chaiken, 1993).

The central theme of functional theories is that changing an attitude requires understanding its motivational basis, or its function for the individual. Knowing what function an attitude performs for a person helps guide the designer of the persuasive message who wants to change the attitude. Whatever function attitudes perform they provide a frame of reference for comprehending and categorizing objects, persons, and events, and only by understanding an attitude's function can attitude change efforts be successful.

An alternative and related theory looks at social relationships that occur in social influence situations (see 6.2). Kelman (1958) looked at three processes of opinion change: (a) compliance, (b) identification, and (c) internalization. Compliance results in only a surface level change. Attitudes are changed only to receive a favorable reaction from another person or group. This attitude is only expressed when the other person is present.

The attitude change resulting from identification occurs both publicly and privately but does not become part of the person's value system. The change is dependent on the relationship with the source but not with the source's presence. Attitudes that are internalized become part of an individual's value system.

McGuire's (1964) inoculation theory is concerned with resistance to change (see 37.4). Research in this area investigates the treatments individuals could receive which would allow them to resist successfully attacks on their belief systems. An analogy is drawn from the biological process of inoculation. Once people are inoculated, they are immune when exposed to the disease. Attitudes are often established in a relatively "germ-free" environment, free from attack. Thus, the individual has little chance to develop resistance to future attacks. McGuire's research strategy was to expose the individual to mild attacks in a control setting in order to motivate the individual to defend his or her beliefs (Himmelfarb & Eagly, 1974; Kiesler et al., 1969; Insko, 1967).

Functional theories are in the mainstream of attitude research. Their theoretical approaches remain conceptually intriguing to investigators because of their breadth and unique
focus on the functional bases for attitudes. Functional theories provide a link between the behavioral theories proposed during the 1950s (consistency theories, early-learning theories, social judgment theories) and the processing and cognitive themes of more recent theorizing.

Attitude and persuasion research is a major area of interest to those in social psychology. Theory building has been characteristic of this research. Only a fraction of this literature has been reviewed in this section of this chapter; however, the information presented provides a basis for information presented later. These theories, especially the functional theories discussed last, provide guidance to the development of recommendations for the design of persuasive messages delivered by media.

**TYPES OF ATTITUDES**

To get the obvious out of the way, attitude is not something a girl gives to you when you praise her before being friends with her. And attitude is definitely not something you show to the same girl after she accepts your compliments and now wants to be your friend. Attitude, in every sense of the word, has more connotations attached to it than just being used as a slang statement among the youth. Technically, attitudes are evaluative statements related to a person, object, or event; either favorable or unfavorable. They reflect our tenacious disposition to react and behave in a certain way towards people and situations. It’s our attitude through which the world sees us and forms opinions and attitudes of its own. And they are nothing but the branches formed out of the seeds that we only sowed based on our experiences, positive or negative. However, attitudes are not to be confused with personality types, for the latter are more rigid in nature. Attitudes, on the other hand, are elastic in nature and can be molded into a different one over time. So, don’t lose heart, for the ball lies in our own court when it comes to forming and controlling our attitudes. We just need to hold our own, stay open minded, and try not to give in to the criticisms of the world. We can’t control their attitude and mindset, but can definitely change ours. Remember, we don’t need to do it for anyone else, but only for ourselves.

**Components of Attitudes**

**Cognitive Component;** It is the belief segment of an attitude. When someone forms an opinion or perception about any person, object, or situation; the cognitive component
comes into play. The opinion may be favorable or unfavorable, positive or negative. For example, if a person says “Life is unfair”, he’s iterating his opinion about how he perceives life is.

**Affective Component**

It is the feeling segment of an attitude. When someone attaches his/her emotions to the opinion that has been formed about any person, object, or situation; the affective component comes into play. For example, if a person says “I hate the fact that life is unfair”, he’s connecting an emotion through hatred, to his opinion of life being unfair.

**Behavioral Component**

As the word itself suggests, it’s the behavior segment of an attitude. When a person attaches a desire to behave or act in a certain way based on the emotions he has attached to the opinion about any person, object, or situation; the behavioral component comes into play. For example, if a person says “I am going to hurt myself and others if life doesn’t stop being unfair to me”, he’s reflecting a desire to act by hurting himself and others based on how he perceives life to be and the emotions he has attached to this perception.

However, a negative attitude need not be always concluded through a negative reaction. Instead of stating “I am going to hurt myself and others if life doesn’t stop being unfair to me”, he could have said “The change needs to start from within myself if I am to make it fair”. As it was discussed, it is in our own hands of how we transform the negative attitude into positive.

**Attitude towards family planning and birth control in Hindu**

Hinduism, more a confederation of religions than a single dogmatically unified one, holds faith in multiple deities. Karma is a strong feature of Hinduism. The basic belief of karma is that one reaps what one sows; it is a demand for accountability that is strongly tied to the belief in reincarnation.

The basis of reincarnation is that a continuous cycle of rebirth exists. One may attain emancipation, nirvana, from this cycle through self-inquiry and self-realization.
Human form is the highest form of life and is attained after innumerable cycles; thus human life is a unique gift through which one may end the cycle of rebirth.

**Beliefs about sexuality and family planning**

Sexual relationships are to be experienced and mutually enjoyed within the limits of marriage. Such relations are for both procreation and pleasure. Marriage is viewed as essential for the stability of social order. Reincarnation requires that children pray for the souls of ancestors; however, a cultural emphasis on patrilineage has created a tremendous emphasis on the need for male children.

Although cultural influences have traditionally encouraged large families, the sacred families illustrate the prototypes of the ideal family, specifically, small and united with a deeply ingrained sense of honor, duty, justice, and righteousness.

**Beliefs about contraception**

Religious doctrine lacks any prohibitions or obligations with respect to contraception; thus all contraceptive methods are acceptable, including continuous contraception. Generally, there is much flexibility within Hindu doctrine, and most decisions are based on intention and motivation.

If the contraceptive intent is not morally wrong, no ethical or spiritual harm occurs.9 Hinduism regards the decision to use contraception as a personal matter for women that is not usually within the scope of religious injunction. The concept of liberty is core to Hinduism—the freedom to choose one’s path must exist, as this is the only way to connect with one’s spirituality. The decision to use contraception and the choice of contraceptive method is therefore a personal choice.

**Abortion and emergency contraception**

Conception is considered the result of a divine act whereby life enters the embryo; thus, abortion and emergency contraception are condemned. Despite this apparently firm stance, there is flexibility. Hinduism has traditionally rejected absolutism and encourages individuals
to enact their moral agency. Although abortion is discouraged, in certain situations, women may decide it is a necessary and moral course of action for their circumstances. Potential cultural limitations

**Sexual health is often considered a taboo topic in traditional**

Indian families, Young women and men may have no education regarding contraception, normal sexual intercourse, or sexually transmitted infections and may not understand concepts of ovulation and timing of pregnancies.

Women are generally not educated about contraceptive options until after the birth of the first child. The birth of the first child is used to assure the families involved that the marriage was a good match thus, among some couples, birth control may be forbidden until the first child is born.

Studies have demonstrated that traditional Indian men do not desire fertility regulation. An attempt made by the woman to influence these decisions could potentially result in physical abuse, allegations of infidelity, or divorce. An attempt made by the woman to influence these decisions could potentially result in physical abuse, allegations of infidelity, or divorce.

When discussing contraception, it may be prudent to ask married women whether contraceptive methods should first be discussed with the husband or if permission to discuss contraception with the wife must be gained from the husband.

**Current cultural trends**

Despite the religious permissibility of contraception, not all Hindu women utilize contraceptive methods. Lack of family planning success in India among Hindu women has been attributed to cultural resistance, sexism, and lack of female empowerment. Factors found to decrease contraceptive use include lower education levels, higher numbers of female family members residing in the home, and decreased accessibility of services.

**Attitude towards Family planning and Birth control in Muslim(Islam)**

Central to the beliefs of Islam is that Allah—God—is the creator of the universe and humankind. Islam is a comprehensive system used to regulate spiritual and political aspects of individual and communal life. By studying various religious sources, Islamic jurists classify
human actions as obligatory, recommended, permitted, disapproved but not forbidden, or forbidden. Distinct schools of Islamic jurisprudence have developed over time. These schools represent different traditions of interpretation and are not considered distinct denominations.

**Beliefs about sexuality and family planning**

Family and marriage are fundamental to Islamic society, yet are not obligatory duties. Individuals unable to undertake the responsibilities of marriage, including the physical care and social, cultural, and moral training of children, should postpone marriage. Parents are obligated to ensure the rights of children are attained. These rights, as prescribed by the Quran, include the right to an education, religious training, future security, and equitable treatment. Islam recognizes the normalcy of sexual drives. Sex is permitted provided it is used within marriage and may be used for procreation and pleasure each sexual act need not be for the exclusive purpose of procreation.

**Islamic beliefs about family planning**

The majority of Islamic jurists indicate that family planning is not forbidden. Muslim opinion regarding the further classification of contraception ranges from permissible to disapproved. Some fundamentalist Muslims insist that any form of contraception violates God’s intentions. Historically, coitus interrupts has been permitted in the Quran. When contraception justification is provided, such as health, social, or economic indications, coitus interrupts becomes recommended. Through analogous reasoning, authorities permit modern methods of contraception as lawful, given that they are temporary, safe, and legal. Any device that does not induce abortion and is reversible may be used. Irreversible sterilization methods are not permitted. Contraception may be used only within marriage.

Justifiable reasons for contraceptive usage include health risks, economics, preservation of the woman’s appearance, and improving the quality of offspring. Health risks need not be life-threatening. Continuous hormonal contraception, as it is reversible, is permissible as a form of contraception; however, it may not be acceptable to some women who value regular monthly menstruation. In contraception discussions with Muslims, health care providers should first
determine whether the couple hold conservative beliefs about contraception and whether they consider contraception to be permissible and encouraged or permissible yet disapproved. The Islamic concept of Hejab—modesty—may affect gynecological care. Some societies interpret this concept as meaning health care practitioners of the same gender are required to carry out all medical examinations. Such religious restrictions among traditional Muslims may prevent women having intimate examinations when a health care provider of the same sex is not readily available, thereby influencing medical care and contraceptive decision-making.

**Abortion and emergency contraception**

Abortion of a viable fetus is considered a serious crime equivalent to that of murder. Emergency contraception is also disapproved. However, the prevailing view in Islam is that both are permissible in certain situations. Depending on the Islamic school and length of gestation, religious opinion varies from unconditional permissibility to unconditional prohibition. Valid reasons may include unacceptable risk of maternal mortality, a deformed or non-viable fetus, rape, and economic indications.

**Current cultural trends**

Opinion of Muslim adherents regarding contraception varies from permitted to permit but discouraged to not permit. When used as synonymous to birth spacing as opposed to limiting the final family size, family planning support increased among traditional couples. In Muslim societies, traditional pressure, familial pressure, and religious pressure influence the decision to procreate. Additional factors found to modify contraceptive usage are gender, socioeconomic background, gender and number of current children, location of residence, country of origin, education, opinions of other women in the household, accessibility of resources, misconceptions about the side effects of modern contraceptives, and associations of fertility with femininity. The low status of Muslim women within certain communities may further hinder contraceptive usage. This inequality is a construct of the communities in which
the women live. According to Islamic law, Muslim women are considered equal to men in terms of religious, social, and patriotic responsibilities

**Attitude towards Family planning and Birth control in Buddhism**

The essence of Buddhism is abandonment of preoccupations with materialistic desires and the passions of life however; specific Buddhist practices are greatly influenced by the cultural traditions and customs of adherents. The greatest objective of Buddhism is enlightenment, which is attained through self change and inner transformation. Most Buddhists believe in kammatic Buddhism, also known as reincarnation, and strive for nirvana, attenuation of the cycle of rebirth. Kamma is a neutral term that means any action produces an effect, positive or negative, in this life and the next. Nirvana occurs when prior bad kamma has been balanced by good kamma.

**Beliefs about sexuality and family**

Buddhism does not stress procreation; thus, the tradition of high fertility is related to cultural rather than religious factors. Marriage and sexuality are considered positive; however, marriage is not a religious duty. Sexuality is neither sinful nor spiritually redeeming nor consecrated through marriage. Sexual activity and thoughts, because of their instinctual and unconscious nature, serve to reinforce unenlightened tendencies. Buddhist practice aims to transform the deepest inclinations of individuals; thus, sexuality is considered an obstacle to enlightenment.

**Contraception beliefs**

The Buddhist attitude towards family planning allows both men and women the right to use any non-violent form of contraception. Family planning is permissible and encouraged when the intention to use contraception is wholesome or non-maleficent. According to Buddhist theory, life begins at the moment of conception, thus non-violent contraceptive methods are those that do not destroy the products of conception. There are no specific prohibitions or obligations regarding contraception in Buddhist theory thus, modern contraceptive methods are permissible. Abstinence is the method of choice; however, other methods, including permanent sterilization and continuous contraception, are not opposed.
IUCDs may be problematic for those who believe that they work by preventing implantation. A discussion about other likely mechanisms of action for the IUCD, including prevention of fertilization, may influence acceptability. Contraception may not be used to engage in self-indulgent activities such as promiscuity. Such behavior is considered to result from ineffective control of one’s passions.

**Abortion and emergency contraception**

Although abortion and emergency contraception are considered murder, both are permissible in certain situations. Any situation can be used to justify terminations (such as maternal health, rape, economic hardship) provided that the intentions of the mother are ethically sound. The moral severity of the termination depends on the state of mind of the mother; thus, unwholesome intentions, such as greed, hatred, or anger, are considered immoral. When terminations are required, early terminations are preferred to later terminations.

**Current cultural trends**

In India, the majority of Buddhist women of reproductive age utilize contraception. Despite this increased usage, uncomfortable feelings toward contraception remain. There is a sense that it is against the traditional culture of sexual values and may lead to widespread premarital sexual intercourse. Also, proper education regarding accurate contraceptive use among women is lacking. This is important since evidence indicates that women are more involved in contraceptive usage than men.