CHAPTER - I
THE INDIAN FAMILY PLANNING PROGRAMME:
EVOLUTION AND GROWTH

This chapter examines the evolution and growth of the Indian family planning programme. The ideas that influenced the programme, and the factors that moulded the official discourse and policy, will be examined in the next chapter, although the two are, of course, inextricably linked.

Close to the dawn of independence, the Indian National Congress established the National Planning Committee in 1938 under the chairmanship of Jawaharlal Nehru, to outline the shape of India's tryst with destiny and to contour it. One of the sub-committees, chaired by Col. Sokhey, was devoted to the question of health policy. The Sub-Committee on Health also considered the question of population, and maternal and child health. Lakshmibai Rajwade forcefully argued her case for the inclusion of "birth control, provision of goods, instructions, demonstrations and consultations" in maternal and child health services. Birth control, she argued,

is obviously a very important function in view of the fact that the high mortality among mothers and children is in part due to too frequent pregnancies involving a terrific strain on the nerves and on a vitality already abnormally low. Children are born not as a creative evolutionary response to the vital urge, but as brittle standardised products of a tired reproductive machinery automatically set in motion by the sexual act. The reproductive system has to be kept fresh and vitalised to respond creatively and must not therefore be subjected to that strain. That can only be done by controlling pregnancy by contraceptive methods.(1)

The Sub-Committee also favoured birth control in the interests of the development of the nation.

We find therefore two compelling -- if not necessarily complementary -- concerns shaping the emerging population policy. The first relates to the benefits to national development, the familiar neo-Malthusian refrain; and the second, to the benefits accruing to women's health through birth control. While not contesting the
latter, it is nevertheless important to note that this emphasis on women as reproductive beings whose "tired reproductive machinery is automatically set in motion by the reproductive act," serves to distract attention from the socio-economic circumstances governing reproductive behaviour. The effort is then to alter this through medical technology directed towards a woman whose reproductive profligacy is posited as a cause for her poverty and ill-health. What this approach entirely fails to take cognisance of, is that of the causes of maternal deaths in the reproductive age group, only an insignificant proportion is due to causes related to pregnancy and child birth. Even within the reproductive age group in women, the major causes of death are infectious and communicable diseases, which are not, of course, responsive to birth control. In other words, this position takes a non-epidemiological approach to the problem of women's health.

The Health Survey and Development Committee, commonly known as the Bhore Committee, was established in 1943, to provide a blueprint for the development of health services in the country. Noting that declines in birth rates had not followed declines in death rates, the Committee concluded that India was indeed confronted with a population problem that could have grave consequences, as "uncontrolled growth of population would outstrip the productive capacity of the country." The Committee recommended assistance by the state to the Birth Control Movement, both on the grounds of the health of mothers and on economic grounds, in the interests of the individual and the community.(2) The doleful imprint of the eugenics movement is obvious in the Report's observation that

the classes which possess many of these undesirable characteristics are known to be generally improvident and prolific. A continued high birth rate among these classes, if accompanied by a marked fall in the rate of growth of the more energetic, intelligent and ambitious sections of the population, which make much the largest contribution to the prosperity of the country, may be fraught with serious consequences to national welfare.

The First Five Year Plan document cautiously observed:

It is not possible to judge whether or not, an increasing population is favourable or unfavourable to development. In the past, periods of
rapid economic development have also been periods of rapidly increasing population but whether there is any causal relationship between the two or how it works one cannot say with any certainty. In periods of rapid development and changing techniques it is questionable whether the concept of "optimum" population can have any precise meaning.(3)

Nevertheless, this caveat notwithstanding, the Plan adds:

The pressure of population in India is already so high that a reduction in the rate of growth must be regarded as a major desideratum. To some extent, improvement in living standards and more widespread education, especially among women, will themselves tend to lower the rate. But positive measures are also necessary for inculcation of the need and techniques of family planning.

The official programme for family planning was launched in 1952 with a modest budget of 65 lakhs.(4) Thus India has the distinction of being one of the first nations in the world to have an official family planning programme and policy.(5) The principal measures envisaged were:

(a) the provision in government hospitals and health centres of advice on methods of family planning;
(b) field experiments on different methods of family planning for determining their acceptability and effectiveness; and
(c) the development of suitable procedures to educate the people on family planning methods.(6)

The Ford Foundation "played an active and innovative" role in these developments. In 1952, Ford's representative in India informed Prime Minister Jawaharlal Nehru that his organisation considered "India's rapid population growth a major problem and was willing to consider appropriate aid in this field".(7) Twenty-one rural and 126 urban family planning clinics were established.(8)

The National Family Planning Programme received funds from private international agencies for the first time; the Ford Foundation granted nine million dollars.(9) The Foundation
chose India as a target for intensive research in demography, contraceptives and distribution systems, thereby following in the path of the Population Council which made a grant to India’s Institute of Public Health for a field study of population control in West Bengal.

Ford’s involvement, it is stated, "firmly established the Foundation in India as ‘an innovator working in the threshold of programme development’ in the population arena." Ford helped create two of the major Indian family planning organisations, the Central Family Planning Institute (CFPI), later rechristened the National Institute of Family Planning; and the National Institute for Health, Administration and Education (NIHAE).(10)

During this period was launched the very influential Khanna Study in Punjab, of which more later.

SECOND FIVE YEAR PLAN

The Second Plan noted:

Regarding population growth, only a few observations seem necessary. Rates of population growth can be altered only over a period, one has to go by the results of trends which commenced earlier. Nevertheless, over a period, the outcome of developmental effort can be noticeably different if population trends are altered in the right direction. This is one of those fields in which traditional modes of thought and behaviour are apt to offer considerable resistance to rational approaches and not many countries can be said to have any definite population policy at government level. Yet, these modes or attitudes are changeable and are probably changing faster than is sometimes realised. The logic of facts is unmistakable and there is no doubt that under conditions prevailing in countries like India, a high rate of population growth is bound to affect adversely the rate of economic advance and living standards per capita. Given the overall shortage of land and of capital equipment relatively to population as in India the conclusion is inescapable that an effective curb on population growth is an important condition for rapid improvement in incomes and in levels of living. This is particularly so, if one bears in mind that the effects of improvements in public health and in the control of diseases and epidemics is to bring about an almost immediate increase in survival rates. While there may be differences as to the likely rates of
population growth over the next 20 or 25 years, indications clearly are that even the utmost effort which can be made -- and has to be made -- at this stage to bring down birth rates, population pressure is likely to become more acute in the coming years. This highlights the need for a large and active programme aimed at restraining population growth, even as it reinforces the case for a massive developmental effort. (11)

Perusing these developments over the first two Plan periods, there appears to be a clear shift of perspective regarding the issue of the relationship between socio-economic and demographic changes. While the First Plan noted, quite correctly, that it is not always possible to judge the relationship between these related phenomena, the perspective is clearly one that envisages demographic changes as dependent variables responding to wide-ranging shifts in social structural factors. It does not indicate therefore that manipulation of fertility alone would be either necessary or feasible. The Second Plan, on the other hand, appears to indicate that population growth is an independent variable and economic change the dependent one. It is, possibly, accidental that this change of perspective was current in the field of demography in the United States of America at this period. Earlier efforts towards the understanding of so complex a phenomenon as the relationship between population dynamics and socio-economic change, had undergone a transformation towards a policy prescription for the third world nations.(12)

In the Second Plan, the allocation for Family Planning increased to five crores; the allocation to the health sector was rupees 225 crores out of a total outlay of rupees 4672 crores.(13) In 1956, after little progress during the First Plan, and following the widely disseminated remarks of the Census Commissioner about "improvident maternity",(14) the first official planning groups and blueprints for family planning were established on a national scale. The Central Family Planning Board, chaired by the Minister of Health, was established. State Family Planning Committees were set up in all states by 1959. Top officials were appointed: at the Centre, a Director of Family Planning responsible to the Director General of Health Services.(15)
During this Plan period, 1,079 rural and 421 urban clinics came into existence. Of these, about a hundred were set up in association with medical colleges and training centres for medical auxiliaries. Training, education and research received a fillip. Contraceptive research commenced at research centres in Bombay, the All India Institute of Hygiene and Public Health, Calcutta, the Central Drugs Research Institute, Lucknow, etc. A Demographic Training and Research Centre was established in Bombay in 1956. In addition, three Demographic Research Centres were set up in Calcutta, Delhi and Trivandrum. With regard to training and education, training centres run by the Ministry of Health were established at Bombay, Ramanagaram in the then Mysore State, and Delhi. A pilot training team was formed by the Family Planning Association of India. Moreover, many State Governments set up regional training centres. Instruction in family planning methods was incorporated in the curriculum of the courses of training of doctors and nurses. School teachers in various states were provided orientation training under the Community Development Family Planning Scheme. The operational strategy of the family planning programme in the first two Plan periods was influenced by the traditional approach of the international planned parenthood movement. The Family Planning Clinics that had been opened emphasised person-to-person instruction on contraceptive methods, based on the philosophy that it was physically possible and morally desirable for couples to control the size of their families; and that a small number of children in a family is good for the society whose general welfare is endangered by too rapid a population growth.

THIRD FIVE YEAR PLAN

The Health Survey and Planning Committee (the Mudaliar Committee) Report, published by the Ministry of Health in 1961, observed that the recommendations of the Bhore Committee were "faltering and half-hearted" in relation to family planning. It recommended that "if the family planning movement is to produce early and successful results, it has to be in the nature of a mass movement." To this end, they recommended strengthening of the Health Ministry. They urged efforts to enlist
greater cooperation from voluntary organisations such as the Family Planning Association of India. High priority was to be accorded to the production of contraceptive supplies. They also recommended that family planning should be an essential part of the activity of all health agencies.\(^{(21)}\)

Of greater interest is the supplement to this Report. A minority recommended the consideration of "appropriate legislative and administrative measures" in view of the urgency and magnitude of the problem, to ensure a fall in the birth rate of the country during the next five years.\(^{(22)}\) The measures suggested include:

(a) graded tax penalties from the fourth confinement onwards;
(b) removal of income tax disadvantages for single persons;
(c) withdrawal of maternity benefit for those refusing to accept family limitation;
(d) limitation of certain government services such as free education, to three children per family;
(e) enlisting the participation of government employees in promoting family planning; and
(f) abortion for socio-economic reasons.

The minority report forebodes, in a sense, the shape of things to come: the iron hand of coercion beneath the velvet glove of rhetoric. The Third Plan document accorded "very high priority to family planning" and noted that

the objective of stabilising the growth of population over a reasonable period must be at the very centre of planned development. In this context the greatest stress has to be placed in the Third and subsequent Five Year Plans on the programme of family planning. This will involve intensive education, provision of facilities and advice on the largest scale possible and widespread popular effort in every rural and urban community.\(^{(23)}\)

The emphasis on the family planning programme as the centre of planned development received impetus from the results of the 1961 Census, which showed a higher rate of population growth than expected.\(^{(24)}\)

A burgeoning of the programme occurred. As against rupees 65 lakhs in the First Plan and five crores in the Second, the outlay for family planning in the Third Plan was rupees 50 crores; health obtained 342 crores.
However, the limitations of the clinic approach were now coming to light. In April 1963, the Director of Family Planning, advised by a Ford Foundation consultant,(25) initiated a reorganisation. The reorganised scheme would emphasise extension education, greater availability of contraceptive supplies, and less dependence on the traditional clinic approach. In other words, inspiration for this changed approach emanated again from the Community Development movement in the United States.(26)

The main programme goal was to be the reduction of the country's birth rate from more than 40 per thousand to 25 per thousand, possibly by 1973. For this purpose, operational goals were defined as achieving, for 90 per cent of the married adult population, three basic conditions viz.

(a) group acceptance of the smaller family size norm;
(b) personal knowledge of specific birth control methods; and (c) easy availability of supplies and services.(27)

A massive expansion of the programme organisation was the result. This included the creation of the posts of Parivar Kalyan Sahayaks and Sahayikas, the addition of Auxiliary Nurse Midwives and male family planning field workers, and an additional lady doctor -- exclusively for family planning -- and a Block Extension Educator at the Primary Health Centre level. Full fledged Family Planning Bureaus were established at the district level. Family planning organisations at the state and at the centre were concurrently strengthened.(28)

The primary health care system, which as the Mudaliar Committee noted, bore no resemblance to that visualised by the Bhore Committee, received a shot in the arm due to the compulsions dictated by the Family Planning programme. Thus the P.H.C had as its family planning personnel, besides the lady doctor, Auxiliary Nurse Midwives, extension educators and health assistants (one per 20,000 population), Lady Health Visitors (one per 40,000 population) as well as statistical and other staff.(29) At the grassroots, the sub-centre staffed by an A.N.M was to be "the
infantry of the programme".\(^1\) The Central Government committed itself to bearing the entire expense of the family planning programme in the states, although the rest of the primary health centre staff remained on the states' health budgets.\(^2\)

As steps were being initiated to implement the Reorganised Programme, the United Nations Advisory Mission visited India in 1965 and suggested the launching of a "Reinforced Programme" parallel to the Reorganised Programme.\(^3\) Three courses of action were recommended under the reinforced programme, viz. an energetic loop (I.U.C.D) programme, an intensified sterilization programme, and the promotion of the use of condoms through wider availability via commercial channels. These recommendations shifted the focus from the reorganised programme with extension approach to an energetic loop programme.\(^4\)

It has been noted that

the designer of the model of the IUCD which was employed at the outset, Mr. Jack Lippes, and other foreign experts visited India and were instrumental in persuading the Government that it was suitable for widespread use. The First U.N. Mission, which examined the family planning programme in 1964, had a major role in this respect.\(^5\)

The role of the U.N Family Planning Mission in "endorsing" the loop is acknowledged in the Report of the Second Mission.\(^6\) The Report of the First Mission commends "the intra-uterine device" for it "offers at present the best possibilities for a large scale, successful programme for reducing the birth rate in India. The plastic loop convinced the Mission that every effort should be made to distribute it on a wide scale."\(^7\)

At its first meeting in December 1965, the Central Family Planning Council recommended the formation of a committee "to review what additions and changes are necessary as a result of the greatly altered situation due to IUCD having come in the forefront of the programme in the staffing pattern, financial provisions etc." The Mukherjee Committee\(^8\) which thus came into being noted that "on account of the

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\(^1\) Military metaphors, alas, do not remain confined to scholarly commentators: the Shrivastava Committee urged that the population problem had to be tackled on a "war footing".
IUCD method becoming available, a mass programme has become feasible on account
of this methods very great clinical and administrative advantage over sterilization."
The Committee recommended a separate and significantly strengthened staff to be in
full-time and overall charge of the family planning programme implementation, with
targets fixed for various levels for the separate components of the programme; but
with an emphasis on the IUCD. Further, the Committee recommended the
establishment of a mobile sterilisation and a mobile education and publicity unit,
attached to each district Family Planning Bureau. The Committee also recommended
the sanction of incentives\(^2\) to both the health personnel and to individuals undergoing
sterilization or accepting IUCD insertion. The Committee noted that their
recommendations received corroboration\(^3\) from the Evaluation Report of the World
Bank (the Bell Mission Report), the UN Evaluation Report, and the Report of the
Family Planning Programme Evaluation Committee.

In 1965-66, the Programme Evaluation Organisation of the Planning
Commission evaluated some aspects of the implementation of the family planning
programme, and made far-ranging recommendations\(^4\) which were in line with the
recommendations of the World Bank and the United Nations. At the Centre, the
Evaluation Report emphasised the need for more administrative and financial
authority, and a greatly strengthened headquarters staff with sections on planning,
contraceptive supplies, administration, training and education, and of field operations
with six regional officers.\(^5\) It was recommended that a Central Family Planning
Organisation be established as a Directorate General in the Health Ministry. The
Director General of Family Planning was to be called the Commissioner of Family
Planning, and be ranked an ex-officio Additional Secretary to the Government. In
December 1965, soon after the new Prime Minister took office, the Ministry was
designated Ministry of Health and Family Planning.\(^6\)

In short, the Third Plan period witnessed the burgeoning of the family
planning programme even as it showed several shifts of policy, strategy and

\(^2\) In a dextrous sleight of hand, incentives are referred to as "compensation for the individual".

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emphases. Family planning came to dominate concerns in the field of health and contoured the directions of health policy.

At the end of the Third Plan there were "3676 rural family welfare planning centres, 7081 rural sub-centres and 1381 urban family welfare planning centres providing supplies, services and advice on family planning". In addition, 450 family planning annexes to primary health centres were established, and 2770 sub-centres constructed.

In view of the serious economic crisis plaguing the country, annual plans were adopted in the years 1966-1969 instead of five year plans. This, however, was not allowed to affect population policy. Indeed, financial inputs into the programme continued to increase. During these years, health obtained an allocation of 140.10 crores; family planning obtained 75.2 crores, compared to 225.9 and 24.9 respectively in the Third Plan.

In April, 1966, family planning was withdrawn from the purview of the D.G.H.S., and constituted into a separate Department of Family Planning in what was then called the Ministry of Health, Family Planning and Urban Development. It has been suggested that this step was taken primarily to impress the World Bank and other aid-giving agencies (such as the Aid India Consortium), with a view to obtaining greater financial support.

During this period, as we shall see again later, the World Bank was increasingly interested in the population policies of developing countries who were prospective borrowers:

All such activity (in regard to family planning programmes) arises out of the concern of the Bank for the way in which rapid population growth has become a major obstacle to social and economic development in many of our member states. Family planning programmes are less costly than conventional development projects.

Again, in line with the recommendations of the first UN Advisory Mission of 1966 that the Directorate (of family planning) "should be relieved from the other responsibilities such as maternal and child health and nutrition", M.C.H. activities
were de-linked from family planning in order to enable field workers to concentrate on family planning.

Enthusiasm for the IUCD now ran so high that policy makers and academics alike were beginning to calculate how many years the programme would have to continue before the "problem was eradicated". In 1966-67, over 900,000 women were fitted with IUCDs; in the following year the number declined to 6,69,000 in spite of the best of efforts, and from then on the decline was quite drastic. In other words, the IUCD strategy proved to be a failure.

The assumption over these years appears to be that family planning was a necessary outcome of contraceptive technology alone, and that sufficient un-met demand existed among the primarily poor agricultural population of the country. This latter assumption was no doubt strengthened by the plethora of KAP studies undertaken.

Following trials in 1967 and 1968, the Nirodh Marketing Programme was launched in September, 1968. Inspired by a marketing specialist from M.I.T., the scheme utilised the marketing outlets of Brooke Bond, Liptons, Indian Tobacco, Hindustan Lever, Tata Oil Mills and Union Carbide to reach potential retail outlets of over two million. And in 1967, the I.C.M.R. recommended the introduction of oral pills on a pilot basis as of August 1967.

FOURTH FIVE YEAR PLAN (1969-74)

The Fourth Plan document noted that the problem of population had, in fact, grown even more acute. The Plan accordingly held that the programme of family planning had assumed national importance warranting the highest priority.

Population growth thus presents a very serious challenge. It calls for a nationwide appreciation of the urgency and gravity of the situation. A strong purposeful Government policy supported by effective programme and adequate resources of finance, men and materials is an essential condition of success.
The Plan noted that the population growth rate is estimated to be 2.5 percent per annum, and that "in order to make economic development yield tangible benefits for the ordinary people, it is necessary that the birth rate be brought down substantially as early as possible." It therefore proposed to aim for the reduction of the birth rate from 39 per thousand to 25 per thousand within the next 10-12 years. The Draft Plan outlay of 300 crores was revised upwards to 315 crore rupees so that the programmes could be strengthened and speeded up. (52) Health obtained 433.5 crores.

The Plan proposed "to step up the target of sterilisations and IUCD insertions and to widen the acceptance of oral and injectable contraceptives." Further, that for intensifying the family planning programme, new schemes like (the) post-partum programme, supply of surgical equipments to hospitals, intensive district and selected area programmes, supply of vehicles at all primary health centres and strengthening of Central and State Health transport organisations have been included for implementation during the Fourth Plan.

The pace of the family planning programme was thus substantially accelerated: a sterilization target of 14.9 million was fixed (53); the efforts of the rural and urban family welfare centres for vasectomy operations were to be supplemented by more than 1000 mobile service units attached to district family planning bureaus.

Thus vasectomy, which had been practised in India in family planning clinics for a considerable time -- it was, for example, available in Madras state in 1955 (54) -- received official impetus, and came to occupy the central thrust of the family planning programme. Several "ingenious" initiatives were undertaken. Dr. D.N. Pai established a vasectomy clinic described as "one of the most successful of the early programmes" at Bombay's Victoria Terminus, to cater to the railway passenger traffic of the order of 200,000 or more people every day. (55)

Possibly inspired by Pai's work in Bombay, Mr. S.S. Krishnakumar, Collector of Ernakulam District in Kerala, organised a historic vasectomy camp in the town hall of Ernakulam in December, 1970. It has been observed that whereas Dr. Pai brought vasectomy to the crowds, Krishnakumar's feat was that he brought crowds to the
operation. (56) An extensive publicity campaign preceded the camp; transport was provided to ferry the clients; and a large incentive, including gifts in kind, was offered along with a "lucky dip" with substantial prizes. Indeed, a "festive atmosphere" was created by the imaginative and enthusiastic Collector. The result was "the remarkable achievement" of over 15,000 vasectomies performed in one month.

The Collector was determined to prove the value of his method, and organised a second camp in July 1971, drawing from a wider region for clientele. Sixty three thousand vasectomies were carried out in this camp "which received a striking place in India’s family planning history." The Collector had produced in one month in Ernakulam 42 per cent of the vasectomies for the whole of Kerala in a year. In the three camps in the years 1970-72, approximately 14 per cent of the couples in the reproductive age group were sterilised, the same proportion achieved in Kerala as a whole in the six years 1965-71.

The World Bank, the UNFPA and SIDA supported these "dynamic" initiatives with considerable funds. Indeed there was considerable excitement in New Delhi, New York and Washington, when against a target of 30,000, the Collector obtained 65,000 cases. (57)

The Department of Health and Family Planning in New Delhi was now becoming convinced of the efficacy of the camp approach, and the states were encouraged to hold camps of their own. (58) Gujarat managed to steal Kerala’s thunder by achieving 160 percent of the annual target in little more than two months. (59) The districts, vying with each other, were encouraged by newspapers that published scoreboards to show which districts were leading in the motivation race. Employers such as the railways, associations such as the Chambers of Commerce and the Rotary vied with each other to assist in the establishment of camps. By 1972-73, most states were holding camps; although in several states where attempts were made to hold repeat camps, the performance was disappointing. (60) At a camp in Gorakhpur in Uttar Pradesh in 1972, 11 vasectomised men died of tetanus. (61)
In 1972-73, 3.1 million sterilisations were performed in India, a peak exceeding previous years and two thirds were accounted for by camps. In 1973-74, the figure was down to 0.94 million. By 1974, despite statements in favour of a suitably modified camp approach, the Department of Health and Family Planning had abandoned its emphasis on the camp approach. This was partly a result of the disasters as at Gorakhpur, and the consequent setback. It was also partly due to the problems experienced in sustaining the camp approach, and the financial stringency of the period.

Meanwhile, in 1971, the Medical Termination of Pregnancy Act was passed, which legalised abortion carried out by recognised practitioners on medical grounds. The inclusion among the grounds for eligibility of failure of a contraceptive device made abortion more or less available on demand. To increase the number of trained personnel, the government undertook training of doctors in MTP techniques in medical colleges and maternity/district hospitals.

Another programme initiated during the fourth plan period was the All India Hospitals Post Partum Programme. It commenced in 1969-70 with the objective of providing advice and services to obstetrics and abortion cases in hospitals, and to provide training in family welfare. It was envisaged that contraceptive services and family planning education would be provided under the programme to the community in the vicinity of hospitals.

In addition to these initiatives, the Government of India, in collaboration with the United States Agency for International Development (USAID) launched the Intensive District Programme. This involved the provision of additional inputs to undertake campaigns in the 46 most populous districts in the country.

To sum up, the Fourth Plan period witnessed, as in the Third, very concerted efforts to consolidate the Family Planning Programme, even as it witnessed shifts in programme strategy and emphases. Nevertheless, towards the end of the Fourth Plan, it was increasingly being realised that the approach hitherto adopted had not yielded commensurate returns. It has been noted that
in 1974 the family planning programme had reached a state of financial and even philosophical disarray. With the total number of acceptors in 1973-74 down 27 percent on the previous year, things looked gloomy for the programme. (68)

A growing awareness among international agencies of the failure of the family planning approach to poverty highlighted the need for a broad-based development approach. As noted:

The failure of over a decade of family planning to substantially lower fertility in a number of societies had led to some questioning it as a method of population control. Still considering rapid population growth a serious problem, some of the disenchanted argued for more coercive forms of population control, while others called for redirecting development benefits to the impoverished to hasten their adoption of small family ideals. (69)

The World Bank and the Population Council endorsed the "developmentalist" perspective.

The echoes of such shifts were increasingly being heard within the country. At the World Population Conference in Bucharest in 1974, the Minister of Health and Family Planning stated that "development is the best contraceptive." He observed:

We are quite clear that fertility levels can be effectively lowered only if family planning becomes an integral part of a broader strategy to deal with the problems of poverty and underdevelopment... Population policy is thus one of the several vital instruments for securing comprehensive social development, and it cannot be effective unless certain concomitant economic policies and social programmes succeed in changing the basic determinants of high fertility. (70)

**FIFTH FIVE YEAR PLAN (1975-1980)**

The Fifth Plan document codified this changed perspective. The Plan noted that

the bulk of our population lives in rural areas where health care services are extremely inadequate. Forty per cent of our population live below the poverty level and must be provided an access to minimum social consumption and investment. (71)
It went on to state:

The primary objective during the Fifth Plan is to provide minimum public health facilities integrated with family planning and nutrition for vulnerable groups -- children, pregnant women and lactating mothers.

Accent was placed on the Minimum Needs Programme which would "receive the highest priority and will be the first charge on the development outlays under the Health Sector."

The Plan noted the inability to obtain the reduction in birth rate targeted in the Fourth Plan, and aimed at the reduction of the birth rate by a more realistic five points by the end of the fifth plan period -- i.e., to a level of 30 per thousand population. To this end, "the programme for family welfare planning will continue to be accorded the same high priority in the Fifth Plan as it occupied in the Fourth."

The strategy adopted was "to increasingly integrate family planning services with those for health, MCH and nutrition" by converting the vertical programme workers into multi-purpose workers who would pay special attention to family planning.

The Plan, in addition to laying targets for physical infrastructure, laid down a target of 18 million sterilisations, 5.9 million IUD insertions, and 8.8 million conventional contraceptive users. In order to implement the programme "as a truly family welfare oriented programme" it was envisaged that the extension of the scope and coverage of the immunisation and nutritional prophylaxis would reduce the infant mortality rate, and improve the nutritional status of children in the 0-6 age group.

The outlay for family planning was increased to 516 crores; health obtained 797 crores out of a total Plan allocation of 53,750 crores, representing 0.96 and 1.49 per cent of the total outlay respectively.

The proclamation of Emergency in 1975 facilitated the passage of the National Population Policy of April 1976. Among other reasons such as the down-turn in family planning programme performance, the strengthening of the view that development was being thwarted by population growth, which therefore called for
more decisive steps, the suspension of normal political processes, and the muzzling of the press made possible the acceptance of the population policy.

The Policy document (72) acknowledged that "our real enemy is poverty," but went on to add that

nonetheless it is clear that simply to wait for education and economic development to bring about a drop in fertility is not a solution. The time factor is so pressing and the population growth so formidable, that we have to get out of the vicious circle (sic) through a direct assault upon this problem as a national commitment.

The Policy announced contained a comprehensive range of measures. Centre-state relations were tilted in a distinctly anti-natalist direction by freezing representation in Parliament; and by the proposed allocation of central resources to the states on the basis of the 1971 Census figures, and not on the basis of current population. Family planning performance became one of the new criteria for financial allocation; eight per cent of central aid to states was linked to their performance in family planning.

The policy statement stressed the importance of female education, nutrition and basic health services, and reiterated the commitment made in the Fifth Plan to reach a birth rate of 25 per thousand by 1984, the end of the Sixth Plan period. The measures specified to achieve this included raising the legal minimum age at marriage to 18 and 21 for females and males respectively; increasing monetary incentives for sterilisation; offering "group incentives" at the level of the village and district; introducing population values in the educational system; drawing all government departments into the "motivation of citizens to adopt responsible reproductive behaviour"; and involving teachers, labour in the organised sector, voluntary agencies, youth and women's organisations in the family planning movement. A new multi-media motivational strategy, directed specially to rural areas, was envisaged. Special measures were proposed to raise female education and organise child nutrition in an attempt to stimulate demand for family planning. (73)
In addition, citing absolutely no evidence, the policy statement asserted that "public opinion is now ready to accept much more stringent measures for family planning than before." It ruled out nationwide compulsory sterilisation, "at least for the time being," only because medical and administrative infrastructure were inadequate for this purpose. However, state governments were permitted to do so if they felt "the time was ripe." State governments were also permitted to introduce rules making employee benefits conditional on sterilisation after two children. Employees of the Union Government, it stated, "will be expected to adopt the small family norm and necessary changes will be made in their service conduct rules to ensure this."

Family planning was included in the Twenty Point Programme of the Prime Minister and the Five Point Programme of her son Mr. Sanjay Gandhi.(74) It has been noted that

for the first time senior politicians went out of their way in speeches on major public occasions to express the Government's commitment to birth control; previously such speeches had been rather rare and, when they happened at all, had usually been confined specifically to family planning events.(75)

In other words, political backing at the highest level was forthcoming for the adoption of a policy which implicitly advocated compulsory sterilisation and the use of administrative machinery to achieve what had hitherto been thought of as "unthinkable".(76)

The Minister of Health and Family Welfare wrote to the Prime Minister that "the problem is now so serious that there seems to be no alternative but to think in terms of introduction of some element of compulsion in the larger national interest."(77) The Prime Minister, Mrs. Indira Gandhi, addressing the Joint Conference of the Association of Physicians in India in January, 1976, stated:

We must now act decisively and bring down the birth rate. We should not hesitate to take steps which might be described as drastic. Some personal rights have to be held in abeyance for the human rights of the nation: the right to live, the right to progress.(78)
It is not surprising then that sterilisations were performed with new zeal in this atmosphere. Targets for sterilisations were set at various administrative levels, most importantly at the level of the district, where the Collector was charged with pursuing the new family planning goals.

The states, for their part, vied with each other to implement the targets set. Indeed, these targets were raised to higher levels by a number of state governments. For example, Bihar doubled it from three to six lakhs, as did Maharashtra, from 5.62 lakhs to 12 lakhs; Madhya Pradesh and Himachal Pradesh almost tripled their targets. Still others, more enthusiastic, quadrupled it: Uttar Pradesh, from four lakhs to 15 lakhs and West Bengal from 3.92 lakhs to 11 lakhs. Punjab increased its target by five times.(79)

The original target of four million sterilisations for 1967-77 was ostensibly reached by September 1976, although the numbers reported and their demographic impact have been questioned. Indeed the Joint Secretary of the Ministry of Health wrote to the State Chief Secretaries that "It may not be much of an exaggeration to say that 1976 was the year of Family Planning in India."(80)

As noted in the December, 1976 issue of the Ministry's publication Centre Calling,

Never in the history of the family planning programme have the States achieved the national sterilisation targets manifold. It ranges from 400 per cent to more than 100 per cent in an overwhelming majority of the States and that too in eight months.(81)

A host of harsh incentives and disincentives were declared by the States: the requirement of a sterilisation certificate before a government permit, rural credit or fertiliser could be granted; denial of admission to schools for those with more than three children; offering rehousing after slum clearance only to those who accepted sterilisation; and so on.(82) In some places, police detachments were employed to obtain motivated clients for sterilisation.(83)

Maharashtra passed the Maharashtra Family (Restriction on Size) Bill 1976. The title first given to the bill was more forthright: it was called the Maharashtra
Compulsory Sterilisation Bill. As the title indicates, the Bill made sterilisation compulsory after three children. The Bill was passed to the Centre for ratification and awaited the President's assent. Other states -- Punjab, Haryana and Uttar Pradesh -- followed suit, but awaited the outcome in Maharashtra.(84)

The fear and resistance these moves evoked soon surfaced. In many rural areas of Haryana, Rajasthan and Uttar Pradesh, there were reports of people attacking or fleeing from official vehicles which were suspected to be involved in the family planning campaign.(85) At other places, people avoided the health centres for fear of being nabbed for sterilisation. At still other places, people refused vaccination fearing it was for purposes of sterilisation. There were confrontations resulting in police firings and deaths, as for example the Turkman Gate episode in 1976. Towards the end of 1976, there was a major episode in Muzaffarnagar in U.P.; the foreign press estimated between 50 and 150 deaths in police firing.(86) These reports were, of course, underplayed. The Prime Minister in a statement in Parliament is reported to have admitted that there had indeed been "some" deaths, but claimed that "some people who had nothing to do with family planning had been killed by violent groups." Sterilisations themselves took a ghastly toll: 1774 deaths were reported.(87)

In the elections of 1977, the government was swept out of power partly due to what came to be described as the "excesses" committed in the name of the family planning programme.(88) The new government also committed itself to checking population growth. In his address to Parliament on March 28, 1977, the President stated:

Family Planning will be pursued vigorously as a wholly voluntary programme and as an integral part of a comprehensive policy covering education, health, maternity and child care, family welfare, women's rights and nutrition.(89)

The Population Statement of the government averred that "family planning has to be lifted from its old and narrow concept and given its proper place in the overall philosophy of welfare."(90)
To this end, the Statement highlighted the need for extension of rural health care, female literacy and legislation for raising the legal minimum age at marriage for females to 18 and males to 21. The Statement also emphasised the need for special attention to research in the field of reproductive biology.

The Statement asserted that the Family Welfare Programme "embraces all the principal areas of human welfare." To symbolise the shift of focus, the programme and the executive department concerned were rechristened the family welfare programme and department respectively. The word target was replaced by the phrase "expectation of achievement."

In view of the ensuing sharp fall in family planning programme performance, the government announced "an entirely new scheme" for the strengthening of rural health care services. The Community Health Volunteers Scheme inaugurated in 1977 -- as a step towards repositing "people's health in people's hands" -- was simultaneously visualised as a scheme for tackling the problem of population "on a war footing."(91)

The Draft Five Year Plan 1978-1983 noted that the climate of coercion and pressure as was witnessed in some parts of the country during the period of internal emergency in connection with the implementation of the Family Welfare Programme resulted in an attitude of antipathy and indifference towards this programme in the post-emergency period.

Thus it committed itself to continue giving a high priority to the programme. Allocations of 765 and 1330 crores were made for family planning and health out of a total outlay of 116240 crores, representing 0.6 and 1.1 per cent of the budget respectively.(92) These figures, however, belie the priority said to have been afforded to both health and family planning in this period. The Plan proposed the establishment of a Working Group on Population Dynamics to study the demographic situation and to make suggestions for the future. The Working Group on Population Policy which was set up, asserted in its Report that "population policy and general development strategy are two sides of the same coin."(93) They viewed the problem in terms of creating the necessary level of demand and maintaining supply of services.
The Group recommended the long-term demographic goal of a Net Reproduction Rate of One for the whole country by 2001 A.D. Towards this end they suggested operational measures. They emphasised the crucial role of "population influencing policies" such as improved health, water supply, nutrition, education and employment. The Group further recommended, citing no evidence, that "since women are the best votaries of the programme," the programme "for the immediate future be increasingly centred around women."

In short, the Fifth Plan period witnessed the failure of yet another approach to population control, that of coercion. We see the same shifts of programme strategy and emphasis that were noted also in the earlier Plans. And yet the goals remained largely elusive. Indeed towards the end of this period it is acknowledged that the programme received a setback.(94) The Fifth Plan objective of reducing the birth rate from 35 per thousand to 30 per thousand by 1987-1979 could not be achieved; in fact, the level of effective family planning couple protection came down from 23.9 per cent in 1976-77 to 22.5 per cent in March 1980 by the government's own admission.(95)

SIXTH FIVE YEAR PLAN (1980-1985)

The Sixth Five Year Plan document, noting the reverse suffered by the family planning programme, sets out to "arrest the trend". The Plan accordingly codified what has been described as the "developmentalist" approach to the population question.(96) As we shall see in the next chapter, over this period grew an awareness among international agencies of the failure of the family planning approach to poverty; thus highlighting the need for a broad-based development approach, which would integrate family planning with programmes aimed at meeting basic needs. The World Bank, under Robert McNamara, now advocated this position, as did John D. Rockefeller and the Population Council.

The Sixth Plan observes:

It is almost axiomatic that economic development can in the long run bring about a fall in fertility rates. However, developing countries
with large populations cannot afford to wait for development to bring about a change in the attitude of couples to limit the size of their families as the process of development itself is stifled by population growth. Limiting the growth of populations is therefore one of the main objectives of the Sixth Plan.

Basing itself on the recommendations of the Working Group on Population Policy, the long-term demographic goal of reducing the net reproduction rate to one by 1996 for the country as a whole, and by 2001 in all the states, was adopted. The targets set for the Plan included 22 million sterilisations, 7.9 million I.U.C.D. insertions, and a couple protection rate of 36.56 per cent. The strategy adopted emphasised

an integrated approach to the problems of public health and proper coordination of activities of different departments having a bearing on family planning such as maternal and child care.

The Plan noted that "the family planning programme has to be made part of the national effort for providing a better life to the people" and drew attention to the Plan's anti-poverty programmes and programmes for literacy -- especially female literacy -- and nutrition programmes. The Plan acknowledges that "high morbidity and mortality rates are responsible for the desire for more children." The aim was therefore

to bring down these rates through improvement of health and nutrition status through various extension programmes of immunisation, prophylaxis, supplementary nutrition and health care services.

The outlay on family planning was again increased to 1010 crores. Health obtained 1821 crores out of a total Plan outlay of 97555 crores(97), representing 1.03 and 1.80 per cent of the total respectively. The strengthening of rural health services was undertaken under the Minimum Needs Programme: the share of MNP in the health budget rose from 17 per cent in the Fifth Plan to 31 per cent in the Sixth. However, this effort at creating health infrastructure was at the cost of preventive programmes: the reduction in medical infrastructure was only 4 per cent, whereas that for the control of communicable diseases was 11 per cent.(98)
During the Sixth Plan period, there was, in line with the suggestion of the Working Group on Population Policy, an increasing emphasis on the sterilisation of women. As frequently observed in the past Plan periods, the operational strategy placed what may only be described as extraordinary faith in what was the latest in terms of technology. Female sterilisations were frequently carried out through laparoscopic sterilisations, often in camps. (99) Again, as so often in the past, what was current in technology was expected to perform extraordinary wonders; and again as in the past, with mounting disappointment.

THE SEVENTH FIVE YEAR PLAN (1985-1990)

Reviewing the progress of the family planning programme in the preceding Plan period, the Seventh Plan document observed that achievement fell short of targets with respect to all components of the programme. (100) And further, that the performance of the MCH component of the programme, in the field of immunization and ante-natal care was "far from satisfactory." The shortfalls are attributed to, among other factors, lack of infrastructural facilities, high infant mortality rates and high levels of maternal and child mortality.

The Seventh Plan set forth the following targets: 31 million sterilisations, 21.25 million IUCD insertions and, during the terminal year, 14.5 million users of conventional contraceptives to achieve a Couple Protection Rate of 42 per cent by the end of the Plan period. In addition to recommending the strengthening of the health infrastructure and the vigorous implementation of the family planning programme with particular attention to the poorly performing Northern states, the Plan emphasises the need to pay greater attention to MCH activities to enhance child survival. The allocation to family planning again increased, to be almost on par with that for health. Family planning and health obtained 3256 and 3392 crores out of a total outlay of 180,000 crores, representing 1.80 and 1.88 per cent of the budget respectively.

The year 1986 witnessed the enunciation of a new national population policy. The National Population Policy of 1986 (101) asserted that family planning
is one of the essential components of the national strategy of growth which places equal emphasis on accelerated development and recognises the fact that the process of development is apt to be lopsided unless socio-economic imbalances among the people, including imbalances in the health services, are speedily removed. It looks at birth control not as an end in itself but as a vital means to the attainment of the goal of 'Health for All' in the shortest possible time.

The policy statement enunciates the government’s commitment to promote a voluntary, two-child norm. To this end, the policy committed itself to bring down morbidity and mortality rates, in particular early childhood mortality, through strengthened health services, enforcement of the law relating to age at marriage, health and population education, educational and employment facilities for women and so on. Incentives and the policy of linking Central assistance to states were to be continued.

In other words, the Policy endorsed the vigorous implementation of the family planning programme which essentially took no new directions or fresh initiatives. Indeed, over the period of the Seventh Plan, the programme has been pursued with renewed vigour concentrating on the most vulnerable section of the Indian population, poor women.(102) As Bose observed, the family welfare programme now

is perceived as the family planning programme, which in effect is the same as the sterilisation programme, which in turn means the female sterilisation programme, which basically means the laparascopic method of sterilisation.

The bureaucratic chain from the Centre to the village level was activated to obtain cases for sterilisation.(103) Achievement of targets in family planning became an important index in the assessment of bureaucrats. The Government of Maharashtra, known for its aggressive pursuit of family planning targets, rewards the "best achievers" among Collectors and Commissioners with rest and recreation holidays in Bangkok.

In spite of all these efforts, the Mid-Term Appraisal of the Plan(104) notes that
a recent report of the Registrar General based on SRS data indicates that the birth rate has not fallen. This is in spite of the fact that couple protection rate has gone up considerably during the period. On the contrary birth rates have shown a rising tendency in some states.

The mid-term appraisal also acknowledges that of the total decline in birth rates during 1961 to 1981, 47 per cent of the reduction has taken place due to rise in the age of marriage, a change in the age structure of the population and other factors. That is to say, factors other than those related to the family planning programme contributed to a substantially large proportion of the decline in the birth rate over this period. The lack of correlation between the Couple Protection Rate and the birth rate has also been commented upon by Bose(105), who notes the paradoxically high Crude Birth Rate of 28.7 in Punjab with a Couple Protection Rate of 62.4; and a Crude Birth Rate of 21.3 with a Couple Protection Rate of 44.6 in Kerala. Haryana offers another example of a state with a high CPR (53.2) and a high CBR (28.7).

The Government of India has belatedly come to acknowledge that the programme has come to a dead end. The Public Accounts Committee in its 139th Report observed that despite massive financial inputs into the programme, the birth rate has remained stationary around 33 per thousand since 1977 (106). In his inaugural address to the XXI International Population Congress in September 1989 the late Prime Minister, Mr. Rajiv Gandhi, observed that there was "inadequate causal connection between our family planning programme and the impact of these on our birth rates"(107), and that "the rate of increase in financial outlays on family planning is not matched by a commensurate decline in birth rates."

In other words, towards the end of the Seventh Plan it was increasingly, if grudgingly, realised that the family planning programme had failed to deliver the goods. The search is now on for some new technical fix out of the impasse, even while certain cosmetic changes such as regionalisation are being contemplated. But, as so frequently in the past, there appears to be a feeling of almost utter helplessness in confronting the problem.
REFERENCES

17. Ibid.
18. Ibid.
22. Ibid.
31. Ibid.
33. Ibid.
36. Ibid.
38. Ibid.
41. Ibid.
42. GOI, Planning Commission, Fourth Five Year Plan, New Delhi, 1969.
52. Ibid.
55. Ibid.
56. Ibid.
61. Ibid.
100. GOI, Planning Commission, Seventh Five Year Plan, New Delhi, 1985.
104. GOI, Planning Commission, Seventh Five Year Plan 1985-90 Mid-Term Appraisal, New Delhi.