CHAPTER III

MEASURES OF POPULATION CONTROL IN INDIA

NEED FOR BIRTH CONTROL:

The child is the father of a man. Children are the best assets of a nation for they are the future citizens of a country. It may be well said that the future of mankind as a whole depends on the growth and well-being of the children. For all round growth, children need nutritious food, clean air and water, proper medical care and prospects of studies. The first requirement of a child is to be born healthy. Healthy mothers generally beget healthy children. The first few days after the birth of a child is really a dangerous period both for the child and the mother. For the birth of a healthy child the mother’s health must be well looked after. The Director of the World Health Organization (WHO) has observed “Each stage of development builds on the one before and influences the next.”¹ This Chapter is devoted

primarily to the review and analysis of the literature available on family welfare and birth control measures.

A woman gaining pregnancy is exposed to a variety of health risk which are natural hazards of child bearing and when she decides to postpone or make an end to child bearing she becomes exposed to some other risks. People tend to neglect the potential complications of a particular contraceptive method without considering the relative safety of contraception compared to the relatively greater risks of child bearing. In fact, the safety or health benefit of family planning must be weighed against the risks associated with unintended pregnancy and child birth. It is the responsibility of the family planning agencies not only to consider these relative benefits but also to inform contraceptive users about such benefits. Birth control is considered to bring in the following benefits -

1) IMPROVES POPULATION'S HEALTH AND MORTALITY:

Birth control may help prevent birth of unwanted child and thus help limiting the size of the family according to the resources of the parents and thus on a wider concept can stabilize the population within the resources of the country
and the world as a whole. Also it can improve people's health and bring down mortality by improving the living standard of the average people. 2

2) IMPROVES MATERNAL HEALTH, CHILDREN'S HEALTH AND REDUCES MORTALITY RATE AMONG CHILDREN AND MOTHERS:

The best period in a woman's life to produce strong healthy and intelligent children is between 20-30 years of age. This is further benefitted by spacing the child birth by three years or so. Women aged beyond 30 years and having quicker pace in child birth increase the risk of maternal death and infant mortality. One of the reasons of reduced maternal and infant mortality rates in the developed countries is the spacing and limiting child birth by conception control measures. On the same ground maternal health and infant's health are improved after adopting family planning methods. 3

The measures taken by the Government to meet the challenge of population growth consists of a two-pronged approach:

1) Clinical Approach and

2) Educational Approach

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3 Ibid.
The target groups of these two approaches are different.

It may be observed from the available statistics that 42 percent of our population are in the age group of 0-14 and 21 percent in the age group beyond 45 years. Considering that the fertility of women is limited between the ages 15 to 45 years, clinical approach in India in the form of Family Planning Programmes covers hardly 37 percent of the total population. 4

Therefore, the educational approach which will cover 42 percent of population in the age group 0-14 acquires extra importance because it is this group which will decide about the population trends in the succeeding one or two decades. 5 Hence necessary population awareness is to be created among them. This new trend in education is named as population Education which will be dealt with subsequently. This does not render infructuous the government thinking in enhancing family planning in the country as both of these

4Salkar, K.H. - Population Education for Developing Countries, Sterling Publishers Pvt. Ltd., p. 64.
5Ibid., p. 65.
approaches are complementary to each other. It will be pertinent therefore, to examine at this stage the details of our Family Planning Programme.

**FAMILY PLANNING PROGRAMME:**

The impact of population rise in the second half of the present century has been rather taxing on the socio-economic life of India. Therefore, attempt has been made to generate voluntary acceptance of family planning as an element of modernisation of living styles. The official programme is designed to generalise knowledge of family planning methods to provide easy access to the means of regulating fertility behaviour and persuade couples to achieve family limitations in their own as well as in the nation's interest. This programme has been pursued for quite some time now and after a great deal of trial and error it has acquired credibility in the eyes of the people. According to the official statistics, in India as a whole, family planning is being practised by 15% of the couples in the reproductive age group.6

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It has been found that in an under-developed country like India, economic development with the concomitant rise in real income and consumption level is associated with the danger of what is called the "Population explosion" especially in the short run, which offsets any benefit from economic development. This highlights the need for an effective, energetic and widespread propaganda for family planning—with an increase in the percentage of literacy and necessary social background for the success of a large family planning programme will be created.

Sir Julian Huxley, the noted British Scientist has stressed the need for family Planning in India. In the opinion of Sir Julian Huxley, the failure to solve the problem of population arising out of its abnormal and alarming growth would surely mean a social and political disaster for the country and expenditure for controlling the growth of population should be looked upon, even from a purely economic stand point, as one of the most profitable forms of investment for a country like India.\(^7\) Thus, economic planning and family planning should run concurrently with the same urgency. Family planning programme

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must be regarded as the key programme in our successive
development plans.

Search for an ideal method to control conception has been going on for centuries. The family planning objectives being very clear all methods in used are available to the people. India is perhaps the only country in the world where sterilizations have been performed at a very commendable rate. Conventional contraceptives have been used in this country for a long time. The oral pill is used on medical prescription by those who volunteer take it.

BIRTH CONTROL METHODS:

1. Contraceptives - temporary method
   a) Without any contrivance
      i) Withdrawal or Coitus interruptus
   ii) Safe period or rhythm method
   b) With some contrivance
      i) Conventional contraceptives - condom, vaginal diaphragm,
   chemical contraceptives (condom and vaginal diaphragm are

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Roy Dr. Somnath, M. D. D. S., N. Phil., Ed. Intra-uterine
contraceptive Device - Proceedings of the first seminar November
29 to December 1, 1966 held at - The Central Family Planning
Institute, L-17 Green Park, New Delhi-16, CFPI Report Series
No. 7 January 1970, p. 3-7.
Mechanical contraceptives).

   ii) Intrauterine contraceptive Device (IUCD)

   iii) Oral contraceptive

2. Sterilizations - Permanent

   i) Male sterilizations - Vasectomy

   ii) Female sterilization - Tubectomy

CONVENTIONAL CONTRACEPTIVES (CONDOM):

Condom is a reasonably effective and safe contraception. It is manufactured in India. India made condom is called ‘Nirodh’ (Sanskrit word meaning prevention). In India three condoms cost 25 paisa at subsidised rate. Over 2.4 million couples (including those who had vasectomy) used ‘Nirodh’ in India in 1974-75 and the distribution was made of cost by the urban and rural family welfare centres and also by some commercial channels. The acceptability was more or less maintained since 1970. According to a government (Govt.) of India estimate 72 condoms are needed per year to protect a couple. 10

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10. Ibid., pp. 251-252.
VAGINAL DIAPHRAGM:

This is a kind of female contraceptive inserted inside the birth organ of a woman which acts as a mechanical barrier and thus prevents pregnancy. This was first described by Haase (1882) from Germany. The acceptability of vaginal diaphragm is low in India. A woman is taught the procedure of fitting the vaginal diaphragm by a doctor or a nurse. The diaphragm must be properly fitted.\textsuperscript{11}

This method once popular before the use of pill and IUCD is still indicated for woman with contra indications for pill or IUCD.

Chemical contraceptives - The various types of chemical contraceptives are - Jelly cream and paste, suppositories foam tablet, Aerosol form, soluble film etc.\textsuperscript{12}

The Government of India prescribes 7 jelly or cream tubes and 72 foam tablets per year to protect a couple. The acceptability of jelly or cream or foam tablets is

\textsuperscript{11}Ibid., p.p 257-258.
\textsuperscript{12}Ibid., p.p 258-259.
Currently not on rise in India. This method is a suitable one in combination with condom or vaginal diaphragm for those with contraindications for pill on IUUD. Conventional contraceptive used in India are condom, jelly/cream and foam tablets. From the point of acceptability, conventional contraceptive in India means condom. 13

INTRAUTERINE CONTRACEPTIVE DEVICE (IUUD, IUO):

Various types of intrauterine contraceptive devices are now available in various sizes, shapes and of various materials. These are -

A) Margulies Spiral (Plastic spiral)
B) Lipper loop (Serpentine plastic)
C) Shirnburg bow (figure of eight plastic)
D) Sonavala loop (Plastic)
E) Antigen F (Plastic with a magnetic strip to be detected by a galvanometer)
F) Mg type (made of steel - not used).
G) SafiT.coil (Plastic)

13 Ibid., p. 259-260.
H) Hall stone ring (Nylon)
I) Dalken shield (Plastic membrane)
J) Otaring (Plastic ring, Japan)

Others are intrauterine membranes and fluid-filled devices, later additions are greguard device (copper T), Copper T and copper loop.  

LIPPE'S LOOP:

This is the most widely used IUCD, devised by Dr. Jack Lippes of Buffalo, New York in 1962. This is manufactured in India. It has four sizes. The nylon thread which attached to the tail end makes removal easier and gives an indication of presence of IUCD inside the uterus.  

Other IUCDs used in some countries are sax T coil, spring coil and Dalken shield and copper devices with a view to improve effectiveness.

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14 Ibid., p. 260
15 Ibid., pp. 260-262.
to improve effectiveness.

Copper IUCD (Cu 7, Cu T, Cu loop) - Copper T is widely used. Copper IUCD is first advocated by Zipper in Chile in 1960. These are available in sterilized packs. Other than doctors, midwives, nurses, trained paramedics can insert and remove loops as this is safely practiced in various countries of the world. The key to IUCD programme is proper training of the personnel in the procedure. Doctors need to be trained as well. Again following pregnancy termination IUCD is inserted immediately. Post abortal insertion is now considered the most important IUCD programme since the woman of this group remains very sensitive to accept IUCD. 16

It is estimated that 15 million IUCDs are presently worn by women throughout the world of which 50-50 are in the developed and developing countries. The lowering acceptability of IUCD are reasoned by many factors namely, inadequate number of trained personnel to run the programme, side-effects particularly bleeding becomes less tolerable by the anemic Indian women. This highly effective low cost contraceptive

16 Ibid., pp. 262-263.
needs careful handling to be an effective contraceptive for Indian women. Copper T. 200 is an acceptable form of IUCD where pregnancy rate failure is not improved but there is better retention rate in young women for the first year. This is due to less bleeding and pain and easier expulsion method. 17

ORAL CONTRACEPTIVE (STEROID CONTRACEPTIVE):

This is the hormone pill when taken orally it acts as the most effective contraceptive at the present time. Rock, Garcia and Pincus from U.S.A. pioneered in the clinical use of the Pill as contraceptive in 1957. Thereafter its clinical use is increasing till now throughout the world. 18

A woman should have medical check up by the doctor to exclude any contraindication for pill taking. It is recommended that the pills are to be taken continuously for a period of 2 years (some say 3-5 years) since prolong and continuous

17 Ibid., p. 267.
18 Ibid.
taking of pill may have some metabolic effect or side effects. It is wrong to prescribe pills for a few months and then to have a break and to start again. This increases failure rate and perhaps upsets the endocrine balance. 19

Doctor's prescription is necessary for taking oral pill. This rule limits the use of oral pill. However, this restriction is ignored in many countries and in the people's Republic of China distribution of pills through trained paramedics (Nurse, midwives, health assistants, barefoot doctors) is advocated. 20

Over 50 million women are at present taking oral contraceptive in developing and developed countries in the world. This is the most popular method of contraception wherever they are available. This is the best contraceptive available at present for those who have no contraindication or do not develop side-effects. This method should be made more available in this country. 21

19 Ibid., pp. 270-271.
20 Ibid.
21 Ibid., p. 273.
The Family Planning Department Govt. of India has started free distribution of oral pill through the family planning clinics from 1974. However oral pill taken by Indian women, particularly in the urban sector from the commercial channels as these were made available since early 1960s.\textsuperscript{22}

STERILIZATION

This is the surgical procedure to bring in permanent sterility. This is a method for limiting child births when couples have desired number of children. By early 1976, about 65 million all over the world accepted sterilization of which 30 million were in people’s Republic of China.\textsuperscript{23}

Sterilization is performed either on the husband by vasectomy or on the wife by tubectomy.\textsuperscript{24}

VASECTOMY

Was acculsion was considered by English Surgeon, John

\textsuperscript{22}Ibid.
\textsuperscript{23}Ibid.
\textsuperscript{24}Ibid.
Hunter in 1775 and Astley Cooper in 1830. It is clinically practised by Harry Sharp (U.S.A.) in 1899. Vasectomy came up in the National Family Planning Programmes in South Asia since early 1950s. India is one of the pioneer countries for the programme since 1956. 25

Vasectomy is a safe, simple low cost sterilization operation that can be made further popular in this country. Vasectomy forms the most popular terminal contraceptive accepted by the Indian People. 26

TUBECTOMY:

Female sterilization by tubectomy is an alternative to vasectomy. Simple tubal ligation was proposed by Lungren of U.S.A. in 1880. This came up in the National Family planning programme in India and elsewhere along with vasectomy since 1956. The method was practised earlier also on medical indication, such as for limitation of child births on request from the couple provided the wife has desired number of children and

25 Ibid.
26 Ibid., p. 274.
psycosexually well adjusted. There are some medical reasons also. 27

Laparoscopic tubectomy which has been introduced only recently is becoming increasingly popular among women. In order to cope with the demand for trained personnel in the laparoscopic technique of tubectomy training arrangements have been strengthened. Various states have set up training facilities locally for training their medical and para-medical staff. 28

There are several methods of female sterilization namely, Minilaparotomy, posterior colpotomy and culdoscopy female sterilization etc. The operation is being performed in hospitals, health centres and camps and the patient can be discharged on the same day after 4-6 hours of the operation. Some of them are discharged after short hospital stay for a day or two. 29

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27 Ibid., p. 275.


Female sterilization is currently widely acceptable method in both developing and developed countries and its acceptability is on rise. This is a suitable method for those who have desired number of children.

THE ABORTION ACT:

Abortion as a method of birth control has been practised since olden times, throughout the world. Legal abortion comes as a relief for contraceptive failure pregnancy. The new Act called the Medical Termination of Pregnancy (MTP) Act has come into force in India with effect from 1st April, 1972. Under this Act a pregnant woman above the age of 18 can get her pregnancy terminated within the first 12 weeks by a qualified doctor, the only condition is that in the opinion of the doctor the continuation of the pregnancy either involves a risk to the life of the mother or is likely to cause great injury to her mental and physical health, or if the child is likely to suffer from physical or mental abnormalities. In case the duration of pregnancy exceeds 12 weeks but is less than 20 weeks an abortion can be performed only when the opinions of two doctors are taken and both of them agree that the continuation of pregnancy will involve substantial risk to the health of the mother or is likely to result in the
birth of a defective child. Pregnancy of a minor woman or
of a lunatic woman can be terminated, only after written
consent from her guardian is obtained. In all cases, however,
the consent of the pregnant woman herself is necessary
(Copy of the M.T.P. Act enclosed in appendix).

Abortions under the M.T.P. programme are conducted by
trained doctors in Govt. hospitals and approved private
institutions. To get more trained personnel doctors from
various institutions like medical colleges, district hospitals,
primary health centres (PHCs), voluntary organisations and
private practitioners are being trained. By the end of March,
1981, a total of 7,037 doctors were trained out of which
1,847 were from PHCs under the programme. As on March 31, 1981,
3,294 institutions were approved to perform abortions under
the programme. Again, by the end of March, 1981, slightly
more than 1.07 million abortions were performed since the
inception of the M.T.P. programme in 1972. It is encouraging
to note that rate of birth reduced convincingly after promul-
gation of M.T.P. Act.

30 Agarwala S.N. - India's Population Problems, op.cit., p. 231.
31 Ibid., p. 232.
India is the first country in the world to have adopted an official policy favouring family planning. Before it did so in 1952, a number of social reformers, thinkers and voluntary organisations had desired the Govt. to adopt a policy of population control as a measure to protect the health of the mothers.\(^{33}\)

In 1916 Sri Pyare Kishan Wattal published his book entitled "The population problem in India" advocating limitation of family size.\(^{34}\) Professor Raghunath Dhondi Karve was the first individual to open a family planning clinic in India in 1925. But he had to pay a price and resign his teaching job. On June 11, 1930, the Mysore Govt. issued orders for opening the first Govt. Birth Control clinic in the world. In that year two family planning clinics were opened by the Mysore Govt. One at Bangalore and the other at Mysore. The Senate of the Madras University agreed to give instructions on contraceptives in 1932 and the Govt. of Madras also decided to open

\(^{33}\) Agarwala S.N. - India's Population Problems, op.cit., p. 214.

\(^{34}\) Selkar K.R. Population Education for Developing Countries, op.cit., p. 67.
birth control clinics in the presidency in 1933. 35

In 1932, the All India Women’s conference at their Lucknow session passed a resolution recommending that "Men and women should be instructed in methods of birth control in recognised clinics". In 1935, the National Planning Committee set up by the Indian National Congress under the Chairmanship of Pandit Jawaharlal Nehru strongly supported family planning. During 1935-36 Mrs. Margaret Sanger, a pioneer of family planning, visited India at the invitation of the All India Women’s Conference. In 1935, the society for the study and promotion of family hygiene was formed with Smt. Cowasji Jehangir as its first president. In 1936, Dr. A.P. Pillai started his training courses in family planning. 36

In 1939, the ‘Birth Control world-wide’ in Uttar Pradesh and Ratree Sewsangha, Ujjain in Madhya Pradesh opened birth control clinics. In 1940, Shri P.N. Supru successfully moved a resolution in the council of states for establishment of birth control clinics. About this time Smt. Rena Dutta toured extensively to organise birth control campaigns on behalf of

35 Ibid., p. 60.
36 Ibid.
the Family Planning association, London. By 1940 the Society for study and promotion of Family Planning incorporated the "Bhagini Samaj Birth Control Clinic" in Bombay. In 1943, the Govt. of India appointed the Health Survey and Development Committee under the Chairmanship of Sir Joseph Bhave which recommended provision of birth control service but mainly for health reasons. 37

After the country's freedom in 1947 much time and thought have been devoted both by the govt. and voluntary agencies to this important aspect of population control. Of these mention must be made of the Family Planning Association of India which was formed in 1947 with its headquarters at Bombay. The Association in subsequent years has done valuable work in the field of population control and successfully drew the attention of the Govt. to this important matter. 38

The Planning Commission was appointed in March 1950 and the panel of Health Programmes of the Commission appointed a committee in April, 1951 to report on population growth and

37 Ibid., p. 69.
38 Ibid., p. 70.
family planning. The report of the committee was discussed in April, 1952 resulting in the formation of two committees: 39

I) Population Policy Committee and

II) Population research and programmes committee

In the meantime, Dr. Abraham Stone was invited to India to advise on the establishment of pilot studies on the use of "Rhythm" method of family planning. A number of studies and pilot projects were carried out during the First Plan period to provide guidelines for the future policy and the development of a national programme. 40

A budget allocation of Rs. 65 lakhs was provided for the family planning programme but only Rs. 1.45 lakh could be spent. In the first five-Year Plan emphasis was laid on the rhythm method which proved to be rather unreliable. The approach in the first plan was research-oriented and it was of exploratory nature and hence no tangible results could be obtained. The progress of the plan was reviewed by the planning commission. It observed that "the programme had progressed enough to call

39 Ibid.

40 Ibid., pp. 70-71.
for its further development on systematic lines for continuous study of population problems and for a suitable central Board for family planning and population problems.41

Thus the central family planning Board came into existence in 1956 and the post of Director of Family Planning was also created to serve in the Ministry of Health. "Family Planning Boards" were established in each of the several states and Family Planning Officers were appointed for the States. So, at the beginning of the countries second five-Year Plan administrative machinery at the centre and the States was firmly set to carry out the programme of family planning in India.42

In the early years of the family planning programme, the Government of India had adopted a "clinic approach" to family planning. It opened a number of clinics with the expectation that the people would avail the advantage of the facilities. This approach was modified in 1962-63 to the "extension approach". The Govt. started giving greater emphasis

41Ibid.
42Ibid.
to motivation and to changing the attitude, norms and values of the people. Social workers and auxiliary nurse midwives (ANMS) were appointed to carry out the motivational work. Other staff, both medical and paramedical were also appointed so that the programme was made target oriented and additional funds were made available. Expenditure in 1962-63, for instance, was more than that incurred in the first and second plan periods combined. Since the fifth plan, the family welfare programme has been integrated with health maternal and child care and nutritional programmes. This approach is called the integrated approach.

The extension approach which had been the key-note of the family planning programme during the Third Five Year Plan did produce some impressive results. This was because of the introduction of Intra-uterine contraceptive device (IUCD) for the first time in India on a major scale. The tremendous popularity gained by IUCD in the first two or three years of its introduction made one feel that the "loop" was perhaps a panacea for our population problem. Unfortunately, this proved to be only a temporary phase, as IUCD lost its popularity

43 Agarwala S.N. - India's population problems, op.cit., p. 216.
because of many reasons, the main being its after effects on the health and well-being of women who used them. But it was found that the change in the approach of the family planning programmes from clinical to extension was suitable to Indian conditions.

The introduction of Anglo-Saxon pattern in India by which specialized clinics were set up to advise women, individually about adequate birth control methods did not work well on the Indian soil for a variety of reasons, mainly due to the shyness of Indian women to contact the specialized clinics where advice on contraception could be obtained. This difficulty was removed in the early 1960's when the isolation of the family planning programme from general public health work ended and the Anglo-Saxon type clinics where individual advice to women folk was given were discontinued. It has been realised that women as well as men should be motivated towards family planning programme more so in countries like India where important decisions about the family were taken principally by men alone. 45

45 Ibid.
As a result "the number of clinics giving birth control advice during the first years of the third plan increased faster than was planned; In January 1963 there were 8,443 such clinics, of which 6,774 were in rural areas as against the target of a total of 4,900 at the end of the third plan in 1965. Only 3,000 or slightly more than a third of all the clinics were specialized birth control clinics.

An organisation has been developed to provide contraceptive information and service to the people — the primary Health centres and sub-centres as units in rural areas and the urban Family Welfare Planning clinic as the unit in urban areas. A Primary Health Centre covers a population of 50,000 to 100,000 and a sub-centre a population of about 10,000. However, the planning commission has approved establishment of more Primary Health Centres and sub-centres to achieve the ultimate norm of one Primary Health Centre for every 50,000 population and one sub-centre for every 5,000 population. An urban Family Planning clinic covers a population of about 50,000. 46

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In the rural areas a rural family planning clinic which forms a part of the primary health centre has medical, paramedical, extension and statistical staff. The Primary Health Centre has a number of sub-centres each being manned by an auxiliary nurse cum-midwife (ANM) and attendant. 47

In the urban areas, there is a family planning welfare centre for every 50,000 population. Quite a few of these urban centres are run by local bodies and voluntary organisations. In cities with four or more urban centres, a city bureau is provided for the supervision of the work of these centres. Steps have been initiated to bring in the urban centres and maternity and child health centres together. 48

At the District level, a District Family Planning Bureau forms a part of the district medical and health organisation and supervises the work of the urban and rural centres in the district. It is headed by a District Family Planning Officer, who is assisted by an extension officer, a mass

47 Ibid.
48 Ibid.
media officer, medical and paramedical staff for services, a statistical officer and an administrative officer. An audiovisual publicity vehicle is also provided to each district in addition to a properly equipped mobile IUCD (Intra uterine contraceptive device) cum- sterilization unit for each 50,000 to 75,000 population. 49

At the state level, a State Bureau is provided as a part of the Directorate of Health Services. The bureau is headed by a State Family Planning Officer, who is of the rank of a deputy, Joint or additional Director. He is assisted by a mass media officer, a health educator officer, medical officers for IUCD and other programmes, statistical and evaluation officers and administrative officers and a complement of secretariat staff. 50

In order to provide adequate leadership and to bring about necessary co-ordination, a full fledged department of Family Planning (now known as the Department of Family Welfare) was created in April 1966 under the Ministry of Health and

49 Ibid.
50 Ibid.
Family Welfare, Govt. of India. The Secretary to the Govt. of India, Ministry of Health and Family Welfare is in overall charge of the Department. He is being assisted by an additional Secretary and Commissioner (Family Welfare) who heads the family welfare structure and a Joint Secretary.

The secretarial wing of the Department looks after the policy planning, budget, grants, foreign assistance and administration. The technical wing looks after training, progress evaluation, research, mass media, transport and contraceptive services. 51

Cabinet committees at the central and state levels have been constituted to give proper direction and policy clearance and to regularly review the progress of the programme. The central cabinet committee is headed by the Prime Minister and the State cabinet Committee by the Chief Ministers of the respective state. The central family planning council is the chief policy making body and is presided over by the Union Minister for health and family welfare. It includes the Health Ministers of all the states and representatives of voluntary organisations. Similar councils also exist in almost all the states. 52

51 Ibid.
For the extension drive the crucial problem was the availability of suitable personnel for doing the work needed. The target as of 1963 was to employ one male field worker in family planning education for each 20,000 persons, which would mean recruiting and training about 25,000 persons for this task.

The family welfare programme is a centrally sponsored scheme and the State Govt./Union Territories receive 100 percent assistance from the Central Govt. The States, however, are responsible for administering the programme. The number of family welfare centres and staff, especially in the rural

53 Salkar, K.R., Population Education for Developing Countries, op. cit., p. 73.
54 Ibid.
areas, have increased considerably as revealed by Table I below:

<table>
<thead>
<tr>
<th>Family Welfare Centres -</th>
<th>Number</th>
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<tbody>
<tr>
<td>As on 1.4.74</td>
<td>1,978</td>
<td>1.4.80</td>
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<tr>
<td>Technical Staff 30.6.74</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Required 5,540</td>
<td></td>
<td>9,278</td>
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<tr>
<td>b) In position 3,441</td>
<td></td>
<td>4,050</td>
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<tr>
<td>c) Percentage 62.1</td>
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<td>76.7</td>
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<tr>
<th>Technical Staff 30.6.74</th>
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<tbody>
<tr>
<td>a) Required 63,389</td>
<td>67,213</td>
<td></td>
</tr>
<tr>
<td>b) In position 47,581</td>
<td>54,464</td>
<td></td>
</tr>
<tr>
<td>c) Percentage 73.1</td>
<td>81.6</td>
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</table>

IUCD and sterilization services are being offered through mobile and state agencies as well as through camps. "Nirodh" (a brand name for condom) distribution is organised

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through three channels. The first scheme provided for free
distribution through all the family planning centres and
sub-centres. 56

Under the second scheme called the Depot Holders
Scheme, a nominal price of 5 paisa is charged for three
pieces of condoms and is retained by the depot holders who
are honorary workers. The third scheme relates to the
distribution of "Mirodh" through commercial channels. This
scheme was launched in October, 1968 and presently twelve
of India's largest and most experienced private consumer
goods marketing organisations distribute "Mirodh" through
their network of salesmen, whole salers and retailers. These
are sold at a subsidised retail price of 25 paisa for three.
Hindustan Latex Ltd., a corporation in the public sector,
has been set up by the Ministry of Health and Family Planning
at Trivandrum manufacture them. 57

FAMILY PLANNING TARGETS 1

The family planning programme in India was adopted

56 Salkar, K.R., loc.cit., Population Education for
Developing Countries, op.cit., p.73
57 Ibid.
as an official programme in the early 1950s. It was recognised in the third plan after the publication of the 1961 census results which showed a higher growth rate than was anticipated. The programme was made time-bound and target oriented. It was only in 1962-63 that the government specified the objective of the Family Planning Programme to reduce the birth rate from the level of 41 to 25 per 1,000 population by 1973. It is not known how the above figures were arrived at but it appears that if the fourth and higher order births are curtailed which constitute around 40 percent of the total births, the above figure can be obtained. This target was fixed at the national level. However, for the States the targets were fixed in 1965-66. Table 2 below indicates the intensity of population problem caused by high percentage of fourth and higher order births.

58 Ibid.
59 Ibid., p. 219.
Out of a total of 21 million children born in India every year 9.83 million or 46.8 percent are fourth and higher order births. An attempt to eliminate the births higher than the third will be a great solution to our population problem. This is the intention of the Govt. of India behind enunciating the policy of a small family of two or at the most three children.61

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60 Ibid., p. 61.
61 Ibid.
How the fourth and higher order children impose a burden on our birth rate and aggravate our demographic situation can well be judged from Table 3 below.

**TABLE 3**

The proportion of fourth and Higher order births to Total births in selected countries 62

<table>
<thead>
<tr>
<th>Country</th>
<th>Birth rate</th>
<th>Preparation to total births</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>1st % order</td>
</tr>
<tr>
<td>England</td>
<td>16</td>
<td>40.0</td>
</tr>
<tr>
<td>Japan</td>
<td>17</td>
<td>38.0</td>
</tr>
<tr>
<td>U.S.A.</td>
<td>25</td>
<td>29.0</td>
</tr>
<tr>
<td>India</td>
<td>40</td>
<td>22.0</td>
</tr>
</tbody>
</table>

Table 3 throws light on the high percentage of fourth and higher order births in India which is 39 percent. Compared to some other countries with low birth rates conclusion may safely be drawn that the real danger in India arises from the fourth and higher order births. In the interest of the country, 62

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62 Ibid.
therefore, it is highly advisable to curb these births.

The family planning target of birth-rate reduction has undergone a number of changes since it was first laid down. For example, in 1966-67, the Govt. revised the objective of achieving a birth rate of 25 by 1973 and instead stated that it was to be achieved "expeditiously". The objective was changed many times on the basis of performance. The annual targets in terms of sterilizations, IUCD insertions and users of conventional contraceptives were also fixed.

It has been estimated that as a result of the family planning programme, about 44.2 million births have been averted since 1956. Upto March, 1981, a total of 33.4 million sterilizations were performed since the inception of the programme and 8.78 million IUCDs were inserted. In addition, in 1980-81, there were about 3.79 million users (equivalent) of conventional contraceptives, mostly condoms. Thus, out of an estimated 116.35 million eligible couples in 1980-81, about 29.32 million couples or roughly 24.3 percent eligible couples were protected. Depending on the use effectiveness of the

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63 Agarwala S.N. - India's population problems., op. cit., p. 220.
method which is taken as 100 percent for sterilization and oral pills, 95 percent for IUD and 90 percent for conventional contraceptives, the number of couples effectively protected were worked out as 26.41 million or 22.7 percent of the total eligible couples. 64

It has been estimated that as a result of the family planning programme, about 44.2 million births have been averted since 1956. It has been estimated that as a result of the family planning efforts in India there has been a marked - decline in the level of birth rate. Prior to 1966, there was little work done in the country in the field of family planning. Since then, during 1965-71, about 6.45 million births are estimated to have been averted accounting for a 2 point decline in the birth rate during the above period. If the birth rate during 1961-71, was 41 per thousand population, then it should be around 39 in 1971. 65

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64 Ibid., p. 221.
65 Ibid.
Again on the basis of the provisional population totals of the 1981 census, an attempt was made to show that between the years 1971 and 1981, the birth rate had declined by about 4 points. Thus, in 1981, the birth rate in India was around 35 and the decadal rate for 1971-81 works out to around 37 per 1000 people. A major portion of this decline is attributed to family planning efforts. Table 4 shows the number of couples effectively protected by various methods of Family Planning.

TABLE 4

<table>
<thead>
<tr>
<th>Year</th>
<th>Estimated No. of couples in Reproductive Age groups (1000)</th>
<th>Sterilization (%)</th>
<th>I.U.C.D. (%)</th>
<th>Equivalent C.C users</th>
<th>TOTAL %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1970-71</td>
<td>93,103</td>
<td>8.1</td>
<td>1.4</td>
<td>1.1</td>
<td>10.6</td>
</tr>
<tr>
<td>1973-74</td>
<td>99,306</td>
<td>12.4</td>
<td>1.0</td>
<td>1.5</td>
<td>14.9</td>
</tr>
<tr>
<td>1976-77</td>
<td>105,677</td>
<td>21.1</td>
<td>1.1</td>
<td>1.8</td>
<td>23.9</td>
</tr>
<tr>
<td>1979-80</td>
<td>112,188</td>
<td>20.1</td>
<td>1.0</td>
<td>1.4</td>
<td>22.5</td>
</tr>
<tr>
<td>1980-81</td>
<td>114,000</td>
<td>20.2</td>
<td>1.0</td>
<td>1.6</td>
<td>22.8</td>
</tr>
</tbody>
</table>

66. Ibid.
It is observed from the Table 4 that the most effective means of effective couple protection is provided by sterilization (20.1%). Out of total of 22.5%, due to old concept of superiority of male over female, tubectomies or female sterilizations though difficult compared to vasectomies are being preferred and 4/5th of the one million sterilizations performed during 1979-80 were tubectomies or female sterilizations. The trend for the last 4 years is in favour of tubectomies forming 73.7% of total sterilizations in India, in 1979-80. The latest techniques of laparoscopy and mini-laparotomies have attained considerable popularity even in rural areas as the procedures are simple and hospitalisation is not required for more than a day. Of the conventional contraceptives, condoms are preferred to oral pills in the family planning centres run by the Govt. The popularity of IUCD is also not much as is seen from the above table.

The figures do not include the non-programme acceptors of family planning who practice contraception through commercial channels and through private doctors, but it is estimated that

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Ibid.
their numbers are not much in the national level and are about 3% of total percent of couple protection. Amongst the non-programme acceptors the most popular methods are sterilisations, condoms backed by induced abortion.69

The official table as furnished above has not taken into consideration number of births averted by induced abortion because of the fact that abortion has not yet been accepted by the Govt. of India as a method of family planning though legal abortion is being done in recognised centres as a back up method of family planning programme under the R.T.P. Act of 1972.70

Medical Termination of Pregnancy is gaining popularity as is shown in table 5 below:

69 Ibid.
70 Ibid.
### Number of Medical Termination of Pregnancy (M.T.P.) PERFORMED

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of M.T.P.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1975-76</td>
<td>214,197</td>
</tr>
<tr>
<td>1976-77</td>
<td>270,870</td>
</tr>
<tr>
<td>1977-78</td>
<td>241,724</td>
</tr>
<tr>
<td>1978-79</td>
<td>305,804</td>
</tr>
<tr>
<td>1979-80</td>
<td>306,870</td>
</tr>
</tbody>
</table>

An analysis based on the M.T.Ps performed during 1977-78, 1978-79 and 1979-80 reveals that in 82-88 percent of the cases, the abortions were performed within 12 weeks of pregnancy; in 977-79 percent of the cases the mother's age was 20 and 35 years. Again, in 40-48 percent of the cases the abortions were performed due to failure of contraceptives, 14-16 percent of the cases were due to grave injury to mental health and another 15-19 percent of the cases were due to...  

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71 Ibid., p. 176.
grave injury to physical health. Request for abortion comes from women of all religious groups. Of the cases reported, about 85 percent were Hindus, around 7.5 percent Muslims, nearly 3.5 percent Christians and about 2.5 percent Sikhs. 72

These official figures include only cases of legal abortions but in this aspect number of non-programme acceptors of illegal abortion much outweigh the figures of legal abortions in averting number of births. It is estimated that over 4 million illegal abortions take place annually in India. 73

Again, it is generally accepted that some form of contraception should be given to all women who undergo M.T.P., especially in the Indian context where over 90 percent of M.T.P. seekers are married women. Data from Indian Council of Medical Research (I.C.M.R.) study has showed that prior to M.T.P. only 25 percent of the abortion seekers had used some form of contraception. At the time of M.T.P. 25 percent accepted tubectomy, 29 percent IUD and nearly 9 percent accepted ca. Thus, M.T.P. brought nearly two-thirds of abortion seekers under effective contraceptive care. 74

73 Meiani Dr. K.M. Ed. Journal of O and G of India (FOULSI) op.cit., p. 176.
Moreover, M.T.P. and concurrent sterilization done in the same sitting might be very helpful in overcoming the domestic problems of poor women. Women are better motivated at the time of abortion to accept contraception. This was clearly brought out by the fact that over two-thirds accepted concurrent contraception at the time of abortion while only 5.4 percent accepted tubectomy and 9.5 percent accepted the pill or IUD at the time of follow-up.\footnote{Ibid.}

Experience over the last twenty years has shown that monetary compensation does have a significant impact upon the acceptance of family planning particularly among the poorer sections of society. In view of the desirability of limiting the family size to two or three children, it has been decided that monetary compensation for sterilization (both male and female) would be raised to Rs. 150/- if performed with two living children or less; Rs. 100/- if performed with three living children; and Rs. 70/-, if performed with four or more living children. These amounts would include the money payable to individual acceptors as well as other charges such as drugs and dressing, etc. and would take effect from 1 May, 1976.
Facilities for sterilization and M.T.P. are being increasingly extended to cover rural areas.  

In addition to individual compensation Govt. is of the view that group incentives should now be introduced in a bold and imaginative manner so as to make family planning a mass movement with greater community involvement. It has therefore, been decided that suitable group incentives should be introduced for the medical profession, for zila (district) and Panchayat families, for teachers at various levels, for co-operative societies and for labour in the organised sector through their respective representative national organisations. Details of these group incentives are being worked out in consultation with the concerned organisations.

Free clinical facilities and supply of contraceptives and various success to clinical services to the poorer sections to whom they were not available till now is certainly a part of the incentives the State can offer. If free medical and child care including immunization of expectant mothers and children against various diseases and of prophylaxis against

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76 Nagendra, S.N. - India's Population Problems, op.cit., p. 236.
77 Ibid.
Deficiency diseases are also taken into account the benefits are quite substantial.

The Govt. has decided to accelerate the progress of the village Health guide schemes which will be funded 100 percent by the Govt. of India from 1.12.81. The States have been instructed to give preference to women in the selection of health guides. This is in addition to Govt. of India's decision in the sixth plan to meet the recurring cost of all new sub-centres set up from 1981-82, the idea being based on that the sub-centres and health guides drawn from the community in the villages would be able to provide the necessary advice, information and services to a large number of rural couples who do not have access to them at present. A large allocation of Rs. 1078 crores had already been made to the family planning programme in the sixth plan and in the seventh plan the targeted expenditure was Rs. 3256.26 crores. The resources will not come in the way of legitimate expenditure to be incurred on achievement of family planning targets.

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The performance of family planning in the sixth five year plan clearly indicates that the programme is being implemented more seriously now by most of the States since a favourable climate has now been created for it. The performance has gone up by 15 percent for sterilization and by 24 percent for conventional contraception in 1980-81. Over the performance of 1980-81, the performance in 1981-82 went up further by 36 percent for sterilization, 19.3 percent for IUD, and 19.5 percent for c.o. users. The progress has been maintained in the current year as well. During April-October 1982 it went higher by 35 percent for sterilization and 36 percent for IUDs and was much higher compared to the corresponding period of last year. Special efforts are required to promote conventional contraceptives and oral pills for which the free distribution and commercial programmes are being strengthened. Additional resources will be found for this. 80

Budget provision and expenditure on family planning have increased considerably since the beginning of the Third

five Year Plan, when the programme was recognised as urgent one, while the budget provisions in the first two five year plans were less than 500 lakh rupees, it was increased to about 2,697/- lakhs in the Third plan. The budget provision in the subsequent plans was further increased. In the sixth five year plan (1980-85), provision for 101 thousand lakhs rupees was made for the family welfare programmes. Like the budget provision, expenditure on the family welfare programmes also increased considerably. The Plan period-wise break up of the outlay/expenditure are summarised in the Table 6.

By the end of sixth five year plan about two thousand four hundred crores (2,400 crores) of rupees had been spent on family planning and in the seventh five year plan the targetted expenditure was well over three thousand crores blatantly much more than what had been spent in the whole

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### Table 6

<table>
<thead>
<tr>
<th>Plan</th>
<th>Outlay/Expenditure (in crores of Rs.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>First five year plan</td>
<td>0.14</td>
</tr>
<tr>
<td>Second five year plan</td>
<td>2.15</td>
</tr>
<tr>
<td>Third five year plan</td>
<td>24.86</td>
</tr>
<tr>
<td>Three Annual Plan</td>
<td>70.46</td>
</tr>
<tr>
<td>Fourth five year plan</td>
<td>284.43</td>
</tr>
<tr>
<td>Fifth plan</td>
<td>408.98</td>
</tr>
<tr>
<td>Sixth plan</td>
<td>226.05</td>
</tr>
<tr>
<td>Sixth plan (1980-85)</td>
<td>391.4</td>
</tr>
<tr>
<td>Seventh plan (1985-90)</td>
<td>3286.0</td>
</tr>
</tbody>
</table>

The findings of 1981 census were reviewed by the central cabinet and certain decisions were taken keeping in...
view that the actual population in 1981 had turned out to be larger than was anticipated, it was decided to promote family planning as a people's movement and encourage different methods of family planning. The target for sterilization had been increased from 22 million to 24 million in the sixth plan, in addition to high targets under other methods already fixed. 34

From the available data it can be inferred beyond doubt that the colossal effort in terms of money and man power put into the programme family planning has made significant gains over the past few decades. The country's population continues to grow annually at a rapid rate - of 2.5 percent per year with a population of almost 700 million recorded in the 1981 census. This growth means India's population could reach one billion mark by the year 2000. 35 The relatively poor socio-economic setting in India has made it difficult to promote family planning in many areas. The progress made by the programme can well be adjudged from the Table 7.

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34 Dutta Barun Sri Asantra Narayan Ed. - 'Newstes' - A Daily Newspaper from Guwahati (Assam) op.cit. P. 3
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Sterilization</td>
<td>1,994</td>
<td>1,776</td>
<td>8,281</td>
<td>105</td>
</tr>
<tr>
<td>2. I.U.C.D.</td>
<td>602</td>
<td>636</td>
<td>581</td>
<td></td>
</tr>
<tr>
<td>3. Conventional contraceptives</td>
<td>3,741</td>
<td>3,036</td>
<td>3,692</td>
<td></td>
</tr>
<tr>
<td>4. Abortions</td>
<td>330</td>
<td>340</td>
<td>270</td>
<td></td>
</tr>
<tr>
<td>5. Birth prevented</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) In a particular yr.</td>
<td>4,740</td>
<td>4,928</td>
<td>3,723</td>
<td>32</td>
</tr>
<tr>
<td>b) Total from 1961</td>
<td>43,960</td>
<td>39,220</td>
<td>24,334</td>
<td>32</td>
</tr>
</tbody>
</table>

From the above discussion, it can be safely gathered that family planning programmes in India is making its impact felt on the population but of course, not as vigorously as it should have been.

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86 Salkar K.R. Population Education for developing countries, op.cit., p. 86.
In India there are roughly 112 million couples of reproductive age groups who need family planning advice and service. These 112 million couples are living in 576,000 villages, and 3,245 towns and cities spread over 1.23 million square miles of area having different terrain, geography, climate and means of communication. Of these nearly 67 million have three or less children and 43 million have four or more children. Family planning knowledge and attitude studies carried out in India have revealed that while very few among those who have three children or less are in favour of family planning, a large majority, between 70 and 80 percent of those with four or more children do not desire to have any additional child. 87

Therefore, if correct knowledge about family planning is given to those couples and if contraceptive service is made available to them a large majority of them would take to the regular use of contraceptives. However besides the problem of physical inaccessibility, widespread illiteracy, specially in the rural areas, lack of adequate mass communication, diversity of language and dialect and general apathy

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87 Agarwala, S.N. - India's Population Problems, op. cit., p. 216.
towards any social change among traditional people have made the task more difficult. Moreover, low standard of living of the masses with consequent poverty and illiteracy allied with the less rapid industrialization and urbanization, have acted as obstacles in creating in them a sense of population awareness and an understanding of the demographic consequences of an unchecked population growth.

Now it is necessary that only family planning methods are preached but a desire should be cultivated amongst the youngsters to adopt family planning as a way of life. The younger generation who will constitute the adult population of the world in the next few decades need to be made cognizant of the factors of their population to develop in them a rational behaviour. In fact, little importance has been given to the circumstances which make a person decide in favour of a small family size and without having really spotted these factors which could impel the potential parent to take a desirable decision.

For achieving the objective of a lower fertility what have been done is to provide with and improve the provision of birth-control clinics and depending on just that much,
perhaps it has failed to realise that the contraceptive devices can mean something only when the potential parent has already decided to restrict the size of his family. It is not possible to realise forcefully that what could be really achieved first by convincing and preparing the potential parent to decide on a small family size. The most basic and primary fertility determinate are capacity to reproduce, opportunity to reproduce and decision-taking to reproduce. Family planning clinics and devices come only after these three factors have already had their effect and the potential parents have taken a decision to take to contraception. For positive result we have to influence the three basic and primary fertility determinants and in that direction unfortunately we have done precious little. It is not possible to influence the capacity to reproduce significantly.88

Actually the desirable decision - taking in favour of a small family-size would be done only by those who are capable of rational thinking and who besides being capable

88 Thukral R. et al. Ed. - "Majma" (journal) - Publication Division, Govt. of India Press NewDelhi, op.cit., p. 30.
of thinking, consider small family-size to be in their interest. The capacity of thinking rationally can come through good education, and to enable people to acquire that capacity, they should be educated properly and adequately. Therefore, education should be considered an important factor of fertility level. Thus a top priority has to be given to educating people if we want to reduce the birth rates. Proper education can develop right attitudes amongst the vast population which has yet to enter the fertility age-group. Proper education can serve as a motivational media for prompting the younger generation with a desire to adopt small family norm.

Researches have no doubt yielded a wider variety of reliable methods of fertility control, but as yet it is believed that the problem of population pressure is a problem which will not be ultimately solved by scientist. Population problem is more a social problem with cultural, economic and political implications and this problem needs to be tackled at human and individual level. A review of some of the latest studies of different fertility factors carried out in different parts of India, indicate that generally the level of education
and fertility are inversely related.

The conclusions of the studies with regard to mean fertility at different levels of education are not uniform. The National Sample Survey indicated that at each higher level of education fertility performance is lower. The number of children born alive to couples declined from 4.03 in the case of illiterate husbands to 2.96 in the case of husbands who were intermediate and above. It declined from 3.63 in the case of illiterate wives to 1.61 in the case of wives who were intermediate and above.

It has been found in almost all the major surveys undertaken in India that the attitude towards family planning which involves the attitudes of couples towards family size, need for a son, spacing, approval and usage of birth control techniques for limiting the number of children or delaying pregnancies, has been found to be closely associated with the educational attainment of couples. The nation-wide survey

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90 Ibid.
covering entire India excepting a few places like Jammu and Kashmir by the operation research group (ORG). Ministry of Health and Family Planning during July, 1970 to January 1971 clearly indicated that as the educational level increases the attitude towards family planning tends to become more favourable. The survey notes that 46.5% of the illiterate wives disapproved birth control methods as against only 6.4% wives who had gone to college. 91

In spite of the differences of the size and characteristics of the samples used in different surveys and different levels of education used by them as the basis of analysis the paramount role of education as a factor, influencing all the spheres of family planning emerges clearly. 92

In India, the Ministry of Health and Family Welfare Commissioned the operation Research Group of Baroda to conduct the second All India Family Planning Survey in 1980-81. Nearly 35,000 married couples of age 15-49 were interviewed. When

91 Ibid.
92 Ibid.
asked to name all the family planning methods they knew of. 95 percent of women named female sterilization, 45 percent named condoms, 44 percent named the IUD and 35 percent named C.C.S., without any prompting. Some 35 percent of couples were using contraception. About 22 percent were using male or female sterilization, 7 percent were using traditional methods, 4 percent were using condoms and 2 percent were using other modern methods. The estimated TFR (Total Fertility Rate) for 1976-81 was 4.7.93

In India, the inverted red triangle has been adopted as the symbol of family welfare. This symbol is widely displayed in urban as well as rural areas. All available mass media are being used for disseminating information about family welfare among the masses. The media unit of the Ministry of Information and Broadcasting gives considerable support to the Family Welfare Programmes through the issuance of press advertisements, production and distribution of a large number of information and educational publications including posters, pamphlets etc.94

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The Family Welfare programme is also projected through a number of programmes of All India Radio and Doordarshan. The AIR broadcasts over 5000 items every month promoting family welfare. The commercial circuits of Doordarshan are also used for promoting the use of Nirodh. Some of the publicity units of the Directorate of Publicity are devoted exclusively to family welfare programmes and for the other units, publicity of family welfare programmes is a major activity. Apart from these, the person to person approach is also being utilised with emphasis on group meetings. The involvement of the community is sought through the participation of local leaders and voluntary workers. 

A meeting of the parliamentarians belonging to various parties was held in Delhi in 1982. The meeting focussed on the major population issues, particularly the need for a national consensus on family planning and political support to the programme. This meeting which was addressed by the Prime Minister has given a fillip to the programme which is bound to make further strides in the coming years. It was

98 Ibid.
mentioned there that Family Planning Programme was included in the New 20 Point programme which seeks to make family planning a people's movement.96

Later, experts thought that the birth rate cannot be brought down by family planning alone. It is closely associated with health, social and economic conditions of society. As such, a new exercise was conducted to achieve the ultimate goal of the family welfare programme that is "Hum doį, Hamare doį" (we are two, we shall have two). The same in demographic terms can be translated as NRR (Net reproduction rate) of unity. This exercise encompassed general health conditions represented by the expectation of life at birth, social conditions through marriage pattern and economic conditions by infant mortality. This exercise was done on behalf of the working group on population policy constituted by the Planning Commission, Govt. of India.97 The recommendations were discussed in the meeting of the National Development Council and on the basis of the approval of the council,

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96Dutta Harish Shri Ramendra Narayan Ed. 'Newstr' a daily news paper from Guwahati (Assam) op.cit.
97Agarwala, S.N. - India's population problems, op. cit., p. 220.
the long term demographic goal (MHR-1 by 1996 for the country as a whole) was incorporated in the sixth five year plan (1980-85) as the objective of the population policy. According to the plan document the above objective of the population policy can be achieved within the stipulated period "only by reducing the birth rate to 21 per thousand of population death rate to 9 and increasing the proportion of couples protected by family planning to about 60 percent". 90

Most of the Chief Ministers in India are now taking keen interest in this programme. It is expected that legislators in the states would also emulate the parliamentarians and help to promote the movement. Voluntary organisations which had been hitherto- confining their services/activities mainly to the urban areas have also to extend their message of family planning and deliver the benefit to the rural areas and extend the necessary services. The scheme of payment of grants to voluntary organisations has been decentralised and simplified. 90

90 Ibid., p. 221.

90 Dutta versus Sri Ramendra Narayan Ed. - 'Newstar' a daily newspaper from Guwahati (Assam) op. cit.
The plan has already a programme of training the opinion of the leaders from the villages for propagating the concept of family planning which has to be implemented vigorously. Greater emphasis on mass media and personal communication between extension workers and the rural population has been laid and ways and means are being worked out to make use of all available channels of communication between Govt. Departments and the people for carrying forward the message of family planning.

It is quite clear that the family planning programme has not yielded the desired results and it is also clear that the failure has been, to a great extent, due to our educational system which, in spite of strong recommendations of three Education Commissions appointed by the Govt. of India in 1949, 1953 and 1964 for radical changes has remained more or less the same as it was in British era. For instance the Kothari Commission, 1964 discussing on India's population problem, at the very beginning of its reports has observed that to check the spurt in population mere coercion in the name of family

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planning be replaced by education and citizens realisation so that the safety and security of the nation may be shouldered by the educated and disciplined citizens themselves as it ought to be, rather than maintained by the police sentinels as it is now. 101

Importance should be given to those factors which make a small family size wanted and useful. Such factors would include a good and convincing social security system, a high status of females in society, a higher marriage age, a high rate of expenditure on children, rapid industrialization, a life full of mobility, non-existence of larger family links and a high urban proportion in population. Education and all the above mentioned factors are important so far as the determination of a fertility level is concerned.

Some improvement has been recorded on the literacy front which has gone up from 39.45 percent in 1961-71 to 46.74 percent in the case of men, and from 18.69 percent to 24.88 percent in the case of women. 102 An analysis shows that 83.6% of our family


planning acceptors came from the rural areas where 75% of the people live as estimated in 1979 and 35% of the husbands and 55% of the wives are illiterate, the literacy rate being 36.17%. These are good features of our national family planning programme as they suggest that family planning is accepted by the people living in the remote villages and by the illiterate groups too. Even then attempts must be made to improve literacy and modernization of the society with which success of family planning is very much related.

NATIONAL POPULATION POLICY OF INDIA:

Earlier, the population policy of India was equated with the family planning policy. A major departure from this approach was made when on 28th April 1976, the Minister of Health and Family Planning, Dr. Karan Singh, declared the new national population policy of India. This policy statement takes into account the complex relationships between the social and economic and political aspects of the population problem and defines the way in which the family planning programme could be pushed ahead with due attention given to the various facts of

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In order to make the population policy successful, a 12 point programme has been drawn by the Health Ministry.  

i) Marriages should be registered compulsorily.

ii) Representation in the legislative assemblies and Parliament should be frozen on the basis of 1971 census till 2001 A.D. to produce the much needed disincentive to grow demographically.

iii) The centre's aid to the states will be on the basis of 1971 census.

iv) States, having good performance in family planning will have an additional central assistance of 8 percent.

v) Special emphasis has been laid on education of girls upto the middle level.

vi) Child nutrition is another element of the programme, because better nutrition will mean larger life expectancy and less desire for an additional child.

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vii) Creation of nation-wide consciousness so that all citizens may be motivated to adopt a responsible reproductive behaviour. No coercive measures are to be adopted.

viii) Monetary incentives for sterilization will be provided to make family planning a mass movement.

ix) Donation for family planning will be entitled for income-tax rebate.

x) Although the policy makes no provision for compulsory sterilization on a countrywide basis yet the centre will assume a neutral attitude towards states enforcing compulsory sterilization for all citizens, without exception.

xi) Co-operation and assistance of non-governmental women and youth organisations will be fully utilised in making the family planning programmes successful.

xii) To make a dent on the masses in order that the population policy might be successful the multi-media such as the films, radio, the Press T.V. drama etc. will all be employed for the purpose. 106

106 Ibid., p. 34.
Our real enemy is poverty, and it is as a frontal assault on the citadels of poverty that the Fifth Five Plan has included the minimum needs programme. One of its five items is an integrated package of health, family planning and nutrition. Far-reaching steps have been initiated to reorient the thrust of medical education so as to strengthen community medicine and rural health aspects, and to restructure the health care delivery system on a three-tier basis going down to the most far-flung rural areas where the majority of our people reside and where child mortality and morbidity are the highest. Similarly, ignorance, illiteracy and superstition have got to be fought and eliminated. In the ultimate analysis it is only when the underlying causes of poverty and disease are eliminated that the nation will be able to move forward to its desired ideals.107

RAISING THE STATUS OF WOMEN;

The status of women is known to have important implications for fertility performance. It is maintained that if the status of women rises, they tend to have fewer children.

107 Singh Dr. Kiren Minister of Health and Family Planning - National Population Policy - New Delhi, 16 April, 1976, p.1.
and they can thus make a meaningful contribution to society. Also, if women are tied down to child bearing and child rearing for the most fruitful years of their lives, they are barred from finding other avenues for self-expression, and self development. Legally, the Hindu woman is well protected to-day. As regards, family law, she is on an equal footing with men. The Special Marriage Act, the Hindu succession Act and the Adoption and Maintenance Act are illustrations of how legislation can attempt to improve the status of women. Thus, monogamy is compulsory, divorce in specified conditions is permitted, and the age at marriage is prescribed.

The Act commonly known as the Sarda Act after the name of its sponsor, Mr. Harbilas Sarda, was introduced in the legislative Assembly of India in 1927. The prescribed minimum age limit was raised to fourteen years for girls and eighteen years for boys. The Act was amended in 1949 to raise the minimum marriage age of females to fifteen years. In 1976, Parliament further increased the minimum marriage age of females to eighteen years and of males to twenty-one years. This has been done in response to the new population policy of India announced in early 1976. A woman's right to adopt a child is recognised and in practically every way including inheritance the daughter is

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108 Ibid., p. 194

Agarwala, S. R. - India's Population Problems
op. cit., p. 109
equated with the son. Dowry at marriage is also legally prohibited. 109

The status of women in India has legally improved considerably socially, too, it is better but a great deal still remains to be done. The status of women in the family is the point of crucial importance as far as fertility performance is considered. It has been observed that the new daughter-in-law in an Indian family is accorded her rightful status only after she produces a child more often than not only after she produces a male child. Aspects of the conjugal relationship which are most conducive to the acceptance of family planning such as communication or companionship between husband and wife, joint decision-making and proper distribution of authority are completely absent at least in the early stages of married life. Efforts have, therefore, to be made to improve the status of the women in the family. 110 "Unless there are changes in the situation of women - political, economic, social and cultural targets of developing countries will not be met". This ominous problem was quoted by Halvi Sipila, Assistant Secretary General
of the United Nations while speaking at the 1977 women's conference in Houston, Texas had echoed throughout the world.\textsuperscript{111}

The experts participating in the Regional Workshop on population and family education held at Bangkok have indicated three types of measures to check rapid growth of population.

1) INDIVIDUAL MEASURES:

Late marriage, self-control, use of contraceptives and longer breast-feeding period.

2) NATIONAL MEASURES:

Family Planning programme provision of clinical facilities, population education programme in schools, rise in the legal age of marriage, withdrawal of certain Govt. facilities to a family beyond a particular size and reward for

family planners/promoters of family planning.

3) INTERNATIONAL MEASURES 1

International organizations be made interested in population control, financial aid for national programme of population control, consultant services for planning national programme of population control, facilities for training personnel for population control, and dissemination of information about population control in different countries. 112

On international level India has taken the necessary assistance from international agencies in her efforts to control population. Even in the initial stages of family planning in India in the 1950's "The most valuable part of the family planning activities was intensive research, often carried out by, or in co-operation with, the United Nations Organizations on American foundations." 113

The success of individual measures depends upon the level of general education attained and the sense of social

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113 Ibid., p. 93.
responsibility an individual has which in turn is partly the result of sound education. In the words of John Ruskin: 
"Education does not mean teaching people to know what they do not know. It means teaching them to behave as they do not behave". 114 It is the responsible task of family planning workers to lead the people by motivating them and making them regular users of different family planning methods.

Family planning has a very limited field of operation. It caters to the needs of married and immediately would be married persons. The success of family planning is accelerated by the very fact that the new entrants in the reproduction field - the married couples - should bring with them a sound attitudinal behaviour towards a small family. However, it is a fact that attitudes cannot be changed overnight. They are mostly formed in childhood when the child's mind remains susceptible to acquisition of outside influences in an easy manner. Therefore, family planning efforts alone will not be adequate to win the race. The battle has to be fought side by side on two fronts; family planning for the adults and education for children in population matters from the very childhood,

114 Ibid.
in order to create in them a love for good and happy life by limiting the size of their families. It is then that the time for such momentous decisions in their lives come. The clinical approach needs to be supplemented by an educational approach.

In respect of national measures of population control, fortunately the central govt. has given to the States a correct lead on all the fronts mentioned in the Bangkok workshop. The population education programme in schools has been launched with the help of international agencies and it appears that within a few years it will make its impact on the school and college syllabi. 115 The National Council of Educational Research and Training (NCERT) has already made a beginning in bringing out some text books on these lines. 116

Family planning stresses the health angle when population education proves to be a bridge constructed within their sight so that younger generation should pass through it in order to negotiate

115 Ibid.

116 Agarwala S.N., - India's population problems, op.cit., p. 235.
the cultural gap between social traditions and technological progress. Population education may be considered as the means of informing students of the causes and consequences in population characteristic thereby, developing in them a type of understanding and awareness of the close inter-relationship between population growth national development and related consequences of individual decisions regarding reproductive behaviour.

In a country like India which is bursting with teeming millions, population education needs to be given top priority. The situation is so grim that something needs to be done quickly and at grass root level. The younger generation needs to be fully informed and exposed to the dangers of the future. They need to be properly educated for leading a planned adult life. A country where 50 percent of population is below 18 years, where marriage is almost universal, where literacy rate is just 30 percent, where the standard of living is low and unemployment has taken a dangerous proportions, population education seems to be most relevant. 117

According to Regional Seminar on population and Family Life Education, United Nations Educational Scientific and Cultural Organisation (UNESCO) Bangkok, 1970, population education is the educational programme which provides for a study of the population situation in family, community, nation and the world, with the purpose of developing in the students rational and responsible attitude and behaviour towards that situation. 118

Prof. Noel David Burston who has given this significant term, says, population education or population awareness refers to factual knowledge about population dynamics required to understand the nature and magnitude of the burden imposed by rapid population growth. 119

The National Seminar on population education held in Bombay in 1969 has given a comprehensive definition of population education. It emphasises knowledge about the quantity and quality of population and the need to control them for

118 Ibid., pp. 248–249.
119 Ibid. p. 249.
happy human existence. According to this seminar, population education is essentially related to human resource development. It is not only concerned with population awareness but also with developing values and attitudes, which take care of the quality and quantity of population. It must explain to the students cause and effect relationship so as to enable them to make rational decision on their own behaviour on population matters. Population Education is an exploration of knowledge and attitudes about population, family living, reproduction education and basic values. It means educating the students about large population or every increasing population and the problems created by population spurt.

India had initiated population education programmes in the late 1950s. Initially family life/sex/health education was considered as population education in India. National population education project was developed by the NCERT in 1979 to institutionalise population education from class I or class X with the financial assistance of the United National Fund for Population Activities (UNFPA). At the international level the

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120 Ibid.
UNESCO is the executive agency and at the National level the Ministry of education Govt. of India is the implementing agency for this project.

OBJECTIVES OF THE NATIONAL POPULATION PROJECT:

a) To establish population education cells at the National and State levels with full-time technical personnel.

b) To develop proto-type curriculum, instructional material, training packages and audio-visual aids.

c) To develop lessons for radio and T.V. programmes.

d) To translate selected population education material from regional languages to English.

e) To assist the States in developing curriculum and material for students, teachers and other personnel.

f) To orient key-personnel from the states, Universities and national organizations through training programmes.

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g) To train teacher educators and administrators in education at the National staff college for educational planning and administration and

h) To conduct research on the impact of population education both in the formal and non-formal streams.122

MORE PLAN OF THE NATIONAL POPULATION EDUCATION PROJECT:

The work plan of the National Population education project is to –

1) Develop curriculum and material on population education,

2) Train personnel

3) Evaluation and research and

4) Publications starting from 1980, the project has been implemented in a phased manner. Now the project is in operation in the entire country. In 1979, the Ministry of Health and Family welfare prepared 15 lectures on population education for use in the universities and colleges.123

122 Ibid.
123 Ibid.
In 1992, University Grant Commission (U.G.C.) have encouraged the starting of Department of Adult continuing education and extension in the Universities. So far, about 100 Universities have established these centres, which are funded by U.G.C. Provision has been made to appoint one project officer (Population education) in every centre to popularise population education in the affiliated colleges. For this purpose population clubs have also been established in many degree colleges. 124

In India, population project - I (IPPI) has started in 1973-74 in Uttar Pradesh and Karnataka aided by World Bank, initiated population education in formal and non-formal sectors. The second population project (IPPII) started in 1980 in Uttar Pradesh and Andhra Pradesh for information education and communication as the chief components. A project was given to the department of population studies at University Tirupati to initiate population education programmes in junior and degree colleges. In India, population project - III (IPP-III) was started in 1984 in Kerala and Karnataka. 125

124 Ibid.
125 Ibid.
Population education should start from the lower classes and should continue up to the secondary and higher secondary stages. This education should be a constant process. It is desirable that small children even in the nursery classes should be made conscious about the scarcity of means and vastness of demands. At the later stages, the idea may be developed and more details may be furnished so that they accept this education in a natural manner.

Again, success of population education programme depends on the teacher. He must be properly trained for the job. Prof. Nurul Husein the former education Minister and Dr. Chandrasekhar, the former Union Minister of Health and Family Planning also emphasised the role of teachers in this movement.\textsuperscript{126} The teachers themselves must learn a great deal about the dynamics of the population problem and what is equally important, must master techniques of imparting such information in an attractive and compelling manner.

To equip the teacher with this area of education some universities had added a topic in some paper others have

\textsuperscript{126} Kochhar S.K. - Pivotal Issues in Indian Education—op.cit., p. 294.
introduced a separate optional paper. Population education is a new technique to arrest the staggering growth of our population. A country haunted by the fears that family planning techniques might erode the moral basis of society and where sex education is considered dangerous, population education alone can create a conducive climate. 127

NEW POPULATION POLICY:

On the recommendations of the working group on population policy the Govt. declared the objectives of the family welfare programmes. The objectives of the family welfare programme as given in the Sixth Five Year Plan (1980-85) document are given below:

The working group on population policy set up by the planning commission has recommended the adoption of the long-term demographic goal of reducing the net reproduction rate (NRR) to one percent by 1966 for the country as a whole and by 2001 in all the states from the present level of 1.67. The

127 Ibid.
Implications of this are as follows. 128

i) The average size of the family would be reduced from 4.2 children to 2.3 children.

ii) The birth rate per thousand population would be reduced from the level of 33 in 1978 to 21.

iii) The death rate per thousand population would be reduced from about 14 in 1978 to 9 and the infant mortality rate would be reduced from 129 to 60 or less.

iv) As against, 22 percent of the eligible couples protected with family planning devices at present 60 percent would be protected.

v) The population of India will be around 900 by the turn of the century and will stabilise at 1200 million by the year A.D. 2050. 129

Programme from 1981-1984:

The Ministry of Education and Social Welfare has launched

129 Ibid.
a special programme with effect from 1980 to introduce population education in the formal system of education. This has been done to create in the younger generation adequate awareness of population problem for the realisation of their responsibilities towards it. This will be done at the cost of 5,321,620 American dollars to be provided by UNESCO. The aim is to cover 93 million students in the age group of 6 to 17 years, 2 million University students and 3 million teachers. In addition to these 45 million school children between the age of 6 to 14 and 143 million people not covered by the age group of 15 to 35 and 100 million adults will be covered by this scheme.\textsuperscript{130}

\textbf{PROJECT ACTIVITIES:}

The activities will be confined to training programme, co-curricular instructional development and evaluation and research.

The scheme is operated in the central sector by the

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\textsuperscript{130}Sodhi, T.S. Edn. & Economic Development, op. cit., p. 136.
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Ministry and is financed by the United National Fund for population Activities (UNFPA). The Ministry of Health and Family Welfare is actively involved in it. An amount of Rs. 4.26 crores has been sanctioned for the project. At state level the State Governments participate in accordance with the approved plan. The National Council of Educational Research and Training (NCERT) provides technical knowhow. A National Steering Committee 1980 was set up with the Education Secretary as its Chairman to co-ordinate the implementation of the programme. The committee held its meeting in December 1980. This programme has now been accepted by almost all states and union territories of India. 131

Family Planning is a gigantic operation which requires the cooperation of medical doctors, social workers, demographers, economists, social scientists and administrators, while doctors are required for providing service, and social workers are needed for motivational work. Demographers are required for evaluation and target setting. The task of demographers however is difficult because of the non availability of reliable data

131 Ibid., p. 137.
for the general population much less for population by
subgroups. There is need to carry out research studies in
depth, specially those dealing with attitudinal and moti-
vational problems. Sociologists can help family planning
programmes by indicating the factors which bring about social
change and by ranking them in order of importance so that
they can be given priority. Medical doctors can give support
to the family planning programme by inventing more acceptable
methods of contraceptives. Economists could lend their techni-
ques for undertaking meaningful cost-benefit studies so that
the administrators can run the family planning programme at
minimum cost and determine suitable priorities for expenditure.
Family Planning is multidisciplinary in nature and there is
urgent need for different disciplines coming together on a
common platform and giving their best to solve this important
problem.132

Family planning programme is an educational and moti-
vational programme. The message of family planning is gradually
reaching the masses and people are becoming aware of the dis-
advantages of large families. This awareness must spread like

132 Agarwala, S.N. India's Population Problems., op.cit.,
p. 226.
wild fire even to the remotest and neglected corners of the country as they are the main contributors to the population problem. Family planning programme is the main stay of economic development of India and on its successful implementation depends the future progress of the country. A multidisciplinary approach is therefore essential.

Now, to achieve the ambitious targets, that is, zero population growth a great task lies ahead of Indian people and not only our govt. but also voluntary organizations must come forward and each doctor whether he or she is a gynaecologist or not will have to perform his or her National duty in helping the family planning programme to check the growing population explosion in the country.

MEASURES OF POPULATION CONTROL IN ASSAM:

Assam constitutes about 2.4 percent (78,523 Sq. Km.) of the total land areas and accommodates 2.9 percent of India's Population. Assam's population began to grow at a much faster rate than in most other provinces. In the history of Family Planning in India Assam plays a significant role and had an important part in all the Family Planning and Family Welfare Programmes (Detail on Chapter IV).

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