POPULATION CONTROL PROGRAMME AND POLICIES: AN OVERVIEW

This chapter is an overview of historical background of contraceptives, policies of the Government towards population control during various five year plans. This also includes change in the population control approach of the Government to Reproductive Health approach.

History of Contraception

Contraception, that is, measure to prevent or control conception, has been attempted by man from time immemorial. In ancient India, people preferred large families due to certain social and religious obligations as well as due to the high infant and child mortality rates prevailing at the time. However, there are references that ancient religious leaders advised small families. The Rigveda says, 'A man with many children succumbs to miseries', which Bhagwan Dash (1975) writes, 'is probably the oldest statement suggesting against a large family'. He also noted that although the ancient texts make no mention of artificial infertility and contraception, there is an indirect reference to the spacing of children: a child born before the sixth year of birth of the previous child is considered to have a short span of life. Dr. S. Chandrashekar (1985) former union minister of Health and Family Planning also acknowledged this fact.

The author of the Upanishads apparently gave some serious thought to the question of contraception and birth control. Remarkably enough, both were considered dharma, ethical and proper for a married Hindu for any valid reason. Although serious clinical efforts at scientific contraception are hardly a century old, the concept of birth control is as old as The Upanishads and the earliest Egyptian civilisation, (State of India's Health, Voluntary Health Association of India, 1992 p.190-91). Its earliest references are found in Egyptian Kahun Papyrus (1850 BC) the Atharva Veda (1500 BC).
and the Bible (Genesis 38: 8-10). The early Chinese, Greek, Roman and Indian Cultures considered the perimenstrual phase as fertile. Vegetable and animal products mixed with honey, oil etc served as vaginal contraceptives. One had to wait till the Renaissance and the discovery of the microscope for more scientific methods. A linen sheath (condom) was introduced by Fallopic (Italy) in 1564, Tubal Ligation by James Blundell (England) in 1823, followed by the diaphragm by Wilde (Germany) in 1825 and the intrauterine device by Richter in 1909. Endoscopic sterilization was advised by Anderson (1937) and popularised by Palmer (1962) and Steptoe (1967). The pill was introduced mainly due to efforts of Djerassi (1951), Pincus and co-workers (1953). The long acting implants followed 16 years later by Croxatto and Segal (Himes, 1963; Potts M. and Peel 1968; O'Dowell and Philips 1994; Rao 1974,1994). The search is continuing for safer and more effective methods like vaginal rings, systemic injections and antifertility vaccines. (Rao, 1996).

Contraception after intercourse or postcoital contraception is an age-old concept. Egyptian papyri have described preparations for this purpose 4000 years back. Tribals all over the world have been practicing postcoital contraception in their own way. Folk methods include violent shaking of lower body for expelling semen, approved even by Soranus, pepper pessaries and post coital douches (washings) with caustics, wine, vinegar, lemon juice, alum, carbonated soft drinks etc. Our modern methods aim at preventing implantation of fertilized ovum, presuming that fertilization has occurred, by delaying its passage through the tubes and rendering the endometrium unsuitable for implantation (Parikh, 2002).

**RELIGION AND CONTRACEPTION**

The Roman Catholic Church does not approve of artificial contraceptive methods but permits only 'natural family planning methods' for spacing. Pope Paul VI in 'Humane Vitae' condemned contraception; Pope John Paul II in his 'Evangelium Vitae' strongly
criticized contraception and equated abortion to murder. Therefore, some of the predominately Catholic countries have a significantly high incidence of unsafe abortions. In Brazil the caesarian section rates in parous women are high to enable concurrent sterilization. Tubal ligations (which is considered less sinful than abortion) is the preferred method in 44 per cent of the contraceptive acceptors and even 64 per cent in northeast Brazil (Correa et al, 1994). Islam is also against gender equity and abortion (Verkunyl, 1993). The Shariat permits spacing with breast feeding for 2 years as it is endorsed by the Quran (Omran, 1993).

The Dalai Lama (1990) recognizes the link between population and environment and supports contraception but not abortion. China, Thailand and Sri Lanka are examples of Buddhist countries where family planning has been successful.

The Hinduism is most liberal in permitting contraception and abortion but unfortunately religion and political leaders in India have not been strong advocates of fertility control. (Rao, 1996). All this indicates that the contraception as a birth controlling technique is an old age phenomenon. The context was different at that time. The practice of contraception was not directly aimed at population control, since population was not social problem those days.

The context of contraception today is altogether different. During the post independence period the main objective of the family welfare Program for the country has been to stabilise population at a level consistent with the needs of national development. Population stabilisation is the long-term objective of the National Population Policy, but is not just restricted to reducing the number of persons living in the country. It aims to enable individuals and couples to plan their families by providing them information and quality services so that there is a zero population growth, together with sustainable economic growth, social development and environmental protection. The National Population policy sums up population stabilisation thus,
it" is a multi-sectoral endeavor requiring constant and effective
dialogue among a diversity of stakeholders, and coordination at all
levels of the government and society. Spread of literacy and
education, increasing availability of affordable reproductive and child
health services, convergence of service delivery at village levels,
participation of women in the paid work force together with steady
equitable improvement in family incomes will facilitate early
achievement of socio-demographic goals."

Achieving population stabilisation calls for a multi-pronged
approach. As far as health and family welfare sector is concerned,
some of the key concerns are:

1. the high unmet demands for contraception;
2. high levels of unwanted fertility, in some places due to high infant
   mortality,
3. early age of marriage and early pregnancies, son preference, and
   poor quality of health care and services.

In India, one in six couples does not get contraceptive services
even though they want it. In some states it is one in four couples.
Moreover, the entire burden of contraception in our country has been
placed on women. Of the total sterilisations, only two per cent is being
under taken on men. Further, the proportion of sterilisation to
temporary methods of contraception is unacceptably high, five times
higher. This means many women go in for sterilisation after having
more than three children, and at an age when they would normally
not bear any more children. It is important now to focus on temporary
methods of contraception, like condoms, to not only increase spacing
between children, but also for protection from STDs and HIV. And, of
course, the qualities of services have to improve.

India has made remarkable progress in different fields since
independence. However, it has been felt that this progress has been
undermined by the rapid population growth, which continues
unabated. Others regard population as the most valuable resource of
a nation, and the management of quantity of population should be rather considered as the first priority. At this juncture, it is necessary to understand population, development, and how they are inter-linked.

The term population, derived from the word ‘people’, is not limited to numbers alone. Population is as much concerned with people as it is with their numbers. The health and well being of the people, the situation of different kinds of people (adolescents, elderly tribals and other marginalised groups) are also matters of concern, as is their absolute numbers. The term ‘development’, for a long time has been viewed as an increase in economic resources using indicators like the GNP and GDP. Over the years, the use of such a narrow economic approach as a measure of well being was rejected and a broader concept of human development is now linked to other critical issues such as – longevity, education and command over resources. This means the ability to live a long and healthy life, the ability to read, write and acquire knowledge, and the ability to enjoy a decent standard of living and have a socially meaningful life. Thus, development now concerns the individual as much as the nation. It now spans the social, economic, and political contexts of the individual and her/his ability to participate, as an equal, in the development process. To measure and compare the extent of development across different states and nations, new indices have been designed - like the Human Development Index (HDI) or the human Poverty Index.

The National Population Policy (NPP) was announced in March 2000, which is an articulation to India’s commitment to the ICPD (International Conference on Population Development) agenda and forms the blue print for population and development programme in the country. The overriding concern of the NPP 2000 is economic and social development of human well being. It seeks to provide quality services and supplies, information and counseling and the
basket of contraceptive choices. It will enable people make informed choices and access quality health services.

It has been envisioned in NPP to accomplish economic and social development to improve the quality of lives that people lead to enhance their well being, and provide them with opportunities and choices to become productive assets in society.

According to the policy document, the immediate objective of the NPP 2000 is to address the unmet needs for contraception, health care infrastructure, and health personnel. And to provide integrated services delivery of basic reproductive and child health care. The medium term objective is to bring the TFR (Total Fertility Rate) to replacement levels by 2010, through vigorous implementation of inter-sectoral operation strategies. The long-term objective is to achieve a stable population by 2045, at a level consistent with the requirement of sustainable economic growth, social development and environmental protection (brochure)

POPULATION CONTROL AND FIVE YEAR PLANS

After independence, India was confronted with wide spread poverty, a disease-stricken population, millions of illiterate people, lack of resources and several other problems. But the country had no dearth of talented personalities who took up the challenge in order to improve the quality of life of the millions. However four valuable years were lost before the five-year socio-economic development plans were initiated in 1951.

FIRST FIVE-YEAR PLAN: (1951-1956)

The Govt of India appointed a Planning Commission in March 1950, with Prime Minister Pandit Jawaharlal Nehru as Chairman, to fulfill the Constitutional obligations.

A number of advisory panels with official and non-official experts were appointed to help the commission determine the priority
areas for development. One such panel was appointed for health and another for Social Welfare. The health panel appointed a subcommittee on population growth and family planning on April 1950, visualising the impending population increase.

This committee submitted its report on 14th April 1951. Some of its observations are as follows

- It recognised the need for Family Planning.
- It delineated specific Govt. measures in relation to family limitations, for example, facilities for sterilization and advice on the use of contraceptives.
- It recommended improvements in population data and systematic studies of the population problem.

Despite these developments, however, family planning could not easily be included under health programmes as Rajkumari Amrit Kaur, the then Health Minister opposed to it. After a great deal of debate, and with the efforts of Pandit Nehru, Family planning was included in the planned programme, but as Rajkumari Amrit Kaur had her reservations about the use of contraceptives, the programme initially began with the rhythm method (safe period). The primary objectives during the first five year plan were:

- To obtain an accurate picture of the factors which contribute to the rapid increase of population.
- To gain further understanding of human fertility and the means of regulating it.
- To devise speedy ways of educating the public
- To make family planning advice and services an integral part of the services on hospitals and health centers.

The approach was to be 'Clinic' based. The method advocated during this period was primarily the rhythm method with some emphasis on the available conventional contraceptives. During this period, the family planning programme was directed primarily at building up active public opinion in favour of the programme and the
promotion of the Family Planning advice and services on the basis of existing knowledge.

During this period, one hundred and forty seven family planning centers were established in the country under various agencies. The state government (86), local bodies (27) and voluntary organisations (34).

SECOND FIVE-YEAR PLAN: (1956 -1961)

The Second Five Year Plan recognised that the rate of economic development would depend upon:

- The rate of growth of the population
- The proportion of current income of the community devoted to capital formation.
- The return by way of additional output on the investment thus undertaken.

The planning commission was aware of the possible constraints on the impact of family planning during this period and was apprehensive of future economic growth.

With this in mind the Govt. of India delineated the following measures:

- To develop services, and the research and training programmes initiated during the first plan period.
- To establish the number of service clinics.
- Introduce sterilization (Tubectomy / Vasectomy) services, free of cost, for both men and women.

The adoption of contraceptive methods is governed by changes in social behavior and attitudes, which cannot be achieved overnight.

This naturally results in a slow decline in the birth rate with consequent increase in population growth, as was revealed by the 1961 Census.
THIRD FIVE-YEAR PLAN: (1961-1966)

The approach to the Third Five-Year Plan stressed such social measures as education, particularly for women, employment, rural water supply and the expansion of family planning programmes. In view of the sharp increase in the population growth rate, as revealed by the Census of 1961, family welfare programmes were given high priority.

The greatest stress had to be placed in the third and subsequent Five-Year Plans on the programme of family planning. This involved intensive education, provision of facilities and advice on the largest scale possible and widespread popular effort in every rural and urban community. In the circumstances, family planning had to be undertaken not merely as a major development programme but as a nation-wide movement, which embodied a basic attitude towards a better life for the individual, the family, and the community.

Although the end of the Five-Year Plan had seen the emergence of reasonably good clinical service facilities, it was observed that the people were reluctant to accept these services. It was for this reason education was given emphasis during the Third Plan, with the understanding that an educated and enlightened population would better understand the advantages of a small family.

In 1962, the Govt set the target of reducing the birth rate to 25 per 1000 population by 1972. To fulfill this objective, the strategy was revised from a 'Clinic based' to the 'extension approach' which included educating the people and providing knowledge and information about various aspects of family planning.

This was to be achieved by family planning workers visiting people at their homes.

Several other measures were adopted during this plan period: Various conventional contraceptives were made available to
the people free of cost in both rural and urban areas through hospitals, Clinics, PHCs, and FP Centres etc.

- To maintain the voluntary nature of the family planning programme, the choice of contraceptive method was left to the acceptors in what is popularly called the 'Cafeteria approach.'
- The intrauterine contraceptive device (IUD), commonly known as 'Loop' insertion was introduced in the programme as a measure of birth control during the last year of the Third Plan.

INTER PLAN PERIOD: (1966-1969)

The policy continued to be the same during this period but in view of rapid population growth, the financial allocation was increased in the hope of reducing the population growth rate.

Certain other vital decisions were taken during this period:

- It was once again reiterated in 1966 that the birth rate was to be brought down to 25 per 1000 population over the following 10 years.
- The sterilization and IUD programmes were made target oriented and time bound.
- The system of giving monetary compensation to the sterilization and IUD acceptors was introduced.
- To give family planning programme proper direction, it was decided to create a new Family Planning Dept. under the Ministry of Health and Family Planning.

From the mid-1960s the Govt. involved such sectors as Defence, Railways, Labour and Post and Telegraph to extend family planning services. Later the public and private sectors also encouraged extending financial assistance to the programme. A fair number of Voluntary organizations were also involved in the field of family planning.
Performance

The performance of the family planning measures adopted, picked up considerably during the Third and interplan periods:

- From January 1962 to March 1966, 10,04758 males and 2,63,823 females accepted sterilization, five times the number of acceptors during the second Plan Period (Up to December, 1961)
- Between 1966 and 1969, the number of sterilization acceptors increased significantly: 38,16,563 males and 5,75,413 females

However, this increase was found to be primarily the result of the introduction of cash incentive schemes thus, although performance improved in terms of quantity, in terms of quality it was far from successful. This is evident from the Census report of 1971. IUD acceptors increased significantly during 1966-67, the number dropped sharply during 1968-69, primarily due to incorrect selection of cases and improper follow up of earlier acceptors.

FOURTH FIVE-YEAR PLAN: (1969-1974)

Government attached the highest priority to curbing population growth during the Fourth Plan. To achieve this, married couples in the reproductive age were the targets in order to:

- Bring about group acceptance of the small family norm;
- Enhance knowledge about family planning methods; and
- Make supplies and services readily available.
- Once again, the Plan reiterated that the family planning programme would remain a centrally sponsored programme for the next 10 years and the entire expenditure would be met by the Central Government.

The plan proposed to ‘step up the target of sterilization and IUD insertion and to widen the acceptance of oral and injectable contraceptives. The use of conventional contraceptives (Condom) was also step up’. The Plan recognised that family planning could be
more effective and acceptable if maternity and child health services are integrated with family planning.

The cost effectiveness and economic feasibility was a matter of concern to bring down the population growth. In this regard Seal and Bhatnagar in their study of the cost effectiveness of the family planning programme (1963-64 to 1970-71) observed that sterilization is the most cost effective method followed by IUD. Use of conventional contraceptive is however, only half as cost effective.

Sterilization acceptors increased gradually during the Fourth Plan, reaching maximum of 3,12,856 during 1972-73, but the number dropped sharply in 1973-74. The increase was due mainly to higher cash incentives and the camp approach, which aside from the actual performance of operations at camps involved a comprehensive campaign to educate people about the advantages of the operation and dispel any apprehensions.

But once again, as shown by the 1971 census the birth rate could not be brought down as desired and population increase continued unabated.

Although performance figures might indicate that the family planning programme was successful, all was not well as brought about by Banerji (1977) in his report of a Case Study of 19 villages. This study has shown that the family planning programme ended up in projecting an image, which was just the opposite of what was actually intended. Instead of projecting an image which reflects respect for the dignity of the individual- the so called demographic approach which offers free choice of methods to the users- and which ensures better health services, the image of family planning workers in rural areas was that of persons who use coercion and other kinds of pressure tactics and offer bribes to entice people to accept Vasectomy and Tubectomy. There had been numerous complaints from villagers that they got no help from the family planning agencies
when they encountered complication after IUD, Vasectomy or Tubectomy, Failure to provide even a rudimentary system of follow up services and elementary medical care had tended to reinforce the negative image of the family planning agencies.

FIFTH FIVE-YEAR PLAN: (1974-1979)

Family planning was given same priority during the Fifth Plan Period. One important policy decision taken during this phase pertained to the manner in which the integrated family planning services would be provided, that is, through, multipurpose workers and the existing centers. The Fifth Plan approach was to increase and integrate family planning services with that of Health, Maternal and Child Health, and Nutrition. Efforts were made to convert more and more vertical programme workers into multipurpose workers who will pay special attention to family planning motivation and services.

The approach during this plan was different from earlier plans. First it introduced the 'National Minimum Needs Programme' for the rural areas to ensure 'a minimum availability of public health facilities which would include preventive medicine, family planning, nutrition and detection of early morbidity and adequate arrangements for referring serious cases to an appropriate higher echelons. Second, it was decided that the family planning programme would be carried forward in an integrated manner along with health, maternity and child health care and nutrition as a strategy towards proper service delivery of family planning components. Third, the plan emphasised a selective approach to family planning, concentrating efforts on eligible couples in the age group 25 to 35 years. With two or more children and newly married couples.

It was in 1974 at the World Population Conference held in Bucharest that Dr.Karansingh, the then Minister of Health and family planning, said what later on oft-repeated slogan: 'Development is the best contraceptive'. In 1975, Prime Minister-Indira Gandhi launched special 20-point Programme for intensive development in certain
fields. While family planning was not included, the youth leader Sanjay Gandhi launched a 4 point Programme at the same time in which family planning was the main component and which was pursued vigorously, perhaps too vigorously as many believed.

One of the major decisions taken during this plan period was to link the amount of cash compensation paid to sterilization acceptors with parity. But despite laudable policies and strategies geared to yield good results the programme suffered a serious blow due to the over-enthusiastic implementation of the sterilization programme by Sanjay Gandhi, often with the use of extra constitutional means. While the number of sterilizations acceptors rose as never before during 1976-77, the voluntary nature of the programme came into question.

The Emergency and the coercion that accompanied sterilization programme left deep wounds on the family planning programme as a whole for years to come. As studies revealed even conventional contraception suffered badly.

In a follow-up study of the 19 villages, which formed the basis of an earlier study, Banerji observed:

The objective of The National Population Policy was to build up a mass movement throughout the country in favour of the small family norms. (But) these objectives have not been achieved. In fact, at many places resort to force to impose sterilization on people has precipitated quite the contrary condition—a mass movement against the family planning programme of the government. It has not been possible to generate a movement even among the personnel of the executive machinery... a substantial proportion of the acceptors belonged to demographically dubious cases such as those with high parity, those with grown-up children and those with wives above the reproductive age. There were also cases where lure for money or the pressure for meeting targets led to sterilization of the spouse of a
previously sterilized individual, sometimes even repeat sterilization of the same individual. Preoccupation of the entire government machinery with attainment of sterilization targets has led to a neglect of other components of the National Population Policy and indeed of the entire programme to improve the lot of the weaker sections of the population. By its association with this type of programme there has been a rapid erosion of the credibility of the community health services. This was dramatically reflected in the near hysterical response of mothers to immunisation programmes offered to schoolchildren by the health authorities.

Ashish Bose (1988) too spoke out strongly against the implementation of the family planning programme during the Emergency. According to him Sanjay Gandhi's 4-point Programme not only had family planning as the first point but it became the only point, which was ruthlessly implemented on a national scale. In Sanjay's vocabulary, the family planning meant only one method - sterilization. His only weapon in implementing the programme was the use of brutal force, unmatched by medieval barbarity. If our assumptions are correct Sanjay Gandhi accounts for roughly 70 lakh forced sterilizations. The Sanjay effect is a combination of coercion, cruelty, corruption, and cooked figures.

The result was of course devastating for the Government, which fell shortly after and already some issue of family planning became an election issue with the change of government at the center.

**INTERPLAN PERIOD: (1978-79 AND 1979-80)**

With change in government, policies also changed. On assuming charge of the Ministry of Health and Family Planning, Shri Raj Narain changed its name to the Ministry of Health and Family Welfare. The family planning programme also came to be known as the family welfare programme.
This is not to say that there was no welfare component earlier. The Fourth and Fifth Five Year Plans included various welfare components related to Maternal and Child Health programmes. The change in nomenclature was more to emphasise the decision to implement the welfare component and steer clear of coercion, force, and disincentives.

One of the most important steps taken towards population control and reduction of maternal and infant mortality at this time was rising the minimum age at marriage for girls. The child marriage restraint (Amendment) Act was passed by Parliament and came into effect from 1 October 1978.

During the period, when the Janata Government was in power, the performance figures for the sterilisation programme were low with an adverse effect on the birth rate. There were several reasons for this with the lifting of the Emergency and restoration of normalcy there was a slump in Family Planning Programme. The changes in government policy also affected the performance; the people's reaction to the programme after the excesses during the Emergency made Government employees, particularly medical officers and paramedical staff, hesitant and afraid to pursue the programme particularly after the Shah Commission of enquiry was appointed to look into and redress the excesses during that time.

The new government wrote Ashish Bose (1988), announced that the Family Planning Programme will do away with force and compulsion and wholly rely on persuasion and education. But apart from renaming 'Family Planning' as 'Family Welfare', there was no change in the programme.

SIXTH FIVE YEAR PLAN: (1980-1985)

With the fall of the Janata Government, Indira Gandhi returned to power in January 1980. The Sixth Five-Year Plan was formulated,
taking into consideration past failures and achievements and keeping in view the vision of the future.

The 20-point Programme was revised and the family welfare programme was included as a major component within it, stressing its implementation on a voluntary basis and portraying it as a people’s movement. The most significant component was the Plan’s recognition of the importance of health. An investment in health is an investment in man and on improving the quality of his life. It is therefore well recognised that health has to be viewed in totality as a part of the strategy of human resources development. The Government reiterated the need to project the programme as a people’s programme backed by support from governmental and non-governmental agencies. The govt made it quite clear that the programme was to be continued on a voluntary basis through education, information and proper interpersonal communication.

Incentives and Awards

Incentives in the form of cash to sterilisation acceptors were first introduced during the late 1960s. The amount fixed was Rs.10 and was intended to compensate the loss of wages incurred by the acceptor. Gradually, the amount increased, and payments began to be made to the motivators, doctors, and other staff as well. Corruption, fake or engineered figures and coercion in an attempt to fulfill targets was the result. Fraudulent practices were naturally, in connivance with the so-called motivators and health and Family Planning staff, including the doctors and the administrators at many places.

Awards given to the best performing states and union territories under various categories was also a controversial system that was introduced during the Sixth Plan period. Huge sum of money (Rs.2.5 crores for the best performing state) was involved, leading to unhealthy and unethical competition amongst the various states. It
led to large-scale manipulation of statistics on Family Planning Programme performance in different states in India.

Health and Family Planning workers at all levels often became so involved in identifying and motivating couples to accept sterilization that persuasion sometimes given way to coercion. The target-oriented nature of the programme compelled them to manipulate statistics to suit their requirements, a phenomenon observed practically all over India. Medical officers, extension educators, health assistants and multipurpose workers, no doubt under pressure from the higher echelons were all to blame for racing to meet targets but failing to secure the people's participation.

Nevertheless, during the Sixth Plan the performance of the various components of the family welfare programme improved slowly but steadily. It was indeed creditable that the government could carry forward the programme of sterilisation when it was still a sensitive issue.

From Sixth Plan period, protection by non-terminal methods (temporary contraceptives viz, condom, CuT, OC pills etc.) began to increase. In fact, it came to be realised that for any real impact on the birth rate the thrust of the programme has to be directed towards encouraging the use of non-terminal methods.

All couples with one child can be persuaded to accept the Intra Uterine Device (IUD) as the choice of contraceptive. Government will have to take effective steps to educate single child couples of the advantages of IUD. Proper selection of cases, careful and adaptive methods of insertion and proper and sympathetic follow-up are imperative for the success of this programme.

There is no programme in India, which specifically addresses young newly married couples. It is indeed astonishing that even as recently as 1988, only about 6 per cent of eligible couples were effectively protected by conventional contraceptive methods. Instead
of concentrating on sterilisation and fulfilling targets by meeting higher parity cases, the energies of the Family Planning workers and others should be diverted and beneficially, towards popularising the IUD, Condoms, Oral pills, etc. so that all the newly married couples might accept these measures for at least 3 years. A concerted effort needs to be made in this direction.

With regard to achievements in the area of various contraceptive methods, performance was satisfactory in comparison to the 1970s but all was not well. Only 58 per cent of the acceptors received follow-up the services. This is indeed a poor reflection of the functioning of the programme and follow-up services, which must improve if the family planning workers are to gain credibility.

SEVENTH FIVE-YEAR PLAN: (1985-1990)

Reviewing the performance of the Sixth Plan, and keeping in view the poor performance of the states of Uttar Pradesh, Bihar and Rajasthan as a result of which the national averages were considerably lowered, the Seventh Plan shifted the target of reaching an NRR (Net Reproduction Rate) of 1 by 2001 AD to the period 2006-2011 AD. To achieve these goals, the Plan emphasised the various components of the family welfare programme as also decided to undertake certain other measures out side family planning which would help persuade people to adopt family welfare measures and thus bring down the birth rate. The Ministry of Health and Family Welfare formulated a revised strategy. Still the goals were not achieved.

The number of sterilizations reached a peak during the Seventh Plan period. The most encouraging aspect of the performance during the Sixth and Seventh Plan period is the fact that the number of non-terminal acceptors also increased gradually.

The number of IUD acceptors crossed the 1 million marks in 1982-83 and gradually increased to almost 5 million in 1989-90. The
number of conventional contraceptive users also increased gradually to 13 million and oral pills acceptors to over 2 million in 1989-90. Although the maternal and child welfare component was to be undertaken through the Universal Immunization Programme (UIP) all over the country, a country wide evaluation on a sample basis by the National Institute for Health and Family Welfare (NIH-FW) in 1989-90 revealed that the programme was far from satisfactory. With only 50 to 60 percent coverage, the lapses must be corrected by the concerned agencies. (State of India's Health, 1992)

EIGHTH -FIVE YEAR PLAN: (1990-95)

It is towards human development that health and population control were listed as two of the six priority objectives of this plan. Health facilities were aimed to reach the entire population by the end of the eighth plan.

Health, Manpower Development and training was given importance. Training of doctors of Indian System of Medicine (Aurvedic) and Homeopathy was reviewed and reoriented to make it congruent with the needs of national health programmes and Primary Health Care. There were about 5.25 lack institutionally trained practitioners of ISM (Indian System of Medicine) and Homeopathy. These practitioners were close to the community not only in geographical proximity but also in terms of cultural and social ethos and as such they could play significant role in primary health care delivery. There are more than 200 colleges of ISM and Homeopathy. One of the important tasks during the eighth plan was to provide adequate facilities for training in these colleges so that the graduates emerging from these acquire the desired level of knowledge and skills necessary for patient care.

The following strategies were adopted for achieving the goals of family welfare during the Eighth Plan.
Convergence of Services provided by various social services sectors, for example, welfare, human resources development, nutrition etc. Based on a holistic approach to social development and population control, integrated programmes for raising female literacy, female employment, status of women, nutrition and reduction of infant and maternal mortality were evolved and implemented.

The programme had become one of People's operations with government cooperation. The young couples, who were reproductively most active, were the focus of attention with necessarily a greater emphasis on spacing methods, although, the terminal methods would continue to remain important means of birth control. The targeted reduction in the birth rate was the basis of designing, implementing and monitoring the program against the current method of couple protection rate. The entire package of incentive and awards were restructured to make it more purposeful. There was an urgent need to secure involvement and commitment of practitioners of all systems of medicine in the population control programme. The practitioners of Indian system of Medicine and Homeopathy, whose number was estimated to be more than half a million and who were the closest to the community, both in terms of place of practice and socio cultural milieu of the community, were involved in the programme.

The base and the basis of the population control programme during the 8th plan was decentralized, area specific micro-planning, within the general directional framework of natural policy aimed at generating a people's movement with the total and committed involvement of community leaders, irrespective of their denominational affiliations and linking population control with the programs of female literacy, women's employment, social security access to health services and mother and child care.
The planning commission observed that given the present situation in the country the achievements are lagging behind the proposed goals for the year 2000. Against this background fresh targets were formulated to be achieved by the end of 9th five-year plan. The goals are revised to slightly lower levels. (Mahajan, Gupta, 2001.) They are as follows:

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<th>Measures</th>
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<td>Infant Mortality Rate / 1000 live births</td>
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<tr>
<td>Growth Rate (per cent) annual</td>
<td>1.6/1.5</td>
</tr>
<tr>
<td>Total Fertility Rate</td>
<td>2.9/2.6</td>
</tr>
<tr>
<td>Immunization</td>
<td>Universal</td>
</tr>
<tr>
<td>Pregnant mothers receiving antenatal care (per cent)</td>
<td>90</td>
</tr>
<tr>
<td>Delivery by trained personnel (per cent)</td>
<td>45</td>
</tr>
<tr>
<td>Institutional deliveries (per cent)</td>
<td>35</td>
</tr>
</tbody>
</table>

TOWARDS RCH

The concern for the reduction of population growth has a long history in India starting in the early 1920s. A family programme was launched in 1952. Family planning was initially promoted primarily as a way for enabling women to regulate their fertility and improve maternal and child health. While this objective remained, concerns about rapid increases in India's population meant that the family
planning programme became a tool for population control. To be successful, family planning programmes need to be associated with social development and people's empowerment programmes, so that they are in a position to take decisions that are in their interest and use services accordingly.

The limitations of the population control approach was recognised through experiences of women all over the world, including India. It was also recognised that women suffer silently from a large number of reproductive illnesses, which were termed the 'silent emergency'. This understanding led to women's health researchers and activists focusing more on women's health and development. The global emergence of HIV/AIDS and other Sexually Transmitted Infections have also brought attention to women's reproductive and sexual health. Three international conferences, of which ICPD was the last, ultimately led to the adoption of a comprehensive reproductive health approach in family planning.

The most significant change in the way population policies and programmes were viewed and which resulted from the ICPD in 1994, and the Beijing Conference in 1995, was that the traditional Population Control approach gave way to the more holistic Reproduction Health approach of which family planning was a part.

The International Conference on Population and Development was held in Cairo, Egypt from 5-13 September 1994. The conference was a watershed event. Delegation from 179 nations participated in the negotiations, leading to the adopting of the Programme of Action (PoA) on population and development for the next 20 years. The PoA focussed on meeting the needs of individual women and men rather than on achieving demographic targets. Empowering women and providing them with the more choices through expanded access to education and health services, promoting skill development and employment were key features of this new approach. Advocating for
universal availability of family planning services, the PoA sets down clear goals on aspects of population, development and reproductive health.

**KEY CONCERNS ARTICULATED IN THE PoA**

Population, sustained economic growth and sustainable development

Efforts to raise the quality of life of all people should be done through population and development policies and programs that seek to eradicate poverty, spur economic growth in the context of sustainable development, achieve sustainable patterns of consumption and production, develop human resources and guarantee human rights of all.

Gender equality, equity and empowerment of women

To achieve equality and equity between men and women, to eliminate all practices that discriminate against women including the girl child and to ensure that men play responsible roles.

Reproductive rights and reproductive health

Reproductive health – care programs should be designed to serve the needs of women, including adolescents, and must involve women in the leadership. Couples and individuals should be able to meet their reproductive needs and prevent unwanted pregnancies. Prevent, reduce incidence, and provide treatment for STDs including HIV / AIDS. Encourage responsible sexuality, which promotes mutual respect, and includes information, education and services (Media Brief 2003).

The important aspects, which were included in the action plan of ICPD, Cairo, were, International Human Rights, Empowerment of women, Reproductive Health, Reproductive Rights, Family Planning, Safe Motherhood and Abortion.
Some of the excerpts relevant to the present study are as follows:

Reproductive Health

A necessary prerequisite to the empowerment of women is the provision of health services and, particularly, reproductive health care. To date, many population programmes have focussed on the provision of a narrow range of contraceptive services in the context of family planning clinics. Such programmes thus respond only to one of women's health needs. The ICPD programme of action acknowledges the need for the broader approach to health as it relates to population and population policies. The document also endorses a modified version of the World Health Organization (WHO) definition of the term 'reproductive health.'

According to WHO, Reproductive health is a state of compete physical, mental, and socio-economic well being and not merely the absence of disease for infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health, therefore, implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide it, when and how often to do so. Implicit in this last condition is the right of men and women to be informed to give access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice. This also refers to regulation of fertility, which are not against the law and the right of access to appropriate health-care services that enable women to go safely through pregnancy and childbirth and provide couples with best choice of having healthy infant. In line with the above definition of reproductive health, reproductive health is defined as the constellation of the methods, techniques and services that contribute to reproductive health and wellbeing through preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal
relations, and not merely counseling and care related reproduction and sexually transmitted diseases.

Thus, the historic International Conference on Population and Development in Cairo in 1994 brought about a paradigm shift in population related policies. The conference helped focus the attention of Governments. On making programmes more client oriented with an emphasis on the quality of services and care. In line with the conference recommendations, the Government of India acknowledged the need to abandon the use of targets for monitoring its family welfare programme. It recognised that the top-down target approach does not reflect user needs and preferences and de-emphasizes the quality of care provided (Ministry of Health and Family Welfare, 1998). Recent research on the different aspect of service delivery, especially at the grass-roots level, including programme coverage, clients provider interactions, and informed choice, also endorses the need to take a different approach to meeting the reproductive and health needs of the Indian population (Koenigh and Khan, 1999) This research suggests that inadequate attention to the quality of care has contributed to the inability of the Government’s family welfare programme to meet its goals.

According to Media Brief, 2003 the definition of reproductive health is as follows. Reproductive health is a state of completed physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system. It implies

- a satisfying and safe sex life
- the capability to reproduce, and the right to decide if, when and how often
- to be informed and to have access to safe, effective, affordable and acceptable methods of family planning
- safe pregnancy, child birth, and a healthy infant
• sexual health which is not merely related to care and counseling but the enhancement of life and personal relationship
• a life cycle approach

In 1996, the existing family welfare programme was transformed into the new Reproductive and Child Health (RCH) Programme. This new programme integrates all family welfare and women and child health services with the explicit objective of providing beneficiaries with ‘need based, clients centered, demand driven, high quality integrated RCH services’ (Ministry of Health and Family welfare, 1996:6). The strategy for the RCH Programme shifts the policy emphasis from achieving demographic targets to meeting the reproductive needs of individual clients (ministry of Health and Family Welfare, 1996).

**Family Planning**

The aim of family planning programme must be to enable couples and individuals to decide freely and responsibly the number and spacing of their children and to ensure informed choice and make available a full range of safe and effective methods. The success of population education and family planning programme in a variety of settings, demonstrates that informed individuals everywhere can and will act responsibly in the light of their own needs and those of their families and communities. The principle of informed free choice is essential to the long-term success of family planning programme. Any form of coercion has no part to play. In every society there are many social and economic incentives and disincentives, in order to lower or rise fertility. Most such schemes have had only marginal impact on fertility and in some cases have been counterproductive.

Governmental goals for family planning should be defined in terms of unmet needs for information and services. Demographic goals while legitimately the subject of government development
strategies, should not be imposed on family planning providers in the form of the targets or quotas for the recruitment of clients.

The success of the ICPD programme of Action, measured in terms of improving women's lives, will depend upon the action taken by governments and non-government organizations (NGOs) in the years to come.

NGOs must devise strategies to hold governments accountable and to ensure that the promises of reproductive rights and empowerment do not ring hollow. An understanding of those portions of the ICPD program of action that represent important advances for women will facilitate the development of such strategies.

SUMMARY OF FIVE-YEAR PLANS

FIRST FIVE-YEAR PLAN:
- Need for family planning
- Facilities for sterilizations
- Advice on the use of contraceptives
- (Rhythm Method-safe period)
- Some emphasis on conventional contraceptives
- Clinic based approach

SECOND FIVE-YEAR PLAN:
- Sterilisation services free of cost for both men and women

THIRD FIVE-YEAR PLAN:
- Clinic based approach to extension approach
- Educating the people and providing knowledge and information about various aspects of Family Planning
- Conventional Contraceptives made available
- Loop insertion introduced.
INTER PLAN PERIOD:
- Sterilisation and IUD programmes made target oriented
- Creation of a new Family Planning Department
- Introduction of Cash incentive schemes.

FOURTH FIVE-YEAR PLAN:
- Step up the target of sterilisation and IUD insertion and wider the acceptance of oral and injectable contraceptives.

FIFTH FIVE-YEAR PLAN:
- Integrate Family Planning services with Health, Maternal and Child Health Nutrition.
- Concentrating efforts on eligible couples in the age group 25 to 35 years with two or more children and newly married couples.

INTERPLAN PERIOD:
- Name changed from Family Planning to Family Welfare
- Raising the age of marriage

SIXTH FIVE-YEAR PLAN:
- Need to project this programme as a people's programme
- Cash incentives to sterilisation acceptors.
- Persuasion for IUD as the choice of contraception after one child
- Energy diverted towards popularising the IUD, Condom, OC pills

SEVENTH FIVE-YEAR PLAN:
- The number of sterilizations reached its peak
- Users of temporary acceptance increased.

EIGHTH FIVE-YEAR PLAN:
- Health Manpower Development training was given importance
- Training Doctors of Indian System of Medicine
- (Aurvedic) and Homeopathy
- Integrated programme for raising female literacy, female employment status, and women nutrition and reduction in Infant and Maternal mortality

NINTH FIVE-YEAR PLAN:

- Converted Family Planning Programme into Reproductive and Child Health (RCH) programme