INTRODUCTION

The growth of population and its pace in India is not commensurate with the goals of sustainable development. Since independence, several programs and strategies have been adopted to regulate fertility and bring the population growth under control. This is clearly reflected in the documents of National Health Policy, National population policy and programs undertaken during various Five Year Plans. However, it appears that, there is still unutilized potential and material available, which needs to be recognised and appropriated. The vast army of General Medical Practitioners is one such human resource, neglected hitherto, in the Population Control Programs. Especially, in the light of the fact that the country is surpassing privatisation process in the economy and welfare services, understanding capabilities of GMPs and their probable role in population control is vital. Thus the significance of the present study.

Against this backdrop, it is important to know the population trends in India and its policy orientations. India's population has increased from 36 crore (1951) to over 102.7 crore (2001). This rapid growth, often seen as an uncontrolled 'explosion' is said to be one key factor hampering India's progress. It has to be understood that population growth occurs naturally and has taken place in all the parts of the world. In the earliest phases, in the absence of proper public health measures, the rates of birth and death taking place within a population were very high, and the population remained static. With advances in public health, as happened in our country from around independence, the death rates started to decline rapidly, while the births still continue to be high. This leads to a phase of rapid growth in the population.

With the advantages of economic and material progress, education, women's empowerment and the availability of contraceptives, birthrates start declining, slowly at first and rapidly
thereafter. This causes the population growth rate to slowly decline, and soon a stage is reached where birth and death rates are equal once again. This cycle of changes which occurs in any population is known as demographic transition. In many European countries the population has now started declining as birthrates have fallen behind death rates, and there is negative growth now. The population growth in India too has been declining steadily over the last two decades or more, and the numbers are no longer increasing rapidly. This trend can be further reinforced through education and empowerment, particularly of women, like it happened in Kerala.

Following are some of the achievements in demographic transition:

- Reduction in Total Fertility Rate - From 6.0 in 1951 to 2.85 in 1998 – 99.
- Increase in female literacy – 8.86 per cent in 1951 to 54.16 per cent in 2001.
- Increase in Life Expectancy at Birth(F) – 40.6 years (1951 – 61) to 63.4 years (1996 – 2001)
- Increase in Contraceptive Prevalence – 10.4 per cent in 1951 to 48.2 per cent in 1998 – 99.
- Despite the fact the couples now have fewer children than earlier, the overall growth in number still appears high because of Population Momentum*.

India has a high a proportion of young persons who are in the reproductive age group or will soon be so. Even if this group produces fewer children per couple, the quantum increase in numbers will be high, because the number of reproducing couples is high. Thus, the birthrate will be high even though the total fertility rate (TFR) is low. According to some estimates, in the period 1991 – 2001 the proportion of population growth due to population momentum was as high as nearly 70 per cent, while unwanted fertility contributed 25
per cent. Only five to six per cent of population growth was due to wanting more children.

India, with its large population and high growth, will take some time before the results of declining fertility start showing explicitly. Put simply, this decline does not look very rapid because India is like an express train whose brakes have just been applied, but since it is very heavy and moving very fast, it will take time before it actually stops. The important thing to note is that the brakes have been applied! (Media Brief, Population Stabilization and Sustainable Development, UNFPA, India, Department of Family Welfare, Government of India, 2003)

Population explosion is a global phenomenon. Population historians concur that, 2000 years ago, the population of the world did not exceed 260 million. In ancient times survival was difficult, and even thousand years later the total had risen only to some 280 million. Then it began to grow, reaching 430 million in the year 1500, 730 million at the turn of the 20th century. Global population reached the 2.5 billion marks in 1950 and 3 billion just ten years later, causing worldwide anxiety. Some prophets of doom predicted that the Earth could never support a population exceeding 5 billion but by 2000 it was over 6 billion. (Egon Diczfalusy, 2002)

Where do we go from here? According to the latest UN projections the growth will continue for at least another 50 years; the world population is expected to increase to 7.937 billion by 2025. This phenomenon will be unique, never previously witnessed and never recurring. (Egon Diczfalusy, 2002)

India has the second largest population in the world. The population total of India as per provisional figures of 2001 census stood at 1,027,05,247 as on 1st March 2001. India’s population has crossed a billion marks as predicted earlier (India with 2.4 per cent of the world surface area accounts for 16.7 per cent of the world population).
During 1990-2000 the United Nations estimated an annual average growth rate of population at 1.4 per cent, while in India it has been 1.9 per cent. The annual growth rate of population of China during 1990-2000 has been about one percent; our population will influence the ultimate size of world population, as in another twenty years we will be the most populous country, leaving China far behind. In the years 1981-91 our population increased by 160.6 million, more than entire population of Japan, 17 million people or 6 Singapore's are being added each year. But our land area remains the same.

The Ganges has not changed, the Himalayas remain the same, the same Sun, the same Moon, and the Rain. If any has declined, the Forest have disappeared, fuel reserves have shrunk, water levels have dropped, but the hollow in the ozone layer has grown larger. The gap between the growing numbers and dwindling resources will increase year after year.

According to the 2001 census of India the total population of Maharashtra is 96,752,247, which is 9.4 percent of India's population. This makes Maharashtra the second most populated state. In 40 years since its formation Maharashtra's population had increased from 39.6 million to 96.7 million, the first three decades actually seeing the population double itself. The fourth decade witnessed an addition of another 18 million people. The population scenario in Maharashtra is not rosy because of the growth rate that now hovers above 2 per cent. The 2001 census revealed several troubling demographic trends in Maharashtra. The density of population increased by more than two and half times from 129 persons per sq.km. in 1961 to 314 persons in 2001. The 96.8 million size of the population in substantially more than the 982.9 million projected by population foundation of India. (Kulkami S., 2002)

In many cases, developing countries' rapid population growth makes it difficult for food production to keep up with demand. Helping couples prevent unintended pregnancies by providing family planning...
would slow the growth in demand for food. This would buy some time to increase food supplies and improve food production technologies while consuming natural resources.

WHY POPULATION CONTROL?

Population control programs help millions of people, providing reproductive health care that saves lives, avoid unintended pregnancies and offer more choices.

Advocacy for family planning is becoming crucial as demand for reproductive health care grows. Worldwide as many as 600 million people use contraception, and millions more would do so with better access to good quality services.

Although fertility levels are falling in much of the developed world, rapid population growth remains critical issue in most developing countries, where needs are great and resources are scarce.

BENEFITS OF FAMILY PLANNING:

Family planning benefits individuals and countries in many ways. Among the most important ways are:

Saving Women’s Lives:

Avoiding unintended pregnancies could prevent about one forth of all the maternal deaths in developing countries. Especially, using contraception avoids unsafe abortion to end unintended pregnancies. It also enables women to limit births to their healthiest child bearing years and to avoid giving birth more times than is good for their health.
**Saving children’s lives:**

Spacing pregnancies at least two years apart helps women have healthier children and improves the odds of infant’s survival by about 50 per cent. Limiting births to a woman’s healthiest childbearing years also improves her children’s chances of survival and remaining healthy.

**Offering women more choices:**

For many women need for controlling their own childbearing, by using effective contraception, can open the door to education, employment and community involvement. Also, compels those women who have fewer children to send their daughters as well as sons to school.

**Encouraging adoption of safer sexual behavior:**

All sexually active people need to protect against sexually transmitted infections, including AIDS. Always using condoms correctly or avoiding sex except in mutually monogamous relationships are the best ways.

**BENEFITS OF SLOWER POPULATION GROWTH**

As more people choose family planning, fertility falls and population growth slows. Although fertility has fallen throughout the world, further declines would make a crucial difference in many developing countries. World population has reached 6 billion and is growing by nearly 80 million people each year.

**Slower population growth and Environment:**

Slow growth of population conserves resources, preserves clean air and water, improves health, eases pressure on cites, and helps avoid conflict. The signs of environmental stress grow on the world’s population increases. The world’s population increases. The world’s population grows by more than 90 million each year. Each of these people needs a portion of the earth’s resources for food,
shelter, energy and water. By 2025, human number may be 50 per cent more than they are today the largest population growth ever seen in so short a time. By the end of this decade more than half of the developing countries may be unable to feed their population from their own lands. Nearly, half of the world’s people will lack sufficient fuel wood. Within two decades, a few large strands of tropical forest will remain. Within three decades, carbon dioxide emissions from energy use in developing countries would triple. Within about four decades, readily accessible supplies of oil will be exhausted. Global warming could rise the oceans by one meter, flooding coasts and displacing millions.

Population, environment and sustainable development have a close and mutually reinforcing relationship, and need a holistic approach.

*Slower Population Growth aids Development:*

The sooner fertility falls to low levels the better most countries will be able to achieve sustainable development. Even small declines in fertility today will make a substantial difference in population size in future. Acting now to obtain support for reproductive health care helps to meet people’s needs today and improves prospects for the 21st century. (Population Reports, 2000)

Family Planning could bring more benefits to more people at less cost than any other single ‘Technology’ now available to human race. But it is now widely appreciated that this will still be true even if there were no such thing as a population problem. (Grant, 1992)

**SOCIAL SITUATION IN INDIA AND POPULATION EXPLOSION:**

India is on the brink of becoming first most populous country in the world. Ours is a unique country and population density differs from state to state in terms of languages, food habits, dress, cultural activities, festivals etc. This country is full of disparities.
Our politicians have practically ruled out making a law for small family norms like what has been made in China. In India emphasis is more on motivation of the people in favor of population control that too, for the last fifty years. This approach has not yielded satisfactory results so far. The reasons may be multiple. The principle reasons being, illiteracy, ignorance, poverty, strong male child desire, lack of political will, poor access to FP services etc. One-thing remains certain that pregnancy is a result of most intimate, most personal act between man and woman, that is, sexual intercourse. Reproduction is a biological rule. Human being is no exception to this. The crux of the population control problem in our country is that people don't want to discuss their problems related to sex openly as any other matter. Therefore, the campaign for family planning is going to have limited use unless the personal relationship of husband and wife are explored. Most of the people in our country do not reach the thinking level of what for sex actually is? Is sex only for pleasure or for the sake of reproduction? Is it to get either son or daughter? In reality, immediately after marriage there is urge for sex and many times desire for child bearing. Most of the married persons cannot decide between sex for pleasure or for pregnancy and therefore, land up in confusion resulting into unplanned pregnancies. Many a time they have to carry pregnancy up to term and confinement even though, their physical, mental and economic situations do not permit.

People in our country hesitate to talk about sex and contraception because our culture does not permit. According to National Family Health Survey India 1998-99, irrespective of whether they had ever used contraception, all currently married women were asked whether they had discussed family planning with their husband, friends, neighbors or other relatives in the past few months. Information on whether women talk about family planning at all and with whom they discuss it sheds light on their level of interest in family planning. Only 21 per cent of the currently married women in Maharashtra discussed family planning with their husbands, friends,
neighbors or their relatives in the past few months. Eighteen per cent of women discussed family planning with their husbands and five per cent discussed with friends or neighbors. Two per cent reported discussion with their mothers-in-law and another two per cent with their mothers. In such a situation doctor is a person who can try and enter into such personal matters to guide the couples. General medical practitioner (GMP) or family physician can be closer guide to the patients. If the GMP understands these concepts then he or she can guide the couples from where the population control begins.

GENERAL MEDICAL PRACTITIONERS:

Private Medical Practitioners is a broader term. It includes all the doctors rendering professional services in private sector, for example, General Medical Practitioners deal with all the general health problems, consultants deal with patients belong with special branch of medical sciences such as - Obstetrician and Gynaecologists, Orthopaedic Surgeons etc and superspecialists who deal with highly specialised health problems. The present study is related to only to those Private Medical Practitioners who deal with all the general health problems irrespective of their qualifications. They are referred as General Medical Practitioners or GMPs from here onwards.

General Medical Practitioners provide healthcare to a large section of population in the society. They have been offering these services for years together. During the course of their practice; they naturally form a bond between themselves and the people. A bond of 'faith.' For any minor illness people immediately rush to their respective GMPs for treatment. These practitioners perform pivotal role in decision making in the management of major health problems in the family. Sometimes these practitioners accompany these patients to consultants as their family members. Such intimate patient doctor relationship can be made use of in another important health issue of national importance and that is implementation of
population control programme. The first United Nations Mission (1965-66) had recommended for vigorous involvement of private practitioners.

GMPs must be technically updated regarding various contraceptive methods and related problems, proper social and positive perspective to keep the small family as a norm. One of the main reasons for the lost battle can be the untrained army. Training of the army of GMPs will boost up their confidence to counsel the patients regarding sex and contraception. People already have faith in the GMPs and will not hesitate or feel shy while discussing the problems related to sex and contraception, thereby, achieving effective contribution of the GMPs to society in population control program. A small number of MBBS and a large number of non-MBBS doctors mainly do general practice. Their orientation towards population control program differs during their learning process in Allopathic, Ayurvedic and Homeopathy medical streams. Despite of this, they can be potentially involved in this program in uniform way.

Active participation of GMPs from private sector would definitely improve the quality of access to FP services. GMPs, provide health care facilities to a large section of society. They get an opportunity to help people decide regarding suitable contraception so as to have better quality implementation of population control program. Any success in this regard depends on the accurate knowledge of basic principle of a range of contraceptive options and the social surroundings of the clients.

Under most circumstances, women's risk of dying of pregnancy is many times greater than use of contraceptive methods and some women with unplanned pregnancies opt for abortions which are all too often performed illegally under unsafe conditions. Exaggerating the dangers of contraceptive use may cause more harms than good. Can we ever hope to make this a people's program without first changing the approach? There are no short cuts and
instant solutions which even the ‘latest advances is contraceptive technology can offer. Family Planning can only be meaningful as a by-product of overall prosperity; not when it is used as a means to chase a mirage.

POLICY SCENARIO

The National Family Welfare Programme has traditionally sought to promote responsible and planned parenthood through voluntary and free choice of family planning methods best suited to individual acceptors (Ministry of Health and Family Welfare, 1980). In April 1996, the programme was named ‘The Reproductive and Child Health Programme’ given a new orientation to meet the health needs of women and children more holistically. The programme now aims at covering all aspects of women’s reproductive health throughout their lives. With regard to family planning, the new approach emphasizes the target free programme of contraceptive use amongst eligible couples, the provision of a contraceptive method and the assurance of high quality care to couples. An important component of the programme is the encouragement of adequate spacing of birth, with at least three years between births. (Ministry of Health and Family Welfare)

The National Health Policy was last formulated in 1983 and since then, there have been marked changes in the determinant factors relating to the health sector.

A comprehensive account of different policies of national importance in relation to improving health care services has been dealt in the Draft National Health Policy 2001. A wide range of health related issues are mentioned. Policies to improve the status are also discussed in it. Some of the issues related to the present study need to be discussed in little detail, for example, involvement of private medical practitioners, improving the access, modification in the training programmes of doctors etc.
Going further, in the present context, the NHP-2001 says, access to, and benefits from, the public health system have been very uneven between the better-endowed and the more vulnerable sections of society. This is particularly true for women, children and the socially disadvantaged sections of society. It is the principal objective of NHP-2001 to evolve a policy structure, which reduces these inequities and allows the disadvantaged sections of society a fair access. As discussed elsewhere, in the present study, systematic involvement of private medical practitioners helps in improving access for various contraceptive methods, goes in accordance with what is envisaged in NHP-2001.

In relation to the present status of medical manpower, the NHP-2001 states; in our country, generally there is paucity of medical manpower, this shortfall is disproportionately impacted on the less developed and rural areas. No incentive system attempted so far has induced private medical manpower in such underserved areas. In such a situation, the possibility needs to be examined for entrusting some limited public health functions to nurses, paramedics and other personnel from the extended health sector after imparting adequate training to them. General Medical Practitioners, in our country form a large group as medical manpower to which if appropriate training is extended, the said shortfall can be corrected. India has a vast reservoir of practitioners in the Indian system of Medicine and Homeopathy, who have undergone formal training in their own disciplines. The possibility of, using such practitioners in the implementation of state/central government training programs, in order to increase the reach of basic health care in the country, is addressed in the NHP-2001.

In any developing country, with inadequate availability of health services, the requirement of expertise in the areas of "public health" and family medicine is much more than the expertise required for other specialized clinical disciplines. In India, the situation is that
public health expertise is non-existent in the private health sector, and far short of requirement in the public health sector. Also, the current curriculum in the graduate and postgraduate courses is outdated and unrelated to contemporary community needs. In respect of ‘family medicine’ it needs to be noted that the more talented medical graduates generally seek specialization in clinical disciplines, while the remaining go into general practice. While the availability of postgraduate educational facilities is 50 percent of the total number of the qualifying graduates each year, and can be considered adequate, the distribution of the disciplines in the postgraduate training facilities is overwhelmingly in favour of clinical specialization. NHP-2001 examines the need for ensuring adequate availability of personnel with specialization in the ‘public health’ and ‘family medicine’ disciplines, to discharge the public health responsibilities in the country. This scenario, of course, is true, in relation to allopathic doctors. The situation in relation to non-allopathic doctors is still problematic as most of them too start their general medical practice without being adequately trained for the services to be extended as per the need of the society. One of the basic needs is providing appropriate training in relation to contraception, and general medical practitioners if trained adequately, can effectively spread the message of population control. In most of the urban areas, public health services are very meager. To the extent that such services exist, there is no uniform organizational structure. The urban population in the country is presently as high as 30 percent and is likely to go up to around 33 percent by 2010. The bulk of the increase is likely to take place through migration, resulting in slums without any infrastructure support. Even the meager public health services available do not percolate to such unplanned habitations, forcing people to avail of private health care out of pocket expenditure.

Alternative system of Medicine; Ayurveda, Unani, Sidha, and Homeopathy – provide a significant supplemental contribution to health care services in the country, particularly in the underserved,
remote and tribal areas. The main component of NHP-2001 applies equally to the alternative system of medicine. Realizing the importance of this group of doctors in health care services, NHP-2001 speaks volumes, especially when the present study deals with the role of such doctors in extending the family planning services more effectively. NHP-2001 further states that, in the context of the availability and spread of allopathic graduates-in their jurisdiction, state governments would consider the need for expanding the pool of medical practitioners to include a cadre of Licentiates of medical practice, as also practitioners of Indian system of Medicine and Homeopathy. Such practitioners, even outside, can provide simple services, as a part of the basic primary health services in underserved areas.

Also, NHP-2001 envisages that the scope of use of paramedical manpower of allopathic disciplines, in a prescribed functional area adjunct to their current functions, would also be examined for meeting public health requirements. These extended areas of functioning of different categories of medical manpower can be permitted, after adequate training and subject to the monitoring of their performance through professional councils.

As mentioned in the Media Brief, 2003, the National Population Policy 2000 has identified 12 keys strategic themes for successful implementation of the policy. Some of these are—

- Decentralized planning and programme implementation
- Meeting unmet needs for family welfare services
- Convergence of services at the village level
- *Working with diverse providers and health systems*
- Empowering women for improved health and nutrition
- Working with under-served population including-slums, adolescents, tribals, men and the elderly
- Child health and survival
- *Collaboration with NGO and private sector*
Working with diverse providers and health systems include GMPs belonging to different qualifications such as Allopathic, Homeopathic, Ayurvedic, about whom the present study is related. Collaboration with NGO and private sector is another key strategic theme of the population policy concerned with this study where emphasis is given to the involvement of medical practitioners from private sector.

The NPP 2000 is gender sensitive and incorporates a comprehensive and holistic approach to the health and education needs of women, female adolescents and the girl children. It also seeks to address the constraints in accessing health services in heavily populated areas and among diverse socio-cultural groups. A running theme of the NPP 2000 is provision of quality health services and supplies and a basket of contraceptive choices. “People must be free and enabled to access quality health care, make informed choices and adopt measures for fertility regulation best suited to them”— It is in this spirit that the NPP 2000 advocates a small family norm.

NATIONAL POPULATION POLICY 2002

Target free approach in administering Family Planning services gives informed choice to the people to voluntarily avail the reproductive health care services. The new NPP 2002 is more than just a matter of fertility and mortality rates. It deals with women’s education, empowering women for improved health and nutrition child survival and health, the unmet needs for Family Welfare services, health care for the under-served population growth like urban-slums, tribal community, hill area population and displaced and migrant-population, adolescents’ health and education, increased participation of men in planned parenthood and collaboration with Non Governmental Organisations (NGOs).
The National Population Policy Goals (NPP)* for 2010 are as follows:

- Address the unmet needs for basic reproductive and child health services, supplies and infrastructure.
- Achieve universal access to information and counseling, services for fertility regulation and contraception with a wide basket of choice.
- 100 per cent registration of births, deaths, marriage, and pregnancy.
- Reduce infant mortality rate to below 30 per 1000 live birth and reduce maternal mortality to below 100 per 1000 live births.
- Achieve 80 per cent institution deliveries and 100 per cent deliveries by trained persons.
- Achieve universal immunisation of children against all vaccine preventable diseases.
- Contain the spread of HIV / AIDS, reproductive tract infections (RTI) and sexually transmitted diseases (STD).
- Promote delayed marriage for girls, not earlier than 18 years, preferably after 20.
- Make school education up to age 14 free and compulsory, and reduce dropouts at primary and secondary school levels to below 20 per cent for both boys and girls.

(The first two goals given in the above list are relevant to the present study)

As mentioned in the Text Book of Preventive and Social Medicine (Park 2000, 16th edition) another important goal for NPP 2010, which is related to the present study is—Integrate Indian System of Medicine (ISM) to the provision of Reproductive and Child Health services and reaching out households.

* (As per brochure published as 'Media Brief 2003 by UNFPA, India and Department of Family Welfare, Govt. of India.)
To achieve these multiple and intricate goals, it is indispensable to call in for the services of vast medical manpower which should include the private medical practitioners.

In the light of the preceding discussion, two points appeared to be noteworthy. They are: a) the mounting pressure on the part of the planners and administrators to control population and b) increasing role of private agencies including GMPs in the implementing population control program. The present study is an attempt to document the status of GMPs, their capacities to function as health care providers and counselors in contraceptive use. The present study is divided into eight chapters-

**CHAPTER SCHEME**

The dissertation is divided into eight chapters. Chapter I is on introduction to the study, which includes magnitude of problem of population explosion, reasons to control populations, focus on National Health Policy, 2001 in relation to present study and the significance of the role of GMPs in population control programme. The chapter II deals with aims and objectives of the study, methods of data collection, scheme of data analysis, sampling frame, profile of the respondents (GMPs), the study area and related themes. The second chapter also includes a brief outline of essentials of contraceptive technology in relation to different methods of contraception along with some related social aspects. Chapter III is an overview of historical background of contraceptives, policies and approaches of the government towards population control during various five year plans. In addition, this chapter deals with how population control program at international level has changed to “Reproductive and Child Health (RCH) Program” after 1994 Cairo conference. Chapter IV dwells upon issues of contraception, its Dynamics, Access and status of Private Sectors. Chapter V focuses on the knowledge of GMPs about the principle and mechanism of action of different contraceptive methods. The variations in
knowledge levels across various categories of GMPs and how the basis for advising a particular contraceptive method varies from situation to situation and across various categories of GMPs have also been discussed in this chapter. Chapter VI concentrates on the awareness and comprehension of GMPs on common problems associated with use of contraceptives and their ability to resolve these problems. The chapter VII documents the perceptions on different contraceptives and population control programme. Disparities in perceptions across various categories of GMPs are discussed in this chapter. This chapter covers couple of miscellaneous aspects such as views of GMPs towards antenatal sex determination and female foeticide; awareness of GMPs regarding MTP (Medical Termination of Pregnancy) Law. Finally, Chapter VIII brings out the summary of findings, conclusions, suggestions and limitations of the study. The suggestions comprise of strategies needed to strengthen the family planning programme.