CHAPTER III

AN OVERVIEW OF FAMILY PLANNING PROGRAMME
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India is one of the poorest countries of the World. However, since independence, it has made considerable efforts for development in various fields through successive Five Year Plans. As seen in the first chapter the ever increasing population growth of our country has become a big barrier to the development. This was realised by our national leaders long back and therefore, the policy on population was formed in 1952. In fact, India was the first country in the World to decide the population policy and launch the family planning programme.

Before we discuss about history of family planning programme in India, let us look into certain demographic characteristics and some important factors influencing population growth.

The need and urgency of family planning programmes depend upon the density and size of the population. Countries, having high density and big size of population with limited resources, need to launch effective family planning programmes. Now let us see the density and size of population of our country.
Density and Size of Population:

According to U.N. Demographic Year Book (1972) India's population is the second largest in the World after that of People's Republic of China. Present population of India holds approximately 158 per 1000 of World population of about 3.8 billion. It has a land area of 3.28 million square kilometers which is barely 24 per 1000 of total land area of the earth of 135.9 million square kilometers. Thus, the population density of India is very high. About 182 persons are living in one square km. in India. Population density of our country is more than double (172 per km.) than that of the People's Republic of China - the largest country in the World (83 per km.). It is about 8 times and 16 times higher than that of U.S.A. (22 per km.) and U.S.S.R. (11 per km.) respectively.

It is estimated that our population as on 1st January, 1976 has crossed the 600 million mark (Govt. of India, Population Policy Statement, 1976) and is now rising at the rate of well over 1 million per each month. Since independence India's population has increased by 260 million from about 340 million in 1947 to about 600 million in 1976. This increase is equivalent to the entire population of the Soviet Union with six times the land area of India. The increase every year is now equal to the entire population of Australia which is 21/2 time the size of our country.
Apart from very large population size and high density, India's rate of growth is horrifying. The census figures show that the growth rate which was 1.33 per cent in 1951, went up to 2.16 per cent in 1961 and 2.48 per cent in 1971. Thus, rather than declining, it has continually shown an upward trend from one decennial census to another.

Trends of Population Growth:

The current population increase is estimated to be around 12 million per year - which is 50 times (500 per cent) higher than the average yearly increase in the population (0.24 million) during 1891 to 1901. During the period of 1901 to 1951 the average increase per year (2.4 million) was 10 times higher than that of 1891 to 1901 as shown in the Table 3.1 on Population increase in India (1891-1976). Similarly average yearly increase in population during 1951-61, 1961-71 and 1971-76 was higher by 32.5 times, 45 times and 50 times respectively than that of during 1891-1901.
### Table 3.1 Population increase in India (1891-1976)

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
<th>Period in years</th>
<th>From</th>
<th>To</th>
<th>Population increase</th>
<th>Average increase per year</th>
<th>How many times increase during the period</th>
</tr>
</thead>
<tbody>
<tr>
<td>1891-1901</td>
<td>10</td>
<td>10</td>
<td>236</td>
<td>238.4</td>
<td>2.4</td>
<td>0.24</td>
<td>-</td>
</tr>
<tr>
<td>1901-1951</td>
<td>50</td>
<td>50</td>
<td>238</td>
<td>361</td>
<td>123</td>
<td>2.4</td>
<td>10 times</td>
</tr>
<tr>
<td>1951-1961</td>
<td>10</td>
<td>10</td>
<td>361</td>
<td>439</td>
<td>78</td>
<td>7.8</td>
<td>32.5 times</td>
</tr>
<tr>
<td>1961-1971</td>
<td>10</td>
<td>10</td>
<td>439</td>
<td>548</td>
<td>109</td>
<td>10.9</td>
<td>45 times</td>
</tr>
<tr>
<td>1971-1976</td>
<td>5</td>
<td>5</td>
<td>548</td>
<td>608</td>
<td>60</td>
<td>12.0</td>
<td>50 times</td>
</tr>
</tbody>
</table>

*This table is enacted by the researcher based on the Census figures and estimated population of 1976.*

### Growth Pattern:

Population growth was slow upto 1921 because of the frequent epidemics of plague and cholera, famines, and the influenza epidemics of 1918-19. During 1921-51, the average decennial growth was around 13 per cent but after 1951 it increased rather sharply to 21.6 per cent during 1951-61 and 24.8 per cent during 1961-71 as per the data published by the office of the Registrar General, India (1972).

### Urban - Rural Distribution:

About 20 per cent of the population lived in urban areas as per the census figures of 1971.

India's rural population of 439 million lives in 575,721 villages, 78 per cent of which have a population.
Sex Composition:

There were about 20 million more males than females as per the Census figures of 1971. The sex ratio has been gradually increasing, from 1,029 males per thousand females in 1901 to the current level of 1,075 in 1971. In other words, there were only 930 females per 1,000 males in 1971. Sex ratio per 1,000 males is very low in the northern States and very high in the southern States varying from 864 females in Haryana to 968 females in Orissa. As the fertility is directly related to the females under reproductive age group, apart from sex composition one should know about the age distribution and age at marriage.

Age Distribution and Age At Marriage:

About 42 per cent of the population were in the age group 0-14 years while 6 per cent were aged 60 and over. The dependency ratio which was 88 in 1961 has been increased by 2 per cent and became 92 in 1971. It is interesting to note that the dependency ratio reported by 1961 census was 10 per cent higher than that reported by 1951 census. This clearly shows the increase in the dependent population of the age groups of 0-14 and 60 and above.

The mean age at marriage, estimated on the basis of the 1971 census was 22.4 years for males and 17.1 years for
females. In comparison to many other developing countries the age at marriage is low in India.

Fertility and Mortality Levels:

The need and importance of family planning and a degree of priorities for the family planning and Maternity and Child Health Programmes can be determined from the levels of fertility and mortality.

The birth rate of India slightly declined from 39.9 per 1000 population in 1951 to 37 in 1970, while the death rate of India considerably declined from 27.4 in 1951 to 15.9 in 1970. Thus, the gap between birth and death rates has widened which in fact has resulted in rapid increase in population (Govt. of India, 1972).

The birth rate of our country during 1970-72 remained at about 37 per 1000 population as per the data available from Sample Registration Scheme of Govt. of India.

As calculated by Pravin Visaria & Jain, some important vital rates are as follows. "The life expectancy at birth during 1961-71 was around 46-47 years for males and 44-45 years for females. These estimates imply an average death rate of 18-19 per thousand, an average birth rate of 40-41 per thousand, a gross reproduction rate of 2.8, and a general fertility rate of around 192. Corresponding estimates for 1951-61, based on the quasistable
population model, give a life expectancy of 37-38
a death rate of 26 and birth rate of around 45"
(Visaria and Jain, 1976:15).

The average birth interval is reported to be
30 to 36 months due to physical separations of spouses,
low coital frequency & considerable number of days of
abstinence due to religion and the social custom of
prolonged lactation (Visaria and Jain, 1976).

High or low acceptance of family Planning has
direct relationship with high or low level of education
and income. Therefore, for our purpose it will be impor-
tant to know literacy level and per capita income of the
people.

Literacy:

As per the census data in 1971, 38.8 per cent
(as compared to 28 per cent in 1961) of the Indian popu-
lation excluding age group 0-4 years, were literate.
Literacy among males (45.3 per cent) was more than twice
as high as among females (21.5 per cent) excluding age
group of 0.4 years. The literacy rate increased from
16.6 per cent of the total population in 1951 to 29.5
per cent of the total population in 1971.

Inspite of the considerable increase in literacy
rates, high population growth has led to a rise in the
number of illiterates in the total population as well as
among the population aged 10 and over. The census figures show that the number of illiterate persons in India increased from 333 to 387 million (16.2 per cent) from 1961 to 1971.

National and per capita income:

The galloping population growth has adversely affected the rate of growth of per capita income, obviously because a given product has to be shared among more persons. The available estimates suggest that the aggregate national income more than doubled in two decades, from Rs. 90.7 billions in 1950/51 to Rs. 197.2 billions in 1973/74 (both at 1960/61 prices). However, per capita income increased by only 34 per cent from Rs. 253 to 340 (at 1960/61 prices). (Govt. of India Report 1960/61 – 1972/73).

Population and Religion:

Religion is an important factor, especially for a sensitive subject like family planning. This is because attitudes are partly conditioned by religious feelings and ideologies.

India is a secular state. People of our country practices a variety of different religious faiths without having any State religion. About 83 per cent of the population i.e. 45.5 million are Hindus (including various sects); 61 million (11.2 per cent) are Muslims while
Christians are 14 million (2.6 per cent), Sikhs are
10 million (1.9 per cent) while Buddhists and Jains
formed less than 1.0 per cent of the population as
per census of 1971. The enclosed table 3.2 also
indicates religion wise percentage increase during
1961-71.

Table: 3.2 Percentage Distribution of Population

<table>
<thead>
<tr>
<th>Religion</th>
<th>1961</th>
<th>1971</th>
<th>Percentage increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hindu</td>
<td>83.51</td>
<td>82.72</td>
<td>23.69</td>
</tr>
<tr>
<td>Muslim</td>
<td>10.70</td>
<td>11.21</td>
<td>30.85</td>
</tr>
<tr>
<td>Christian</td>
<td>2.44</td>
<td>2.60</td>
<td>32.60</td>
</tr>
<tr>
<td>Sikh</td>
<td>1.79</td>
<td>1.89</td>
<td>32.28</td>
</tr>
<tr>
<td>Buddhist</td>
<td>0.73</td>
<td>0.70</td>
<td>17.20</td>
</tr>
<tr>
<td>Jain</td>
<td>0.46</td>
<td>0.47</td>
<td>28.48</td>
</tr>
<tr>
<td>Others</td>
<td>0.37</td>
<td>0.41</td>
<td>19.59</td>
</tr>
<tr>
<td>Total</td>
<td>100.00</td>
<td>100.00</td>
<td>24.80</td>
</tr>
</tbody>
</table>

Source: Ministry of Information and Broadcasting.
Publication Division, India: A reference
As seen from table 3.2 an unequal increase in percentage of some religious groups might have created some ill feeling among a few people having strong attachment for their religions. This might have resulted in creating some negative feeling for family planning among a few members of some religions organisation. Any how, the number of such persons in the total population is perhaps negligible. Inspite of difference in increase in population of some religious groups as per the census figures of 1961 and 1971, on the whole one does not find any organised opposition to family planning on the ground of religion. Therefore, it can be said that by and large people of India believe in secular state in real sense and have largely realised the importance and need for family planning programme.

After having this demographic picture and knowing about important factors influencing population growth, now we shall try to have a brief historical background of the programme. As such even in 19th Century some of our leaders and voluntary organisations were quite aware about the problem of population increase. This can also be seen from a review of the main events that took place in the first half of the 19th Century.

**Historical Events in Family Planning (Thoughts, Process and Leadership):**

1916 Mr. P.K. Wattal highlighted the problem in his Book "The Population in India".
Family Planning as an organised movement began in India in 1923. Prof. N.S. Phadke started the Birth control league in Bombay with a group of doctors, social workers, jurists & reformers. Propagation of Family Planning & distribution of contraceptives were the main functions of the league.

A similar organisation was also started in Poona around the same time by Mr. G.D. Kulkarni. Of course, these kinds of initial efforts were concentrated in urban areas of some cities.

In a letter to Mrs. Margaret Sanger, in 1925, Great Poet Rabindranath Tagore wrote "I am of the opinion that Birth Control Movement is a great movement not only because it will save women from enforced and undesirable maternity, but also because it will help the peace by lessening the number of surplus population of a country, scrambling for good and space outside its own rightful limits."

The first state sponsored birth control clinic was started in Bombay by a leading educationist and scholar Prof. K.D. Karve.

Neo Malthusian League was founded in Madras City.

First Govt. Family Planning Clinic in Bangalore.

The All India Women's Conference took a stand on birth control and emphasised again in 1933.
1931 Dr. A. F. Pillay performed the first vasectomy for birth control in his clinic in Bombay.

1935 The Society for the Study and Promotion of Family Hygiene was founded in Bombay under the leadership of Lady Cowasji Jehagir, which took name of Family Planning Society in 1940.

1938 Shri Subhash Chandra Bose, the then president of the Indian National Congress, advocated a definite restriction of numbers. He appointed a National Planning Committee under the Chairmanship of late Shri Jawaharlal Nehru.

1940 The above committee recommended:

a. In the interest of family happiness family planning and limitation of children are essential and state should adopt policy to encourage these.

b. Establishment of birth control clinics.

c. Stress was laid on spread of knowledge about cheap and safe methods of birth control.

d. Prevention of use or advertisement of harmful methods (abortion).

e. Gradual raising of marriage age.

f. Discouragement of polygamy and eugenic programme including sterilisation of persons suffering from transmissible diseases such as insanity & epilepsy.
1940 Shri P.N. Sapru moved a resolution in the Council of states calling upon to establish birth control clinics in India.

1946 The Health Survey and Development Committee appointed by Govt. of India in 1943 under the chairmanship of Sir K.C. Bhore recommended:

a. that Govt. should provide instructions regarding contraception as well as free contraceptives in public institutions - as birth control cannot be secured "to any material extent" by self control.

b. research for safe and effective contraceptive.

c. study of population problems.

d. control over sale and manufacture of contraceptives.

1949 Formation of family planning association of India.

1951 First All India Conference on Family Planning was organised in Bombay in 1951. Eminent persons like Mrs. Ram Rao, Mrs. Wadia and others participated with Dr. S. Chandrasekhar as President.

The Conference:

1. Urged the Central Govt. to devise measures, which will provide through hospitals, and medical and welfare centres, education and appliances for those
who are anxious to limit their families;

2. Called on the Government to enact legislation that will raise, (a) the status of women to one of practical equality to men, and (b) minimum age of marriage to 18 for women and 21 for men, urged every man and woman to recognise their obligations to the child & accept the principle of planned parenthood;

3. Demanded that the subject of family planning be made required part of the curriculum in medical schools & training centres for nurses and health visitors;

4. Demanded that the Central Govt. establish adequate research and experimental departments to explore the availability of indigenous material and to test their effectiveness for use as contraceptives and to maintain statistical records of the same;

5. Stressed the need for an all out effort to propagate the principle of family planning;

6. Recommended that legislation be put into effect that could empower the authorities to enforce (i) sterilisation of the mentally and physically unfit, and (ii) the medical examination of men and women before marriage;

7. Recommend that marriage guidance clinics be set up by the State & local Govts. (Family Planning Association of India Report, 1951).
As seen from above, efforts to popularize birth control in preindependent India were made mainly by voluntary organisations, social workers and progressive professionals. In the initial stages, majority of the leaders did not realise the seriousness of the over population problem and failed to give priority to the programme of family planning even after independence. Of course, some of the congress leaders like Subhas Chandra Bose and Jawaharlal Nehru had endorsed the idea of birth control and stressed the need to control population increase by use of contraception.

The Father of our Nation, Mahatma Gandhiji, believed in family planning and stressed the need to control family size by self restraint but did not approve the artificial means for birth control. Gandhiji did not recommend it on moral grounds. Due to this, family planning was perhaps not given the required social recognition. Even after independence most of the political leaders continued to give low priority due to their negligible political commitment for family planning. Gandhian ideological opposition to modern contraceptives seems to have influenced the masses as well as several important leaders and social workers at different levels including the first Minister of Health of Independent India. Perhaps this might be one of the underlying reasons for low credibility of family planning and low priority given to it even after independence. Perhaps,
due to ideological differences about contraceptives, some sort of confusion among leaders of our country was also observed. Though, Govt. of India had accepted population policy & launched national family planning programme since 1952, initial phase of the programme was marked with hesitation. Administrative & political low level of commitment was observed even though the country had favourable atmosphere and non-conservative leadership of the then Prime Minister Jawaharlal Nehru.

Apart from ideological reasons, there were several other factors which have influenced the family planning programme in India especially after early 60s. These factors are as follow:

"Initial ideological inhibitions were overcome in 1960s, when the economic crisis created by the failure of agricultural production in India....Besides ideological and economic conditions, there were other factors that influenced change in birth control policies: contraceptive technology, elite perception of the mass response to birth control policies, the international environment and historical experience with birth control movement."
(Maru, 1976:38).

Having an overview of the historical background, now it will be appropriate to give the development of national family planning programme through various Five Year Plans.
Progress of Family Planning Programme through Five Year Plans:

It will be more relevant if we try to understand the efforts through five year plans by the Govt. by launching national family planning programme in view of the strenuous and gigantic task to be achieved in consideration of the gravity and urgency of the population problem which we have tried to understand in the earlier chapter.

First Five Year Plan: (1951-1956)

In the First Five Year Plan, the Planning Commission recognised that "Population Policy is essential to Planning" and for a blueprint for planned development, population problem came to the fore-front.

The Planning Commission recommended in 1951:

i. The provision in Govt. hospitals and Health Centres of advice on methods of family planning for married persons who require such advice.

ii. Field experiments on different methods of family planning for the purpose of determining their suitability, acceptability and effectiveness in different sections of the population.

iii. Development of suitable procedures to educate the people of family planning methods.
iv. Collection, from representative sections of the population, of information on reproductive patterns, and on attitudes, and motivations affecting the size of the family.

v. Study of the inter-relationships between economic, social and population changes.

vi. Collecting and studying information about different methods of family planning (based on scientifically tested experience in India and abroad) and making such information available to professional workers.

vii. Research into the physiology and medical aspects of human fertility and its control. (Govt. of India, First Five Year Plan, 1952).

In 1952, Govt. of India was the first in the World to take up the Family Planning as the National Policy of the Government.

In 1952, a Population Policy Committee was appointed under Chairmanship of Minister of Planning.

In 1953, Govt. of India constituted a family planning research and programme committee consisting of eminent medical and public health persons, demographers and social scientists in the country.
In 1953, the committee under the Chairmanship of the then Health Minister, Rajkumari Amrit Kaur expressed concern about the after-effects of sterilization and hence the approach toward sterilization was cautious and conservative.

During the First Plan, a few Family Planning clinics (143) were established. These centres catered mostly for women clientele through distribution of mainly diaphragms and foam-tablets. As per recommendation of the Planning Commission, Dr. Abraham Stone was invited to India to advise on pilot studies on the use of 'Rhythm Method'. Also a Family Planning Cell in charge of part-time officer was created in the office of the Directorate General of Health Services.

**Second Five Year Plan: (1956-61)**

Further progress was made during the Second Five Year Plan. With a provision of 30 million rupees, few more urban Family Planning Centres were established and condom was introduced as an additional conventional contraceptive. Definite administrative structure took shape under the auspices of National Family Planning Programme. During this period setting-up of:

(a) Central and State Family Planning Boards for giving guidance and laying down policies.

(b) Demographic Research Centres.
(c) Centres for research in medical and biological aspect of reproduction and population problems.

(d) A rural training and demonstration centre.

(e) Touring Training Teams. (Govt. of India, Year Book 1974-75: 3)

Stress was laid on education. Sterilization operation as permanent method was introduced during this period. Broad based training programme was established which has included National institution for training for instructors/training officers. Family Planning bias was also introduced in different types of ongoing training programmes of teaching institutions for medical and paramedical personnel. A Family Planning Board was formed and Director of Family Planning at Centre and State Family Planning Officers at State levels were appointed.

During this plan period a few people took advantage of the Family Planning clinic as the approach adopted was not suitable to masses of our country.

The second plan document also envisaged the relationship of population increase to economic development. The Plan stated:

"The logic of facts is unmistakable & there is no doubt that under the conditions prevailing in countries
like India, a high rate of population growth is bound to effect adversely the rate of economic advance and living standard per capita. Given the over all shortage of land and of capital equipment relatively to population as in India conclusion is inescapable that an effective curb on population growth is an important condition for rapid improvement in incomes and in levels of living". (Second Five Year Plan 1956:7)

As the planners and national leaders realised that economic growth will be slowed down if the population growth is not checked more attention was given to family planning in second plan as compared to the First Plan and the financial allocation(out lay) for family planning was also increased from Rupees 6.5 million in the First Plan to 49.7 million. (Annual Report, GOI, 1965:180)

As rightly reviewed by B.L.Raina (Raina,1966: 113-114) the development of a national programme began to emerge with the second Five Year Plan. In November,1955, at an inter-departmental meeting the machinery for the co-ordination of population and vital statistics and demographic studies was reviewed. This led to formation of a standing committee for co-ordination of high level family planning boards which were
established at the centre and in the states. Training Centres and centrally financed field units in the states were also set up. Centres for Research and training on demography, reproductive physiology, communications and action research were established.

The national programme was launched with four main components:

1. Education to create the background of contraceptive acceptance;
2. Service through rural and urban centres, including provision of sterilization facilities;
3. Training of personnel and
4. Initiation of research studies and printing of education material on Family Planning.

Mass education material such as large number of posters, pamphlets and folders, films, film strips, slides and exhibits were produced. With a view to popularize Family Planning through community leaders, public minded leaders of State and district levels were appointed as honorary family planning education leaders. Liberal grants were given to local bodies and voluntary organisations to open and run the family planning clinics in their areas.

During the Second Five Year Plan a post of Director of Family Planning was also created at the Centre
to boost up the programme. Efforts for establishing definite administrative structure at centre and state levels and expanding family planning services through clinic approach were made.

Third Plan: (1961-1966)

A critical review of the programme which was made in 1963 indicated that 'clinical approach' had recognised very limited clientele and the need to adopt extension approach in order to extend education and services closer to the people.

Community extension approach was adopted instead of clinic approach and Family Planning social workers attached to the Family Planning Centres, had to go to the couples to motivate them for family planning through extension education. The loop (IUD) was introduced as one more method for family limitation. Supply of contraceptive devices like condoms, diaphragms and jelly was made free and broad based extension education programme was introduced. A central family planning council under the Chairmanship of Union Minister of Health was established under the provision of Article 263(C) of the Constitution of India consisting all the State Ministers of Health, representative of voluntary organisations and some distinguished individuals. Regional Family Planning Centres for inservice training were also established. At block level, the Primary Health Centre
and sub-centres became a peripheral organisation to provide services in health and family planning. Since 1965, the programme has witnessed many innovations in the administrative set up in the sphere of motivation and education.

In July, 1965, IUD was introduced in the programme. Facilities for IUD insertions and sterilizations were provided not only free but also with compensation to the individuals for out of pocket expenses, conveyance and loss of wages. Steps were taken to have adequate supplies of condoms by stepping up indigenous manufacture of contraceptives.

Education and motivation programmes were geared up to help people realise their desire for small family norm; messages were flashed continuously and repeatedly through all modern mass communication media and the traditional cultural media to which people are accustomed. The strategy was personified by the inverted, vertical, equilateral, red triangle with the slogan "Do Ya Teen Bache Bus."

Besides the in-built evaluation on the basis of statistical data flowing from the periphery to the centre, independent evaluation and concurrent assessment during the plan period provided corrective measures & useful guidelines in formulation/ratification of programme strategy.
Inter-Plan period: (1966-69)

It was decided that Maternity and Child Health (MCH) schemes should be integrated with Family Planning. Compensation money for IUD and sterilization acceptors was introduced. Considering the demand, a factory in public sector for manufacturing of condoms (Nirodh) was established during this Inter Plan Period. Since 1967 targets for sterilization, IUD and condom distribution were given on population basis for the first time.

By the end of this plan period, the total numbers of urban and rural Family Welfare Planning Centres and sub-centres were increased to a great extent as shown below:

- Rural F.W.P. Centres: 4326
- Rural sub-centres: 22826
- Urban F.W.P. Centres: 1797

The financial provision during the Third Plan period was about 300 million rupees. More urban and rural Family Planning Centres were established & sterilization was accepted as one of the methods for checking the growth of population. It was also realised that mere establishment of Family Planning Centres was not sufficient to bring people to the clinic. Extended Family Planning Programme was therefore
introduced since 1963-64. Family Planning Social Workers attached to the Family Planning Centres had to go out in the community, motivate people for accepting one of the Family Planning methods and then bring them to the centre for services.

In urban areas, voluntary organisations were encouraged to establish Family Planning Centres with 100 per cent financial assistance. Such centres were established for population varying from 10,000 to 50,000. Earlier, subsidised price was charged as per the income of the conventional contraceptive users. Afterwards it was decided to supply all contraceptives free. Other services like sterilization and IUCD were also made free to the public.

In rural areas, the Family Planning Centre was attached to the Primary Health Centre. Each Primary Health Centre catered to a population of about 85,000.

In addition, family planning services were provided free in all hospitals, run by Government or Local Bodies. Additional beds for free tubectomy operations were also provided in Government, Local Body and Voluntary Organisation or Trust Hospitals. (Reserved Bed Scheme of the Govt. of India under Family Planning Programme)

During this period, cafeteria and campaign approach was adopted and special stress was laid on Mass Education by utilizing modern and indigenous mass media and by ensuring co-ordination and cooperation between different media units of the State and Central Governments.

Following schemes were initiated during the Fourth Plan Period:

1. Selected Intensive Districts with more inputs.
2. Sanction of the Post-Partum Scheme in 255 hospitals.
3. Immunisation Programme on a mass scale.
4. Prophylaxis against Nutritional anaemia. (Govt. of India, Year Book, 74-75:5)

High priority was given for construction of buildings for working and living accommodations for medical and para-medical personnel in rural areas in the earlier years of the Plan but due to financial constraint, some restrictions were imposed on this activity during 1973-74.

In the Fourth Plan (1969-74), family planning programme found its place as a programme of the highest priority. Since incomes were low and economic development a desperate need, population growth was seen as an important
variable determining the rate of improvement in per capita income and economic prosperity. The objective was to reduce the birth rate from 39 in 1968 to 25 per 1000 population in 1980-81 on the basis of an active family planning programme. In order to achieve this objective, Demographers at Central level had worked out the yearly targets for different family planning methods since 1966-67. Since then, the programme gradually became more and more time-bound and target-oriented.

**Targets for Family Planning:**

As regards targets and achievements, till 1965-66, no targets were given by the Central Government and the achievements of each State depended upon the importance attached to the programme by the State concerned. For the first time, during 1966-67, adhoc targets for sterilization were given to each State, depending upon their performance during previous years. It was also realised at this stage, that unless the programme was made target-oriented and time-bound, no tangible results could be achieved to lower the birth rate.

During 1967-68, targets for sterilization, IUD and condom distribution were given on population basis for the first time. It has been worked out by the demo-
graphers that a sterilization will prevent roughly 1.5 births, an IUD 0.5 births and a condom 0.05 births. Targets for different Family Planning methods were mostly based on population and previous year's performance (sometimes). The Government of India (1969) based on the expert demographers' calculations has given the following formula:

"If the eligible couples accept family planning sterilizations after having one, two or three living children the birth rate would fall to 9, 16 or 25 respectively."

This is however, only a demographic concept which may not have any practical application. This is especially in view of the fact that most of the eligible couples do not come forward for sterilization till they have 3 or more children, with at least one or two male issues.

Out-lay and Expenditure:

One of the effective ways to know about the priority given and commitment to family planning programme is to find out total out-lay and expenditure of the programme.
Table: 3.3 Out-lay & expenditure on Family Planning Programme and percentage of total out-lay not spent in different Plan Periods.

<table>
<thead>
<tr>
<th>Period</th>
<th>Out-lay in lakhs</th>
<th>Expenditure in lakhs</th>
<th>Not spent in lakhs</th>
<th>Not spent percentage of total out-lay not spent</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Plan</td>
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@ Provisional Welfare

Source: Family Planning in India, Year Book 1974-75, Govt. of India, Ministry of Health and Family Planning, New Delhi.

Note: Columns No. 4 & 5 are inacted by the researcher.

It is interesting to observe that during First Plan period over 3/4 of the budget allotted to family planning programme was not spent. This may be attributed to low level of commitment and low priority given to the Nationa Family Planning Programme in the initial Plan period. This may also be due to weak and vague ideological basis of the Indian political system. Even
during the Second Plan period, this situation does not seem to have improved and as a result over 56 per cent of total out-lay was unutilised. This might be because the gravity of the population problem was not realised by the national level leaders and others. Anticipated increase of high population growth rate and specifically 1961 census results served as an eyeopener to the Government and top leaders of India and therefore comparatively greater attention was given to family planning programme in the Third Plan. This can also be clearly seen from the very low percentage of the out-lay amount not spent during third plan. During Third and specifically during the Fourth Plan, wholehearted support and top priority was given to the programme by many leaders of the country. This can be seen not only by increased expenditure but also by the gradual increase in family planning performance, specifically during the Inter-Plan, Fourth and Fifth Plan periods.

**Fifth Plan: (1974-79)**

In the beginning of the Fifth Five Year Plan, integrated package deal of family planning, health, nutrition and maternity and child health services was religiously pursued as a part of the new strategy of delivering integrated health services to the people.
It was later on linked with the Minimum Needs Programme which has a basic aim of improving the quality of life of a large section of our people who have long remained victims of poverty and under-development. The total out-lay amount earmarked for the Fifth Plan is Rs. 5160 million.

The Fifth Plan document mentions that family planning will continue to have the same high priority as in the Fourth Plan. It lays down the objective of bringing down the birth rate to 30 per 1000 population, a drop of 5 points by the end of the Fifth Plan and a further drop in birth rate to 25 by the end of the Sixth Plan. During the plan period, more and more vertical programme workers will be converted into Multi-Purpose Workers (MPW) scheme, who will pay special attention to purveying family planning motivation and services.

"An integrated approach for the delivery of the package family planning, Health, Maternity & Child Health (MCH) and nutritional services to the community has been accepted in the Fifth Five Year Plan, for which multi-purpose workers would be needed. It has been decided to introduce multi-purpose approach on phased programme throughout the country in the Fifth Plan. The adoption of multi-purpose approach has added a new
dimension to the Training Programme hitherto conducted separately for family planning personnel and workers engaged in various other national health programmes." (Govt. of India, Year Book, 1974-75: 15)

During the second year of this plan period, Emergency was declared in India and great emphasis was laid on family planning programme.

**Emergency Era:**

India has passed through a period of political upsurge during the last 2 years. On June 26, 1975, the then Prime Minister, Mrs. Indira Gandhi, declared a State of Emergency in our country. Press censorship was imposed, democratic freedom guaranteed in the Constitution of India was suspended and many opposition leaders were arrested (Park, 1975: 996-1013).

Emergency tightened up the administrative machinery and time-bond programmes for development in different fields were launched by giving higher priorities. Family Planning Programme was also considered one of the top priority development programmes. Indian Congress Party declared full and active political support to family planning and asked their workers to wholeheartedly support the cause of family planning. Governmental and political support and consciousness helped in
achieving higher targets of sterilization especially vasectomy in all the States and Union Territories of India by use of administrative pressure and even some force in several parts of the country. Encouraged with the initial results, the Government of India prepared a new population policy in order to give a big push to the family planning programme.

During the emergency period from June 26, 1975 to February, 1977, willingness and ability of the political system increased and some sort of compulsion & coercion were used for achieving the desired social change. Emergency suddenly changed the political process and for the first time along with the other developmental programmes, National Family Planning Programme was given real top-priority at National level. The announcement of National Population Policy on April 16, 1976, brought for the first time, active political support from Central & State level leaders. The Maharashtra State Legislative Assembly passed a bill to enforce compulsory sterilization for all eligible couples having three or more children (Maru, 1976:380). Some other States like Haryana and Punjab also declared their intention for considering introduction of legal compulsion in their family planning programmes. Any how, Central Government did not endorse compulsory sterilization Bill of Maharashtra State considering the non-feasibility of implementation and the possible repercussions of such drastic legal measures.
In addition to the adoption of incentive approach as per new population policy April, 1976, most of the States introduced several disincentives and used administrative pressure and in some cases coercion in their enthusiasm to achieve higher targets of sterilization. All this did result in a significant quickening of performance and an unprecedented record of about 8.1 million sterilizations during 1976-77. During the emergency era, an atmosphere for using some sort of compulsion in family planning programme was created as there was hardly any opportunity for the people or the press to outlet their real feelings against compulsion due to press censorship and restriction on freedom of speech.

The national population policy announced by the Govt. of India on 16th April, 1976 placed emphasis not only on family planning methods but also emphasized measures, beyond family planning, such as raising age of marriage, increasing female literacy, nutrition and health for children and mothers. It is gratifying to note that political awareness of population problems and need to take urgent actions to control population increased to a great extent for the first time in the history of Indian Family Planning Programme. It might be due to active leadership provided by some of the committed political leaders during the emergency and acceptance at lower levels without any expressed resistance.
During emergency era, political & administrative pressure for achievement of high targets of sterilization (especially vasectomy) was so great that in the quest of achieving these targets administrative pressure, coercion and some sort of compulsion were used in several States. Consequently, this led to excessive emphasis on sterilization especially vasectomy as the most favoured family planning method.

Political Repercussion:

In February, 1977, the emergency was lifted and the press and people got an opportunity to express their suppressed feelings and hostility against the forcible actions and coercion used for family planning, especially for vasectomy. Family Planning was one of the issues made out by opposition parties and people during the elections. The result of the election is one known to all of us. Family Planning issue was one of the important reasons for the grave defeat of the congress party and the emergence of a new party and Government at the Central level.

A New Approach:

The Janta Party Government has adopted a new approach to Health and Family Welfare. A new name was given to the family planning programme. It is now known as Family Welfare Programme, which is considered far more
suitable and meaningful. In fact, family planning became one of the components and integral part of family welfare. Education is considered imperative for popularising small family norm and motivating eligible couples to accept desired methods of family planning. The new approach is people-oriented rather than only programme-oriented. The dignity of human beings and their rights as an individual were given due recognition in the new approach.

A statement of population policy issued on April 28th 1977 by Shri Raj Narain, Union Minister of Health and Family Welfare clearly stated as below:

"The Government attaches the highest importance to the dignity of the citizen and to his right to determine the size of his family. We have no doubt that by and large the people of India are conscious of the importance of responsible parenthood; given the necessary information and adequate services, they will accept the small family norm."

On a number of occasions, Mr. Raj Narain has emphasized the need for vigorous and sustained programme of education and motivation for achieving the results through voluntary acceptance.
India Cannot Afford Population Rise:

On April 28th 1977 a two day conference of all State Health Ministers and Secretaries was convened by the Government of India and a new population policy was announced. In his inaugural address, the Prime Minister of India, Mr. Morarji Desai said that "India cannot afford population rise". The Prime Minister struck a confident note when saying that there would be wider voluntary acceptance of planned parenthood. He was emphatic that the country could not afford the population rise at present, but at the same time Family Planning could not be forced down on the people. Both the Prime Minister Mr. Desai and Health and Family Welfare Minister Mr. Raj Narain, commended to the State representatives the new National Plan for taking medicare to the villagers' doorsteps. The existing rates of compensation (Graded higher incentives of Rs. 100, 50 and 25 for the acceptors of male or female sterilization with 2, 3 and 4 or more living children respectively) would continue for the present. The rate of higher incentive was again modified recently and uniform rate of compensation of Rs. 100/- irrespective of parity has been declared.

The statement while announcing new population policy is categorical: "Care must be taken to ensure
that the acceptors of sterilization are not coerced or pressurised for taking to this method. The country wide target set for acceptors of all methods of population control i.e. targets for sterilization, IUD (loop) and conventional contraceptives, has been set at 10 million for the year 1977-78.

In the context of the voluntary nature of the programme, voluntary agencies will play a key role in the implementation of the programme. The State Ministers have been asked to allot specific areas of action to the voluntary sector. The population policy announced by the new Government has continued the programme objective to bring down the birth rate to 30 per 1000 population by March 1979 and 25 per 1000 population by March 1984 i.e. by the end of Sixth Five Year Plan. Thus, in fact we do not find any major change in the population policy announced by the new Government. The only very significant change in approach is that it will be purely on voluntary basis and special care will be taken to ensure that people are not pressurised for accepting family planning methods. Thus, an educational approach supported with higher incentives and other motivational efforts will be pursued with target oriented programme having the
same objectives. A target of 4 million sterilizations, during the current year 1977-78 has been fixed by the Government of India as sterilization is still accepted as one of the most effective methods.

Significance of Sterilization:

Till now we were talking about family planning in general. Now let us see the place of sterilization in the national family planning programme. It is said that we have accepted a cafeteria approach in family planning. But in reality we do not have varieties of methods available so that the eligible couple could choose any one of them e.g., a newly married couple has a choice of Nirodh only as IUD (loop) is not advised for nullipara eligible couples and oral pills are still not given to all eligible couples. Even for couples having 1 or 2 children, only two methods viz., Nirodh and IUD are available. Similarly after two or more children, the only terminal method available is sterilization. If it is accepted by husband, vasectomy operation is available and if by wife, tubectomy operation is available. Thus, there is hardly any choice even for those accepting permanent (one time) method of family planning.
Spacing methods, like Nirodh and Oral Pills need to be used every time. Considering the low socio-economic and educational levels of Indian people, these methods have become popular in our country which is contrary in case of the countries like Japan (for Nirodh) and U.S.A. (for Oral Pills). These methods also required sustained motivation as the couples have to use them regularly without taking any chance. Due to high illiteracy, poverty, rampant ignorance and social and religious values among the majority of the couples, we find several socio-cultural barriers for accepting family planning especially spacing methods. It is therefore, a most difficult task to create strong motivation on a sustained basis for the use of the specific spacing methods. IUD (loop) was thought to be an answer but it has also several side effects and women by and large have not accepted it on a mass scale. It is also not an ideal method. Therefore, sterilization has a special significance in family planning programmes.

Sterilization operation requires only a one-time action and in comparison to other spacing methods it is more effective, especially among the majority of our people with low socio-economic standards. There are two types of sterilization: male
sterilization which is called vasectomy and female sterilization which is called tubectomy. As seen earlier vasectomy is simpler, easier, economical and more convenient to perform on a mass scale than tubectomy which is a major operation and requires hospitalisation for a week. It take only five minutes to perform vasectomy operation and no hospitalisation is necessary. It is a minor operation and is known in local language as 'NASTAR' (a small incision).

Though vasectomy is very simple, effective and easy, it was not popular in most parts of the country in the initial period due to prevalence of several misgivings and misconceptions about vasectomy. The attitude of the people towards vasectomy was also not favourable due to ignorance and some sociological reasons. Male is the dominating and earning member in the family while female is given very low social status especially in the traditional society of rural India. Thus, tubectomy was more popular even though it is a major operation. Moreover, as women are the sufferers in having more deliveries and children, it is easier to motivate females rather than males for sterilization.

After discussing special significance of Family Planning Programme, now let us have an overview of sterilization programme.
Sterilizations, for males and females, are being performed in India since the beginning of the birth control movement in the 1930s. During the later 1950s, sterilization gained increased official support. Madras and Maharashtra were the two States who had taken leadership in family planning in general and sterilization in particular. Madras State offered special incentives to its employees in the form of special leave with pay for about a week and cash grant to cover transport charges and other incidental expenses in May 1958 (Gopalswami, 1959:53). Thus, Government of Madras was pioneer in adopting the "INCENTIVE APPROACH" in 1958 while Maharashtra Government in 1960, organised sterilization camps by mobilizing all available resources of the area in order to achieve higher targets and had pioneered the "CAMP APPROACH" (Govt. of India Report, 1960:181). Thus, Maharashtra became champion in sterilization by contributing as many as one third of the total sterilizations performed in India in 1960 through successful organisation of mass sterilization (vasectomy) camps.

Later on, both these approaches were endorsed with caution (to maintain quality) by Government of India and adopted by other States for achieving higher
targets of sterilization, especially Vasectomy operations.

Government of India emphasized that acceptance of vasectomy or tubectomy operations by the eligible males or females should be voluntary and it was necessary to take the consent of both husband and wife. Moreover, in the initial stages, Central Family Planning Board insisted that sterilization operations should be performed only by the trained surgeons in hospitals and institutions where such facilities exist and not in family planning clinics (Govt. of India Report, 1959).

Later on, the condition of taking consent of the spouse, before accepting sterilization, was removed. Even at present a woman can undergo tubectomy operation without the consent of the husband. This shows that the family planning programme has given equal status to woman and has accepted her right to decide whether she should undergo tubectomy or not. Indian women have also been given the right to decide whether or not she should continue her pregnancy or terminate i.e., abortion. Thus, even for abortion, she is not required to take consent of the husband. This can be considered as one of the several steps being taken for establishing equality of sexes in India.
As seen earlier the percentage of tubectomy operations has remained higher than that of vasectomy operations in the initial period of 4 years from 1956 to 1959. Then since 1960 the percentage of vasectomy operations have remained much higher than that of tubectomy except during the two years of 1973-74 and 1974-75 (57.2 and 54.8 per cent tubectomies to total sterilization) when the performance of vasectomy was very low, which can be attributed to the withdrawal of higher incentives and the campaign approach.

It is most interesting to observe that the sterilization programme got real momentum from 1967-68 onwards. It is noteworthy that when nation-wide sterilization (mainly vasectomy) campaign approach (mostly with higher incentives) was adopted, the achievement in sterilization was spectacular. As for example, the sterilization performance in the year 1972-73 was 3.12 million (due to this approach) against the a performance of only 0.94 million during the year 1973-74. The low performance during 1973-74 is due to absence of camp cum-incentive approach (as the Govt. of India decided in beginning of 1973-74 not to give incentive and organise massive camps).
Remarkable Achievement:

Although sterilization programme was well established in the early 1960s, it got momentum and achieved rapid progress only after 1966-67. During first decade i.e., from (10 years and 3 months to be exact) 1956 to 1967, roughly 1.67 million sterilizations were performed while in the next decade i.e., from April 1967 to March 1977, roughly 25.23 million sterilizations were performed, which is about 15 times (1400 per cent) more than that of during the previous decade (1956 to 1967). Among all Nations of the World, India's performance of about 27 million sterilizations (Govt. of India Report, 1977) is not only the highest but a landmark in the field of Family Planning.

Annual Variation in Performance:

It was beyond the imagination for anyone to think before 2 decades (when sterilization was included in the family planning programme in 1956) that the number of sterilizations would increase from about 7000 in that year to more than eight million during 1976-77 and that the total sterilizations performed upto March 1977 would reach upto 27 million sterilizations. The year wise performance in sterilization as well as the ratio of male to female sterilizations have been given in the enclosed in Appendix 6. The
increase in number of sterilizations as well as ratio of male to female sterilizations, was generally gradual with a few exceptions, as can be seen from the table.

It is interesting to observe that out of nearly 10 million sterilizations performed during 1956-71, more than 9 million sterilizations were performed during 1965-71 while less than 1 million sterilization were performed during 1956-64 which shows the noteworthy increase in the number of sterilizations in the later period. This upward trend continued during the current decade and reached the peak of about 8 million sterilizations during the year 1976-77.

The sterilization performance in 1971-72 and 1972-73 and again in 1975-76 and 1976-77 has shown a sharp rise due to the tremendous response to vasectomy camps wherein higher incentives were offered to vasectomy acceptors. The experiences of Ernakulam and Gujarat indicate the magnitude of achievement when a well organised state-wide massive vasectomy campaign is organised. The yearly sterilization performance of Gujarat State during 1966 to 1971 ranged from 39,776 to 100,557. The number of vasectomy operations performed in Gujarat in a short period of 2 months in 1971-72 was 221,933 vasectomies (230,449 total sterilizations) due to a massive vasectomy campaign (Thakor & Patel, '72:187).
The sharp and sudden decline in the number of sterilizations during 1973-74 is mainly due to discontinuation of big vasectomy camps and non-payment of higher than normal incentives to the acceptors of the sterilizations and also because of the drastic cut in family planning grants.

It also reveals that the percentage of male sterilization (vasectomy operations) has gradually increased after 1957 until 1967-68 when it reached a peak of 89.6. Whenever, there is better annual performance in comparison to the previous years, it is generally a larger number of male sterilizations rather than the female sterilizations. Because vasectomy operation is easier, less expensive with minimum operative risk, in comparison to tubectomy (female sterilization), it is possible to achieve dramatic results by performing vasectomies on a mass scale.

During the period of January, 1956 to March, 1976, it is interesting to observe that there is remarkable variation among the States in percentage of male sterilizations ranging from 89 per cent for Orissa to 54.1 per cent for Karnataka (Year Book, Govt. of India, 1975-76).
Variations By States:

Since the States of our Country vary considerably in population size and in terms of diversity in language, culture, socio-economic and demographic characteristics, there is bound to be major variation among the States in family planning performance. The analysis of the variations has been based on the percentages of couples in the reproductive age (Wife's age between 15 and 44 years) protected through different family planning methods in addition to the absolute number of persons accepting any specific family planning method. This can be very well seen from the data given below.

It is interesting to note that 18.8 percent couples, in the reproductive age group, are protected upto 31st March, 1976 by different family planning methods viz., 14.0 percent by sterilization, 1.5 per cent by IUD insertions and 3.2 per cent by conventional contraceptives (such as condoms, oral pills). The highest percentage of couples protected by sterilizations upto March, 1976 are in the States of Maharashtra (28.0), Kerala (21.7), Tamil Nadu (20.6) and Gujarat (20.0) while the lowest percentage of couples protected by sterilization upto March, 1976 are in the States of Meghalaya (0.3) and Arunachal
Similarly in case of IUD and CC users, the State with highest percentage of couples protected is Haryana (7.5 per cent by IUD and 12.9 per cent by conventional contraceptives).

Variations in Sterilization by States:

The State-wise cumulative performance of sterilization per 1000 population in India upto March 31st, 1975, varies from 0.6 in Nagaland to 51.8 in Maharashtra. It is noteworthy that the cumulative rate shows wide variation among most of the States. (Govt. of India, Year Book, 1974-75: 63)

A study done by the World Bank to identify the factors responsible for explaining the variation among the States, using regression analysis, shows that on the whole, programme input variables explain a higher proportion of the variation in programme output (1971-72) than socio-economic variables. Two inputs, namely, locally run urban service points and rural field workers, explain about 90 per cent of the variation in acceptor rates. (Bhatnagar, 1964: 1-14).

Number of Living Children:

The number of living children (Bhatnagar, 1964: 8) at the time of sterilization is an important factor while deciding the acceptance of sterilization. It is
one of the most commonly recorded characteristics of sterilised persons. In 17 selected studies (Chakravarty, 1966: 418-422) with a sample size of over 200 sterilized males, the mean number of living children was found to range from 3.5 to 5.4. With the exception of four (Chaset, 1962: 512-517) of these studies, more than 70 per cent of the males sterilized had four or more children.

The mean of living children for sterilized females ranged from 4.4 to 5.4 in seven selected studies (Chitre, Suxena and Rangnathan, 1964: 36-49) with a sample size of over 100 females. With the exception of one study, (Coyaji, 1964: 485-493) more than 70 per cent of the women in the remaining six studies had four or more children.

A number of Indian States seem to have adopted standards regarding the number of living children required before sterilization is permitted (Dandekar, 1959: 220-232). The actual data shows that the standards were not strictly maintained. For example 2.5 per cent of a sample of 1,581 males sterilized in Cannanore District of Kerala, had no living children (Dandekar, 1963: 147-154).

There are studies to show that fewer couples with no living son volunteered for sterilization than
couples with no living daughter. Among a sample of 3,465 vasectomised men, there were only four men with no son, but 287 with no daughter (Dandekar, 1963: 212-224).

A sample study done in Gujarat in 1973-74 with a sample size of 1,019 vasectomies and revealed that the mean number of living children to vasectomy and tubectomy acceptors was 3.9 and 4.2 respectively. (Shah and Khatri, 1975: 4).

Thus, it seems that the average living children per sterilization is comparatively lower in Gujarat than that of other States. This may be due to higher no. of couples protected by sterilization in Gujarat and comparatively better qualitative work which may be attributed to the intensive family planning education and motivation programme of the State.

If the sterilized persons have mostly 4 to 5 children, the family size (with husband and wife) will be consisting of 6 to 7 numbers which cannot be considered as a small family. This reveals that only number of sterilizations performed is not the answer to the problem. If the couples accept sterilization with lesser number of children (2 or 3), then it will have greater demographic effect. Thus, the quality of the performance is very important but so far, not achieved significantly.
In order to have a desired quality of the programme, education and motivation programme needs to be intensified. Greater the effectiveness of the education & motivation programme, greater number of couples (with 3 or less children) will come forward to accept family planning. The education process is very complex and there is no readymade formula to be followed for effective education. Therefore, there is a felt need to search and research for newer and better approaches of strategies in order to have effective education in the field of family planning communication.

For the World's largest demographic country like India, it is necessary to check the rapid population growth mainly by intensive educational and motivational efforts. This has created a felt need to search for strategies and approaches for effective family planning education and motivation. Despite the fact that Indian Family Planning Programme has been operative for the last 20 years and, intensively at least from last 10 years, it has so far not been able to achieve the set goals.

Evaluation of National Family Planning Programme:

Evaluation of the programme can be done in terms of achievement of the objective of the programme.
Earlier when the national family planning programme was started the objective in 1962 as decided by Govt. of India was to reduce the birth rate from 42 to 25 within a period of 10 years. In between several committees and commissions were set up to evaluate the programme and they found that it was not possible to achieve the desired goal in a stipulated time limit and therefore, from time to time the objective of National Family Planning Programme was changed and the Government tried to make it more realistic by setting up more achievable objectives. Even the so-called realistic objective was not achieved in toto. Possibly this was due to several reasons, such as lack of active participation and commitment of the leaders, lack of intensive education, non-availability of any ideal method and the existence of more or less bureaucratic administration of the Government. No doubt strenuous efforts have been made by the Government and the people to reduce the birth rate rapidly but the objective to be achieved is really a difficult task especially for a developing country like India having high illiteracy rate and existence of rampant ignorance, misconceptions and deeply rooted socio-cultural and religious values.
In spite of unusual efforts made by Government of India for the success of family planning programme, we have really not been able to slow down the rate of population increase.

This makes us to rethink about our problem of Population Growth and the objective set up to solve the problem. If we agree that the ultimate real objective of family planning programme is to curt the growth rate and then evaluate the programme in light of this objective, we will find that the result is not very promising. On the contrary, results are very discouraging as the population growth rate has increased steadily over the years. Simultaneously, several problems like unemployment, inadequate housing and food, illiteracy, riots, violence, strikes etc. have also been on the increase for which one of the most important reasons is the enormous increase in population.

Ogle (1969:1) Ex. Family Planning Commissioner of Maharashtra State has very rightly observed that, "when even the educated people have not fully realised the gravity of the problem, it is not at all surprising that illiterate and ignorant sections of the population do not feel concerned about it." He has further observed:
"In short, the family planning programme started with a research oriented approach. In the Second Plan, it experimented with the clinical approach and had to subsequently resort to the extension oriented approach in the Third Plan. In the intervening period between the Third and Fourth Plan the programme has become target oriented and time-bound; but unless it becomes really community-oriented it would be rather difficult to achieve any spectacular results." (Ogle, 1969:IX). In the Fifth Plan period incentive approach was adopted and the performance was improved. During this plan intensive efforts were made to involve voluntary organisations, officials and non-official agencies.

For achieving a real success in family planning the present Government programme has to be made 'PEOPLE'S PROGRAMME'. Until all the eligible couples participate and accept the desired family planning method in time, it will be difficult to check the galloping growth rate. The danger of unmanageable population pressure is so much that we should try to bring down the growth rate to zero level. This will be difficult even if all eligible couples limit their families to 2 children. But from practical point of view, this is too high an ideal goal and most difficult to be achieved. This can also be
Table: 3.4  Number of births averted due to various methods of Family Planning in India since 1961.

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<td></td>
</tr>
<tr>
<td>1972-73</td>
<td>2.1423</td>
<td>0.4894</td>
<td>2.6317</td>
<td>12.6376</td>
<td></td>
</tr>
<tr>
<td>1973-74</td>
<td>2.7107</td>
<td>0.4796</td>
<td>3.1903</td>
<td>16.8279</td>
<td></td>
</tr>
<tr>
<td>1974-75</td>
<td>2.9629</td>
<td>0.4638</td>
<td>3.4267</td>
<td>20.2546</td>
<td></td>
</tr>
</tbody>
</table>

@ Provisional

seen from the megre impact of family planning programme in India in terms of number of births averted due to acceptance various family planning methods.

Impact of Family Planning Programme in India:

Since inception of the programme, upto March, 1975 about 20.58 million births have been averted due to acceptance of various family planning methods as seen from table 3.4. It is interesting to note that maximum births of 14.5 millions out of 20.58 were million (i.e. 70.45 per cent) were averted due to main terminal method of sterilization. As per the Government of India (Year Book, 1974-75:77) 18.8 per cent of couples in the reproductive age-group are currently protected by various family planning methods till the end of the year 1975-76. This means that inspite of launching National Family Planning Programme intensively since last 1½ decades, 81.2 per cent of the couples in the reproductive age group of the country (till March 1976) have not been brought under the fold of family planning. As observed by Potts (1972: 1-2), "There are enormous number of people now born who have not yet entered the fertile years, and whatever is done on a world scale these people are going to become parents, although birth rates may fall, the absolute
number of births taking place is going to go on increasing for a long time. India was the first Government in the World to acknowledge this need - it is thought that the efforts of those engaged in family planning may have prevented nine million births. So the net consequence of nearly 20 years commitment to family planning is that the country has been able to set its problems back by a mere nine months. What is even more alarming is that if India achieves its goal of trying to check the present population birth rate in a generation (which is a modest goal but one which is doubtful of being achieved), then, as a result of the imbalance in population which has already occurred, the country will still be growing by one million additional people every month in a generation's time."

As the performance of family planning has considerably improved in last 5 years, the births averted due to various methods have also increased from 10 million in 1971-72 to over 20 million in 1974-75. Eventhough, the net consequences of family planning programme is that while India has prevented 20 million births in 20 years i.e., on an average 1 million births per year have been prevented. The yearly net increase in population is 12 million. Thus, looking to the enormous increase in population (12 million) the number of birth prevented (on an
average 1 million per year) is very megre. Thus, the family planning programme has not made any significant headway in preventing the huge number of births taking place in the country. Thus, overall impact of the progress made is not very significant. This shows that the solution of this burning problem is not easy in the present circumstances.

After having an overview of Indian Family Planning Programme, now we shall have an overview of the family planning programme in Gujarat. Though family planning is a centrally sponsored scheme and almost cent per cent grant is available from Government of India, the responsibility for its implementation and achievement of targets has been given to the States.

Gujarat is known for its innovation, initiative and leadership in several fields such as industry, co-operation and family planning. As our present study is undertaken in Ahmedabad, Gujarat, it will be worthwhile to have an overview of the family planning programme in Gujarat.
Family Planning Programme in Gujarat:

Falling in line with the central directive, family planning programme was started in Gujarat State (part of the erstwhile Bombay State) in the latter part of the First Plan.

The early years were, however, of an exploratory nature and a beginning was made by setting up a few family planning centres in urban areas. The main stress was on distribution of conventional contraceptives to women. During the 2nd Plan Period, more urban centres were established and family planning workers were appointed at Primary Health Centres in rural areas. Nirodh (condoms) were made available in urban and rural areas. A small beginning was made in the sterilization programme through organisation of sterilization camp. An amount of Rs. 15/- was provided as compensation for loss of wages for males and for women undergoing sterilization, an amount of Rs. 25/- was provided.

Staffing Pattern:

The 1961 Census came as a real shock to the planners as India's population growth (2.1 per cent) was much higher than was anticipated. A serious thought was given to the organisational structure
at National, State, District and Block levels.
The high powered Committee, headed by Shri Makerjee, the then Union Health Secretary, made elaborate recommendations regarding staffing at various levels. These were accepted by the Central Government and the present staffing pattern with a big infrastructure came into existence during the latter part of the Third Plan.

In Gujarat, the State Family Planning Bureau is headed by a Deputy Director and assisted by an Assistant Director (Family Planning), as Assistant Director (Maternal and Child Health) and other State Officers. The Bureau has a demographic and evaluation wing as well as mass education and media wing.

Similarly, Family Planning Bureaux have been set up in all the districts (with proportionately lesser staff). 251 Rural Family Planning Centres have been established at the Primary Health Centres. The rural family planning centre has a staff of a Medical Officer (Class II), a Health Visitor, a Block Extension Educator, an Auxiliary Nurse-Midwife. Sub-centres have been established at the rate of 1 for 10,000 with a staff of one Auxiliary Nurse Midwife.
Building for the staff at the Main Centre and at the sub-centres are constructed.

In urban areas, family planning centres have been established by voluntary organisations and Local Bodies, who receive 100 per cent assistance by way of grants from Government. In Gujarat State, 151 urban family planning welfare centres have been established so far.

The urban and rural family planning centres, in addition to carrying out education and motivation work, supply conventional contraceptives and provide services for vasectomy operations and IUCD(loop) insertions.

Under the scheme for reservation of beds for female sterilizations, beds are reserved in hospitals for performing tubectomy operations. By March, 1976, total 683 beds have been reserved of which 336 beds have been reserved in Government Hospitals, 63 beds have been reserved in hospitals run by local bodies while 284 beds in hospitals run by voluntary organisations. The target prescribed by the Government under this scheme is 30 tubectomy operations per bed per year. With a view to provide prenatal, antenatal
and post-natal clinical guidance and services, post-partum programme has also been started in 5 Medical Colleges and selected hospitals of the State.

Progress Review of Family Planning in Gujarat:

The key to the provision of contraceptive services to about 51 lakh eligible couples in Gujarat is the Programme’s "cafeteria approach" providing a wide range of effective and approved methods for family planning. The various methods of family planning available at present range from sterilization and IUD to conventional contraceptives, such as condoms (Nirodh) and oral tablets.

Significance of Vasectomy Programme:

From a meagre 1261 sterilization operations in 1957, the number has shot upto 85,037 in 1967-68 and since then nearly one lakh sterilization operations were being carried out each year upto 1972-73. Since inception of the programme in 1957 upto March 1977 about 16 lakhs sterilization operations have been performed in Gujarat. Of the total sterilization operations up to March,1976 since inception 7.2 lakhs (or 56.5 per cent) were vasectomy, 5.59 lakhs or 43.5 per
cent were tubectomy operations as shown in Table 3.5. It is most interesting to see that whenever the percentage of tubectomy decreased & vasectomy increased considerably, the total number of sterilization operations showed very high increase. This can be clearly seen from the performance during the years 1971-72 and 1976-77. This means that spectacular success in sterilization can be achieved mainly by intensifying the vasectomy programme rather than tubectomy programme. Even at national level this phenomenon seems to be correct as can be seen evidently from the sterilization figures for the year 1976-77 wherein 6.9 million vasectomies and 1.2 million tubectomies were performed giving a total of about 8.1 million sterilizations against the target of 4.29 million sterilization for the year.

As seen earlier vasectomy operations is a popular method of family planning programme even in this country. Of course, impact of sterilization depends upon the number of living children of the acceptors. "In India, the prevalence of early child bearing, the infrequency of contraceptive practice, and declining infant and child mortality rate make it possible for a woman to have several living children at an early age. For this reason, the number of living children
Table: 3.5 Sex-wise break-up of sterilization: operations done in Gujarat, since 1957.

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Sterilization</th>
<th>% age of Tubectomy &amp; Vasectomy to total Tubectomy &amp; Vasectomy to total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Vasectomy</td>
<td>Tubeectomy</td>
</tr>
<tr>
<td>1957</td>
<td>146</td>
<td>1 115</td>
</tr>
<tr>
<td>1958</td>
<td>236</td>
<td>2 004</td>
</tr>
<tr>
<td>1959</td>
<td>385</td>
<td>3 250</td>
</tr>
<tr>
<td>1960</td>
<td>826</td>
<td>4 153</td>
</tr>
<tr>
<td>1961</td>
<td>4 107</td>
<td>6 857</td>
</tr>
<tr>
<td>1962</td>
<td>4 050</td>
<td>6 984</td>
</tr>
<tr>
<td>1963</td>
<td>7 125</td>
<td>9 311</td>
</tr>
<tr>
<td>1964</td>
<td>12 158</td>
<td>16 877</td>
</tr>
<tr>
<td>1965</td>
<td>8 788</td>
<td>14 060</td>
</tr>
<tr>
<td>Jan. to March</td>
<td>1 056</td>
<td>3 545</td>
</tr>
<tr>
<td>1966-67</td>
<td>17 535</td>
<td>22 241</td>
</tr>
<tr>
<td>1967-68</td>
<td>38 790</td>
<td>46 247</td>
</tr>
<tr>
<td>1968-69</td>
<td>50 823</td>
<td>49 736</td>
</tr>
<tr>
<td>1969-70</td>
<td>49 232</td>
<td>45 076</td>
</tr>
<tr>
<td>1970-71</td>
<td>44 104</td>
<td>50 433</td>
</tr>
<tr>
<td>1971-72</td>
<td>248 363</td>
<td>46 312</td>
</tr>
<tr>
<td>1972-73</td>
<td>55 499</td>
<td>41 224</td>
</tr>
<tr>
<td>1973-74</td>
<td>10 367</td>
<td>49 630</td>
</tr>
<tr>
<td>1974-75@</td>
<td>87 342</td>
<td>67 415</td>
</tr>
<tr>
<td>1975-76@</td>
<td>79 999</td>
<td>73 024</td>
</tr>
<tr>
<td>1976-77@</td>
<td>206 070</td>
<td>111 043</td>
</tr>
</tbody>
</table>

Cumulative since ince-927 001 | 670 537 1 597 538 | 42.0 | 58.0

a couple has at the time of the husband's vasectomy is an important measure of the potential effect of the vasectomy programme on fertility levels as the wife's age at the time of her husband's vasectomy.

The mean number of children ever born per acceptor was 5.9 and the mean number of surviving children 4.3. Among those acceptors (29 per cent) who had not experienced the death of a child, the mean number of children ever born was 4.4. Another study of vasectomy acceptors in rural areas throughout India also showed that the mean number of living children ranged between 4.0 and 4.6 (Saxena, 1971). These data suggest that a minimum of four living children was a pre-condition to accepting vasectomy in these rural areas (Saxena, 1971).

It is interesting to observe that out of 16.27 million sterilization performed up to March '75 in India majority of them 12.13 million i.e., about 75 per cent were vasectomies. Thus, for achieving tangible results in family planning, from the presently available family planning methods, vasectomy seems the answer.
A comparative review of performance in respect of sterilization operations during 1971-72 with the previous year 1970-71 performance showed an increase of 2,00,138 sterilizations during 1971-72. The average monthly sterilization operations during the year 1971-72 was 24,446 as against 7,878 during the corresponding period of the previous year 1970-71 showing an increase of 211.7 per cent. During the year 1976-77 the annual sterilization performance was 3.17 lakhs (over 2.1 lakhs vasectomies) which is more than double than the annual performance of over 1.5 lakhs sterilization during the years 1974-75 and even for the year 75-76. This spectacular success was possible due to the high performance of vasectomies during 1976-77 and same is the case for spectacular performance in 1971-72.

Campaign Approach Adopted by Gujarat:

The decision to hold a state-wide massive sterilization campaign was taken by the State Family Planning Bureau, Gujarat in September, 1971, following the spectacular success of the Kerala programme especially Ernakulam experience where 63,418 sterilizations (62,902 vasectomies and 516 tubectomies) were performed in July 1971 camp (Krishnakumar, 1972:181). However,
as opposed to the Kerala programme where the resources—both men and material—were concentrated in one district (Ernakulam), the Government of Gujarat adopted a largely decentralized approach in the hope that the latter method would pay higher dividends than the former more centralized approach. The Ernakulam camp was initially organized as a district-wide programme with a single main camp functioning at the district headquarters. However, because of higher incentives and state-wide publicity, over two-thirds of the acceptors came from outside the district. The Gujarat State officials were concerned with the possible dangers of a single district camp. Besides creating problems of transportation, the single district camp approach may affect the quality of services provided at the camp since doctors performing vasectomy operation on a massive scale may be over-worked. It may also increase the problems of follow-up because acceptors coming from outside the district cannot be given the same level of attention and may even be lost to follow-up when they return to their districts.

In view of these real dangers and taking the local situation into consideration, it was decided to
hold a state-wide campaign with each district holding three to ten main camps at central locations and several mini camps in far-flung areas. A detailed plan of operation was prepared by the State Family Planning Bureau in advance for organising such a campaign from 15th November to 31st December, 1971 with the active involvement of Panchayati Raj Institutions.

**Gujarat Campaign: A Landmark in Sterilization**

A achievement of about 2,23,000 vasectomies and 9,000 tubectomies in a period of 2 months in the Gujarat Campaign is remarkable by any standard and is an important landmark in the history of family planning especially sterilization. More than 1,000 decentralised vasectomy camps were organised throughout the State. Wider coverage of both area and population are possible through multiple camps. The campaign has help not only to popularize vasectomy operations, but also to promote group acceptance of small family norm (Thakor and Patel, 1972:192).

Key reasons for the grand success of this campaign were as follow:

1. Higher than usual incentive to the acceptors of vasectomy operations.
2. Active involvement and participation of 3 tier Panchayati Raj Institutions.
3. Role played by top officials and non-officials.
4. Advance planning.
5. Intensive mass communication and Extension Education before and during the campaign.
6. Efficient management of Vasectomy Camps, provision of proper services and after care.
7. Innovative and effective Awards.

After discussing the sterilization programme and camp approach adopted by Gujarat, now let us have a brief review of other methods and method wise total acceptors of family planning.

**IUD (Loop) Programme:**

Since inception of the IUCD programme in 1965 upto March, 1976, 2.58 lakhs IUDs have been inserted in Gujarat State, giving a cumulative rate of 8.6 per 1000 population. As has been observed throughout the country, after making a very good beginning in the first year of its start, IUD insertions showed a downward trend every year in Gujarat State also, reaching to the lowest figure of 8,835 insertions in the year 1971-72 but then gradually increased during
1973-74 (17,332), 1974-75 (23,155), 1975-76 (23,113) and 1976-77 (28,175).

Conventional Contraceptive Users:

Conventional contraceptives include spacing methods such as Nirodh, Diaphragm, Jelly. Anyhow, out of these, the only Nirodh is the widely used spacing method.

The use of conventional contraceptives in Gujarat has been considerably increased since the year 1969-70. The rate of conventional contraceptives was 6.7 per thousand population during 1976-77 as against only 2.3 per thousand population during the year 1969-70. The number of conventional contraceptives users during the year 1976-77 was 1.9 lakhs against 1.8 lakhs in the previous year 1975-76.

Total Acceptors:

We have seen the progress made in respect of three important family planning methods viz., sterilization, IUD and C.C. users. Taking into account of all these three methods, the total number of acceptors in Gujarat have been found increasing from year to year. As against 3.6 lakhs total acceptors during 1975-76, the total acceptors during 1976-77 have increased to 5.4 lakhs, thus, showing a percentage increase of 51.0
per cent over the previous year 1975-76.

Since inception upto March 1977, the total family planning acceptors under all the three methods are 20.84 lakhs. The total acceptors since inception upto March 1977 under sterilization, IUCD and conventional contraceptive users is given in Table 3.6.

Table 3.6 Total Acceptors by Family Planning Methods since inception upto 31st March, 1977, Gujarat.

<table>
<thead>
<tr>
<th>Family Planning Method</th>
<th>Total Acceptors in lakhs</th>
<th>% of total Acceptors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sterilization operations</td>
<td>15.98</td>
<td>76.6</td>
</tr>
<tr>
<td>IUCD insertions</td>
<td>2.87</td>
<td>13.8</td>
</tr>
<tr>
<td>Conventional contraceptive users, 1976-77</td>
<td>1.99</td>
<td>9.6</td>
</tr>
<tr>
<td>------------------------------</td>
<td>--------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Total</td>
<td>20.84</td>
<td>100.0</td>
</tr>
</tbody>
</table>


The table reveals that Gujarat has more than 76.0 per cent of the total acceptors under the sterilization programme since inception of the programme.
Medical Termination of Pregnancy (MTP) Programme:

The Medical Termination of Pregnancy (MTP) Act, 1971, has been implemented in Gujarat State from April, 1972. Under this Act, legalised termination of pregnancies have been allowed under certain conditions such as a danger to life, rape, failure of contraceptives, environmental reasons, mental and physical reasons etc. The following table 3.7 shows the progress of MTP programme from 1972-73 to 76-77.

Table: 3.7 Year-wise Number of MTP Institutions are Recognised and MTPs conducted.

<table>
<thead>
<tr>
<th>Sr. Year</th>
<th>No. of Recognised Institutions</th>
<th>No. of Functioning Institutions during the year</th>
<th>No. of Medical terminations of pregnancies conducted at the end of the year.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 1972-73</td>
<td>26</td>
<td>26</td>
<td>637</td>
</tr>
<tr>
<td>2. 1973-74</td>
<td>49</td>
<td>75</td>
<td>2 633</td>
</tr>
<tr>
<td>3. 1974-75</td>
<td>110</td>
<td>185</td>
<td>5 684</td>
</tr>
<tr>
<td>4. 1975-76</td>
<td>41</td>
<td>226</td>
<td>10 995</td>
</tr>
<tr>
<td>5. 1976-77</td>
<td>96</td>
<td>322</td>
<td>15 389</td>
</tr>
</tbody>
</table>

This shows that with increase in number of recognised institutions and the number of MTPs also
increases. During second year of implementation of the Act, MTPs reported were more than 3 times than that of the previous year, while, during the third year, MTPs reported were more than twice as compared to preceding year. During 1975-76 and 1976-77 the number of MTPs conducted are roughly doubled and tripled respectively than that of MTPs conducted during the year 1974-75.

Post Partum Programme:

The objective of the post partum programme is to maximise the extent of contraception among the target population in the community catered to by the institutions which attract large number of confinement cases. With this objective in mind, Government of India had started 8 post partum units during 1970-71 and 1971-72. 12 post partum units were further commissioned during the year 1975-76. Thus, there were 20 post partum units at the end of the year 1975-76 in Gujarat.

After reviewing the routine programmes, now let us discuss the new scheme on multipurpose workers. The objective of the scheme is to cover hitherto uncovered non-privileged rural population for providing health care. As decided by Government
of India. The scheme is going to be introduced throughout the country in near future.

**Multipurpose Workers Scheme:**

Since inception of the health programme, various category of workers viz., vaccinator, malaria worker, family planning worker, MCH worker etc., were working for different health programmes. They were recruited for carrying out their respective jobs in the given areas. Many times, the same population was covered by different categories of workers.

Later on, it was proposed to have single multipurpose worker for all health programmes in a compact area with reduced population of about 5 to 7 thousand. The scheme was introduced in one or two Talukas of each district of Gujarat on an experimental basis in the end of the year 1973 and continued in subsequent years. Gujarat State is pioneer in the country in implementing the MPW scheme in whole of the State from the beginning of the current year 1977-78. Now, family planning is one of the functions of all multipurpose workers and there is no separate category of family planning workers as per this new scheme. If not specially emphasized they are likely
to neglect the difficult job of motivating couples to accept family planning method. In that case, the family planning performance may go down.

**Impact of Family Planning in Gujarat:**

In Gujarat, 1.45 million births have been prevented due to various methods of family planning from 1961 to 1975-76. The figure of annual births prevented due to family planning in Gujarat has gradually increased from about 112,000 in 1970-71 to 204,000 in 1974-75 and 216,000 in 1975-76 (State F.P. Bureau Report, 1976-77). Maximum number of births were averted by high acceptance of sterilization. About 24.7 per cent of the couples are currently protected in Gujarat as compared to 18.8 per cent in India up to March 1976. Any how, in view of the very high growth rate of Gujarat, much better performance is desired for solving the problem.

**Economics of Slowing Population Growth:**

According to Government of India during 1971-72, an average expenditure per equivalent sterilization comes to Rs. 205. As per the research study done by Simmon (1971) one sterilization prevents 2.32 birth and prevention of one birth saves Rs. 2750/- for
the Government. In other words Government spends about Rs.2750/- on a child. Prevention of birth for a family means less responsibility of 1 additional child. On an average the middle class family spends about Rs.5000/- to 15000/- for rearing and bearing the child, educating the child and for fulfilling other personal and social requirements including marriage (State family planning Bureau, Gujarat's unpublished Report, 1970-71).

The achievement of economic gains by preventing births is unimaginable and therefore, in a poor country like India in particular, we should spend many times more on family planning. The programme has so far not demonstrated any significant impact on reduction of the spiraling rising population growth in India. This problem is common for more than 30 developing countries of the World.

"The problem lies partly in the low level of commitment of resources. No country in the World spends even a fraction of one per cent of its Gross Net Population [GNP] on fertility control, yet most spend five to ten per cent of GNP on economic development. Diverting even a small portion of these traditional development expenditures to family planning could significantly reduce fertility and promote economic development as well."
To prevent currently unwanted births, which is the expressed goal of most family planning programs, no more than ten per cent of the total population need be directly involved. With existing contraceptive technology, it should not, in principle, cost more than around Dollar 5/- per acceptor per year to service this fraction of the population. In per capita terms for the nation as a whole, the cost would be about 50 Cents and far less than the roughly Dollar 10/- per capita that most nations now spend on economic development." (Holmes, 1971:41).

Need for Research Studies:

Thus, there is a great need for more investment on family planning as it is fully justified and as a result it will be helpful in raising per capita income and in solving so many burning problems of the nation which otherwise will need many times higher budget in future than the budget really required for population control.

Research studies on biomedical, demographic, communication, social and operation aspects of family planning have been undertaken since inception of the programme and based on their findings efforts have
been made to influence population policy and strategies of programmes.

**Purpose and Need:**

Today, the family planning programme is at a juncture where services for family planning could be made available to millions, but the biggest problem is of motivation i.e., how to prepare or motivate millions of eligible couples for accepting family planning methods. In order to motivate people for family planning mainly three methods are employed viz., Individual approach, group approach and mass approach. In the individual approach, emphasis is placed on motivating people by person to person contact. This approach has been followed since the inception of the programme while mass approach was introduced at a later stage. In mass approach we may include several activities such as mass communication, distribution of Nirod, organisation of vasectomy camps and celebration of family planning week/fortnights/months. In group approach an effort is made to educate and motivate the members of existing or formulated groups by an informal communication through discussions on family planning.
It is felt that an understanding of the group dynamics will enhance the effectiveness of group approach, which by and large has so far remained very limited in the field of family planning education and motivation. Therefore, the researcher has tried to study the effectiveness of this approach in the following chapters.